

New Jersey

UNIFORM APPLICATION

FY 2026/2027 Combined MHBGSUPTRS BG
Application Behavioral Health Assessment and Plan
SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 05/28/2025 - Expires 01/31/2028
(generated on 08/12/2026 11.32.44 AM)

Center for Substance Abuse Prevention
Division of Primary Prevention

Center for Substance Abuse Treatment
Division of State and Community Systems (DSCS)

and

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

State Information

State Information

Plan Year

Start Year 2026
End Year 2027

State SUPTRS BG Unique Entity Identification

Unique Entity ID MLGMLZ76EMC3

I. State Agency to be the SUPTRS BG Grantee for the Block Grant

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

II. Contact Person for the SUPTRS BG Grantee of the Block Grant

First Name Valerie
Last Name Mielke
Agency Name New Jersey Department of Human Services, Division of Mental Health and Addiction Services
Mailing Address PO Box 362
City Trenton
Zip Code 08625-0362
Telephone (609) 438-4330
Fax (609) 341-2302
Email Address Valerie.Mielke@dhs.nj.gov

State CMHS Unique Entity Identification

Unique Entity ID MLGMLZ76EMC3

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

Agency Name New Jersey Division of Mental Health and Addiction Services
Organizational Unit Office of Planning, Research, Evaluation, Prevention and Olmstead
Mailing Address 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 Department of Human Services, Division of Mental Health and Addiction Services
Mailing Address PO Box 362
City Trenton
Zip Code 08625-0362
Telephone (609) 438-4330
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 8/29/2025 9:30:59 PM

Revision Date 3/30/2026 9:15:26 AM

VI. Contact Person Responsible for Application Submission

First Name Renee
Last Name Burawski
Telephone (609) 438-4330
Fax (609) 341-2302
Email Address Renee.Burawski@dhs.nj.gov

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

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

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

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

State Information

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

Fiscal Year 2026

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
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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 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs.

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or

attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

State: _____

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

Signature of CEO or Designee¹: _____

Title: Deputy Commissioner of Health Services

Date Signed:

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

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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.).
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16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

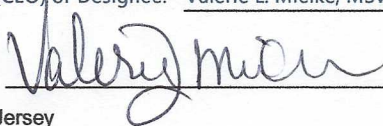
The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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 Designee¹: 

Printed: 8/12/2025 10:31 AM - New Jersey

Page 6 of 7

Title: Deputy Commissioner of Health Services

Date Signed: 08/15/2025
mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:



State of New Jersey

OFFICE OF THE GOVERNOR

P.O. Box 001

TRENTON, NJ 08625-0001

PHILIP D. MURPHY
Governor

November 7, 2025

Arthur Kleinschmidt, Ph.D., MBA, LPC, LAC
Principal Deputy Assistant Secretary
Office of the Assistant Secretary for Mental Health and Substance Use
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville, MD 20857

Dear Dr. Kleinschmidt:

As the Governor of the State of New Jersey, for the duration of my tenure, I delegate signatory authority to the Deputy Commissioner for Health Services overseeing 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's (SAMHSA) Substance Use Prevention, Treatment and Recovery Services Block Grant (SUPTRS BG), Community Mental Health Services Block Grant (MHBG) and Projects for Assistance in Transition from Homelessness (PATH) grant.

Sincerely,


Philip D. Murphy
Governor

c: Sarah Adelman, Commissioner, DHS
Valerie L. Mielke, Deputy Commissioner for Health Services, DHS
Renee C. Burawski, Assistant Commissioner, DHS DMHAS

State Information

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

Fiscal Year 2026

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

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

Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
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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;
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 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;
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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 Designee¹: _____

Title: Deputy Commissioner of Health Services

Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

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

Fiscal Year 2026

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

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

Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

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

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

3. Certifications Regarding Lobbying

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

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

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
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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.

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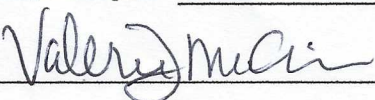
The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or 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 Designee¹: 

Title: Deputy Commissioner of Health Services

Date Signed: 08/15/2025
mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:



State of New Jersey

OFFICE OF THE GOVERNOR

P.O. Box 001

TRENTON, NJ 08625-0001

PHILIP D. MURPHY
Governor

August 23, 2024

Miriam E. Delphin-Rittmon, Ph.D.
Assistant Secretary for Mental Health and Substance Use
Office of the Assistant Secretary for Mental Health and Substance Use
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville, MD 20857

Dear Dr. Delphin-Rittmon:

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

Sincerely,


Philip D. Murphy
Governor

c: Sarah Adelman, Commissioner, DHS
Valerie L. Mielke, Deputy Commissioner of Health Services, DHS
Renee C. Burawski, Assistant Commissioner, DHS DMHAS

**New Jersey Division of Mental Health and Addiction Services
Mental Health Block Grant Supplemental Funding
Bipartisan Safer Communities Act (BSCA)
Narrative and Budget Allotment #4
Performance and Budget Period IV: 9/30/2025 - 9/29/2027**

Set Aside Funds

Coordinated Specialty Care Community Integration

The 10% ESMI/FEP set aside funds will be leveraged with the MHBG 10% set aside to fund Coordinated Specialty Care (CSC) Community Integration services (CI), evidence-based practices for serving the ESMI population. There were five teams awarded CSC CI programs to increase access to services across the State, serving 18 of the 21 counties in New Jersey. The CSC CI programs serve individuals with first-episode psychosis and affective psychosis. Individuals ages 15-35 are eligible for the CSC program that have an early serious mental illness for less than or equal to 2 years at the time of admission to the CSC program. The CI, step-down program, is designed to meet the need of the increasing number of individuals with early psychosis in need of a transitional support program post-CSC intensive treatment. Once admitted to the CSC, individuals can titrate up or down in the units of service and frequency of visits as needed and can remain in the CI program as long as clinically indicated. The transition between levels of care will be virtually seamless for the individual as the treatment team will remain the same for the continuity of services. CSC-CI will serve the population through a comprehensive service model that includes the use of individual therapy, psychotropic medication, group psychotherapy, multi-family group therapy, peer support, and supported employment and education services.

Crisis Receiving Stabilization Centers

The 5% Crisis Services set aside funds will be leveraged with the MHBG 5% set aside and additional BSCA funds as indicated in the budget below to fund the implementation of Crisis Receiving Stabilization Centers (CRSCs). NJ DMHAS has awarded five Crisis Receiving Stabilization Centers which will advance the development of the crisis continuum based on the National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit. CRSCs will provide an appropriate alternative to the use of local hospital emergency services and inpatient psychiatric hospitalization by providing crisis stabilization services and linkages to services and support. CRSCs will be open for referrals, walk-ins, and drop-offs by first responders 24 hours per day, 7 days per week, every day of the year for individuals 18 years of age and older with a primary SMI, SUD, or co-occurring disorder who are experiencing acute psychiatric symptoms that could interfere with community tenure. At a minimum, services will include access to trained staff who can provide intensive supports, including assessment, crisis stabilization, engagement, psychoeducation, identification of strengths, collaborative problem solving, and individualized crisis planning. Overall, the aim of this program is to decrease the utilization of local hospital emergency services and in-patient psychiatric hospitalization, while maintaining crisis stabilization treatment.

New Jersey's Department of Human Services houses the Division of Mental Health and Addiction Services (DMHAS). Located within DMHAS is a specialized behavioral health-focused unit referred to as the Disaster and Terrorism Branch (DTB), which is responsible for activating the State's behavioral health disaster response plan. The DMHAS partners with over 120 contracted community behavioral health agencies to provide services to those experiencing SMI and emerging behavioral health concerns. The DTB will use the Bipartisan Safer Communities Act (BSCA) funding to expand its existing behavioral health services continuum in the aftermath of traumatic events that impact the psychological health of those individuals living with SMI and SED. Outlined below are multiple initiatives that help support this work.

Learning Management System

With BSCA funds, DTB has secured a robust learning management system (LMS) to ensure consistency and quality of training and messaging. The target audiences for the LMS are Disaster Response Crisis Counselors, First Responders, and behavioral health providers who serve those with SMI and SED. Our Director of Training will create content to specifically speak to best practices for First Responders regarding individuals with SMI and SED. We are exploring a collaboration with 988, allowing their crisis workforce to utilize our LMS. The content focus would be crisis workforce wellness, prevention of burnout, and strategies to manage those seeking help for emerging mental health concerns or serious mental illness. This collaboration would better equip crisis staff to manage compassion fatigue, occupational stress, and the SMI population. Funds are designated for training content creation, platform usage, and technical assistance.

Critical Incident Stress Management

Critical Incident Stress Management (CISM) is a comprehensive multicomponent crisis intervention system. CISM interventions range from the pre-crisis phase through the acute crisis phase to the post-crisis phase. CISM teams have been an important part of the behavioral response for First Responders in New Jersey for the past two decades, but attrition has led the teams to fold or be chronically understaffed. DTB proposes continued coordination with a Statewide CISM team in New Jersey to increase training for law enforcement, fire, dispatchers, and EMS to rebuild the CISM Infrastructure. DTB will collaborate with the CISM Coordinator to host specialized training for First Responders related to the SMI and SED populations.

TLC SED Collaboration

The Traumatic Loss Coalition (TLC) is funded through the New Jersey Department of Children and Families (DCF); we plan to leverage this relationship to serve children experiencing SED in the custody of DCF. Preparing children and the staff they work with to cope with traumatic events. Specifically, TLC will partner with these providers to offer the "Managing Sudden Traumatic Loss" (MSTL) response model and other beneficial resources to serve this population.

BTAM Team Initiative

The NJ BTAM (Behavioral Threat Assessment and Management Team) is a centralized resource focused on the sharing of information and knowledge, and leveraging the support of law enforcement and behavioral health professionals for threat management. When law enforcement or a school identifies a community threat, the team convenes to provide consultation in reviewing individuals at risk for engaging in violence or other harmful activities and recommend intervention strategies to manage the risk. The team includes representatives from several agencies including law enforcement, intelligence, education, and behavioral health sectors. An unfortunate reality is that adults with SMI and children with SED can pose a significant risk to themselves and others if not treated and assisted. The team's goal is to avert incidents from occurring by creating diversion pathways for at-risk individuals into behavioral health programs. .

SMI Collaborations

DTB anticipates reaching the SMI population through organizations that can prepare and assist this vulnerable population in times of crisis. We plan to collaborate with the NJ Volunteers Active in Disaster (VOAD), NJ Community Organizations Active in Disaster (COAD), and similar organizations whose mission aligns with the BSCA grant. They seek to improve preparedness and support mental health resilience and recovery after traumatic events. The DTB will host regional training for behavioral health providers, obtaining nationally recognized subject matter experts on the SMI/SED population. Areas of training will be recognizing and addressing pathways to violence, responding to active shooters, Stop the Bleed training, and other relevant topics. By offering these trainings specifically to SMI/SED providers, DTB plans to expand its reach to this vulnerable population.

DTB will collaborate with NJ 211, which has a broad reach in the state and specializes in providing social service-related resources and information regularly, particularly during times of crisis. A key focus of this collaboration is the continued development of a strong relationship with NJ 211 and DTB's disaster response partners. NJ 211 will play an essential role in identifying available resources and assisting individuals with SMI and families of children with SED in locating additional community support during emergencies.

NJ EPA

DTB is expanding its partnership with the New Jersey Emergency Preparedness Association (NJEPA) to offer a Crisis Behavioral Health Training Series to be debuted at their annual conference in 2026. The annual conference averages over 1,500 participants statewide, consisting of Emergency Partners, Law Enforcement, and other First Responders. The NJEPA is a non-profit 501(c)3 organization, whose sole purpose and responsibility is to provide affordable emergency preparedness training to local, regional, and State Emergency Managers and First Responders. The NJEPA provides training, collaboration, and promotes the development of public and private partnerships in preparation, response, recovery, and mitigation in all types of emergencies and disasters. DTB plans to offer training to better equip emergency responders to consider and address the needs of those with behavioral health concerns as it relates to planning, response, and recovery. Topics include crisis intervention and de-escalation approaches for working with individuals with SMI, identifying and meeting the needs of those with substance abuse treatment needs, and preventing first responder suicide.

NJ EMS Taskforce: MH Resiliency Officers

Due to the difficult environments EMS personnel encounter every day, and the impact of both direct and vicarious trauma, NJ's EMS workforce is facing a challenge in maintaining their mental health resilience. As such, the role of Mental Health Resilience Officer (MHRO) was created by New Jersey's EMS Taskforce. A MHRO is responsible for engaging with peers to develop their understanding of mental health issues and resilience; recognizing peers who are experiencing mental health stressors and crises and navigating them to services for help; and supporting the development of a culture of mental health resilience and emotional wellness in their squad. DTB has the opportunity to expand the number of MHRO positions throughout the State. The goal of this collaboration is to train, educate, equip, and provide support to this population of First Responders.

BSCA Allotment 4 Budget

8/8/2025

Set Aside Funds	
ESMI/FEP 10%	\$185,433
Crisis Services 5%	\$92,716
Subtotal	\$278,149
Programmatic Initiatives & Contracts	
Multiple Sub-Awardees/Contracts/Programmatic Initiatives	\$820,000
Crisis Receiving Stabilization Centers	\$500,000
Subtotal	\$1,320,000
Supplies & Materials	
Deployment/Exercise Items/Printed Supplies/Materials	\$15,000
Subtotal	\$15,000
Personnel	
Part-time CISM Coordinator	\$28,000
Behavioral Threat Assessment & Management Staff Time	\$65,000
DTB Unit Staff Time	\$50,000
Subtotal	\$143,000
Training, Conferences & Travel	
SMI/SED/Mass Casualty/Behavioral Threat/Disaster Related	\$98,181
Subtotal	\$98,181
GRAND TOTAL	\$1,854,330

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: 05/28/2025 Expires: 01/31/2028

Footnotes:

This form is not applicable to the NJ Department of Human Services, 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 prevention system (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and SUD services. States should also include a description of regional, county, tribal, and local entities that provide mental health and SUD services or contribute resources that assist in providing these services. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

1. Please describe how the public mental health and substance use services system is currently organized at the state level, differentiating between child and adult systems.

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

1. 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 and one out of every three children. DHS serves older New Jerseyans, individuals and families with low incomes; people with developmental disabilities, or late-onset disabilities; people who are blind, visually impaired, deaf, hard of hearing, or deaf-blind; parents needing child care services, child support and/or healthcare for their children; people who are dealing with addiction and mental health issues; and families facing catastrophic medical expenses for their children. Through DHS' eight divisions, it provides numerous programs and services designed to give eligible individuals and families the help they need for economic and health challenges. They include health insurance through NJ FamilyCare or Medicaid, food assistance through NJ SNAP, independent living supports, personal care services, and much more.

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

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

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

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

2. Mental Health Services

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

New Jersey's has 21 counties and each 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 by the county's Designated Screening Center (DSC) in accordance with state regulation (NJAC10:31-5.3(a)). The SRC is comprised of representatives from the county's 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, a representative from the county Mental Health Board, community provider representation, Program for Assertive Community Treatment (PACT), Integrated Case Management Services (ICMS), family and consumer organizations, and a representative from the SMHA. The SRC is charged with the collection and review of service data as well as monitoring the provision of acute care services statewide. Each county has at least one Designated Screening Center with mobile outreach and 24-hour access. The county-based Designated Screening Centers generally determine who meets the commitment standard and requires inpatient treatment.

The community mental health system of services provides for eight levels of care: (1) prevention and early intervention; (2) crisis stabilization services <24 hours; (3) crisis stabilization and diversionary services > 24 hours; (4) acute care services; (5) peer recovery support; (6) family support; (7) treatment and rehabilitative services; (8) county and state psychiatric hospitals. The SMHA contracts for statewide, regional and county/local behavioral health services. Statewide contracted services include services for populations such as: Crisis Assessment Response & Enhanced Services (CARES) program which provides consultation and training to our hospital and community providers regarding individuals dually diagnosed with a mental illness and developmental disability; Statewide Clinical Outreach Program for the Elderly (S-COPE) which provides consultation and training to nursing facilities and DMHAS residential providers who serve older adults (55 years of age and older) who are at risk of psychiatric hospitalization; and ACCESS which provides community-based behavioral health 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 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 Training Centers to provide training and information to providers regarding co-occurring services for individuals with a mental illness and substance use disorder and housing with enhanced supports for individuals with co-occurring medical needs, development disorders, substance use disorders.

According to its 2023 URS Data Table 3, & 14a, the SMHA served 338,007 unduplicated adult (age 18+ years) persons receiving services SFY 2023. There was a total of 338,007 individuals served in all settings in SFY 2023. Of the total number of unduplicated adult persons receiving services in SFY 2023, there were 317,698 (93.99%) served in community settings; 1,701 (0.5%) were served in State Psychiatric Hospitals, 18,241 (5.39%) were served in other psychiatric inpatient settings, and 675 (.19%) were served in the institutions under the Justice System. Of the total number of unduplicated adults (338,007) served in all settings by the SMHA in SFY 2023, 120,126 (35.53%) were reported to have SMI.

According to its 2024 URS Data Table 3, & 14a, the SMHA served 83,334 unduplicated adult (age 18+ years) persons receiving services SFY 2024. There was a total of 83,334 individuals served in all settings in SFY 2024. Of the total number of unduplicated adult persons receiving services in SFY 2024, there were 77,396 (92.87%) served in community settings; 1,693 (2.03%) were served in State Psychiatric Hospitals, 3,059 (3.67%) were served in other psychiatric inpatient settings, and 255 (.03%) were served in the institutions under the Justice System. Of the total number of unduplicated adults (83,334) served in all settings by the SMHA in SFY 2024, 30,098 (36.11%) were reported to have SMI. Please note that the numbers from URS SFY24 Table 3 are unduplicated within the same row or service setting, but can be duplicated between rows, e.g., the same client may be served in both state psychiatric hospitals and community mental health centers during the same year and thus would be reported in both rows.

SFY24 has decreased numbers comparing with SFY23, because SFY24 URS tables were only based on the data entered in a newly developed web-based data platform which does not have the full data volume as of yet. DMHAS began transitioning to this new client level data system, the USTF+, to conform to SAMHSA reporting requirements for the Mental Health Block Grant (MHBG) as well as to move to a more secure web-based application. DMHAS has been providing trainings for providers on the USTF+ as well as implemented a newsletter to inform providers of any changes to the system on a regular basis as DMHAS strives to improve upon functionality and incorporate enhanced functionality. DMHAS has also implemented ongoing meetings with system administrators at the provider level to gather feedback and enhance compliance with reporting. Due to the transition from the USTF Legacy reporting system to the new web-based application, DMHAS has seen a decrease in reporting into the system as providers are trained. DMHAS has staff that are responding to help tickets in a timely manner to address client record-specific data entry issues. It should be noted however, that the Quarterly Contract Monitoring Report (QCMR) collects duplicated data across programs. In SFY 23, there was a total of 261,861 individuals served (of those served 242,279 were 18 and older) and in SFY 24,

there were 270,263 individuals served (of those served 251,501 were 18 and older).

Persons diagnosed with a SMI are the statutory population for SMHA funded services. However, the SMHA also provides services to other individuals including persons with first episode psychosis, individuals in need of crisis services, access needs, older adults, individuals with co-occurring mental health and substance use disorders, hearing impairment, and co-occurring developmental disability.

Many of the activities of the SMHA focus on inter-organizational coordination and collaboration to improve access for statutory 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 (administers WorkfirstNJ, TANF, General Assistance, SNAP, Child Care services), and Division of Medical Assistance and Health Services (Medicaid). In addition, there is coordination with the DCF's Children's System of Care (CSOC) and Division of Child Protection and Permanency (DCP&P), Department of Health, Attorney General's Office of Alternative and Community Responses, Department of Community Affairs (housing/homeless) and the New Jersey Housing and Mortgage Financing Agency (NJMHFA). There is also coordination with the Division of Vocational Rehabilitation Services (DVRS) within the Department of Labor and Workforce Development, the Department of Corrections, the Department of Military and Veterans Affairs (DMAVA), and the Department of Education (DOC) and interbranch coordination with the Administrative Office of the Courts (AOC).

The Five Criteria in State Mental Health Plan

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

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

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

1. Prevention and Early Intervention Services

A. Coordinated Specialty Care (CSC), Coordinated Specialty Care, Community Integration (CSC CI)

The SMHA has utilized the CMHBG 10% set-aside funds for providing services to individuals with first episode psychosis (FEP) since FY 2017. A Request for Proposal was issued in June 2016 for three agencies to provide Coordinated Specialty Care (CSC) services for individuals with FEP. Oaks Integrated Care, Rutgers University Behavioral Health Care (RUBHC), and Care Plus Inc NJ, became operational on November 1, 2016 and 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 three programs began with a caseload of 35 each and doubled in size, reaching their capacity. Each agency had been covering 7 counties which presented as a challenge for providers in covering the vast territory as well as for the individual's receiving services because of the time spent traveling to the provider agency. The programs had also been receiving referrals and calls for early psychosis or "Affective Psychosis." which did not meet the FEP criteria at that time.

In 2023, DMHAS utilized the Substance Abuse and Mental Health Services Administration's (SAMHSA) Community Mental Health Block Grant (CMHBG) Early Serious Mental Illness 10% Set-Aside, CMHBG COVID-19 Supplemental Funding, and CMHBG ARPA (American Rescue Plan Act) funding to implement a Community Integration Program (CSC CI) designed to address the need for additional coverage in the state and the CSC continuum of care. A Request for Proposal was issued in November 2023 for six agencies to provide Coordinated Specialty Care (CSC) for the population with Early Serious Mental Illness (ESMI) and a Community Integration Program designed to address the need for the ESMI population along the continuum of care. DMHAS expanded from three awarded programs to five awarded programs, which are currently funded and operational. The five programs are: Rutgers University Behavioral Health Care which serves the Central Sub-Region 2 (Middlesex, Somerset & Union) and Southern Sub-Region 1 (Burlington, Camden, Gloucester & Salem). Legacy Treatment Services serves the Southern Sub-Region 2 (Atlantic, Cape May & Cumberland) and Care Plus NJ, Inc. serves Northern Sub-Region 1 (Bergen, Passaic, Essex & Hudson) and Northern Sub-Region 2 (Morris, Sussex, Hunterdon & Warren). Each provider agency has implemented a CSC program and a Coordinated Specialty Care Community Integration (CSC CI) program. In addition to expanding from 3 programs to 5 programs and adding a step-down component, NJ enhanced staffing of the CSC CI model in order to provide for an enhanced caseload of 200 per team for a combined caseload for CSC and step-down (CI) in 2025 as well as future projected caseloads of 300 and 400. The CSC CI teams will

be able to provide services to individuals with FEP or with affective psychosis. Individuals with affective psychosis were contacting the CSC teams but previously could not be served due to the restrictions in the admission criteria. The CSC teams can now provide services to individuals with ESMI.

New Jersey's CSC programs utilize a coordinated team approach emphasizing the importance of addressing each individual's unique goals, needs, and preferences through shared decision making and collaborative treatment planning. Services will utilize the evidence-based practice methods including, but not limited to, person-centered therapy, cognitive behavioral therapy (CBT), peer wellness coaching, trauma-informed care, individual resiliency training (IRT), psychoeducation, and supported employment and education. Program staff shall provide community outreach services, evidence-based pharmacological treatment, supported employment and education services, individual and group psychotherapy, case management, family therapy and multifamily psychoeducation, peer recovery and 24-hour-accessible recovery support.

The CI program provides continued treatment for the client after the client has completed the CSC program. The CI program will use the "Stepped-Care" treatment model for clients with an ESMI diagnosis. The Stepped-Care treatment approach is a "3 tier" system where clients can titrate up or down the level of service modality depending on their recovery and/or the need for additional services and supports. Individuals in the CI program receive more or less intensive care and units of service in accordance with their assessed need and treatment plan. Individuals will continue to receive CI services from their current CSC treatment team in accordance with assessed level of need in order to preserve continuity of care. Once admitted to the CSC, individuals can titrate up or down in the units of service and frequency of visits as needed and can remain in the CI program as long as clinically indicated.

New Jersey's CSC programs serve individuals between 15-35 years of age with an ESMI diagnosis (psychosis must be of non-organic etiology) for less than or equal to 2 years at the time of admission to the CSC program with or without previously receiving treatment. Those served in the CSC-CI program are individuals 15 years of age and older with an ESMI diagnosis that is non-organic. In Fiscal year 2024, the combined CSC CI program had treated 244 individuals. The expansion of the CSC program to include Coordinated Specialty Care Community Integration, significantly increased service capacity. In Fiscal year 2025, the combined CSC CI program had treated 568 individuals. To support this expansion, clinical staffing has increased from 6.0 FTEs to 12.0 FTEs, enabling the State to better address the growing demand for Early Serious Mental Illness (ESMI) services, including both initial interventions and step-down support. A data evaluation staff assists in data collection and evaluation. The agencies are required to submit: Quarterly Contract Monitoring Reports (QCMR); Quarterly Programmatic Progress Reports, and Quarterly Report of Expenditures (ROE) reports that tracks federal fiscal spending for each agency. The data evaluation staff reviews quarterly data to monitor the progress of all clients, to evaluate the CSC CI programs, and also to address all federal data evaluation and reporting requirements.

The New Jersey CSC CI programs have implemented and collected data that include four diagnostic outcomes: Suicidality, Quality of Life, Social & Global Functioning, and Severity of Depression. Additional measures include: client data, medication monitoring, psychiatric hospitalization, discharge information, length of stay, re-admission dates, and substance use. Provider agencies employ 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 CI programs. MIRECC GAF is the primary assessment tool used to determine symptom progress in the CSC CI client base. Scores are collected on a quarterly basis and compared against previous quarter scores. The Colombia Suicide Severity Index is used at intake, after each hospitalization, and on a discretionary basis to assess client suicidality. These measures have also been used by other RAISE programs outside New Jersey and proven to be sound measures for symptom severity among the FEP population. Clinical Global Impressions Rating Scale is used to measure severity of illness, global improvement and therapeutic response. WHODAS (World Health Organization Disability Assessment Schedule) is used to measure disability and functional impairment. BPRS (Brief Psychiatric Rating scale) is used to gather information about the presence and severity of psychiatric symptoms. ACES (Adolescent Childhood Experiences Scale) is given at the time of initial clinical assessment and for a 6-month treatment update.

Since the inception of the program in 2017 through June 30, 2025, the NJ CSC and CSC CI programs have received over 3,466 referrals, served 2,557 individuals, and provided 304,404 units of service. In SFY 2025, the CSC CI programs began reporting client level data via the Unified Services Transaction Form Plus (USTF+). According to the data reported via USTF+, 448 individuals were served in the CSC CI programs. 372 of the 448 individuals were prescribed antipsychotic medication. 81% (302) of the 372 individuals were adherent to their medication regimen. The CSC CI module is new to the USTF+ and the providers were trained in SFY 2025 to report the data. It is noteworthy that data reported via the Quarterly Contract Monitoring Report (QCMR) reveals that 568 individuals were served in SFY 2025. DMHAS will continue to work with providers to have the USTF+ data reconcile with the QCMR aggregate data. In SFY 2024, New Jersey made 5 awards for its CSC CI program, 3 of these awards were new programs. All CSC CI providers have been received 3 half-day trainings from OnTrack NY. The overall decrease in the adherence rate is expected to improve as the new programs develop. NJ saw a low rate of adherence in 2017 when the initial programs first opened and then saw and improvement overtime. NJ data is reported for all individuals enrolled in the CSC CI programs regardless of length of stay. A review of literature for early psychosis medication adherence reveals the following for good adherence: 85% at 1 month [2]; 69% at 6 months [1]; and 59.3% at 12 months [2]. NJ will be looking at the possibility of capturing data at these points in time for comparison with benchmark data. Additionally, a study from Yesien et al [3], found adherence rates are to vary from 40% to 60% in individuals with first episode psychosis.

CSC and CSC CI have provided a stable system for individuals with early psychosis to interact in the community through gainful

employment, continuing education and return to school, and improved level of functioning for those who remain in care for a consistent period.

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

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

As a part of its work and effort to eradicate stigma, the Council posts training videos related to stigma awareness and messages of hope and recovery on its website. The council conducts outreach to schools, the media and other organizations. Community partnerships focus on collaboration with individuals to ensure that input, information and guidance in regarding messaging, and approach are accurate and appropriate. Staff from NJAMHAA coordinate the implementation of the Stigma Council activities. Outreach activity has been in the form of virtual webinars, conferences, in-person learning forms, and community events.

Communication with the Public through Correspondence and Phone Calls

One of the many functions of the Council is to keep the communication lines open with the stakeholders in New Jersey. This has been accomplished through a variety of avenues, including email correspondence and telephone conversations. Among the many ideas and subjects that have arisen through these interactions with stakeholders, several overarching themes have been prevalent. These include responses to inquiries as to how to get involved with the Council, including how to become a member of the Council; comments concerning Council work, efforts, and functions; general inquiries about the Council's goals and mission; requests to have information placed on the Council website; and even issues unrelated to the Council because the individuals did not know where else to turn. No matter what the communication may have been, someone from the Council promptly responded to each request with an acknowledgement of its receipt and guidance related to each request.

Stopping Stigma newsletter

FY2025: Third issue in October 2024; the May 2025 issued
FY2024: Launched in October 2023; second issue in May 2024

Each issue of this publication is sent electronically to 5,179 people, including state and federal legislators and policymakers; general and mental health trade associations; county mental health administrators; and 149 media outlets (print, radio and television; statewide, in the tri-state area and nationally; general and others specific to health/mental health). The newsletters are also announced via press releases, posted and highlighted on the Stigma Council website, and among the materials at events, where many individuals have expressed interest in them.

Press Releases and Media Advisories

FY2025: 2
FY2024: 3

Each press release was sent to the 149 media outlets and posted on the Stigma Council website.

Stigma-Free Zone Learning Collaborative virtual sessions

FY2025: 414 attendees across two events
FY2024: 125 attendees across two events.

Additional In-person and Virtual Events

FY2025: An in-person event, Showcasing the New Jersey Governor's Council on Mental Health Stigma, was held on July 16, 2025. The DMHAS Assistant Commissioner received recognition as a State Champion in the fight against stigma.

FY2024: May 22, 2024, Addressing the Youth Mental Health Crisis: Fostering Understanding and Partnerships to Further Support the Younger Generations, virtual – 125 attendees; August 14, 2024, Engaging Vulnerable Youth and Young Adults, in person - 126 attendees

In FY 25, the Council hired a part time Outreach Coordinator. The Outreach Coordinator is responsible for educating the community on mental illness and ways to combat stigma related to it. The coordinator has brought a renewed energy to the Council and is working to engage stakeholders statewide on how to mobilize communities on mental health stigma related matters.

C. Suicide Prevention

Compared with the rest of the United States, New Jersey has low rates of deaths by suicide, consistently varying between lowest and second lowest in the nation (CDC, WISQARS). However, suicide rates in NJ are following national trends and have steadily risen over the years.

The last fully confirmed age adjusted rate was in 2022. New Jersey had an age-adjusted suicide rate of 7.65 deaths per 100,000 people (compared to 14.2 nationally). Known risk factors of suicide, which include mental illness, serious physical illness, chronic pain, alcohol and opioid use, gambling problems, loss, economic concerns, trauma, stress, and loneliness, and suicide risk was exacerbated by COVID-19. A CDC survey conducted in 2020 at the onset of the pandemic found that almost 11% of adults had seriously considered suicide in the last month and that the rates were significantly higher among respondents aged 18-24 years, certain ethnicities, unpaid caregivers for adults, and essential workers. We expect to see long term effects from the pandemic that will likely impact the rate of suicide attempts in the future.

There were 769 deaths by suicide in New Jersey in 2022 and 721 deaths in 2023 (not fully confirmed), making suicide the 15th leading cause of death that year. These represented a slight increase from 704 deaths by suicide in 2021. In New Jersey, the highest risk occurs between the ages of 55 and 59 years, when the rate of suicide was 13.1. The state ranks second nationally in rate of teenage suicide deaths, at 5.3 per 100,000. However, the rate of suicide deaths in age-group 15-24 had increased by 18% from 2020 to 2021. Firearms were the leading mechanism for suicide for men 55 and older and across all age-groups in 2021. Veterans and services members have high risk for suicide, and firearms are the major method of suicide in these populations. DMHAS has been working with the NJ Department of Military and Veterans Affairs (DMAVA) for the last few years on the SAMHSA Governors Challenge to Prevent Suicide in Service members, Veterans, and their Families, which is described in more detail below.

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

Suicide prevention will be addressed by the recent expansion of 988 and crisis services in N.J. In SFY25, the SMHA utilized approximately \$9.5 million from a combination of federal grant funds including the COVID Supplemental Act, ARPA, and the SAMHSA 988 State and Territory Improvement grant to contract with a marketing agency for a statewide high-profile public messaging campaign for 988. The SMHA now funds four (4) centers that together provide in-state response to calls, chats and texts through the 988 Suicide and Crisis Lifeline. The 988 Lifeline is a national hotline offering one-on-one support for mental health, suicide and substance-use related problems for anyone 24/7.

Together, the New Jersey 988 Lifeline centers respond to calls 24 hours a day, every day of the year from individuals who are seeking assistance or information for themselves, friends or relatives that may be at risk of suicide and in need of services. In Calendar Year 2024, NJ 988 Lifeline centers received a total of 84,406 calls, of which 67,503 answered in state (goal is for 90% answered in state). Geo-routing calls from the closest cell towers to the individual was recently added to give a general location of the caller. To further promote the Lifeline throughout New Jersey, the SMHA has translated and printed brochures in ten languages in N.J. for distribution.

The SMHA has been in the process of sunsetting the NJ Hopeline in order to further promote and expand the 988 Suicide and Crisis Lifeline in NJ. While the Hopeline number remains operational, marketing for the Hopeline has ended and callers are being encouraged to dial 988 instead.

In addition to the 988 Lifeline, NJ has several other helplines available for individuals in need:

Veterans and their families can call a crisis helpline at:

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

In 2019, the Medical Director's Office spear-headed the implementation of the state's suicide prevention initiatives. In 2025, the DMHAS reorganized suicide prevention efforts such that suicide prevention activities are shared between the DMHAS Medical Director's office and the office overseeing 988 and crisis continuum services overseen by the Division. These efforts are assisted by the Suicide Prevention Advisory Committee. The membership of the Committee consists mostly of DHS, DCF, and DOH employees, as well as members from the state universities and persons with lived experience. There are other DMHAS offices that contribute

to 988 and crisis continuum services as well as suicide prevention activities.

The Governor's Office annually issues proclamations declaring Suicide Prevention Month and/or a Suicide Prevention Week in September. Each year, the Committee has convened an annual Suicide Prevention Conference, which has been held for the last nine years (except for being cancelled in 2020 because of COVID). The conference has grown in attendance every year. More than 1,800 people registered for the 2024 conference. Attendees included people with lived experience, person receiving services, medical professionals, social workers and community social service providers, educators, community health providers, hospital-based providers, community agencies, administrators, state representatives, and executive leadership. DMHAS also provides other training on suicide prevention throughout the year, and this is aided by the Division's capability to provide CMEs (continuing medical education) for physicians to attend; CE's (continuing education) for other behavioral health disciplines are also being provided at the trainings through the Rutgers University Technical Assistance Center.

The state's major suicide prevention initiative is to implement the Zero Suicide approach statewide in NJ and consolidate suicide-related activities under the combined offices. The Zero Suicide approach is based in the belief that suicide deaths for individuals under care within health care systems are preventable. The Zero Suicide Institute under the Education Development Center (EDC) is recognized as the leading proponent and training entity of this model. DMHAS offered 3 virtual Zero Suicide Academies in with the EDC 2020, and additional ones in 2021-2024. In 2025, Rutgers University Behavioral Health Care provided the trainings on the Zero Suicide approach. This is a signature training for health and behavioral health organizations seeking to dramatically decreasesuicides among those in their care. Using the Zero Suicide framework, participants of the health care system learn how to incorporate best and promising practices into their organizations and processes to improve care and safety for individuals at risk under their care. Funding for this project was included in the DMHAS' budget for suicide prevention. In 2025, DMHAS began coordinating with DCF in promoting the Zero Suicide approach statewide.

DMHAS has participated in the Governor's Challenge to Prevent Suicide Among Service Members, Veterans and Their Families (SMVF), which is led by the New Jersey Department of Military and Veterans Affairs (DMAVA) in collaboration with the United States Department of Veterans Affairs (VA). The initiative has been working to develop and implement state-wide suicide prevention best practices for SMVF, using a public health approach. With the support of the governor, each state formed an interagency military and civilian team to develop a strategic action plan to advance the National Strategy for Preventing Veteran Suicide. Teams are encouraged to include suicide prevention coordinators representing the state public/behavioral health agency, VA, and National Guard. The NJ initiative has three priority area workgroups that are developing and carrying out a plan to ensure that veterans are identified, screened and assessed for suicide, risk factors and related needs, and that lethal means counselling and safe firearm storage education are provided to them.

In response to the fact that firearms are the most common means of suicide death and firearm access significantly increases the risk for suicide, DMHAS has partnered with the Rutgers University School of Public Health's Gun Violence Research Center (GVRC) to address suicide by firearm and to promote firearm safe storage and decreasedaccess. The GVRC has developed and presented in numerous webinars for DMHAS, and has initiated several projects that try to promote community awareness of lethal means safety and the risks of unsecured firearm access; the most recent GVRC initiative involves the training of clergy and of key community members, such as barbers and hairdressers, who can raise awareness and influence the public on the risks of unsecured firearms and suicide in the community. Other GVRC initiatives have involved training of healthcare providers on suicide and lethal means and the development of an online firearm storage map. In SFY26, the plan is to fund the Rutgers-GVRC to implement The Armory Project (TAP) approach in N.J. The TAP will facilitate safe, voluntary, out-of-home storage with vetted firearm dealers to help prevent suicide.

The goal is that this proven initiative will more effectively remove firearm access to veterans and other members of the public who are at risk of suicide. This allows for involuntary removal of firearms on a temporary basis during an episode of mental health crisis or other need, and it complements the state's availability of involuntary firearm removal through the police and judiciary by use of the states' Extreme Risk Protective Order (ERPO) law. DMHAS is actively working with the Office of the Attorney General to promote the ERPO alternative, which has been proven to save lives.

All community behavioral health programs contracted by the Department of Human Services (DHS) and/or licensed by the Department of Health (DOH) are required to report unusual incidents regarding individuals they serve, including self-injury and suicide. The DMHAS agencies report these incidents to the DHS Unusual Incident Reporting and Management System (UIRMS). DMHAS requires providers to intensely analyze each of these events to assess opportunities for improvement in their systems and processes. The reports of the providers are reviewed for patterns and trends among agencies. DMHAS regularly confers with the epidemiology office in DOH, which regularly receives and analyzes data from the Violent Death Reporting System (VDRS), which is a public health reporting system managed by the CDC that provides detailed and timely surveillance system of all violent fatalities DOH also receives NJ data from other systems that capture non-fatal suicide attempts of those receiving treatment through emergency room visits and inpatient hospitalizations. There are also pilot initiatives to develop county-level suicide fatality review teams that will examine complex factors that could have contributed to the suicide deaths of adult individuals. DCF has had a longstanding Child Fatality and Near Fatality Review Board that is independent of the department and that reviews child fatalities and near fatalities to identify their causes and the implications of these deaths to services that are being provided.

2. Crisis Stabilization Services < 24 hours

A. Call Centers

988 Implementation was funded by State Appropriations, the COVID Supplemental Plan and the American Rescue Plan Act (ARPA). New Jersey originally had five (5) call centers that provided services for the 988 Suicide and Crisis Lifeline. These centers received certification by Vibrant Emotional Health (Vibrant) for meeting the minimum clinical, operational and performance standards.

In April 2022, DMHAS was awarded approximately \$2.5 million from the SAMHSA 988 Capacity Building Grant to prepare Lifeline centers for the anticipated increase in call, chat, and text volume due to the transition to 988. As of September 2022, following the State's procurement process, funding from a combination of federal grants including the SAMHSA 988 Capacity Building Grant, Mental Health/Substance Abuse Block Grants and American Rescue Plan Act, totaling \$3.7 million was awarded to the five (5) NJ Lifeline centers.

In December 2022, NJ DMHAS was awarded an additional \$1 million through the SAMHSA 988 Capacity Building Supplemental Grant. Of this award, approximately \$340,000 was awarded to four (4) of the five (5) 988 Lifeline centers in New Jersey based on their existing contract amounts (one center declined additional funding).

With these original contracts, 988 Lifeline centers were able to expand their capacity to meet the growing demand. Comparing calendar year data from 2021 to 2023, NJ experienced a significant increase in call volume while increasing calls answered. From 2021 to 2023, call volume increased 36% and centers were able to respond to 38% more calls.

Original contracts from these funding opportunities were scheduled to end April 2024 in alignment with the project period of the SAMHSA 988 Capacity Building Grant. To maintain center funding and in turn, statewide 988 operations, NJ DMHAS applied for and received a No Cost Extension on these funds from SAMHSA and was able to extend contracts until September 2024.

In September 2023, NJ DMHAS was awarded the SAMHSA 988 State and Territory Improvement Grant. This grant provides NJ DMHAS with approximately \$12 million over the course of three (3) years (Sept 2023 – Sept 2026) for projects such as increasing the workforce to support the growing 988 demand and continuing both statewide and messaging about 988.

Additionally, funding of \$12.8 million was allocated in the State Fiscal Year 2023 (SFY23) budget toward the expansion of the 988 Lifeline network. In January 2023, using approximately \$1.9 million of these state appropriations, NJ DMHAS published a Request for Proposals (RFP) soliciting applications to establish a Managing Entity (ME) for the New Jersey 988 Suicide and Crisis Lifeline system. Carelon Behavioral Health was awarded this contract.

Among the NJ 988 ME's responsibilities are to:

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

NJ DMHAS prioritized the spending of \$10 million in state appropriations to enhance NJ 988 call, chat and text services. Using state appropriations, an RFP to award \$10 million in State funds was published in March 2024 with the goal of expanding 988 Lifeline center capacity sufficiently to answer 90% of state-based calls, chats and texts. In September 2024, approximately \$7 million from this State-funding opportunity was awarded to two (2) of the five (5) original 988 Lifeline centers. One (1) of the five (5) original centers decided to end their 988 Lifeline services on July 31, 2024. The other two (2) centers that did not receive awards remained committed to providing 988 Lifeline services but struggled to identify replacement funds to maintain their operations. NJ DMHAS, using a portion of SAMHSA grant funds, was able to provide contract extensions to these two (2) centers to continue these necessary services at their current levels.

In March 2025, with the remaining state funding and approximately \$1.3 million from the SAMHSA Improvement Grant, NJ DMHAS published a Request for Letters of Interest (RLI) to provide ongoing funding to these two (2) centers for the purposes of not only maintaining their current level of operations but expanding their services to contribute towards the goal of achieving a 90% in-state answer rate. Final awards were issued June 2025. The goal is to reach a minimum of 90% in-state answer rate with no more than 10% of calls being routed to the national backup system. Comparing data from CY 2023 to CY 2024, NJ saw a 36% increase in call volume while answering 36% more calls. Looking at Vibrant data from SFY24, NJ had a 78% in-state answer rate. In the first eight (8) months of SFY25, NJ increased its in-state answer rate to 82%. NJ 988 Lifeline centers continue to recruit and onboard staff to expand the capacity for responding to calls, chats and texts. Increased funding based on demand and the identification of additional ongoing funding streams are vital to reaching and maintaining this goal.

To establish a "no wrong door" philosophy for 988, NJ DMHAS has been working closely with multiple agencies in New Jersey's system of acute care and crisis response. Agencies include the Department of Children and Families' (DCF) Children's System of Care (CSOC)/PerformCare (serving children and adolescents), ReachNJ (substance use treatment resources and referrals), The Department of Human Services' Division of Developmental Disabilities (DDD), and NJ211. NJ DMHAS has established warm

transfers between 988 and these partner agencies. These transfers are used after an initial assessment determines staff on other call lines could be helpful to the individual in crisis.

NJ DMHAS has also been working closely with its partners within the 9-1-1 system to establish bi-directional warm transfer protocols and procedures between 9-1-1 and 988. Once these are in place, whether an individual calls 988 or 9-1-1, they will be connected to the most appropriate professional and level of care. This plan is consistent with the no wrong door approach and will allow emergency personnel (first responder, emergency medical services and fire fighters) to handle situations that need their skills, equipment and expertise. Predating 988, the Hopeline transferred calls to 911 as necessary. 988 continues to transfer calls directly to 911.

B. Mobile Crisis Outreach Response Teams (MCORTs)

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

MCORTs support individuals 18 or older by de-escalating crises, providing linkage to ongoing community services, and follow-up support. MCORTs collaborate with family members or loved ones to assist and support the individual in crisis when appropriate. The goals of the Mobile Crisis Outreach Response Team program are:

- Provide timely access to crisis intervention services;
- Stabilize the person receiving services within their community;
- Prevent hospitalization, re-hospitalization, and recidivism whenever it is safe to do so; and
- Deliver behavioral healthcare to all New Jersey residents.

MCORTs are dispatched by the NJ 988 Managing Entity, Carelon, after a 988 Lifeline Center determines a community-based response, without emergency responders, is necessary and appropriate. MCORT is a voluntary service and the individual must provide consent prior to dispatch.

For the MCORT program, the state has been divided into nine (9) Regions based on geography and population. This information was also used to determine the minimum number of teams to operate in each Region. One of the goals of the MCORT program is to provide an in-person response within one-hour of the initial dispatch.

In October 2023, NJ DMHAS published an RFP to award approximately \$16 million in state funds to up to nine (9) agencies establish a total of 62 MCORTs across the 21 NJ counties, based on the regional system identified above. Through this procurement process, four (4) agencies were awarded contracts to operate MCORTs in eight (8) of the nine (9) regions while Region 9 went unawarded. In May 2024, NJ DMHAS posted an additional RFP to establish an MCORT program in Region 9. The successful bidder was awarded a contract in September 2024.

On March 3, 2025, MCORT services were launched statewide with limited hours of operation. On August 11, 2025, MCORT services expanded to full 24/7 availability. From March 3rd through July 31st, MCORT completed 247 dispatches. In SFY 2025, there were 148 individuals served by MCORT and 197 units of service.

In December 2024, DMHAS received approval of its Medicaid State Plan Amendment (SPA) requesting for MCORT to be Medicaid-supported under Section 1947 of the U.S. Social Security Act. The SPA will provide an enhanced match for 3 years, then move to a standard 50% reimbursement through the federal medical assistance percentage (FMAP) for MCORT services.

C. Crisis Receiving Stabilization Centers

DMHAS has made awards to five provider agencies to develop crisis receiving stabilization centers (CRSCs) which will advance the development of the crisis continuum in NJ based on the National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit with utilizing funding from the mental health block grant 5% set aside, Covid Supplemental funding from the MHBG and SUPTRS grants and ARPA funding from the MHBG and SUPTRS grants. When this program is implemented and the centers are in operation, commencing late 2025 / early 2026, they will provide onsite crisis services for up to 24 hours to individuals 18 years of age and older with a mental illness, substance use disorder or co-occurring disorder and in need of immediate crisis intervention and stabilization for a behavioral health crisis.

CRSC offers a no-wrong-door access to crisis stabilization, operating much like a hospital emergency department (ED) that accepts all walk-ins, first responders drop offs, and fire department drop offs. The individuals served in the program will receive community-based treatment and supportive services 24 hours a day, 7 days a week, every day of the year, with the goal of mitigating the need to use the ED to access community-based services and preventing unnecessary or inappropriate hospitalization and provide short-term (less than 24 hour) community-based services to individuals experiencing a suicidal, mental

health or substance use crisis. Individuals will be available to walk-in for immediate crisis response services.

The objective is to develop an appropriate alternative to the use of local hospital emergency services and in-patient psychiatric hospitalization, by providing crisis services and placement support for those in need of permanent housing. The goal of these programs is to decrease the utilization of local hospital emergency services, designated screening centers, and in-patient psychiatric hospitalization while maintaining crisis stabilization treatment. The program will also result in cost savings through the decrease in avoidable ED visits, inpatient admissions, first responder engagement, and 911 calls.

These facilities include access to trained staff who can provide assessment, crisis stabilization, intensive supports, engagement, psychoeducation, identification of strengths, collaborative problem solving, and individualized crisis planning. Services will be offered in a safe, clean, community-based environment conducive to the recovery process. Medication management, administration, and education will also be offered. Medication-Assisted Treatment will also be available at the CRSCs. Clinical staff in the program will strive to stabilize individuals and address mental health needs. The program will offer continuity of care promoting continued stability and ensuring linkages are arranged that meet the needs of the individual.

3. Crisis Stabilization and Diversionary Services > 24 hours

A. Crisis Diversion Homes

Crisis Diversion Homes (CDHs) are funded by the ARPA plan. In order to bridge the gap between homelessness and permanent housing, DMHAS has awarded two crisis diversion homes with 5 beds, each home will be staffed 24 hours a day, every day of the year. This program will provide community-based stabilization in a home-like setting and is not long term or permanent housing. The length of stay for this program is dependent upon an individual's need and is anticipated to be up to 30 days. At a minimum, staffing will include licensed and credentialed clinicians, nursing staff, behavioral health technicians, and a prescriber. Although the crisis diversion homes are not permanent, individuals experiencing a recent psychiatric hospitalization or relapse will receive the support they need from professionally trained and dedicated staff to continue their recovery in the community in a home-like environment. The services and supports will be prioritized for individuals who are referred from Crisis Receiving Stabilization Centers (CRSCs) and from Mobile Crisis Outreach Response Teams (MCORTs).

This additional level of care in the crisis continuum will help decrease the number of individuals in local emergency departments and emergency screening, while also serving as a referral source for crisis receiving and stabilization facilities for individuals with complex behavioral health needs that require significant services and supports to avert hospitalization and successfully return to the community. Additionally, referrals may come from community inpatient programs as a step-down from short-term acute inpatient services providing the opportunity to further stabilize the client and connect the client with services and supports depending upon availability. The Crisis Diversion Homes will include linkages to peer supports, clinical services, and housing with a goal of community re-integration to permanent or long-term housing and supports for the person receiving services.

B. Crisis Diversion Beds

The DMHAS contracts with mental health providers to provide 14 crisis beds in three different homes. These are residential settings that are staffed 24 hours a day 7 days a week. The homes focus on providing a recovery oriented residential setting for individuals to help avoid a mental health crisis or hospitalization. The length of stay in these homes is designed to be short term, and typically less than 30 days. The homes focus on rehabilitative skill development, crisis planning, and individual recovery goals. Additionally, DMHAS contracts with a provider for a fourth home consisting of 5 beds to provide crisis housing and services for individuals that are dually diagnosed with a mental illness and a developmental disability.

C. Peer Respite Beds

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

D. 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 avert admissions to state hospitals. Individuals who do not stabilize and require continued inpatient treatment may be transferred to a state or county hospital at the conclusion of their approved length of stay in the contracted Diversion bed. The hospitals that contract for Diversion beds maintain additional bed capacity that is not governed by their DMHAS Diversion contract and serve a similar

population in this additional capacity.

DMHAS currently contracts for access of up to 52 beds at three private psychiatric facilities including Carrier, Hampton, and Northbrook that offer an alternative to state psychiatric hospitalization. Most contracts specify a cost per bed-day of \$745.08. The actual spending in calendar year CY 2024 was \$11,575,372.00. There were 809 admissions utilizing 19,850 bed days and 95% were diverted from a state hospitalization. In CY 2023 there were 707 admissions utilizing 17,250 bed days and \$9,192,839.30 and 94% were diverted from a state hospitalization.

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

A. Designated Screening Centers (DSC).

The SMHA funds 23 Designated Screening Centers (Screening and Screening Outreach) programs across the 21 Counties. The Screening and Screening Outreach Program is designed to provide psychiatric emergency services including screening, assessment, crisis intervention, referral, linkage, and crisis stabilization services, 24 hours per day, 365 days per year, in every geographic area in the state. According to the SMHA's Quarterly Contract Monitoring Report (QCMR) database of information self-reported by the screening programs, there were 71,175 episodes of care to these screening centers during SFY 2024 and 74,755 episodes of care in SFY 2025.

B. 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 2024, the state's 12 Affiliated Emergency Service Programs delivered 27,070 episodes of crisis care (3 Hudson, 1 Middlesex, 3 Monmouth, 2 Morris, 1 Passaic and 2 Union Counties) and received \$4.85 million in funding. There were 25,755 episodes of care delivered in SFY 2025.

C. 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 \$24.5 million and serve all 21 counties. In SFY24, there were 17,739 individuals served and 17,161 in SFY 2025.

D. Involuntary Outpatient Commitment (IOC).

DMHAS now funds eighteen Involuntary Outpatient Commitment (IOC) programs that serve all twenty-one New Jersey Counties. Annualized funding is \$6.5 million to support these programs, which have an aggregate statewide service capacity to serve 575 persons. During SFY 2024, a total of 1,080 persons were served in IOC, with an average active ongoing caseload of 420. There were 1,048 served in SFY 2025. 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.

E. Short Term Care Facilities (STCFs).

In order to meet the needs of individuals who require involuntary in-patient psychiatric services, the SMHA currently designates 410 Short Term Care Facility (STCF) beds. The SMHA has allocated \$24.6 million in subsidies for STCF beds. Each designated bed receives a \$60K per annum subsidy to support the enhanced staffing and programming required by the designation. There are currently 410 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 2024, the state's System Review Committee database indicates that the occupancy rate for STCF beds was 76%.

5. Peer Recovery Support

The Office of Office of Advocacy and Peer Services (formerly named the Office of Consumer Affairs) in the Medical Director's unit has a key role in ensuring that individuals with mental illness, substance use disorder, or a co-occurring disorder receive a continuum of prevention, early intervention, treatment and recovery support services delivered by a well-trained workforce. The Manager of the Office of Advocacy and Peer Services is a person with lived experience who leads the unit; oversees peer-run community wellness centers, respite programs, and other peer support programs; as well as contracts for peer training and other services. The manager retired after over 20 years of state service and DMHAS will be looking to fill this position. DMHAS continues to look for opportunities to integrate individuals with lived experience into the workforce. One example is the integration of peers in mobile crisis outreach teams and CRSCs. Additionally, DMHAS has posted guidelines for organizations considering the integration of individuals with lived experience into their workforce. The manager of the Office of Advocacy and Peer Services is a member of the DMHAS Divisions Executive Staff committee and is involved in leadership activities with providers. Feedback from the peer provider community is received directly in virtual meetings that are held bi-monthly with peer providers, who share accomplishments and ideas, ask questions or raise concerns with each other and with DMHAS staff.

The manager of the Office of Advocacy and Peer Services supervises a full-time staff person with lived experience of substance use and/or co-occurring mental health issues and so provides feedback to DMHAS staff overseeing co-occurring and SUD services. DMHAS Ombudsman and as coordinator of a Secret Shopper program. The staff person shares other role in the Advocacy and Peer Services unit; including the Ombudsman and Secret Shopper services. The Ombudsman receives complaints or concerns about provider services, while the Secret Shopper program involves peers making calls to agency providers while presenting typical client scenarios. She also sits on panels that review and score RFPs and other proposals made to DMHAS and is currently recruiting for a larger pool of potential peer candidates to help conduct these reviews.

Division of Mental Health and Addiction Services (DMHAS) Office of Advocacy and Peer Services (formally Consumer Affairs); has direct oversight of most mental health peer-operated services delivered in the New Jersey community. This Peer run office is supervised by the Division's Office of the Medical Director.

The office employs two individuals with lived expertise within the office. One peer, who has been part of DMHAS since 2011 serves as the manager of the office and as the Division's Mental Health Ombudsman. The managers purview includes the Community and Hospital based Wellness Centers, the Peer Respite program, CHOICES (Smoking Cessation), Peer training for mental health, Peer operated Warmline, NJ Mental Health Cares information line. The other lived expertise person has been with the Division for one year and is in a full-time role. She has been a tremendous addition to the Office of Advocacy and Peer Services and has made great connections with the peer workforce across New Jersey.

DMHAS works in tandem with people having lived experience, family members, providers and other stakeholders, to promote recovery and wellness for persons managing a mental illness, substance use challenge or co-occurring issues, through a sequence of prevention, early intervention, treatment and recovery services provided by a well-trained and skilled workforce.

State-wide Consumer Advisory Committee (SCAC) meets quarterly on a virtual platform through TEAMS. Virtual meetings are facilitated by the Office of Advocacy and Peer Services personnel. SCAC membership consists of the 22 Community Wellness Center peer managers, three hospital-based Wellness Center peer managers. These meetings generally include a presence by Executive leadership, including the DMHAS Medical Director and the Division's Deputy Assistant Commissioner. There DMHAS Office of Community Services Regional staff also attend the meeting.

DMHAS shares recent updates with the attendees and answers individual questions. The Community Wellness Center peer managers are asked to share updates about their centers and discuss needs of the community members they serve. Topics include individual accomplishments, community challenges, concerns and ideas, and participants are comfortable asking questions and learning innovative skills from their fellow Peers.

The SCAC members have provided the Division of Mental Health and Addiction Services with feedback that they find the quarterly meetings helpful, but they would like some of the meetings to be in person. The Division benefits from hearing from these front-line service providers to better understand the community's needs.

In 2024, DMHAS rebid the Community Wellness Centers (CWCs) and added funding dollars to provide more competitive salaries for the Center's Peer workforce, to enhance programing and expand community outreach. Many centers have added marketing strategies and provide a vast variety of community outreach. There have also been many centers adding additional satellite sites. These services take trained staff members into their communities to work with individuals who may not get to the centers or that don't know about the services offered at the Wellness Centers. Each Community Wellness Center is expected to be open at minimum 25 hours at the primary location. Those hours of operation must include two nights and one weekend day.

As the world has moved beyond the pandemic, DMHAS has made certain all centers are returning to in person activities, as well as still providing some virtual recovery groups to their participants who had gotten used to the virtual model. These combined services hybrid centers allow more participants to engage in activities offered. The centers are an essential part of their individual community. Many operate in the structure of a "home" with living rooms, kitchens, game rooms, libraries, rooms with exercise

equipment and craft rooms, to name a few. They are a place where participants can engage in social interactions, by sitting in a cozy welcoming space and having conversations with each other. They can eat together and build the ties of a family environment.

Wellness Centers provide a space that is non-stigmatizing and always works to be respectful of one another's similarities and understanding of each other's differences. Members can play a game of pool or air hockey, as well as chess or board games. The centers offer wellness and recovery groups and other group activities such as healthy cooking classes or arts and crafts. Outside trips are taken regularly to places like the grocery store, food pantries or Walmart. Staff from the centers also go into the communities and bring wellness-related activities with them, as well as marketing items to introduce people who have lived experience or have family members with mental health or co-occurring needs to available services and other resource opportunities. They visit other types of Human Services centers, Veteran's centers, libraries and churches and will sometimes hold scheduled wellness-focused groups or similar activities at these locations.

The peer staff represented within DMHAS Office of Advocacy and Peer Services make frequent visits across the State to better support the varieties of activities that people sharing their lived experience provide to the Community. It is also an opportunity to share the impact of peer work and engage to support each other. Site visits have included both community-based and hospital-based Wellness Centers, 988 call centers, Peer Warmline call center and Mobile Community Outreach Team (MCORT) work sites. As new centers (provider agencies) have opened their doors, the Office of Advocacy and Peer Services staff have attended these Grand Opening events. It has brought joy and support to work in a collaborative manner and for the community service providers to be aware that their services are appreciated and supported by the Division of Mental Health and Addiction Services.

Currently, DMHAS Office of Advocacy and Peer Services is working on a plan to have a state-wide, yearly, in person SCAC meeting that would allow the peer Wellness Center managers engage and network face-to-face. The Whole Health Learning Community Initiative, funded by DMHAS, has already started this multi-agency engagement across the Wellness Centers. The initiative has created an environment of comradery and built wonderful collaborations between providers. Plans are being made to invite the peer managers of the Substance Use Recovery Centers to come together with the Office of Advocacy and Peer Services staff and share their lived experience to initiate quarterly meetings for Substance Use peer programs.

A long-term objective of this office is to allow both groups of peer managers to gather collectively and meet their counterparts who operate DMHAS Substance Use Recovery Centers and Community Wellness Centers. This will build an environment that supports seamless transitions from one service center to the other, for participants in need of Community-based services from either or both operating community service centers.

RFP Reviews. As part of the internal DMHAS Request for Proposal review process, DMHAS includes staff members with lived experience to sit on all of the reconciliation committees to review and score any proposals that are submitted to the DMHAS. Peers use the value of lived experience, as current and/or past recipients of mental health services and/or co-occurring services, to bring their unique perspective to the review meetings. The awareness that peers bring to the review teams has impacted other staff's viewpoints when scoring proposals, creating an understanding that leads to open discussion, which may impact scoring decisions and final awards. The Division has included Peers in the review process for over fourteen years.

Community members with lived experience and family members of persons receiving services, also participate in the RFP process, in the capacity of consultants. These community members review proposals and submits a written and oral summary of each proposal to the RFP team lead. The representatives are compensated for their input. The team lead discusses each review with the community member, and responses are shared with the DMHAS internal review committee before each proposal is scored. The perspective of the community members is shared and considered, as part of the overall process.

DMHAS Mental Health Ombudsman is a DMHAS staff person with lived experience. The Ombudsman responds to callers who use the Division of Mental Health and Addiction Services (DMHAS) Ombudsman Line, which is a non-crisis line, that is monitored Monday through Friday from 9:00am to 5:00pm. The line accepts recorded messages 24/7. It is important for the Ombudsman to develop trust with the caller to allow the caller to feel comfortable being open and honest about their call. For this, the Ombudsman must possess learned engagement strategies which they use to work with the caller. The Ombudsman begins the conversation by letting the caller know it is the formal complaint line for DMHAS services. A process is in place to resolve most issues in a swift, confidential and effective manner.

This role requires outstanding communication and interpersonal skills, knowledge of resources of other professionals, problem solving skills and the ability to be empathetic. The DMHAS Ombudsman role is filled by a Peer with lived Mental Health service experience, who is also a family member of a person(s) who has received Mental Health and co-occurring services.

DMHAS Secret Shopper Initiative, at the Assistant Commissioner's directive, the Office of Advocacy and Peer Services introduced the DMHAS Secret Shopper Program. The purpose of this project was to generate feedback about how our provider agencies are responding to calls made by persons who pose as clients. The program has provided the Division with valuable information to learn about some of the experience when calling a provider, the availability of appointments and challenges that client can receive trying to access services.

The Program currently has two community-based callers. One caller with mental health lived experience and one impacted by mental illness and substance use disorder were hired to the initiative, and they split the phone calls between MH agencies and SUD agencies. Each participant is issued a State allotted cell phone to use when making calls to providers. This is important because they are asked to leave a message for a call back when they reach an answering machine. Each participant also receives an email account connected to the Division's network. The Secret Shopper sends a synopsis of each call to the Initiative Supervisor at the end of each month. A total requirement of 15 outreach calls per month are expected per participant. In past periods the expectations were higher and it was found to be an overwhelming demand on the individuals. They are paid by the State as consultants for their services.

The feedback from such calls to agencies is tracked and monitored. In the past the agencies received a letter detailing the Shopper's experience. There is a plan to once again alert provider agencies of the outcome of each of these calls. The initiative has no intention to create blame for a problematic call. The Secret Shopper Initiative has been used to enhance services and to make systemic awareness of a DMHAS expectation to demonstrate respect, knowledge and to offer support an individual seeking services for any behavioral health related condition.

Some issues identified by the Secret Shoppers have included:

Calls being answered by an answering machine rather than speaking to a live person.
Long wait times to get an appointment for emergent issues.
Having to call another number to make an appointment.

An outcome of this project, was that a pro-active group of providers met with DMHAS Executive Leadership to try to resolve some of the concerns expressed to DMHAS. One of these concerns was the regular use of answering machines and calls not being returned in a timely manner or not returned at all. The agencies didn't like this practice either, however, the providers communicated that they could no longer afford the cost of having a receptionist available to take calls.

Both groups brainstormed and some resolutions were discussed and implemented. The agencies stated that using an answering machine was necessary due to staffing and funding constraints.

Some more issues identified by the Secret Shoppers included:

Answering systems were malfunctioning or went to random unmonitored mailboxes.

Agencies went out of business or merged, and the directory numbers were no longer valid.

Block Grant funded Community-based Peer-operated Service Providers

Legacy Treatment Services

Legacy Treatment Services operates Crosswinds, a peer-run mental health crisis respite center in Toms River, NJ. This program provides crisis respite services for 7-14 days for adults who need a supportive residential environment to work towards wellness and recovery and avoid psychiatric re-hospitalization. The program has several peers on staff who work with consumers to develop WRAPs and PADs and run peer support groups. Consumers have access to staff on a 24/7 basis to receive needed supports, while working to be linked with essential services, such as housing, financial assistance, physical health care and mental health care. The program also has peers in substance use recovery on staff who can assist consumers who have both mental health and substance use concerns work towards their own recovery. The success of the program is such that consumers have graduated from the program and worked to obtain peer certificates to come back as volunteers or employees in Crosswinds.

Legacy also operates several programs that have peer staff available to provide support. Kairos House, a similar residential program to Crosswinds, also employs peer workers on staff to provide support. Crisis programs include 988 Mobile Crisis Outreach Response Teams, in which a certified peer is part of a response team for in-person community crisis outreach. The Screening and Crisis Intervention Program (SCIP) employs peers to provide support for in-person outreach, emergent case management, and follow-up supports to those experiencing psychiatric crisis. Involuntary Outpatient Commitment programs employ peer case managers who use their own story of wellness and recovery to connect with consumers who are court-ordered to outpatient mental health treatment.

Community Support Services has peers on staff specifically to work with individuals developing WRAP plans and Psychiatric Advance Directives. Lastly, the Outpatient department has peers on staff to provide individual peer to peer sessions to those who receive therapy and medication management.

Consumer Parent Support Network

The purpose of the Consumer Parent Support Network is to support parents with a diagnosis of a mental illness in their parenting efforts and to promote the healthy functioning within their families.

The Consumer Parent Support Network uses traditional case management, combines it with support groups, education and advocacy, using mentors. Each program participant has the opportunity to select from a variety of support services that can strengthen their role as a parent. Our Parent Support staff assists with needed referrals and case management. Our Parent Advocates are both parents and people with lived experience. They can help a person negotiate the challenges of parenting by acting as a mentor, sounding board and source of encouragement.

Mental Health Association of Essex and Morris

Mental Health Association of Essex And Morris (MHA E&M) embeds peer led services throughout several programs within the agency as it recognizes the importance of the ability to connect with the individuals served through shared life experience.

The Forensic Peer Support Staff for Decreasing Recidivism provides off-site and in-home, hands-on support to mental health individuals playing a role in supporting these individuals from start to finish. Peer support helps individuals transition out of the justice system and build stability in their mental health and everyday lives, increasing socialization and successful tenure in the community. Peer Support Staff offers guidance, encouragement, and advocacy to keep participants engaged and connected to needed resources. The Peer Support staff co-facilitate peer groups which helps the individual receiving services develop coping skills and navigate the ups and downs of recovery. Sharing the lived experience of navigating mental health challenges and a similar history provides participants with motivation, builds hope, establishes trust, and creates an ability to relate to one another.

Peers with lived experience are employed at the Community Wellness Centers provide appropriate They partner with community providers for available services and coordinate resource events at the Community Wellness Centers. Lived experience professionals share life experiences, provide engagement and promote skill-building services, creating a collaborative and caring relationship, that focuses on strengths-based, person-centered services. Additionally, the Lived Experience Professionals (LEP) provides support in recovery planning through evidenced-based practices, such as Motivational Interviewing, and through advocacy. LEP are equipped to assist with managing crisis and de-escalation and promoting the integration of physical and mental health wellness which nurtures growth and development.

The Peer Support Staff employed in the Mobile Crisis Outreach Response Team (MCORT) provide evidence- based crisis services, to an individual identified by 988, who is experiencing a mental health or substance use disorder crisis in the community and is agreeable to an outreach. The person in the community who is experiencing a crisis can get non-clinical support from Outreach Team. The MCORT teams have a peer worker who offers support beyond the resolution of any immediate crisis. The peer team member can follow up on the person, making connections to social services and other services that may increase early intervention access. When appropriate there is collaboration with family members, friends or loved ones to assist and support individuals in crisis on an as-needed basis.

MHANJ Peer to Peer Support Line is a peer-operated warm line that offers emotional support, hope, encouragement and resources to callers. Peer to peer Support line is staffed by people who have lived experience with mental health challenges who provide supportive communication with callers who share mental health challenges. The warmline provides telephone peer support to individuals with mental health difficulties, in lieu of using more traditional emergency psychiatric services. All Peer Line staff receive specialized training and have monthly team meetings to discuss caller issues and receive additional support.

Catholic Charities of Greater Trenton

Riverbank Community Wellness Center

Since its inception in 1997, the Riverbank Community Wellness Center (RCWC) has been at the forefront of the Community Wellness Center initiative, significantly impacting the lives of individuals dealing with mental health and co-occurring issues.

A key aspect of the RCWC is its peer-led model, which involves staff members who have first-hand experience with mental health and substance use challenges. The center offers a wide range of life skills, training and educational programs that focus on self-care and help decrease social isolation. RCWC empowers its members to lead healthier and more balanced lives. Monthly groups are tailored to address the specific needs of individuals, including those with mental health concerns, co-occurring challenges like, substance use, chronic medical issues, aging, and individuals experiencing homelessness.

Positioned as a central resource hub, the RCWC is dedicated to helping individuals navigate the complexities of mental health services and co-occurring challenges. A team of trained peer counselors is available to assist members in accessing vital resources, such as housing assistance, SNAP benefits, health insurance, tax preparation aid, and vocational support. Additionally, the center collaborates with the South Jersey Food Bank, collecting 300 pounds of food every two months, which includes fresh produce and nutritious items for community meals that are served three times a week. There is also a food pantry available to members and the public at any time for those in need.

In late 2024, the RCWC was awarded a new contract from DMHAS, which has facilitated an expansion of services. As a result, the center has extended its operating hours at our Burlington location to five days a week, in addition to providing services one night a week at two satellite sites, one in Browns Mills and one in Maple Shade. Furthermore, the acquisition of a 15-passenger van

enables transportation for up to 40 members to and from various center activities, enhancing accessibility for those in the community.

The RCWC is pleased to report that for the grant year 2024-25, as of March 24, 2025, it has welcomed nearly 150 consumers, providing 813 self-help activities and 428 wellness and recovery activities to them.

Riverbank Transportation & Roads to Recovery

Since 2001, the peer operated Riverbank Transportation program (RBT) has been offering rides to individuals with mental health challenges who aspire to pursue employment or education but face difficulties accessing public transportation. Recognizing that transportation often poses a significant obstacle to achieving vocational goals, RBT serves as a reliable and cost-effective alternative to rideshare options, playing an essential role in promoting independence. The program averages 75 rides per month and charges \$2.00 per journey.

Roads to Recovery (RTR) is another peer-run transportation initiative that provides rides for participants of community recovery groups like Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Gamblers Anonymous. This service caters to co-occurring peers, located within a ten-mile radius of Westampton and is offered at no cost. In 2024, RTR facilitated nearly 100 rides for those engaged in their recovery efforts. However, due to financial constraints and staffing shortages, the RTR program has been temporarily put on hold until further notice.

It is worth mentioning that both RBT and RTR are peer-operated programs employing three part-time drivers along with one dispatcher, which allows them to achieve their own recovery objectives. Additionally, we take pride in noting that all bi-annual satisfaction surveys conducted among RBT and RTR consumers indicate complete satisfaction with the services provided.

Center for Family Services

Better Future Community Wellness Center (BFCWC) is a peer-run, peer-operated wellness center providing support, connection and recreation for adults with mental health issues who seek community, friends, social outlets, and relaxation. It provides a warm and welcoming environment where individuals can access needed community-based social services, receive peer support, and be informed about mental health, substance use disorder, and co-occurring issues in a supportive environment. No individual is denied full access to or participation in services or activities. This safe and non-restrictive environment provides all participants with a sense of hope and allow them to come together to engage in peer-to-peer support and be offered social, educational and recreational opportunities to address individual needs.

Better Future Community Wellness Center provides members with meaningful activities to decrease co-occurring substance use and mental health issues in a place where they will feel accepted and valued. It is equipped with trained, compassionate staff and community-based resources in a safe environment, consumers receive welcoming, non-institutional services from peers with similar experiences who are in recovery. Social connection can influence an individual's educational attainment, workplace satisfaction, economic prosperity, and overall feelings of well-being and life fulfillment. Social isolation and loneliness have repeatedly been linked to negative physical and mental health outcomes across studies nationwide. Risk factors associated with social isolation include living in rural and/or urban areas where resources are limited, having a chronic physical or mental illness, and lack of transportation, among others. BFCWC goal is to bridge this gap and offer non-restrictive, peer support for consumers with long-term physical and mental health conditions in various locations to significantly improve their quality of life and knowledge, skills and confidence to manage their health and physical functioning.

The BFCWC is a vital community-based initiative aimed at empowering adults who are recipients of mental health services to take control of their well-being, foster resilience, and support one another on their journey to recovery. It is operated by peers who have experience with mental health challenges and can provide one-on-one or group support to program participants. The center offers regular workshops and educational sessions covering a variety of topics such as stress management, emotional regulation, mindfulness, and self-care. There are also organized social events, group outings, and recreational activities that foster a sense of community and provide opportunities for social interaction and recreation. The center holds various support groups facilitated by peers that focus on specific mental health conditions or common challenges, providing a space for sharing and mutual support. This program plays a significant role in decreasing stigma, fostering recovery, and promoting well-being for all participants.

List of Services Offered (BFCWC)

Peer-operated wellness centers are community-based organizations run by individuals with lived experiences of mental health or substance use challenges. These centers provide various interventions aimed at supporting recovery, wellness, and empowerment. Some common interventions include:

1. Peer Support Groups: - Facilitated by trained peers, these groups offer mutual support and shared experiences to help individuals manage their mental health or substance use challenges.
2. One-on-One Peer Support: - Personalized support sessions where peers offer guidance, encouragement, and resources based on their own recovery journeys.

3. Wellness and Recovery Education: - Workshops and classes focused on topics like stress management, coping skills, nutrition, exercise, mindfulness, and other wellness strategies.
4. Resource Navigation: - Assistance in connecting with community resources, such as housing, employment, healthcare, and social services.
5. Social and Recreational Activities- Organized events and activities to promote social interaction, decrease isolation, and build a sense of community.
6. Advocacy and Empowerment - Training and support for individuals to advocate for their own needs and rights, as well as to participate in broader advocacy efforts for systemic change.
7. Skill-Building Workshops: - Training sessions on practical skills such as financial management, job readiness, communication, and problem-solving.
8. Holistic Health Services: - Access to complementary therapies like yoga, meditation, art therapy, and other holistic practices that support overall well-being.
9. Outreach and Community Engagement: - Efforts to reach statutory populations and raise awareness about mental health and wellness within the broader community.

These interventions are designed to create a supportive environment where individuals can share experiences, gain new skills, and build a network of supportive relationships, all of which are crucial for sustaining long-term recovery and wellness

The Mental Health Association in New Jersey; Peer Services Across New Jersey Synopsis

ACWC: Atlantic Community Wellness Center "Individuals Concerted in Effort" has over four decades of experience in providing people access to meaningful activities in a place where individuals are accepted and valued. MHA staff have an intimate understanding of the value of social connections which contribute to members' health, feeling of safety, prosperity, and ability to be resilient. ACWC became the first center to adapt to the need within the community and offer "center without walls" concept and modality of services which allowed greater access to people living throughout the county. The ACWC provides four core services, peer support activities, wellness recovery classes, training/education workshops, and community engagement. Peer support activities include supportive counseling, information/referral/linkages, end-to-end application & paperwork assistance, system navigation, promoting coping skills/selfcare, boundary/limit setting, and others. Wellness Recovery Classes include topics such as healthy behaviors: physical activity & nutrition, health literacy & decreasing the use of substances (e.g., tobacco, alcohol, drugs, caffeine, sugar), social isolation/supports (community connections), healthy relationships/belonging, and Mental Health: Stress, Anxiety, Depression Management/Emotions, Grief/trauma, self-esteem/motivation/self-care. Training and education workshops focus on unmet needs including food/ housing/utility instability, financial resource strains, employment, and education. ACWC been an integral partner training first responders to produce better outcomes for our residents in crisis providing peer delivered training and perspective.

OCWC: Ocean County Community Wellness Center; Journey to Wellness (JTW), provides a holistic approach to mental wellness, offering free peer support and wellness services to individuals looking to enhance their mental health, well-being, and self-care. Through structured support groups, wellness coaching, skill-building workshops, and socialization activities, JTW fosters resilience, self-advocacy, and personal growth in a non-clinical, stigma-free environment. Staffed by individuals with lived experience of mental health and/or co-occurring challenges, JTW fosters an environment of understanding and empathy, allowing participants to connect with others who have similar journeys. Peer support staff serve as mentors and advocates, guiding participants in navigating their recovery paths while providing encouragement and motivation. Utilizing recovery-oriented, person-centered, and trauma responsible approaches, JTW creates a space where individuals can openly discuss their struggles and triumphs without fear of stigma, empowering community members to take charge of their mental health, build resilience, and cultivate a sense of belonging, ultimately contributing to a healthier and more connected community. JTW's mobile wellness unit, "Wellness on Wheels" (WOW Van) offers curbside wellness and support throughout Ocean County, truly embodying "meeting a person where they are at" in all ways possible, by providing access to information, referrals, wellness & support out in the community. By meeting people where they are, the WOW Van breaks down barriers and ensures that individuals who may not otherwise seek support can connect with peer specialists in a safe, non-judgmental environment. The WOW Van is deployed throughout the week and whenever needed, including scheduled community events and outreach efforts.

Ocean County Community Peer Recovery Center; ROADS Recovery Center Recovery, Opportunities, Acceptance, Dignity, and Support (R.O.A.D.S.) offers a supportive space where individuals are accepted & valued, regardless of stage, phase, or recovery pathway. ROADS provides participant-centered support encouraging individuals to be in the driver's seat of their own recovery. ROADS is designed to offer support, help prevent recurrence of SUD, and promote sustained recovery by being recovery-orientated, person-centered, trauma-informed, and focused on peer support. ROADS offers services that address the members' recovery, wellbeing, and unmet needs. ROADS follows SAMHSA's Recovery Oriented System of Care Principles & focuses services including food, housing, utilities, transportation, finance, substance use, mental health, & co-occurring, education/employment,

social isolation/connections, healthy behavior, etc. ROADS also offers a community-driven approach, having strong partnerships across Ocean County to connect individuals with additional recovery resources.

UBW: United by Wellness was designed and built by MHANJ Peer Leadership Team to expand access to peer-to-peer support on a virtual platform for peers across New Jersey and beyond. Peer staff, interns and volunteers working with MHANJ's wellness centers, Individuals Concerted in Effort, and Journey to Wellness (JTW) combined resources along with other MHANJ to create a virtual wellness center that was launched in 2022. UBW currently provides free access to over 50 support groups weekly, which are offered 7 days a week to over 1800 current active members. A comprehensive array of groups offer support, wellness, spiritual, education, socialization, training, community meetings for both mental health and co-occurring individuals in recovery. UBW has recently expanded to partner with a Center for Independent Living to engage those with disabilities dealing with behavioral health challenges.

The Peer Recovery Warmline has been an integral part of NJ peer services since 2009. The warmline is fully staffed and supervised by experienced peer staff who provide support, education, advocacy and "personal peer to peer support" to the most isolated person in recovery. Utilizing WRAP (Wellness Recovery Action Planning) and IPS (Intentional Peer Support) models, the team operates 7 days a week, and volunteers to work all the holiday. Each year over 40,000 calls are answered each year. The PRW offers an optional text/chat component that provides daily text messages of support throughout the day and week. This provides another level of support and connection. PRW operates as part of the MHANJ Call Center that has multiple behavioral health lines – that provides easy access warm transfers to information and referral- through NJ Mental Health Cares- that also provides the PRW with a vast data base community recovery support services to share with peer warmline callers. In 2022, MHANJ advocated for peers to play a major role in crisis response. As a result, peers hired for the 988 call line facilitate easy warm transfers to PRW for 988 crisis callers. MHANJ continues to expand the role of peers in the operation of the call center – with many peers integrated across all our lines in partnerships with strong support, supervision, and clinical backup- proving their value to NJ's crisis response network.

Consumer Connections: Building a strong peer workforce has been the goal of MHANJ Consumer Connections since it was founded in 1997. Consumer Connections has been training peers to work in paid positions within New Jersey's mental health system for over 25 years. Over time, the program has evolved into a comprehensive workforce development initiative, supporting the growth of the Certified Recovery Support Practitioner (CRSP) credential, New Jersey's only mental health peer certification recognized by Medicaid. Consumer Connections continues to strengthen the peer workforce by providing all required CRSP training, including the 84-hour Core Training and WRAP Seminar I, offering scholarships for credentialing fees, and assisting peers throughout the credentialing process. Additionally, the program serves as a liaison to the state certification board, offers career counseling and vocational services to programming alumni, and delivers a full range of technical assistance and training to peer employers in mental health and co-occurring services within the adult system of care. Recognizing the importance of co-occurring capacity in the peer workforce, Consumer Connections is committed to expanding expertise in this area. To that end, the program provides Core Training graduates with access to the Certified Peer Recovery Specialist (CPRS) training, which leads to New Jersey's substance use disorder (SUD) peer credential. Consumer Connections has secured additional funding through ARPA federal dollars to expand programming in 2025. This funding has enabled the program to increase the number of Core Trainings from three to five, WRAP Seminar I workshops from six to ten, and CPRS trainings from one to three. Additionally, this expansion has allowed the program to hire two additional full-time peer trainers, further strengthening training capacity. Funding to support CRSP credentialing scholarships has significantly increased the number of credentialed individuals in New Jersey, more than doubling the total within just one year. With continued funding and strong policy leadership, MHANJ has established a solid foundation to meet the evolving needs of New Jersey's peer workforce and to drive sustainable growth in the field. However, a significant challenge is that ARPA funding is a one-time allocation that will end in September 2025. It is already clear that there is sufficient demand to continue operating at this expanded capacity, but without sustained funding, it is uncertain how the program will be able to maintain its staffing levels and training capabilities beyond the third quarter of 2025.

The Whole Health Learning Collaborative: NJ Peer Connections is a program of the Mental Health Association in New Jersey, that is funded and designed to assist and support the 20+ Division funded Community Wellness Centers (CWC) in the state of New Jersey. This program unifies and unites all NJ CWCs for the cause of Whole Health Care by prioritizing the eight dimensions of wellness in all centers and the services provided to the community in which they serve. Whole Health is based on SAMHSA's 8 Dimensions of Wellness, which promotes mental health care is more than just psychological but covers many different aspects of life (social, spiritual, emotional, intellectual, vocational, financial, and physical health). In WHLC's 1st year of programming, WHLC assisted each CWC create wellness-based goals to implement whole health initiatives in their centers. All centers were given in-person and virtual technical assistance, a liaison for feedback with the Division, and communal support and education through regionalized events across the state. Each CWC was awarded Wellness Dollars to fund these initiatives and given an opportunity to share their successes and best implementation practices at the programs ended statewide event.

The regionalized events, offered in the North, Central, and Southern parts of the state, offered great educational and networking opportunities for all CWCs helping to create a network of support cross organizationally and statewide for the staff of the Wellness Centers. Educational workshops included: PADS, Choices, Recovery-Based Solutions, Creative Minds, Peer Advocacy, WRAP, Resource Sharing, and more. Due to its success, the Whole Health initiative was refunded through ARPA (until March 2025) funding to sustain the momentum and collaborative efforts of the centers and focus and prioritize the integration of the four newly awarded CWCs. This round of funding allowed for on-going in-person and virtual technical assistance to the newly

awarded centers and other CWCs who needed assistance integrating their newly established goals and priorities resulting from the new CWC contracts. It also allowed for an additional two in-person regional events welcoming in the new Community Wellness Centers to the statewide community and in an effort to help each center reach its full potential. This program enhanced the CWCs by allowing them the opportunity to learn, network, and advocate for each other to better the people they serve. It can only be hoped this initiative can continue in some way in the future as this tie between all the CWCs is long overdue and extremely necessary in the success of the CWCs.

Hospital-based Wellness Centers

Collaborative Support Programs of New Jersey (CSPNJ). CSPNJ's Hospital Wellness Centers on the grounds of Greystone, Ancora, and Trenton Psychiatric Hospitals serve as essential, recovery-focused spaces led by individuals with lived experience. These centers provide peer support, wellness activities aligned with the 8 Dimensions of Wellness, and advocacy opportunities through COMHCO and the NJ Behavioral Health Planning Council. Programs such as the Hearing Voices Network, skill-building workshops, and the Hospital Cell Phone Project empower individuals to navigate their recovery journey with greater autonomy. We receive an average of 10 referrals to the HCPP monthly, effectively engaging and enrolling more than four-fifths of those interested. Recognizing the need for technology supports for discharged from State Psychiatric Hospitals and the challenges individuals with psychiatric conditions encounter in navigating the emerging technology-based healthcare system, State Psychiatric Hospitals partnered with DMHAS and its contracted provider Collaborative Support Programs of New Jersey (CSPNJ) to provide cell phones for patients upon discharge. From the inception of the program to the present, 200 patients discharged from Ancora, 150 patients discharged from GPPH, 200 patients discharged from TPH, and 5 patients discharged from AKFC received state funded cell phones that include data plans for unlimited talk and text for 6-months along with protective cases for the phones. Furthermore, the patients received training on the phones that were configured to have direct access to service notifications and appointment reminders. Additionally, CSPNJ collaborates with Community Wellness Centers to assist eligible individuals in applying for Lifeline cell phone services, helping ensure sustained connectivity beyond the initial six months. The approach empowers individuals receiving the phones, as they retain the ability to keep their phone number moving forward, which supports continuity and personal autonomy. In 2025, the project was expanded, and an additional 300 phones were purchased with state resources to replenish the supply for future hospital discharges. Additionally, CSPNJ's Program Aide roles and Unit Wellness Providers strengthen transition planning by participating in Life Management and Community Integration Meetings, offering advocacy in treatment team discussions, and expanding peer support sessions for those facing complex discharge challenges. Through structured wellness activities, peer support calls, and Health & Well-Being Surveys, CSPNJ ensures individuals receive personalized, continuous support that fosters a successful transition from hospitalization to independent living.

Recognizing the critical role of stable housing in recovery, CSPNJ has partnered with Ancora State Psychiatric Hospital to launch the Community Housing Options Tour, an innovative initiative that enhances discharge planning by connecting hospital staff and individuals served with real-world housing solutions. This program introduces participants, including supported housing providers, wellness center staff, and individuals preparing for discharge, to various housing models such as Residential Health Care Facilities, boarding homes, and independent supported housing. By improving understanding of recovery-oriented housing that emphasizes autonomy and community integration, this initiative strengthens collaboration between hospital discharge teams and community-based providers. As a result, there has been a marked increase in proactive engagement in discharge planning, leading to more successful transitions. Given the measurable success at Ancora, CSPNJ is expanding this initiative to Trenton Psychiatric Hospital, with plans underway to bring it to Greystone Park Psychiatric Hospital.

Looking ahead, CSPNJ is dedicated to scaling and strengthening its hospital wellness centers with innovative programming designed to enhance recovery outcomes and community reintegration. Planned initiatives include the relaunch of virtual Community Wellness Center groups, an employment pilot program incorporating Indeed job search training, and the expansion of Program Aide roles at Trenton Psychiatric Hospital. To foster engagement across centers, CSPNJ will introduce a statewide basketball tournament, expand Peer Gatherings featuring CSPNJ Wellness Institute workshops, and provide Peer Certification training for staff pursuing CPRS and CRSP credentials. To recognize member achievements, CSPNJ will implement a Certificate of Achievement program for vocational and wellness milestones. Additionally, contingent on funding, CSPNJ will organize community integration trips and conference opportunities, further reinforcing the organization's commitment to holistic recovery. With sustained investment, CSPNJ's hospital wellness centers will continue to serve as transformational spaces that empower individuals, decrease hospital recidivism, and build a bridge to lasting independence.

Wellness Respite Services

Respite is a safe, peer-run alternative to an inpatient psychiatric hospitalization and our services are at no cost to guests. Our Wellness Respite House is staffed 24 hours a day, 7 days a week by people who are trained and experienced in supporting others to transform a crisis into an opportunity for enhancing personal wellness and recovery. During the final quarter of the 2024 calendar year, all three of our respite houses averaged occupancy rates of over 98%.

The mission of our Wellness Respite Services is to provide an alternative to hospitalization which instills a sense of hope, empowerment, and fosters recovery and wellness to pursue valued life roles and personal goals. Each Respite House is a clean, safe, supportive, tranquil and non-judgmental environment in a residential community.

We offer intensive peer support and involvement in wellness activities to help guests to restore balance, and plan for adjustments when they return to their home, their associated valued roles, and their community activities. Guests meet with staff for one hour every day to learn coping skills for their wellness goals. Guests can stay at the house for a maximum of 10 days. If there is a waiting list or if a guest chooses to remain at home, we can provide wellness planning and intensive phone contact and outreach in the community for up to 10 days. After completing a Respite House stay or Intensive Outreach, all guests are offered up to 30 days of continued support through a follow up wellness plan and phone contact and outreach in the community for up to 30 days. Respite staff have developed a robust and intentional marketing plan designed to raise awareness among potential guests, families, service providers, and key community partners. Beyond traditional outreach, staff take an active and engaged role in the community, consistently promoting the lifesaving and life-changing support that Wellness Respite offers. For example, in 2025, Respite staff presented at the Whole Health event, sharing insights about Wellness Respite's mission, services, and impact on the lives of those seeking alternatives to hospitalization. Thus, as of March 2025, we have supported over 3,950 guest stays. Lastly, despite limited capacity (15 beds), the impact is profound: 84.38% of Respite guests avoided hospitalization during their stay. And 91.62% felt valued and respected by peer staff; while 95.48% reported improved ability to manage their emotional and practical needs.

Community Wellness Centers

The Community Wellness Centers (CWC's) at CSPNJ provide a welcoming and supportive environment where individuals can access a range of peer-operated services to support their journey toward wellness. These centers are dedicated to fostering a sense of belonging and empowerment through personalized peer support, wellness activities, and community engagement. Whether in-person or virtual, peer mentors and support staff offer compassionate guidance, ensuring that every visitor has access to encouragement, advocacy, and resources that align with their unique needs. By centering services around the eight dimensions of wellness emotional, physical, social, intellectual, occupational, environmental, financial, and spiritual CWC promotes holistic well-being that extends beyond traditional healthcare models to over 16,000 unique members across our 15 locations.

The comprehensive services offered at CWC's go beyond immediate wellness support by addressing essential life needs. Through wellness groups, substance use support, and advocacy connections, members and visitors receive structured guidance tailored to their specific challenges. Linkages to crisis intervention, permanent housing, healthcare services, and community resources ensure that individuals have a strong support network during difficult times. The centers also assist with obtaining identification, applying for mainstream benefits, and navigating the complexities of services. These offerings create a foundation for self-sufficiency and stability, allowing individuals to regain control over their lives while feeling supported by a compassionate community.

What sets CWC's apart is the quality of care and dedication embedded in peer-operated services. Every interaction is rooted in lived experience, empathy, and a deep understanding of the challenges individuals face. Peer mentors not only provide resources but also foster meaningful connections that encourage self-advocacy and resilience. By emphasizing the uniqueness of each member's journey and integrating the eight dimensions of wellness into all services, CWC's ensures that every person who walks through its doors receives individualized, respectful, and comprehensive support. This person-centered approach makes the Community Wellness Centers a vital resource for those seeking to improve their well-being and transform their lives.

COMHCO

COMHCO continues to lead innovative and high-impact peer advocacy efforts across New Jersey, demonstrating the power of lived experience in shaping policy and service delivery. Over the past year, we have expanded engagement through monthly virtual membership meetings, providing real-time updates on critical issues such as Medicaid waivers, the integration of behavioral health services, and the expansion of involuntary commitment laws. Notably, we saw a significant increase in participation from individuals currently residing in state psychiatric hospitals, reflecting the success of our outreach and the growing demand for peer-led advocacy. Our quarterly leadership meetings have also strengthened peer involvement in county mental health boards and state and national stakeholder groups, ensuring that individuals directly affected by policies have a seat at the table. Additionally, our advocacy efforts have been instrumental in combating homelessness and promoting housing rights to support recovery.

A cornerstone of our work is the Annual Statewide Conference, which in 2024 brought together over 300 participants to engage in workshops on legal advocacy, voting rights, psychiatric advanced directives, and cross-disability advocacy. This event has become a vital platform for educating and empowering peers while fostering community connections. In preparation for our 2025 conference, we have implemented membership pulse surveys to ensure programming aligns with the needs and priorities of our community. In tandem with this, we have expanded our coalition to reach young adults, individuals with co-occurring substance use challenges, and statutory populations. These efforts are reinforced by our structural growth, with updates to our by-laws establishing a 13-person board with regional representation from all areas of the state.

In September 2024, COMHCO partnered with the National Disability Rights Network to host screenings of Accessing Democracy by Jack Rosen at the CSPNJ Annual Fall Fest and at local community wellness centers. This powerful film was part of a broader effort to promote civic engagement. During the same month, we collaborated with the REV UP campaign to increase voter registration and education, emphasizing bi-partisan voter education and accessibility for individuals with disabilities.

As part of our continued commitment to peer engagement, we will also be holding two statewide town halls to gather feedback from peers, as recommended during our monthly membership meetings. These town halls will serve as open forums for individuals to share their experiences and shape advocacy priorities. In addition, we will conduct workshops focused on telling your story and coalition building, equipping peers with tools to effectively share lived experiences and strengthen collaborative efforts across the state.

Looking ahead to the 2026–2027 funding period, COMHCO is committed to sustaining and expanding these initiatives to further elevate the voice and impact of peer advocacy. Our focus will be on strengthening our infrastructure, increasing accessibility to advocacy opportunities, and continuing to challenge policies that create stigma with behavioral health conditions. SAMHSA funding will be critical in supporting these efforts, allowing us to enhance virtual engagement, develop new leadership pipelines, and expand peer-led initiatives that promote recovery, autonomy, and meaningful involvement in the community. By investing in peer-driven solutions, we can continue to drive systemic change and improve outcomes for individuals navigating behavioral health challenges in New Jersey.

Certification training for staff pursuing CPRS and CRSP credentials. To recognize member achievements, CSPNJ will implement a Certificate of Achievement program for vocational and wellness milestones. Additionally, contingent on funding, CSPNJ will organize community integration trips and conference opportunities, further reinforcing the organization's commitment to holistic recovery. With sustained investment, CSPNJ's hospital wellness centers will continue to serve as transformational spaces that empower individuals, decrease hospital recidivism, and build a bridge to lasting independence.

Prevention Resources

The Community Wellness Center (CWC) in Hunterdon provides individualized peer services focused on holistic well-being and personal empowerment. Each guest meets with a Peer Advocate to develop a personalized "wellness plan," setting goals and tracking progress across the Eight Dimensions of Wellness—physical, emotional, occupational, spiritual, financial, mental, environmental, and intellectual well-being. This tailored approach ensures that each person receives support that meets their specific needs while fostering personal growth and self-sufficiency.

Beyond individual plans, the CWC emphasizes a strong sense of community, where guests actively contribute by cooking for one another, offering support, and sharing resources. This community of mutual aid promotes dignity and pride while creating a welcoming, home-like atmosphere rather than a traditional service facility. The center operates six days a week, offering activities such as yoga, meditation, journaling, nutrition classes, and recreational programs.

Adding to the sense of community, the CWC offers Peer-led programming and services at several satellite locations; wellness classes at the Fisherman's Mark food bank in Lambertville, yoga and meditation at the Hunterdon County libraries, as well as wellness programming offered to the residents of Veterans Haven North, in Glen Gardner. The CWC also distributes food both on site and in the "Little Free Food Pantries" located throughout the town in conjunction with the Flemington Food Pantry. All programs and services are provided by a Peer, or an individual with lived experience in mental health.

CHOICES (Consumers Helping Others Improve their Condition by Ending Smoking) is an innovative peer outreach program dedicated to addressing tobacco use among individuals with mental illness in New Jersey. For two decades, CHOICES has been at the forefront of delivering education, resources, and motivation to smokers with mental illness. The program employs trained mental health peer counselors, known as Consumer Tobacco Advocates (CTAs), who work tirelessly to support smokers in their journey toward a healthier lifestyle. The program was originally conceptualized to use peer counselors to reach out to smokers with serious mental illness living in the community. This approach was an advantage in reaching individuals who might not be motivated to talk to a health care provider.

Entering its 20th year, CHOICES has continued to evolve its approach to tobacco education and intervention. While the program maintains its core mission of providing educational presentations to consumers in mental health treatment across all levels of care, the 2024-2025 grant year has seen a significant expansion. This year, CHOICES introduced Learning About Healthy Living (LAHL) groups at four Community Wellness Centers, enhancing peer-led support and education. The centers include:

Moving Forward CWC (New Brunswick)

CARE Center (Neptune)

Riverbank CWC (Burlington)

Freedom Trail CWC (Somerville)

These biweekly groups meet for 12 sessions and provide structured education, linkage to tobacco treatment resources, referrals, and continued peer support. The LAHL curriculum, developed by CHOICES founder and medical director Dr. Jill Williams, an addiction psychiatrist, remains an essential tool in delivering impactful education, as well as a continuity of communication between the consumers attending the centers and the CHOICES team. The full curriculum is accessible [here](#).

During the 2024-2025 grant year (July 2024 to present), CHOICES reports the following metrics, which will increase by approximately 20-25% by the end of the grant period:

81 in-person and virtual visits to mental health treatment providers across New Jersey. (As of March 25, 2025)

Engagement with 1,088 consumers who smoke, providing education and motivation for tobacco dependence treatment. (As of March 25, 2025)

Two newsletters published and distributed to over 1,500 consumers and mental health agencies, reinforcing the importance of tobacco treatment.

Additional Programs Provided with the CHOICES Educational Site Visit and Carbon Monoxide Monitoring and Feedback:

2024-2025, St Clare's Inpt Unit, Broadway House, Booker BH, Donald Mays CWC, Camden CWC, Princeton House, Ancora Psychiatric Hospital, Essecare, SERV Annual Conference, UBHC Cherry Hill, Options, Up Your Alley, Broadway House, Greystone, Main Hospital, West Bergen Mental Healthcare, Future Dreams, Bergen County Wellness Center, Jewish Family Services of Atlantic and Cape May Counties ,Greystone Wellness, Catholic Charities East Windsor, Mt Carmel Guild Cranford, Mt Carmel Guild Newark

Since its inception in 2005, CHOICES has built an impressive legacy:

2,098 community visits conducted, reaching over 61,935 individuals with mental illness who smoke.

13,490 individuals received individualized feedback sessions, including carbon monoxide monitoring and personalized discussions about the health and financial impact of smoking.

As CHOICES celebrates its 20th anniversary, it reflects on past achievements while planning for future growth. Program focus continues to include tobacco education, cannabis education, including structured healthy living groups will ensure continued relevance and effectiveness. The enthusiasm and engagement of CTAs has been instrumental in inspiring participants and fostering hope that positive behavior change is possible.

With ongoing dedication, CHOICES remains committed to supporting individuals with mental illness in achieving better health outcomes and promoting a tobacco-free future. The program's sustained impact highlights the power of peer-led initiatives in driving meaningful change within the mental health community.

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

A. 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 decreasing symptomatic behaviors of the family member with a serious mental illness. Families also learn patterns of communication and levels of environmental stimulation which have been demonstrated to decrease 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 decreasing symptomatic behaviors of the family member with a serious mental illness. Family psychoeducation is offered in each of New Jersey's 21 counties via the county IFSS Program. According to QCMR data reported by providers, 3,505 families received services provided by IFSS in SFY 2024 and 3,847 in SFY 2025.

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 families throughout the state has always provided a significant challenge for the IFSS programs. IFSS programs invest significant effort and energy in attempting to reach families in all regions. Visits occur on a regular basis to a wide variety of mental health programs.

IFSS staff also establishes contact with local churches and clergy as well as appearing at public meetings and events such as health fairs in their respective counties. Additionally, IFSS programs maintain a positive relationship with the New Jersey Chapter of the National Alliance on Mental Illness (NAMI NJ). NAMI NJ affiliate offices are located in each county.

NAMI NJ is contracted with the SMHA to provide support, education, advocacy and referral services to statutory populations.

B. Acute Family Support Programs (AFS)

The Acute Care Family Support Project is a service embedded in the emergency room. The service is available to families with an adult member experiencing a psychiatric crisis and being assessed in a Screening Center or Affiliated Emergency Service. They provide onsite or offsite support to the family while their loved one is being assessed, educate them regarding services/treatment in an acute care setting, including the commitment process, and link them to existing family support in the community. Family may also include significant others and primary caretakers. In 2022, there were ten programs serving residents of eleven counties, which include Atlantic, Bergen, Burlington, Camden, Cape May, Essex, Hunterdon, Middlesex, Monmouth, Passaic, Union. Due to COVID-19 restrictions on hospital units, there was a decreased activity in these programs through 2024 and 2,607 individuals were served. In SFY 25, there were 3,495 individuals served in AFS.

7. Treatment and Rehabilitative Supports

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

A. 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, 2 Camden, 1 Cape May, 1 Cumberland/Salem, 1 Essex, 1 Gloucester, 1 Hudson, 1 Hunterdon, 1 Mercer, 2 Middlesex, 1 Morris, 1 Ocean, 1 Passaic, 1 Somerset, 1 Union and 1 Warren) in order to create quick access to intensive outpatient services for individuals seeking access to treatment through the acute mental health system. These new programs are designed to create dedicated access for person receiving services referred from emergency rooms and other acute settings. In SFY 2024 there were 3,069 individual receiving services and 2,608 in SFY 2025.

B. Program of Assertive Community Treatment (PACT).

Program of 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 individuals with SMI. The program is designed to meet the needs of individuals 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 statutory population, PACT teams offer highly individualized services, employ a low staff-to-individual ratio, conduct the majority of their contacts in natural community settings (e.g., individual's residence), and are available to help individuals address psychiatric crises 24 hours a day. Service intensity is flexible and regularly adjusted to individuals' needs. Per the evidence-based model, individuals are eligible for PACT for an indeterminate period as clinically needed.

Most New Jersey PACT teams are staffed with eight to ten full-time equivalent direct care staff and can serve between 70-75 individuals at any point in time. There are 31 PACT teams in New Jersey. PACT services are available in all 21 counties of the state. The SMHA contracts with 10 different non-profit agencies that operate these teams. Since state fiscal year 2010, the SMHA has expanded twenty of the 31 teams with additional staffing. As an Evidence-Based Practice (EBP), Assertive Community Treatment is endorsed by SAMHSA. PACT will continue to be integral to enhancing the network of community mental health services. According to QCMR data reported by providers, there were 2,440 persons receiving PACT services in SFY 2024 and 2,361 in SFY 2025.

C. 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 statutory 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 statutory 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 persons receiving services to mental health services in their agency such as, outpatient or partial care programs. All PATH programs link individuals to behavioral health and co-occurring services, entitlements and housing (emergency, transitional and permanent) within their communities. In SFY 2024, there were 1,562 persons served by PATH and 1,699 in SFY 2025.

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, and strategies to reach the statutory population.

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

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

Individuals eligible for services may have challenging behaviors related to frequent untreated mental illness or lengthy hospitalizations and homelessness. This may include a history of non-engagement with services, refusal to leave a hospital setting, active substance use disorder, lack of financial benefits, forensic history 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 integration, housing stability, wellness, recovery, and resiliency. Illness management, socialization, work readiness and employment, peer support, and other skills that foster increased self-direction and personal responsibility for one's life are also addressed. Person receiving services are expected to be full partners in identifying and directing the types of support activities that would be most helpful to maximize successful community living. This includes use of community mental health treatment, medical care, self-help, employment and rehabilitation services, and other community resources, as needed and appropriate. According to QCMR data reported by providers, there were 5,765 persons served in SFY 2024 and 5,842 person receiving services in CSS in SFY 2025.

E. Residential Services. DMHAS-licensed supervised residential options offer on-site staff support and assistance with activities of daily living according to client needs. Housing opportunities include supervised apartments, and group homes. Additionally, residences may address particular needs: of individuals with serious mental illness and/or co-occurring substance use disorders, short-term Respite Care, Crisis, and Deaf/Blind. These group homes provide different levels of staffing based on the license for the particular homes ranging from In SFY 2024 there were 2,658 persons served in residential services and 2,701 in SFY 2025.

F. Supported Employment (SE). The Division of Mental Health and Addiction Services (DMHAS) provides evidence-based practice (EBP) supported employment services since 1988. SE is provided statewide for adults (18 years of age and older) with serious mental illness and/or co-occurring mental illness and substance use disorders by assisting with choosing, obtaining and retaining integrated employment in jobs of their choice within their skill and credential set. The services are provided through 20 fee-for-service (FFS) contracted community mental health provider organizations. In SFY 2024 there were 1,549 individuals served in SE and 1,412 served in SFY 2025.

G. Supported Education (SEd). DMHAS has also provided SEd services since 2006. SEd services are available to individuals with serve mental illness and/or co-occurring disorders who either want or are currently matriculating in post-secondary education. Through four FFS contracted community provider organizations, Sed is accomplished throughout reach services aimed to assist people with reach their postsecondary academic goals. Services are individualized and flexible based on student choice and career goals. In SFY 2024 there were 165 served in SEd and 187 served in SFY 2025.

H. Illness Management and Recovery (IMR). Training and consultation of the IMR program in the state psychiatric hospitals continues through a Rutgers University affiliation with the NJ Department of Health, which is called the State Hospital Psychiatric Rehabilitation Initiative (SHPRI). The mission of the affiliation is: to improve the quality of care provided at NJ's State Psychiatric Hospitals through consultation, education, program development, and evaluation, using psychiatric rehabilitation goals, values and principles as well as current research. SHPRI has created an online learning hub on a website as a reaction to the COVID19 pandemic. The site is a collaboration between Rutgers and the New Jersey Department of Health state hospital leadership. The

site offers trainings across a variety of subjects including IMR and is free and accessible to all NJ state hospital staff. IMR was offered on-site at the three regional and one forensic state hospitals until about April of 2020, when COVID-19 required a rethinking of how to provide IMR because patients could no longer co-mingle in the hospitals' centralized treatment mall. Rutgers provided training in facilitating the IMR program in the state psychiatric hospitals. Also, a vocation version of IMR has also been implemented call VIMR or vocational IMR. The difference is that the person's goal is specifically focused on employment.

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

IMR is provided at Ann Klein Forensic Center (AKFC). The program delivers a structured, step-by-step process that equips individuals with the essential information and skills needed to set and achieve their personal recovery goals. It is conducted in a group format at AKFC, ensuring a supportive and collaborative environment. AKFC is proud to offer this program to our patients.

The nurses (facilitators) were trained with a one-hour online introductory course, followed by an in-class discussion led by a consultant from Rutgers University on the IMR module. The registered nursing staff (RNs) participated in training focused on the module's content and delivery. We hold four sessions weekly—two in the morning and two in the evening—each lasting 60 minutes and designed for AKFC patients. Currently, two licensed practical nurses (LPNs) have completed the online course and will soon attend the in-class discussion for a new module. Additionally, the STU operated by Ann Klein Forensic Center incorporates IMR in their individualized treatment modalities for residents, prioritizing interventions that alleviate barriers to discharge and support resident goal.

Ancora Psychiatric Hospital (APH)

The Ancora program under the leadership of the social work administration in collaboration with psychiatric rehabilitation provides IMR in group treatment and as a support to discharge planning. IMR is incorporated in transition of care at an on-grounds cottage designed for skills practicing in preparation for discharge.

Trenton Psychiatric Hospital (TPH)

At Trenton Psychiatric Hospital, the psychosocial rehabilitation teams provide IMR through Group and Individual therapy in various iterations and complexes over the campus. There are various offerings about IMR programming with robust IMR group offerings in each of the four complexes. IMR Happy Life curriculum is an example of adaptation of the evidenced IMR principals with an emphasis on belief in recovery, providing an ability to better understand the mental health lived experience. Relapse prevention and coping skills are provided as part of IMR curriculum, and individualized IMR sessions are provided to support treatment goals and individual skill building. IMR curriculum specific to the individual needs of patients who are on Conditional Extension Pending Placement (CEPP), is provided to meet the unique needs of long-term patients transitioning back to community life.

Greystone Park Psychiatric Hospital (GPPH)

Greystone Park Psychiatric Hospital utilizes an interdisciplinary approach for IMR interventions through a nurse led model, providing both group and individual sessions. Additionally Social Work leads IMR interventions including a unique IMR program designed for deaf and hard of hearing patients.

The New Jersey Division of Mental Health and Addiction Services (DMHAS) continued to emphasize the incorporation of Illness Management and Recovery (IMR) into the foundation of principles and practices of a recovery-oriented, person-centered system of community mental health services. IMR implementation continues to be supported by state regulations concerning New Jersey's partial care/partial hospital (PC/PH) systems and community support services programs (CSS). As part of outpatient mental health agencies' contractual agreements with DMHAS, IMR providers are asked to track persons receiving IMR services and whether or not IMR was delivered via group and/or individual sessions.

Through a contract with Rutgers UBHC-Technical Assistance Center (TAC), DMHAS provides the following services for agencies across the state and within a given fiscal year:

Three 2-day IMR introductory trainings (with a focus on programmatic implementation)

IMR post-training consultation sessions for individual agencies (via onsite, virtual and/or telephone)

Supplemental IMR trainings to support implementation

Monthly IMR Roundtables (virtual consultations for IMR-trained and contracted community provider network).

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

IMR virtual and in-person training by the Rutgers UBHC TAC continued in FY 2024 despite the ongoing impact of staff turnover and position vacancies. The total number of IMR practitioners trained in FY 2024 was 112. Thirty-seven IMR Practitioners received training from 16 Community Support Services Programs. Another 75 IMR Practitioners received training from 44 Partial Care/Partial Hospital Programs.

Data on service recipients is limited to a degree since some agencies did not submit FY 2024 IMR data. However, those who did submit reports noted that, for Community Supportive Services (CSS), 147 clients received IMR services. For Partial Care / Partial Hospital programs, 4,916 clients received services. Combined, for FY 2024, the TAC received reports of 5,063 clients receiving IMR services. This is despite only 22% of CSS programs and 40% of Partial Care / Partial Hospital programs reporting.

During FY 2024, the TAC held monthly IMR virtual Roundtables in order to provide continuing support for staff / agencies seeking to enhance their implementation efforts. For FY 2024, 73 staff from 19 agencies, including direct IMR practitioners, supervisors and clinical directors participated in the 90-minute Round Table discussions.

In September of 2024, in collaboration with DMHAS, the Rutgers TAC held a 20th Anniversary event commemorating 20 years of IMR training and implementation in New Jersey. The event included a talk by Kim Meuser and Susan Gingrich who discussed the past and future of IMR both in New Jersey and worldwide.

Crisis Intervention Team. DMHAS funds a CIT Center of Excellence through Legacy Treatment Center. The Center facilitated the development of new county CIT efforts. Presently nineteen of twenty-one counties as well as the NJ State Police provide training to first responders, dispatcher and mental health staff in CIT. These counties offer the training to other counties and municipalities as well as their own. For calendar year 2025 to date, there have been 27 40-hour classes, 4 one-day dispatcher programs, 2 NJ virtual training classes, 3 advance trainings and 3 academy one day trainings.

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

Re-entry Services (Intercepts 4-5) The SMHA has offered Re-entry services (Forensic Case Management) from county correctional facilities since 2000. Programs have between 1 to 2 case managers who interview and enroll potential candidate while in jail, provide pre-release planning and then successful linkage and coordination to mental health and other social/community services. No psychiatric or treatment services are directly provided by the programs but rather link existing mental health services. Counties include: Atlantic, Bergen, Burlington, Camden, Cumberland, Essex, Gloucester, Hudson, Monmouth, Morris (also included some county funding), Middlesex, Mercer (also included county funding), Passaic, Ocean, and Union.

Veterans Prosecutor Program was established through legislative action in 2017. Operated by local prosecutor offices, it affords a veteran with lower-level charges an opportunity to access treatment services with access to treatment services. This program is potentially available in every county, however, the referral rate is low. The SMHA was actively involved in the implementation and in supporting training as well as providing mental health and support services for those veterans who are not eligible for VA services.

Chief Justice's Mental Health Committee: The Chief Justice of the NJ Supreme court through the Acting Administrative Director revitalized this committee in December of 2019. The committee is co-chaired by the Commissioner of the Department of Human Services and a Presiding Judge. The Asst. Commissioner for the SMHA as well as a senior manager and other staff are represented on the committee. The collaborative includes a pilot, training, and data and treatment subcommittees. Through a collaborative effort, the committee will examine points of intersection between person receiving services and the judiciary and how mental health services may be accessed as well as examine best practices and potential pilot programs.

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

J. Integrated Case Management Services. ICMS works collaboratively with the person receiving services, their family/significant others (as appropriate) and other collateral contacts to assesses the individual's strengths and needs; develop a service plan based on this assessment; refer and link individuals to needed services, including medical and dental services; and monitor engagement in services. In SFY 2024, there were 4045 individuals served and in SFY 2025 there were 3,847 served with ICMS services.

K. Outpatient Services. Outpatient services include counseling interventions provided by trained clinicians to individuals living in the community who require non-immediate care that can be delivered on a scheduled basis. Interventions may include individual, group, and family therapy; medication counseling and maintenance, assessment and testing, outreach services, and referral. In SFY 2024 there were 85,623 individuals served in outpatient and 75,608 in SFY 2025.

L. Partial Care. Rehabilitation services are provided within partial care and include engagement strategies that are designed to connect with individuals in order to enter into therapeutic relationships supportive of the individual's recovery. Activities assist a person receiving services to identify, achieve and retain personally meaningful community integration and other personal goals over time which help the person resume normal functioning in valued life roles in self-chosen community environments. In SFY 2024 there were 6,300 served in partial care and 5,802 served in SFY 2025.

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

Coping skills, adaptive problem solving, and social skills training that teach individuals strategies to self-manage symptoms;

Psycho-education that provides factual information, recovery practices, including evidence-based models,

Development of a comprehensive relapse prevention plan that offers skills training and individualized support;

Medication self-management, behavioral tailoring, simplifying a consumer's medication regimen, and motivational interviewing assist and support person receiving services in adhering to their medication regimens;

Wellness activities that are consistent with the consumer's self-identified recovery goals. Wellness activities may address common physical health problems, such as tobacco dependency, alcohol use, sedentary lifestyle and lack of physical exercise, and overeating and/or poor nutrition including connection to primary medical and dental services;

Skill development needed for consumer-chosen community environments, facilitating consumer-directed recovery and re-integration into valued community living, learning, working and social roles by developing critical competencies and skills; and

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

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

The multidisciplinary clinical team and advocates within the facility for management of behavioral issues for individuals who would not benefit from inpatient psychiatric stays. S-COPE equips staff by sharing best practices and offering trainings. S-COPE also gets referrals from screening/crisis to follow up with patients upon discharge back to their nursing homes. All assessments and treatment recommendation offered are consistent with promising practices and/or evidence-based practices. S-COPE staff develop reports on their consultations, and it's contracted for intakes, consultation calls, both telephonic and on-site annually.

S-COPE staff also provides training to crisis/screeners, primarily to nursing homes. All trainings are developed by the S-COPE team and trainings topics can be suggested by providers that they serve.

N. Legal Services. Legal assistance provided to mental health clients, either through agency referrals or self-referral, by a network of DMHAS-funded legal service agencies. Assistance may include advice and guidance, case coordination, and court representation for issues such as government entitlements, housing, evictions, employment, etc. In SFY 2024, there were 2025 served by Legal Services and 1900 served in SFY 2025.

O. Certified Community Behavioral Health Program (CCBHC) New Jersey has 7 Demonstration CCBHC providers. The CCBHC is required to provide 9 Core Services, including crisis, ambulatory treatment, mental health care for veterans, peer and family

support, case management (TCM), primary care screening and monitoring, screening diagnosis and risk assessment. Psychiatric rehabilitation services are also one of the nine required services. The CCBHC agencies provide rehabilitative services through direct service or through and agreement with the designated collaborative organization. This includes supportive employment, supportive education, independent living skills, medication management and transitional services for individuals who have and are moving back into the community. There were 21,994 persons served by CCBHC.

8. State and County Psychiatric Hospitals

A. State Hospitals

The Department of Health (DOH) operates four adult psychiatric hospitals. The care at the hospitals serves people with persistent and severe mental illness who need intensive, inpatient care and treatment. Effective August 20, 2018, the Division of Mental Health and Addiction Services (DMHAS) was transferred to the Department of Human Services, while state psychiatric hospitals remained under the supervision of the Department of Health. The State Mental Health Authority (SMHA) previously operated the state hospitals until this reorganization. The SMHA and the Department of Health continue to work collaboratively to facilitate discharges from the state hospitals as well as increasing diversionary efforts which provide opportunities for individuals to live, work, and learn within their community. The development of supportive housing in 2006, the Olmstead settlement agreement in 2008, the Olmstead unit in 2009, and subsequent expansion of diversion staff, have contributed to a decrease in state hospital census. The state regional psychiatric hospital census has decreased from 2,109 in SFY 2006 to 982 in SFY 2025, a decrease of 53.44%. The data from SFY 2006 to SFY 2025 excludes Ann Klein Forensic Center (AKFC) and includes Hagedorn Psychiatric Hospital (HPH) for SFY 2006. HPH was subsequently closed on 6/14/12. The end of year census for Ann Klein Forensic Center (AKFC) for SFY 2025 was 189. The state regional psychiatric hospital admissions have decreased by 80% from 2,938 in SFY 2006 to 587 in SFY 2025 (excluding AKFC and including HPH).

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

Ancora Psychiatric Hospital (APH) has 515 CMS certified beds as an adult inpatient facility that offers a multidisciplinary team approach for the development and implementation of care. Ancora also has cottages on grounds, of which one is available to the state hospital as a training cottage. The remaining cottages are occupied by community providers. Ancora meets the needs of its mentally ill clients in the areas of admissions, acute and chronic psychiatric units, gero-psychiatric units, a sub-acute medical unit, and a secure care unit (forensic). The mission of APH is to provide quality comprehensive psychiatric, medical, and rehabilitative services that encourage maximum patient independence and movement towards community living with an environment that is safe and caring. In SFY 2025, Ancora began work with Rowan School of Medicine to augment staffing and increase medical educational opportunities for staff to advance best practices in evidenced based treatment.

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

Trenton Psychiatric Hospital (TPH), located in West Trenton, Mercer County, primarily serve the residents of central New Jersey. Trenton Psychiatric Hospital has 400 CMS certified beds, as well as cottages on the grounds. TPH provides a holistic approach to patient care from initial assessment and the treatment of the human response to current and potential mental health problems. TPH ensures its patients (and their families) competent, compassionate care as patients individualized care goals are reached. In 2023, TPH started its first clinic (Steppingstone Substance Use Disorder (SUD) Clinic) in the Marquand building providing the cottages, substance use treatment, on day program treatment model. A second SUD clinic, RISE & SHINE opened in January 2025. TPH has collaborated with Northern and Southern Centers of Excellence in establishing Addiction Programs at TPH, arranging Continuing Medical Education (CME).

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

B. County Hospitals

The SMHA supports three county operated psychiatric facilities that operate as part of the continuum of services. These facilities are located in Bergen, Essex, and Hudson counties. Effective 10/15/2024 the ownership of Union County's Cornerstone was transferred to a private owner and ceased to be a county psychiatric hospital.

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

The county hospital census has decreased by 5.3% from 569 in SFY 2010 to 539 in SFY 2025. During this same time, the county hospital admissions decreased by 10% from 6,264 in SFY 2010 to 5,439 in SFY 2025. DMHAS began collecting data from the county hospitals in SFY 2010.

9. Olmstead Initiatives

Over the last few years, the SMHA has been successful in its delivery of services to individuals in the state psychiatric hospitals as well as in the community. Much of this success is due to the implementation of various initiatives resulting from the Olmstead Lawsuit. In April 2005, New Jersey Protection and Advocacy, Inc., now known as Disability Rights of New Jersey (DRNJ) filed suit against the New Jersey DHS on behalf of psychiatric patients who were found to no longer meet commitment standards, but for whom no appropriate placement was available. The official term for the status assigned is Conditional Extension Pending Placement (CEPP). The SMHA issued its initial Olmstead Plan known as the Home to Recovery CEPP Plan in January 2008.

Although the Olmstead Settlement agreement was the result of a lawsuit initiated in 2005, this Settlement resulted in an investment in the mental health system for needed community, residential and other services. The Olmstead Settlement agreement can be viewed at:

http://www.state.nj.us/humanservices/dmhas/initiatives/olmstead/olmstead_settlement_agreement.pdf, The settlement agreement included performance indicators for improved community integration, each with its own individual measures for every year covered by the Settlement Agreement. The performance indicators were:

Creation of community-based (i.e., Supportive Housing) placements;

Discharge of long-term CEPP persons receiving services awaiting discharge since July 1, 2008 or prior;

Increased rates of discharge within four to six months of CEPP designation

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

As per the Administrative Bulletin 5:11 persons receiving services in state psychiatric hospitals are assigned to community service providers who have the option of either accepting the person receiving services or requesting additional supports from DMHAS. In addition to community providers, state psychiatric hospitals have the option within their discharge planning process of collaborating with community service providers to request additional supports for the person receiving services in their potential new living situations outside the institutions. Such requests and other efforts toward successful discharge are to be documented within the Individual Needs for Discharge Assessment (INDA). Assignments are based on hospital treatment team recommendations as well as the individual's preferences. The assigned provider is expected to participate in treatment team meetings. The early involvement of community providers in the treatment planning process fosters familiarity between provider and the person receiving services, allowing for immediate planning on the part of the provider to prepare to meet the individualized needs of each person receiving services upon discharge into their care. This preparation is critical to ensuring that the person receiving services is provided with necessary community supports and thereby maximizes his/her chances of sustained community tenure. It is born out of high-level interagency collaboration.

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

DMHAS has enhanced its Supported Employment services to include an in-reach pilot within the three regional state hospitals. Implemented in July 2015, this pilot program serves individuals who are ready for discharge and examines their interest in competitive employment outside the hospital. This in-reach is supplemental to the Division's existing Supported Employment services, which are available in each of New Jersey's 21 counties. Supported Employment services include assistance accessing benefits counseling; identification of occupational skills and interests; and the development and implementation of a job search

plan based on the consumer's strengths, interests, needs, and abilities. The ultimate goal for person receiving services receiving Supported Employment services is to obtain meaningful and competitive employment as a means of further ensuring sustained community tenure.

The Home to Recovery II Plan includes outcomes geared toward monitoring sustainability of the Division's community integration efforts. These outcomes include but are not limited to enhanced utilization of Supportive Housing, expansion of CSS opportunities, a decrease in census; fewer admissions to state hospitals; and a decrease in the number of individuals on CEPP. The average state hospital census for the 4 regional state hospitals in SFY 2008 (year of the settlement agreement) was 1,951 and there was an average of 2,763 admissions that year. The CEPP census on 6/30/2008 was 938. The percentage of individuals on CEPP of the total census was 49.9% on 6/30/2008. Additionally, there were four regional hospitals in SFY 2008 as Hagedorn Psychiatric Hospital closed in SFY 2012. The average state hospital census for the three regional state hospital in SFY 2025 was 982 (a decrease of 49.67% from 2008), there were an average of 587 admissions (decrease of 78.75% from 2008), and the CEPP census on 6/30/25 was 195 (decrease of 79.2% from 2008). The percentage of individuals on CEPP of the total census was 19.9% on 6/30/2025 (decrease of 60.12% from 2008). In SFY 2008, there were 3,051 individuals receiving services in supportive housing. In 2024, there were 5,765 individuals served by CSS and 5,842 served in SFY 2025.

A. Validation of Vacancy Tracking Systems. The Bed Enrollment Data System (BEDS) was developed in 2013 for the furtherance of deliverables to the Olmstead lawsuit settlement agreement with Disability Rights NJ1 to facilitate the communication of accurate information between state hospitals and community residential providers regarding bed needs and available housing inventory. The system has replaced the process of cold calls to agencies and the utilization of quickly outdated paper tracking sheets. In the Spring of 2021 BEDS was updated to contain functional improvements, including search features and the addition of short-term care facility (STCF) beds, to give the SMHA a better view of the acute care system.

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

Beginning in 2023, DMHAS has utilized Covid Supplemental and ARPA funding to procure a web-based data system for tracking referrals and vacancies for beds and services, including status of the referrals, disposition, and communication regarding the referrals. Additionally, the database has a crisis management module for call center intakes and mobile outreach dispatch. The crisis management module went live on March 3, 2025.

B. Enhancements to Community Capacity. From 2010 through 2014, DMHAS was charged with the creation of 695 beds expressly for the community placement of person receiving services on CEPP status in the regional state hospitals and 370 beds to be created for person receiving services who are already in the community and at high-risk for hospitalization and/or homelessness. This equates to a total of 1,065 placements to be created over the five-year period covered by the settlement. The SMHA met and exceeded this goal, creating 1,436 new placements. Of these, 941 were set aside for the discharge of CEPP person receiving services from state hospitals (exceeding the settlement goal of 695 by 246 or 35%), and 495 were reserved for persons receiving services at risk of hospitalization (exceeding the goal of 370 by 125 or 33.78%). In total, the SMHA exceeded its goals for placement creation by 34.83%, which amounts to 371 placements above its required deliverable. The Division continued creating new placements for the SMI populations, reaching a total of 1,808 new placements by the end of SFY 2016, with 1,274 reserved for CEPP discharges and 534 set aside for persons receiving services at risk of hospitalization. There were 1,060 number of new placements created from SFY 2017 to SFY 2025. This would also include recycled subsidies and multiple re issuance of subsidies. DMHAS will be funding approximately 40-60 new subsidies in SFY 2026.

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

D. 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 DCEO. Follow-up on systems raised by ICRC and discussion of resolution strategies are discussed. In addition, policy or systems that may involve collaboration with another Division or state Department, are discussed at these meetings and elevated to Olmstead leadership to address. Olmstead staff also use these meetings to update the hospital leadership on any new administrative bulletins, requests for proposals, updates or changes to the vacancy tracking system, and/or trends identified in the data.

E. Utilization Management of Statewide Residential Vacancies and Community Referrals: Meetings are held three times weekly between the DMHAS Olmstead Diversion Unit staff and State Psychiatric Hospital Placement Entities to review residential vacancies and community referral requests. This frequent communication promotes efficiency in filling residential vacancies and managing

the various requests for housing from Centralized Admissions, STCFs, and other entities who submit requests for DMHAS housing.

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

G. State Hospital infrastructure modernization. The SMHA has embarked on multi-year technology initiative to modernize technology systems such as the State's Oracle database for hospital census management, and the expansion of the state hospital based developed Provider Order Entry System (POES). These efforts provide a singular data footprint for both DMHAS and the state psychiatric hospitals to share various aspects of data pursuant to CEPP management.

H. State Hospital and Community Training

The SMHA, through DMHAS' Olmstead unit provided level of care trainings to the treatment teams at each of the three regional state hospitals. The Olmstead unit staff facilitated discussions on community treatment options and social service programs to support individualized discharge planning. Training was also provided to Community Support Services providers.

Recently the state hospitals have begun formative discussions with the community providers on collaborative discharge planning through on-site events such as provider open houses and expanded in-reach along with hospital tours of community provider agencies.

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

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

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

According to figures released by the United States Census Bureau, the 2024 adult population of New Jersey was 7,448,667. The size of the New Jersey child population was 2,052,184. 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 2024 was 402,228. Using the upper SMI limit of 7.1%, the estimated number of adults with SMI in New Jersey in 2024 was 528,855. Accordingly, using the lower SMI limit of 3.7%, the estimated number of SMI adults in New Jersey in 2024 was 275,600.

According to URS Table 2a, a total of 93,572 unduplicated persons ages 18 and over received services in programs provided or funded by the SMHA in FY 2024. SMHA served 34,750 unduplicated adults with SMI (refer to URS data table 14a) in FY 2024. That was 8.64% of the total estimated adults with SMI in New Jersey receiving services (402,228). The objective of the SMHA is to continually increase the number of adults with SMI that may receive emergency mental health services and non-emergency community mental health services. Also shown in URS data table 14a and 14b, out of the total 34,750 unduplicated adult with SMI served by SMHA in FY 2024, 17,107 (49.3%) were ethnic minorities. SMHA will ensure that all statutory populations continue to have access to mental health services in New Jersey. New Jersey has not established a methodology to estimate incidence of SMI among adults and will be requesting technical assistance.

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.

1. Services to Homeless Populations

DMHAS operates Projects for Assistance in Transition from Homelessness (PATH) program using a combination of federal and state funds. The statutory population is homeless adults or those at risk of homelessness who have a serious mental illness, including

those with co-occurring substance use disorders who are not currently engaged in and are resistant to mental health and other community support services.

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

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

In SFY 2024, the PATH programs in New Jersey provided outreach to 2,559 individuals and served a total of 1,562 persons. There were 638 program participants that were linked to mental health services, 92 to substance use treatment services, 166 to primary health/dental care, 368 to financial services, 299 to temporary housing/shelter, 250 to long term housing and 292 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. In SFY 2025, the PATH programs in New Jersey provided served a total of 1,699 persons.

Services provided under the certified (community behavioral health clinic) CCBHC initiative are available to all who meet programmatic criteria. 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. In Year 6 (2022-2023) only 1.6% of CCBHC clients were experiencing homelessness. CCBHC services include case management services designed to assist clients in addressing homelessness or who need services. The CCBHCs also include one provider agency, AtlantiCare Behavioral Health, that serves a rural population in Southern New Jersey.

2. Services to Rural Populations

The SAMHSA 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 pocket of Atlantic County to be apart of the CCBHC's demonstration project funded by CMS. The CCBHCs offer services within a holistic framework, thereby closing a treatment gap that frequently results in inadequate service provision for individuals with co-existing social, physical and behavioral health care needs. New Jersey's CCBHCs offer, through direct services or through affiliation 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.. The CCBHC Demonstration Program was extended to September 2025.

Currently, the New Jerseys Division of Medical Assistance and Health Services (Medicaid) in collaboration with DMHAS and the Department of Children and Families is developing a Medicaid State Plan Amendment to enable the CCBHC Demonstration providers, including Atlanticare, to sustain the CCBHC after the Demonstration ends in September 2025.

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

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

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

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.

1. State funding/training

The Division of Mental Health and Addiction Services (DMHAS) is dedicated to community--based mental health services and is advancing community supports for individuals 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 2025, State appropriations for mental health community providers were \$421million. A significant portion of which has been dedicated to 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 eight 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 many providers and clients to Fee for Service reimbursement, and away from fixed cost or overall cost reimbursement contracts. DMHAS believes that the combination of more attractive Medicaid rates and the transition to a direct Fee for Service reimbursement approach for non-Medicaid services (with enhanced rates), will lead to greater access for clients and a more transparent, accountable and efficient behavioral health service delivery system. DMHAS continues its commitment to consumers and providers, by ensuring reimbursement opportunities to providers when staff resources are deployed. DMHAS reimburses MH FFS contracted providers for non-Medicaid covered services. This reimbursement accomplishes two important things: 1. these ancillary but critical services support consumers' community tenure and 2. it limits reimbursements to the services provided.

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 2025 was approximately \$5.7 million.? In addition, DMHAS hosts quarterly meetings and webinars that served as training opportunities for the provider community. DMHAS staff deliver these trainings, which are funded by our State General Fund appropriations.

Goals

While New Jersey currently has cost-based contracts and fee-for-service arrangements with approximately 118 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 22 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 \$38 million for state fiscal year 2025. 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.

2. Federal funding

The Division leveraged other sources of funding to support community mental health services. In addition to the Mental Health Block Grant, the other primary sources of federal funding in SFY 2025 were the Projects for Assistance in Transition from Homelessness (PATH) grant, American Rescue Plan Act (ARPA), and the Bipartisan Safer Communities Act. The PATH grant provided \$2.2 million to support our contracts for that program. DMHAS was awarded \$39,121,366 in ARPA funds to expend by 9/30/25. These funds have been allocated for Crisis Services Crisis Receiving Stabilization Centers and 988 Implementation, Coordinated Specialty Care Community Integration, Psychiatric Emergency Screening Services Peer Recovery Services, Crisis Diversion Homes, Web-based Electronic Referral System and Crisis Management Module, , Community Health Law Project, Teen Mental Health First Aid, Co-Occurring SMI/IDD Initiative, Older Adult Expansion, Fee for Service, Designated Screening Services, Consumer

3. Staffing

As of June 30, 2025, the total staff in the New Jersey Division of Mental Health and Addiction Services (DMHAS) were 267, consisting of 205 full-time employees and 62 staff on a part-time or consultant basis. 17 staff are dedicated to Mental Health Block Grant (MHBG)-specific activities. Many other staff across the Division dedicate time and effort to mental health programs and contracts.

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

4. Mental Health Block Grant (MHBG) Expenditure plan

In State Fiscal Year 2026, DMHAS will continue to expend MHBG resources on prescribed and allowable activities. This reflects our commitments for Coordinated Specialty Care Community Integration for Early Serious Mental Illness including First Episode Psychosis (FEP) and Affective Psychosis (10% of the grant), Crisis services, including Crisis Receiving Stabilization Centers (5% of the grant), Behavioral Health Planning Council activities, Administrative functions (limited to 5% of the total grant), and resource, development, and training.

As always, the largest portion of our anticipated expenditures reflects community care programs for clients with Serious Mental Illness (SMI). While New Jersey currently has cost-based contracts and Fee for Service arrangements with 118 unduplicated agencies that provide eligible Community Mental Health services, to facilitate fiscal reporting and administration, and minimize the audit burden on our providers, DMHAS has allocated the available Block Grant funding to a select group of about 22 provider agencies who deliver services under Fee for Service arrangements. These agencies provide direct treatment services (including Outpatient, Residential, Partial Care and Case Management) to clients, most of whom have SMI. DMHAS Fiscal staff review data from our expenditure claiming system to allocate the funding appropriately.

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

A. Screener Certification: The SMHA contracts with Rutgers University Behavioral Healthcare technical assistance center to provide Screener Certification Courses for psychiatric emergency screening service staff. These courses, offered four times per year new staff, are comprised of eight full days of instruction and include training related to the wellness and recovery model, New Jersey's civil commitment statute, providing care in the most appropriate environment, suicide assessment, outreach with police and working with youth.

B. The Mental Health Awareness Training Grant: The goal of this initiative is to empower anyone working with adolescents and young adults, first responders, or veterans to increase their mental health awareness, equip them with resources on how to appropriately react to crisis and provide linkage to professional, peer, and self-help resources. Mental Health First Aid, Youth Mental Health First Aid, and Question. Persuade. Refer. (QPR) are the evidenced-based suicide prevention trainings that are being offered at no cost through this initiative.

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

Objective: 24 training sessions annually with an aim of 600 training participants.

Outcome: 768 training participants completed the 8-hour Mental Health First Aid course.

Objective: 48 training sessions annually with an aim of 960 training participants.

Outcome: 1,195 training participants completed the 2-hour Question. Persuade. Refer. course.

In the federal fiscal year 2024, there were 1,963 individuals trained Statewide under the MHAT grant, surpassing our goal of 1,560. Data indicators were submitted into SPARS (SAMHSA's Performance Accountability and Reporting System) on a quarterly basis as required. The following objective was surpassed with an outcome of 98%; Objective: 85% or more training participants will indicate an improvement of knowledge, attitudes and beliefs related to mental health prevention and promotion. To add, quarterly monitoring meetings continue to be completed with our assigned SAMHSA representative. Monthly flyers with training dates and zoom links are distributed to State and county partners and posted on the State website. Additionally, we are receiving and fulfilling more request for in person trainings.

We continue to offer these important suicide prevention trainings to school districts/personnel, case management organization, and the general public. At this time, the MHAT program is managed by our Training Coordinator under the supervision of the Grants Staff. To add, an administrative support staff was recently hired to assist the Training Coordinator with registering training

participants.

C. Disaster Response Crisis Counselor Certification: The DRCC training curriculum was created in response to the need for a trained workforce to provide crisis counseling to NJ residents in the event of a community crisis or larger scale disaster response. The core courses for initial certification are:

1. Introduction to Disaster and Trauma Counseling: Basic Training for Disaster Response Crisis Counselors
2. Issues in Disaster Response and Recovery
3. Ethical Issues in Crisis Response
4. Key Concepts in Psychological First Aid
5. National Incident Management System (NIMS 700) /Incident Command System (ICS 100) Note: NIMS and ICS training are offered by FEMA and can be taken on-line.

In 2024, there were five (5) opportunities for individuals seeking certification to complete the required courses named above. Additionally, current DRCC's are expected to maintain their certification by attending recertification courses, last year fourteen (14) recertification courses were conducted by Disaster and Terrorism Branch staff.

As of March 2025, there are a total of 490 Active DRCC's in the 21 NJ counties: Atlantic (71), Bergen (71), Burlington (76), Camden (64), Cape May (49), Cumberland (44), Essex (72), Gloucester (55), Hudson (48), Hunterdon (41), Mercer (61), Middlesex (81), Monmouth (130), Morris (84), Ocean (100), Passaic (64), Salem (40), Somerset (69), Sussex (48), Union (78), Warren (38).

At this time, DMHAS is in the second cycle of a funding opportunity that assist County Mental Health Administrators recruit, engage and sustain their respective DRCC volunteer workforces.

Psychiatrist Residency Training and Psychiatric Advance Practice Nurses (APNs) Program DMHAS has supported the training and hiring of psychiatrists and psychiatric Advanced Practice Nurses (APNs) in its contracted programs. The state has a significant need for more of these critical professionals and so has been involved in the development of programs to increase the numbers of psychiatrists and psychiatric APNs in the state. Most of the state's support in past years has been focused on increasing the numbers of Psychiatric APNs in community mental health programs serving individuals with serious mental illness. However, while the APN program is no longer being funded, beginning in 2022, DMHAS has received funding provided by the state legislature to support the training of adult psychiatry residents and of child and adolescent psychiatry (CAP) fellows in the state.

The legislative funding has had the goal of increasing the number of adult and child psychiatrists who are practicing in the state. The state funding of positions in psychiatric training programs has been provided since SFY 2023, when one new resident in each of the then 11 residency programs was funded. In SFY 2024, two residents per program were funded, as were two CAP fellows in the state's two CAP Fellowship programs. In SFY2025, the funding had been decreased but still supported new residents and CAP Fellows in most of the programs. In the years that the initiative has been in place. The funding has supported a total of 64 new resident positions and 7 new CAP fellowship positions.

These programs are overseen out of the DMHAS Medical Director's office. One requirement of the residency and CAP training programs for new residents is a focus on public and community psychiatry. As such, all programs are required provide training on a public and community psychiatry curricula, and to provide trainees with experience in settings that expose them to services for vulnerable clients with serious mental illness and substance use receiving services in community-based settings. these populations. Another related aspect of the legislative funding is to provide a program that promotes interest among medical students in the field of psychiatry. The state has used funding to support two separate but related initiatives in SFY2024 and SFY2025. The two initiatives have outreached New Jersey medical students and invited them to participate in a variety of activities and educational forums on psychiatry practice.

While DMHAS no longer has a program that directly funds psychiatric APN positions, the Division supports the role of psychiatric APNs in the provision of services in contracted clinics and providers. As licensed independent practitioners, psychiatric 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 can 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). Psychiatric APNs were also a large proportion of the practitioners who prescribed medication for opioid use disorder (MOUD) to address the overdose crisis, and they remain critical prescribers in this role.

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

NJ Higher Education Student Assistance Authority (HESAA) to address the critical shortage of behavioral healthcare providers, the Behavioral Healthcare Provider Loan Redemption Program offers loan redemption to eligible providers in exchange for up to six

years of service. Eligible behavioral healthcare providers included psychiatrists, licensed psychologists, licensed social workers, licensed clinical social workers, psychiatric nurse mental health clinical specialists, board certified behavior analysts, licensed clinical alcohol and drug counselors, licensed professional counselors, and licensed associate counselors. The program will provide up to \$50,000 to redeem an eligible participant's cumulative outstanding student loan balance in exchange for every two full-time years of service at an approved site, for a total of \$150,000 in loan redemption in exchange for up to six years of service.

E. 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, Tobacco Cessation, wellness and recovery programs, and Illness Management and Recovery training.

SSA

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

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

On June 29, 2012, Governor Chris Christie signed a bill that further reorganized DCF into a single point of entry for all families with children, youth and young adults living with either developmental disabilities or substance use disorders, or both. This realignment of substance use treatment and developmental services is intended to improve 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 use 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 use and co-occurring disorders treatment at all levels of service in an efficient and coordinated manner from the statewide and regional level to the local levels, thus enhancing access to services, coordination of services, alignment of policies and contracts, and workforce development efforts.

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

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 use 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 inpatient, residential and ambulatory treatment programs and facilities.

DHS/ DMHAS is working with DOH licensing office to comment on ambulatory regulations that impede integrating services, with the goal of streamlining the regulations and increasing integration of services. The plan is to develop a single, unified ambulatory care regulation that will allow integrated services to operate seamlessly. The draft rule was released for comment on April 21, 2025 and allows for a 60-day comment period.

An integrated rule will establish licensure and operational standards for the development of an integrated licensing system by which an outpatient facility that provides healthcare services, including primary care and reproductive health services; behavioral health services, including ambulatory mental health treatment, substance use disorder and/or other addiction treatment services; opioid treatment program services and/or any combination of these services. The proposed regulatory structure includes facility standards for healthcare and behavioral healthcare services including opioid treatment program services (draft issued by NJ Department of Health) and program standards for behavioral healthcare, including opioid treatment program services (issued by the NJ Department of Human Services, Division of Mental Health and Addiction Services). The draft standards proposes regulatory and policy reform that streamlines the application process for greater standardization of regulations across service types, providers greater flexibility for best practice and innovation and will support funding reform that will support the provision of integrated services.

2. Please describe the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and substance use services.

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

1. State Government

The Division of Mental Health and Addiction Services in New Jersey (DMHAS) is a Division under the New Jersey Department of Human Services. The DMHAS serves as the Single State Agency (SSA) for Substance Abuse and the State Mental Health Authority (SMHA) as designated by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). The mission of the Division of Mental Health and Addiction Services is to promote opportunities for adults with serious mental illness to maximize their ability to live, work, socialize, and learn in communities of their choice. This is accomplished through a comprehensive system of care, including psychiatric inpatient settings and community-based support services comprised of partnerships among the DMHAS, other State agencies, consumers, families, providers, and mental health advocates, with the understanding that adults with serious mental illness are entitled to dignified and meaningful lives. This mission is realized in both new and existing Division programs by application of the following operating principles: Services are to be delivered by means of a comprehensive system of care, which emphasizes the most appropriate settings to promote the highest level of functioning; There must be continuity of care and coordination of services within the State and between the public and private sectors; The range of services within the system of care must respond to the needs of the individual consumers ; The Division must assure appropriate, high quality care for the State's most severely disabled citizens in State psychiatric hospitals and for the less disabled citizens in community programs

The Division oversees the provision of a broad range of community mental health and addiction services throughout the State, and contracts with various entities to provide and support community-based prevention, early intervention, treatment, education and recovery services, including for at-risk. It contracts with approximately 320 agencies for a wide range of community mental health services that assist consumers living in the community; and supports and monitors a wide variety of substance use treatment and prevention services providers designed to decrease the misuse of alcohol and other drugs through effective evidence-based treatment.

The Division monitors and participates in the provision of community for quality assurance and improvement, training, program development, evaluation, management, information systems, fiscal and systems planning, and compliance with required assessment and treatment protocols and contract requirements.

The Division coordinates and manages addiction treatment services delivery for criminal justice programs through collaboration with other state entities, including the Administrative Office of the Courts, Department of Corrections and State Parole Board. It is responsible for the Statewide Intoxicated Driving Program, which schedules individuals convicted of driving under the influence for detention, screening, evaluations, education, and treatment referral and oversees the Intoxicated Driver Resource Centers (IDRCs).

The Division contracts with community agencies to provide screening services in order to decrease inappropriate inpatient or outpatient commitments and avoid unnecessary incarcerations. The Division designates funds and, with the Department of Health, regulates the provision of mental health services at inpatient units in acute care hospitals known as short term care facilities, as well as the assessment, referral, commitment, and crisis intervention functions of screening centers.

Through the Division's Disaster and Terrorism Branch, the Division works with Federal, State and local emergency management to coordinate and provide disaster crisis counseling.

2. County Government

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

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

1. Department of Human Services, Division of Medical Assistance and Health Services (DMAHS).

DMHAS, the SMHA in the Department of Human Services, and the Medicaid Division, DMAHS, have 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 goals.

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

The DMHAS and DMAHS are collaborating on several initiatives that are part of the New Jersey approved Medicaid Comprehensive Waiver. These include: transitioning of services for person receiving services with the dual diagnosis of Intellectual/Developmental Disorders and Managed Long Term Services and Supports (MLTSS); collaboration related to the carve-in of managed psychiatric inpatient services, including the waiver of IMD private hospitals; and the development of Behavioral Health Home (BHH) Services. The state's 7 BHH programs in N.J. exist in 4 counties and offer a wide variety of health promotion and wellness activities in addition to connecting individuals to the care they need. BHH staff provide care coordination for clients' medical needs and help them to make and keep appointments, take prescribed medication plans, find transportation, plan healthy meals, and set exercise routines, among other services. Four site visits were held in July; these sites were All Access Mental Health, Catholic Charities, Stress Care, and Meridian. The visit focused a chart review on metabolic syndrome documentation. Vantage, Behavioral Crossroads, and CarePlus will be reviewed at a later time.

7 Current Providers: All Access Mental Health- Mercer County, Catholic Charities-Mercer County, CarePlus-Bergen County, Vantage-Bergen County

Stress Care-Monmouth County

Meridian Hospitals Corp-Monmouth County, Behavioral Crossroads- Atlantic County

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 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 integration 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.

Integration of Behavioral Health into Managed Care Organizations (MCOs).

The NJ Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), and DMHAS have a united goal of furthering the State's efforts to support whole person care. Traditionally, many behavioral health (BH) services are excluded from the managed care delivery system and are instead delivered on a fee-for-service basis. Over the course of the 1115 demonstration renewal period, New Jersey conducted a systematic review of all behavioral health services to assess, on a service-by-service basis, whether it was appropriate and feasible to integrate such services into managed care. This process review occurred in phases, involved close consultation with stakeholders and the public, and was conducted over a few years. The State has hosted a series of sessions to share the details of implementation and solicit feedback from stakeholders, NJ FamilyCare (Medicaid) members, communities served, and the overall healthcare community.

DMHAS joined DMAHS in fall of 2023 as NJ began planning to integrate the management of Medicaid funded behavioral health services into the five managed care organizations. It was decided that the process would be rolled out in Phases with Ambulatory services for youth and adults integrated January 13, 2025. Phase Two II will include Residential and opioid treatment program services and will be implemented no earlier than January July 2026. Some services such as children's SUD services include in the Children's System of Care will be reviewed and considered for a Phase III roll out with the goal date for that is not yet undetermined.

DHS engaged the services of Boston Consulting Group to work with our two divisions to develop a smooth and orderly implementation informed by behavioral health providers, advocates, and individuals with lived experience. It was the DHS primary goal that no Medicaid enrollee experience an interruption of services. To that end, there has been significant stakeholder input including, separate provider, family and advocate, and enrollee focus groups, as we began the process. As implementation policies and procedures began, we relied on stakeholder advisory groups. In addition, the DHS staff at both divisions have presented and solicited input at multiple provider meetings, at conferences, and in other forums.

To prepare providers and enrollees for the launch of Phase I Integration, DHS held monthly trainings on a variety of topics. Whenever relevant, the MCOs presented at these meetings to train providers and enrollees on their individual systems and requirements. Phase I of the Integration was launched on January 13, 2025. All training materials and a Provider Manual are on the divisions' websites. An email address and hotline for all concerns and problems were developed and distributed. Currently, the DHS staff from both divisions participate in daily huddles where we review provider, enrollee, and MCO feedback and concerns. DHS reviews data including but not limited to, provider networks, numbers of prior authorizations, timeliness of payments and individuals enrolled. DHS holds individual and group MCO meetings to address issues.

NJ was also a recipient of a CCBHC Demonstration Grant, which includes a variety of services such as screening and referral for physical health needs and Health and Wellness services. Currently, seven CCBHCs are in operation (as of 7/1/17) as a part of the Demonstration Grant. Medicaid has been a partner throughout, having developed the Prospective Payment System that NJ is utilizing for this project. SMHA continues to partner with Medicaid to monitor and assist in the ongoing implementation of the CCBHC. DMHAS also works with Department of Children and Families (DCF) on implementation of the CCBHC. Currently, DMHAS and NJ Medicaid are working to sustain the CCBHC model in NJ. Currently NJ Medicaid, and DCF are collaborating on the develop a Medicaid State Plan Amendment to sustain the CCBHC after the Demonstration ends September 2025.

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

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

Department of Human Services, Division of Developmental Disabilities (DDD). SMHA Olmstead staff collaborate with DDD staff regarding the discharge planning of individuals dually diagnosed with both intellectual developmental disabilities and mental illness (DD/MI) who are being treated the state psychiatric hospitals. DDD has also hired full time Transitional Case Managers (TCMs) that are assigned to each respective state hospital. The DDD TCMs have primary responsibilities at the state hospitals focusing on securing placement for the state hospital DD/MI population who meet level of care for Community Care Program (CCP) residential placement, working collaboratively with hospital staff to address any discharge barriers that may be present, and coordinating support services for DD/MI individuals who do not meet level of care for the CCP. 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 management occur to address systems level issues and barriers to community re-integration. Staff from DDD are also members of the Behavioral Health Planning Council. The SMHA has developed an RFP process to promote the development of community-based supportive housing opportunities and other support services for person receiving services with co-occurring mental health and developmental disabilities.

2. Department of Children and Families.

Interdivisional and interdepartmental collaboration between DMHAS and the DCF CSOC is frequent. Leadership from each Department/Division have collaborated on grants and other initiatives to enhance the continuum of services for youth and those transitioning to the adult service system. Staff from CSOC attend monthly Behavioral Health Planning Council meetings to better coordinate services.

3. DMHAS Medical Director's Behavioral and Primary Health Integration Office.

The SMHA Medical Director's Office has an Integration unit with the goal of promoting integration between behavioral health agencies and primary health care providers. The main goal of the initiative is to provide persons receiving services with mental health and/or substance use disorders (SUDs) increased access to primary care and to improve collaboration between behavioral health agencies and primary health care providers in order to promote and improve general health, including the treatment and prevention of infectious diseases. The Division of Medical Assistance and Health Services (DMAHS) and the office are working closely on a number of initiatives to provide case management, increase medication assisted treatment, and ensure collaboration between behavioral health and primary care practitioners. Behavioral health homes and certified community behavioral health clinics (CCBHCs) are specific initiatives that the integration office is overseeing.

Also, the office has just finished overseeing a five-year grant-funded initiative called 'Promoting Integration in Primary and Behavioral Health Care, or PIPBHC, which had provided integrated treatment for HIV and Hepatitis C in primary care clinics to clients referred from opioid treatment programs and syringe access programs. One accomplishment of this work has been to successfully lobby for the removal of the Medicaid requirement for an infectious disease consultant to manage treatment of individuals receiving direct-acting antivirals for hepatitis C; this has allowed primary care practitioners to initiate Hepatitis C medications and increase access to this treatment. This 5-year grant ended in March of 2025, with outcome data showing that the integrated care model increased access to and completion of treatment for infectious diseases such as hepatitis C, as well as improved outcomes for those with HIV. DMHAS was awarded a second PIPBHC grant in August 2024, which promotes the collaborative care management (CoCM) model of integrated primary and behavioral healthcare. This grant focuses on delivering behavioral health screening, assessment and treatment in three primary care clinics for individuals with co-occurring medical needs.. The grant aims to build capacity by working by providing virtual psychiatric consultation and by training to the clinics' medical staff to collaborate with onsite behavioral health clinicians on clients' care.

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

Although much work has been done to develop a set of regulations that integrate these services, work in this area continues. DMHAS continues its work with the Department of Health licensing office to develop integrated ambulatory regulations with the goal of streamlining the regulations and increasing integration of behavioral health and primary care services. The goal is to develop a single, unified regulation that will remove current barriers and allow integrated services to operate seamlessly. DOH has announced that the draft integrated or 'Single Rule' regulations will be publish for public comment in late April, 2025.

4. NJ Housing and Department of Community Affairs (DCA).

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

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

The NJ SMHA relies on Community Support Services (CSS) as its standard for community integration in providing housing and mental health services. CSS is a rehabilitative service intended to increase consumer choice in the types and sources of mental health services that they receive. It is also intended to involve the individual in the development of an individualized rehabilitation plan (IRP) designed to improve the chances of those diagnosed with mental illness to maintain valued life roles in employment, education, housing, and social environments. The SMHA reports 5,765 individuals served by Community Support Services (CSS) in SFY 2024 and 5,842 individuals served in SFY 2025.

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 receipt. The SHC will provide apartment inspections within five days of the consumer's submitted complete packet. The SHC will also make rental payments by the payment due date for all individuals with a subsidy managed by the SHC.

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

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

SSA

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

Division of Medical Assistance and Health Services (DMAHS).

1. NJ FamilyCare's Comprehensive Demonstration Waiver.

NJ FamilyCare's Comprehensive Demonstration ("The Waiver") was renewed on March 30, 2023 and continues to include an Opioid Use Disorder (OUD)/Substance Use Disorder (SUD) continuum which provides authority for the New Jersey Department of Human Services' Division of Medical Assistance and Health Services (DMAHS), to serve individuals with a substance use disorder or opioid use disorder in a full continuum of care. The continuum matches beneficiaries with the most appropriate services to meet their needs 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 program standards. Beneficiaries have access to high quality, evidence based, OUD and SUD treatment services ranging from acute withdrawal management, ongoing chronic care in cost effective settings, and care for comorbid physical and mental health conditions.

The New Jersey has waiver authority to:

Claim expenditures for services provided in an IMD for a statewide average length of stay of less than 30 days.

Add a new level of care to the continuum for long term residential treatment, ASAM 3.5; Develop peer recovery support staff and care management programs that engage, support and link individuals with an SUD in the appropriate levels of care; and move to a managed delivery system that integrates physical and behavioral health care.

The Comprehensive Demonstration is a five-year demonstration and is now valid through the end of June 2028. As part of the

waiver requirements New Jersey is expected to continue reporting data as part of the SUD Monitoring Protocol and track progress toward the Demonstration's goals.

2. Presumptive Eligibility

The SSA, in collaboration with NJ FamilyCare, has established and is expanding mental health and SUD service providers who are able to enroll consumers needing treatment services in 24 -72 hours through presumptive eligibility (PE). PE allows a certified provider to enter information directly in the FamilyCare enrollment application that is then checked, and a temporary Medicaid number assigned. The application goes through verification, and if successful, a permanent Medicaid number is assigned. As of July 14, 2025, 267 behavioral health provider agencies have been certified to take PE applications.

3. Integration of Behavioral Health into Managed Care Organizations (MCOs).

The NJ Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), and DMHAS have a united goal of furthering the State's efforts to support integrated, whole person care. Traditionally, many behavioral health (BH) services are excluded from the managed care delivery system and are instead delivered on a fee-for-service basis. Over the course of the 1115 demonstration renewal period, New Jersey conducted a systematic review of all behavioral health services to assess, on a service-by-service basis, whether it was appropriate and feasible to integrate such services into managed care. This process review occurred in phases, involved close consultation with stakeholders and the public, and was conducted over a few years. The State has hosted a series of sessions to share the details of implementation and solicit feedback from stakeholders, NJ FamilyCare (Medicaid) members, communities served, and the overall healthcare community.

DMHAS joined DMAHS in fall of 2023 as NJ began planning to integrate the management of Medicaid funded behavioral health services into the five managed care organizations. It was decided that the process would be rolled out in Phases with Ambulatory services for youth and adults integrated January 1, 2025. Phase II will include Residential and opioid treatment program services and will be implemented no earlier than July 2026. Some services such as children's services include in the Children's System of Care will be reviewed and considered for a Phase III roll out with a goal date that is not yet determined.

DHS engaged the services of Boston Consulting Group to work with our two divisions to develop a smooth and orderly implementation informed by behavioral health providers, advocates, and individuals with lived experience. It was the DHS primary goal that no Medicaid enrollee experience an interruption of services. To that end, there has been significant stakeholder input including, separate provider, family and advocate, and enrollee focus groups, as we began the process. As implementation policies and procedures began, we relied on stakeholder advisory groups. In addition, the DHS staff at both divisions have presented and solicited input at multiple provider meetings, at conferences, and in other forums.

To prepare providers and enrollees for the launch of Phase I Integration, DHS held monthly trainings on a variety of topics. Whenever relevant, the MCOs presented at these meetings to train providers and enrollees on their individual systems and requirements. Phase I of the Integration was launched on January 1, 2025. All training materials and a Provider Manual are on the divisions' websites. An email address and hotline for all concerns and problems were developed and distributed. Currently, the DHS staff from both divisions participate in daily huddles where we review provider, enrollee, and MCO feedback and concerns. DHS reviews data including but not limited to, provider networks, numbers of prior authorizations, timeliness of payments and individuals enrolled. DHS holds individual and group MCO meetings to address issues.

Work on Phase II of the integration is beginning with the benefit of lessons learned from the Phase I implementation.

Division of Medical Assistance and Health Services and Department of Children and Families.

DMHAS was selected to be one of the eight Certified Community Behavioral Health Clinic (CCBHC) demonstration states. The NJ CCBHC demonstration providers began services in July 2017. This project is a collaboration between the Department of Human Services' Division of Medical Assistance and Health Services (DMAHS) and DMHAS and the Department of Children and Families (DCF). NJ has been working with our partners at the DCF Children's System of Care (CSOC) in an effort to improve the CCBHC provider capacity to increase the numbers of children served.

There are seven behavioral health providers that are part of NJ's demonstration and that have been certified as CCBHCs by the DMHAS. The Federal Demonstration was extended to September 2025. DMHAS and DCF are working with our sister agency, DMAHS to develop a Medicaid State Plan that will sustain the service. In addition, in NJ, there were 11 providers in 2022, 6 providers in 2021, and 9 providers in 2020 who were awarded SAMHSA CCBHC expansion grants.

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

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

DMHAS developed a Memorandum of Agreement with DCF to provide services for the Partnership for Success grant that DMHAS was awarded in 2018 but ended in August 2023.

New Jersey State Parole Board. Memorandum of Agreement (MOA) exists 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.

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

On December 21, 2021, an extension and modification MOA between NJSPB and DMHAS to expand Intensive Outpatient Treatment Services (IOTSS) in order to provide rapid access to mental health services to parolee clients in need of mental health or co-occurring mental health and SUD treatment through the Mutual Agreement Program (MAP). Access to IOTSS is intended to provide an option for Designated Screening Programs and other acute care and hospital referral sources to assure that appropriate, intensive, community based, recovery-oriented outpatient services. Through IOTSS Parolee with an exacerbation of the symptoms of mental illness and/or a co-occurring substance abuse disorder receives comprehensive assessments, Wellness and Recovery Action Plans (WRAPS), Medication Administration and Education, Individual Therapy, Structured Group Therapy, Illness Management and Relapse Prevention Groups.

Department of Corrections. Since 2017, DMHAS has collaborated with the Department of Corrections (DOC) to provide Intensive Recovery Treatment Support (IRTS) pre- and post-release services to a cohort of eligible individuals with substance use disorder. Services are provided by staff from Rutgers University Behavioral Healthcare. Funding is braided so no pre-release services are funded with SUPTRS; DOC state funds are used for services provided pre-lease and supplies not permitted by SUPTRS.

In October 2020, NJ Governor signed legislation for the decreased sentences and early release of certain NJ state prison inmates incarcerated for non-violent offences. The law was effective in early November 2020. Through January 2021, almost 3,000 inmates were released. Approximately 800 of these individuals had an Opioid Use Disorder diagnosis and 364 enrolled in the IRTS program. Two additional IRTS teams were developed to serve them. early release of certain NJ incarcerated (compassionate release) to decrease the number of incarcerated individuals in the prisons during COVID. The law was effective in early November 2020. Through January 2021, almost 3,000 individuals incarcerated in prison were released. Approximately 800 of these individuals had an Opioid Use Disorder diagnosis and 364 enrolled in the IRTS program. Two additional IRTS teams were developed to serve them.

IRTS links eligible individuals to recovery services necessary to support wellness and successful community re-integration. It helps individuals address issues such as health/wellness, treatment adherence, employment, housing, and opportunities and skills to enhance the individual's ability to participate in meaningful life activities. IRTS teams can provide services to a maximum of 840 participants for up to six months prior to release and up to 12 months post release. To date, 5,792 individuals have been referred to the program.

State Police. Between 2014-2022, the Regional Operations Intelligence Center operated by the New Jersey State Police developed and operated the Drug Monitoring Initiative (DMI), to address the pervasive use of heroin, opiates, and the violent crimes and burglaries that are directly correlated with this nationwide crisis. The DMI was a nationally recognized program with a robust multi-state drug intelligence capability that collects and analyzes law enforcement and healthcare data in order to help law enforcement and public healthcare experts develop strategies to combat drug activity in their jurisdictions. Some highlights of the initiative are:

- The incorporation of public health guidance into the drug monitoring intelligence process
- The ability to coordinate the collection, analysis, and mapping of drug incidents statewide
- The expedited analysis of drug seizures to better direct criminal investigations and health resources
- Training law enforcement, fire service, and emergency medical service personnel statewide

DMHAS made frequent use of data provided by DMI for prevention needs assessment and planning.

goals and priorities. The primary focus of this interdepartmental group is to decrease risky behaviors and promote the adoption of health enhancing behaviors. Additionally, the DOE will continue to participate in DMHAS' State Epidemiological Outcomes Workgroup (SEOW) to review survey instruments that can be jointly used to collect data required by both entities, and to coordinate schedules for administering student surveys so as to minimize duplication of data collection efforts.

In 2024, the DOE asked DMHAS to take over the administration of the YRBS High School Survey from the Centers for Disease Control and Prevention (CDC). DMHAS was required to apply for the five-year grant issued by the CDC, which was awarded to DMHAS in July 2024. DMHAS has been working closely with DOE through this transition period.

Department of Health. DMHAS collaborates with its partners at DOH in several areas and across a variety of offices. A major initiative DMHAS worked with DOH on was devising new proposed rules creating a single, integrated license for outpatient health care facilities. This reform will cut historical red tape and enable providers to deliver integrated primary care, mental health, and addiction treatment services. This comprehensive, whole-person approach is proven to deliver improved health outcomes and better patient experience. The proposed new rules address longstanding obstacles and a complex regulatory regime that have impeded health care providers' ability to offer coordinated physical and behavioral health services. The proposed rules were released on April 21, 2025, for public comment. The public comment period was for sixty (60) days. DOH is still under review of those comments.

Division of HIV, STD and TB Services (DHSTS). DMHAS collaborated with DHSTS on a project with the National Alliance of State and Territorial AIDS Directors (NASTAD) and the JSI Research & Training Institute, Inc. (JSI). They were provided one-time funds to support activities related to the Strengthening Systems of Care for People with HIV and Opioid Use Disorder (SSC) project. Funds were meant to support time-based activities focused on enhancing systems of care for people with HIV and OUD and in alignment with state technical assistance plans developed for the project. Funding was made available to support technical assistance (TA), training, and capacity development activities of New Jersey, one of the nine states selected to participate. JSI was funded by the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) Projects of National Significance to work with nine states and provide technical assistance (TA) on strengthening systems of care to address OUD and HIV treatment, care, and recovery needs. DMHAS and DOH were partners in this project and met monthly with the consultants. The SSC conducted their initial site visit in February 2020 and concluded the monthly technical assistance meetings in August 2022. The two Departments worked on a TA plan with JSI and the final sustainability plan containing six goals was completed and provided to DMHAS and DOH in September 2022.

Stigma and its effects contribute to the syndemics of HIV and OUD, acting as an obstacle to care for people seeking services. An area to be explored will be data sharing among the two Departments to determine the number of individuals in SUD treatment who have HIV and the number of individuals who have HIV that are in SUD treatment. The information will be utilized by both Departments to help improve health outcomes for this population by better engaging individuals to seek either HIV or SUD treatment.

Office of Primary Care and Rural Health. DMHAS works with the Manager of the DOH Office of Primary Care and Rural Health on enhancing integrated care at the state's FQHCs, which includes working collaboratively on an RFP in 2025 to build integrated behavioral health into an additional FQHC. In November 2024, DMHAS presented at the 3rd Annual New Jersey Rural Health Conference hosted by the Department of Health to discuss the Travel Reimbursement and Invoicing Program (TRIP) that was developed to remove transportation as an obstacle to accessing health and behavioral health services. The presentation was part of a session on "Innovative Methods of Healthcare Delivery".

Office of Communicable Disease Services. DMHAS works with Office of Communicable Disease Services in efforts to address Hepatitis C and other communicable diseases common to those with a SUD and the DOH Office of Certificate of Need and Licensure to streamline and make effective the state's provider licensure requirements.

Office of Population Health. During calendar years 2020-2022, DMHAS collaborated with the DOH Office of Population Health on its ORO project. The goal of the project was to decrease the number of opioid prescriptions written in the ED and, instead, use alternative non-opioid pharmacological and non-pharmacological (nerve blocks, massage, etc.) approaches addressing, DMHAS issued one-year awards to 11 hospitals and in 2022 made four additional awards. DMHAS managed the program, and the DOH developed a learning collaborative in which awardees were required to participate. During 2020-2022, 114,817 patients received the ORO protocol, and 1,006 providers were trained by May 2021.

Office of Population Health. The New Jersey Department of Health (NJDOH) is in the development phase of the Healthy New Jersey 2030 (HNJ2030) State Health Improvement Plan to promote, strengthen, and evaluate the State's efforts to improve the health and well-being of all people. The Office oversees the statewide health assessment and health improvement plan. DMHAS was a member of the Healthy New Jersey (HNJ) Action Teams between 2022-2023 and will be participating in the re-convened the HNJ Advisory Council to evaluate and prioritize the strategies that were proposed. The teams have been reorganized based on the 2025 SHIP Priority Areas: Access to Quality Care, Healthy Communities, and Healthy Living. DMHAS will serve on the Healthy Living Action Team.

Division of Disaster Preparedness, Resiliency and Emergency Medical Services (DPREMS). DMHAS has been collaborating with DPREMS for years. DMHAS works with this Division's Office of Data Analytics, Resources, and Infrastructure to receive information

on EMS transports of individuals who were reversed from an overdose with naloxone to emergency departments. This allows DMHAS to better monitor the performance of our OORP programs that provide recovery support to these individuals at the specific hospitals where they are located. The OORP program is in 75% of NJ Acute care hospitals.

DOH Office of Women's Health (OWH). DMHAS has formed a new partnership with the DOH Office of Women's Health. The Office for Women's Health (OWH) is dedicated to protecting and strengthening women's health in New Jersey by fostering healthy families and communities. OWH promotes evidence-based healthcare services with a focus on accessibility, innovation, and integration to empower women to live long, healthy, and autonomous lives. The New Jersey Maternal Data Center aims to assure data regarding maternal health and related outcomes are transparent to policy makers, consumers, and relevant stakeholders in New Jersey, through dissemination of data visualizations focused on the maternal health ecosystem.

In partnership with the OWH and the Department of Human Services (DHS) Division of Mental Health and Addiction Services (DMHAS), this project aims to develop a comprehensive spatial analysis and mapping initiative focused on substance use disorder (SUD) among the maternal health population. Utilizing data from the Maternal Data Center and matched hospital discharge and birth certificate records, the project will map treatment access points, including Maternal Wrap-Around (MWRAP), Intensive Outpatient Treatment for Substance Exposed Infants (IOT-SEI), and Medication-Assisted Treatment (MAT) programs, alongside key maternal and infant health outcomes. This visualization will identify geographic gaps in treatment and prevention services, particularly in the critical postpartum period, to support interventions and improve maternal and infant health outcomes.

Other DOH Offices. As a SAMHSA Prescription Drug Abuse Policy Academy State, NJ applied for a unique technical assistance opportunity in 2014 through the SAMHSA supported NCSACW to address the multi-faceted problems of NAS and SEI. NJ DMHAS as the lead State agency, partnered with DCF and DOH, and submitted a successful application (no funding attached). The IDTA goal was to develop uniform policies/guidelines that address the entire spectrum of NAS and SEI from pre-pregnancy, prevention, early intervention, assessment and treatment, postpartum and early childhood. The IDTA provided technical assistance to NJ to strengthen collaboration and linkages across multiple systems such as addictions treatment, child welfare, and medical communities to improve services for pregnant women with opioid and other substance use disorders and outcomes for their babies. The Core Team included over 60 individuals representing multiple State Departments and Divisions, community stakeholders, treatment providers, and the medical community. Three goals were established (1) Increase perinatal SEI screening at multiple intervention points (2) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women screening positive on the 4P's (Parents, Partner, Past and Present) Plus get connected for a comprehensive assessment by establishing formal warm-handoffs and other safety net measures; (3) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women delivering SEIs and their babies and any other eligible children, receive early support services for which they are eligible. Workgroups were formed. The Labor, Delivery and Engagement (Infants) workgroup developed the Birthing Hospital Survey with input from the medical community and perinatal cooperatives. The survey was disseminated statewide in 2017 to labor and delivery hospitals. The survey sought to understand how pregnant women with SUD and SEI, treated, and triaged with partners at discharge and if NAS was explored. The results were intended to guide Departments in establishing statewide guidelines for best practice; aid in the development of cross system models to ensure families get access to services; establish education needs on issues of SEI and NAS and identify high risk areas. In an effort to increase access to SUD treatment and decrease unmet treatment needs of pregnant and parenting women with an OUD and based on the survey findings, DMHAS engaged Rutgers Robert Wood Johnson Medical School to provide technical assistance and training through the Extension for Community Healthcare Outcomes (ECHO) Program. DMHAS Office of Treatment and Recovery Supports continues to support the ongoing Maternal Child Health-Pregnant and Parenting Women with Opioid Use Disorder ECHO series.

New Jersey was awarded another round of In-Depth Technical Assistance (IDTA) through the National Center on Substance Abuse and Child Welfare's (NCSACW) 2023: "Advancing Collaborative Practice and Policy: Promoting Healthy Development and Family Recovery for Infants, Children, Parents, and Caregivers Affected by Prenatal Substance Exposure". The Department of Health is the lead State Department and NJ state representatives include the Departments of Children and Families, Human Services, and the Governor's Office. The state team includes an individual with lived experience. The DMHAS Women's Treatment Coordinator represents the Department of Human Services. The overall goal is to increase awareness of pregnant women and SUD, through increased education and maximizing messaging through the perinatal work force; increase awareness and access to treatment, Plans of Safe Care, and improving screenings in hospitals and healthcare providers. Four goals have been established:

Conduct a statewide landscape analysis of resources available to individuals with a SUD and understand how referrals are made to appropriate resources and levels of care;

Address gaps in the SUD system of care to establish comprehensive and fluid collaborative approach among state agencies, healthcare providers, and community-level and non-profit organizations to address substance use during and after pregnancy;

By 2025, create and execute a state-wide prenatal Plans of Safe Care process that enables community and clinical partners to formally support a birthing woman;

Support birthing hospitals in updating their protocol related to screening and referring pregnant women with SUD; and subsequently engaging in a comprehensive approach to implementing Plans of Safe Care in New Jersey.

Division of Medical Assistance and Department of Health. DMHAS participated on the Maternal and Child Health Policy Innovation Program (MCH PIP) Alumni Policy Academy from August 2023 through April 2024 convened by the National Academy for State Health Policy (NASHP) with support from the Health Resources and Services Administration, Maternal and Child Health Bureau (HRSA-MCH). State partners include DHS with Medicaid as the lead agency, DMHAS and representatives from the DOH and DCF. The overall goal is to improve maternal health outcomes by addressing obstacles (e.g., transportation, child-care, language/low literacy, discrimination) to accessing maternity care; effective referral processes for health-related social needs of pregnant and parenting women. DMHAS maternal child health initiatives (IOT-SEI and MWRAP) provide intensive case management, recovery supports, and services to assist pregnant and parenting women with SUD and co-occurring to access care, address obstacles to help improve maternal health outcomes.

DMHAS participates in a multi-department SUD Health Information Technology (HIT) Plan Workgroup between these two Departments. The Workgroup was formed to promote interoperability between behavioral health and physical health providers caring for SUD/ODU individuals, the State of New Jersey. A total of \$5.4 million in funding was allocated for a milestone-based SUD provider incentive program. The program is now administered by the Department of Human Services, after execution of an MOA that transferred the administration from the Department of Health. It is described more fully under system improvements.

NJ Department of Military and Veterans Affairs (DMAVA). The United States Department of Veterans Affairs (VA) partnered with the Substance Abuse and Mental Health Services Administration (SAMHSA) to continue the Governor's Challenges to Prevent Suicide Among Service Members, Veterans and Their Families (SMVF). For the Governor's Challenge, New Jersey and other participating states are working to develop and implement state-wide suicide prevention best practices for SMVF, using a public health approach. New Jersey began participation in the 2021 Governor's Challenge cohort, and the Division continues to participate in these meetings with DMAVA. DMHAS is part of an interagency military and civilian team to develop a strategic action plan to advance the National Strategy for Preventing Veteran Suicide. Teams are encouraged to include suicide prevention coordinators representing the state public/behavioral health agency, VA, and National Guard. DMHAS initially was co-leading the Governors Challenge along with the NJ Department of Military and Veterans Affairs (DMAVA) and continues to actively participate. This team has produced a state plan to address suicide, and more recently has been meeting to implement goals and objectives in three priority areas set forth by SAMHSA and the VA to prevent suicide for SMVF. The three Priority Area workgroups which are: 1) Identifying SMVF and Screening for Suicide Risk, 2) Promoting Connectedness and Care Transitions, and 3) Lethal Means Safety and Safety Planning.

For Priority Area 1, a goal that has been developed is to conduct another SMVA Needs Assessment Survey in CY 2025 (the last one was in 2022) to determine what supports providers need in serving Veterans. A second goal is to develop a "Have You Served Campaign". As part of this campaign, an effort will be made to help identify American Indian Veterans in New Jersey. A third goal is to develop an "Ask the Question" website following the model developed by New Hampshire. A meeting was held with the DMAVA web designer in July 2025 to begin providing an outline for the website. A goal for completion of the website was set for December 2025. The "Ask the Question" is intended to educate service providers to better understand and providing support and care to military veterans.

Office of the Attorney General. ARRIVE Together is an initiative out of the Attorney General's Office in partnership with DMHAS' contracted providers that has been in effect since 2021 and expanded in 2023 to all 21 NJ counties. ARRIVE Together is a program that pairs law enforcement officers with mental health professionals to respond to behavioral health crises. The goal is to provide immediate support, de-escalate situations, and connect individuals in crisis with appropriate mental health services. This collaborative approach aims to improve outcomes for those experiencing mental health crises and enhance the safety of both the individuals in crisis and the responding officers. DMHAS continues to partner with the Attorney General's Office of Alternative Community Response throughout the implementation of this key initiative.

Department of Labor. The New Jersey Department of Labor and Workforce Development (NJDOLE) Pathways to Recovery Initiative launched in 2019 connects residents impacted by the opioid crisis to employment and offers supportive services in job readiness, skill building and obtaining industry recognized credentials. NJDOLE announced in March 2025 the availability of an additional \$5 million in grant funding for organizations to offer training, employment, and retention services for individuals in recovery. Eligible applicants—including nonprofits, for-profits, government entities, and higher education institutions connected to mental health or opioid treatment centers—can receive up to \$1 million over 24 months starting June 1, 2025. Since its inception, the program has expanded statewide, forged over 1,550 employer partnerships, and supported more than 4,150 participants.

NJ Higher Education Student Assistance Authority In June of 2024, the Department collaborated with the Department of Children and Families and Higher Education Student Assistance Authority to launch the Home and Community Based Services (HCBS) Provider Loan Redemption Program. The program provided eligible workers with up to \$50,000 in loan relief in exchange for one year of service at an approved HCBS location and is funded with \$17.5m in funding from the American Rescue Plan Act.

Eligible professions included psychiatrists, social workers, registered nurses, alcohol and drug counselors, marriage and family therapists, and numerous other HCBS positions providing healthcare, behavioral health, and social services to individuals with medical needs, mental health conditions, and disabilities.

448 individuals enrolled in the loan redemption program, selected from over 1,000 applicants, with the largest groups of participants being registered nurses, licensed social workers, DCF care managers, and licensed professional and associate

counselors.

Law and Public Safety. The Office of Alternative and Community Responses (OACR) within the Department of Law and Public Safety (LPS) strives to, among other things, incorporate public health strategies into public safety responses to the opioid and addiction crises. The Opioid Policy and Response Bureau (OPRB) within OACR provides funding for Operation Helping Hands (OHH), which supports programs in which law enforcement officers play an active role in identifying individuals with substance use disorders (SUD) and together with community partners serve as an entry point to treatment and/or recovery support services. DMHAS and the Office of Alternative and Community Response (OACR) are meeting concerning naloxone distribution and better coordination of services with the goal of continued sustainability. Another goal is to better align where naloxone is distributed and where actual overdoses are occurring.

3. Please describe how the public mental health and substance use services system is organized at the regional, county, tribal, and local levels. In the description, identify entities that provide mental health and substance use services, or contribute resources that assist in providing these services. This narrative must include a description of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

IV. Description of Regional, County and Local Entities that Provide Behavioral Health Services; How These Systems Address the Population Needs

In NJ, the administration and organization of the mental health system includes both centralized, and county or locally based characteristics. A broad array of mental health services is offered in the community, with a number of well-established programs that operate in all NJ counties. The SMHA funds community agencies that provide an array of services including intensive services such as Integrated Case Management Services (ICMS). Persons receiving ICMS services are linked to services upon discharge from a state hospital, county hospital or Short-Term Care Facility (STCF) for 12 months post discharge from an inpatient setting. Other key mental health services available in all parts of the state include Psychiatric Emergency Screening Services, Early Intervention Support Services (EISS), Programs for Assertive Community Treatment (PACT), Outpatient, Acute Partial, Partial Hospital, Supported Employment, and Community Support Services (CSS). Additional programs such as Coordinated Specialty Care Community Integration (CSC CI) are available in many regions of the state, with expansion efforts in progress.

The population in NJ is varied in its makeup. Staff providing services must ensure consumer access. Mental health agencies are required to adhere to licensing standards that require professional credentials and well-trained staff. 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 meet the needs of the population. Several programs and the populations that they serve are described below. By virtue of setting (e.g., hospital emergency departments), coverage (e.g., rural entities), admissions practices, and regulatory protections, acute mental health care programs serve all individuals who satisfy eligibility requirements.

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 well-trained and capable of meeting the needs of clients. Additionally, the grantee is required to ensure that there is a training strategy related to access, quality, and outcomes. Supported Employment and Supported Education are provided throughout the state.

1. DMHAS Services to Statutory Populations

The SMHA provides services to adults with SMI and children with SED with block grant funding. Persons receiving services include those who are at risk of hospitalization and homelessness, population experiencing early psychosis (First Episode Psychosis (FEP) and affective psychosis), persons receiving services in need of SE/SEd, individuals in crisis or receiving emergency services, older adults 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, where mental health Criteria 1 and 4 were addressed. Additional services to specific populations are described below.

2. First Episode Psychosis (Non-Affective) and Affective Psychosis

First Episode Psychosis (FEP) refers to the early stages of someone experiencing psychotic symptoms or a psychotic episode. The Coordinated Specialty Care (CSC) program is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, family members as active participants. CSC provides comprehensive services that include evidence-based pharmacological treatment, supported employment and education services, individual and group psychotherapy, care management, family therapy, and recovery support in community and clinical settings. Services provided to individual clients in a CSC program usually do not exceed 2 years. The population served by CSC are individuals between the age of 15-35 who have experienced psychotic symptoms for less than two years and their psychosis is non-organic. There were 244 individuals served in SFY 2024 and 568 served SFY 2025 with the expansion of the program. NJ originally funded three teams. A need was identified for an increase of available services to individuals with FEP, for access to services for individuals with affective psychosis, as well as for step-down services for those completing the CSC program.

Due to this increased need for services, NJ expanded its Coordinated Specialty Care (CSC) program for First Episode Psychosis to include Affective Psychosis with the start of the Coordinated Specialty Care Community Integration Program (CSC CI). Affective Psychosis is manifest by symptoms of psychosis that are present with mood episodes and most typically involve bipolar disorders or major depressive disorder. Bipolar disorders are defined by the experience of manic and depressive episodes. The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; APA, 2013). The CSC CI also provides the stepped-care approach to provide the opportunity for individuals in CSC to remain engaged with their current team. The Stepped-Care treatment approach is a "3 tier" system where clients can titrate up or down the level of service modality depending on their recovery and/or the need for additional services and supports. CSC-CI program serves individuals 15 years of age and older with an ESMI diagnosis that is non-organic. There are currently five funded CSC CI teams and a sixth region that is not currently covered. In SFY 2024, 189 individuals were served in the CSC program with an additional 55 individuals served in CI program. DMHAS utilized Mental Health Block Grant, Covid Supplemental and ARPA funding to develop these services.

3. Crisis Continuum

A. Crisis Call Centers 988 Implementation. The 988 crisis call centers (also known as contact centers) were funded by both the COVID Supplemental Plan and the American Rescue Plan Act (ARPA). New Jersey originally had five (5) call centers that provided services for the 988 Suicide and Crisis Lifeline. These centers received certification by Vibrant Emotional Health (Vibrant) for meeting the minimum clinical, operational and performance standards. As of September 2022, following the State's procurement process, funding from a combination of federal grants including the SAMHSA 988 Capacity Building Grant, Mental Health/Substance Abuse Block Grants and ARPA, totaling \$3.7 million was awarded to the five (5) NJ Lifeline centers.

With these original contracts, 988 Lifeline centers were able to expand their capacity to meet the growing demand. Comparing calendar year data from 2021 to 2023, NJ experienced a significant increase in call volume while increasing calls answered. From 2021 to 2023, call volume increased 36% and centers were able to respond to 38% more calls. In state fiscal year (SFY) 2024, Lifeline centers received 75,664 incoming calls and answered 59,533 for a statewide 79% answer rate. Calls not answered in NJ were handled by Vibrant's network of national backup centers.

One (1) of the five (5) original contact centers ended their Lifeline services as of July 31, 2024. Contracts with the remaining four (4) centers using these funds ended in September 2024 and were replaced by new contracts using state appropriations and SAMHSA 988 State and Territory Improvement Grant funds. New Jersey now has four (4) Lifeline centers of which all four (4) respond to calls originating in New Jersey and three (3) also respond to chats and texts originating in-state.

B. Mobile Crisis Outreach Response Teams (MCORTs)

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

On March 3, 2025, MCORT services were launched statewide operating weekdays from 7am to 3pm. On March 31st, 2025, MCORT expanded its hours to weekdays from 7am to 7pm. The week of August 11, 2025 MCORT expanded hours to 24 hours per day, every day of the year.

C. Crisis Receiving Stabilization Centers (CRSCs)

CRSCs are currently in the developmental stages and will be established with the mental health block grant 5% crisis set-aside. Covid Supplemental and ARPA funding have been used in the planning, development, staffing, and purchase of equipment and supplies (subject to and limited by federal guidance issued by SAMHSA on July 29, 2025) that are needed to stand up the facilities. The DMHAS has awarded five crisis receiving stabilization centers (CRSCs) which will advance the development of the crisis continuum in NJ based on the National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit. The population served includes individuals who are 18 years of age and older with a primary SMI and/or SUD experiencing acute symptoms that could interfere with community tenure. DMHAS will be using the "no wrong door" concept and partnering with community crisis responders. Services will be available 24 hours per day, 7 days per week, 365 days a year and include access to trained staff who can provide assessment, crisis stabilization, intensive supports, engagement, psychoeducation, identification of strengths, collaborative problem solving, and individualized crisis planning. Services will be offered in a safe, clean, community-based non-hospital environment conducive to the recovery process. Medication management, administration, and education will also be offered. Medication-Assisted Treatment will also be available at the CRSCs. The program will offer continuity of care promoting continued stability and ensuring linkages are arranged that meet the needs of the individual. The goal of this program is to decrease the utilization of local hospital emergency services, designated screening centers, and in-patient psychiatric hospitalization while maintaining crisis stabilization treatment. DMHAS has awarded five agencies to develop up to five centers statewide.

D. Crisis Diversion Homes (CDH)

Crisis Diversion Homes are funded with ARPA funds and will be established for the purpose of offering temporary transitional housing for up to 30 days, within a 24-hour supervised setting. DMHAS has contracts with providers to stand up two crisis diversion homes, each with 5 beds and are staffed 24/7. CDHs will serve individuals 18 years of age or older with an SMI or a co-occurring substance use disorder, forensic involvement, or co-occurring developmental disability. This program will provide community-based stabilization in a home-like setting and is not long term or permanent housing. Therapeutic and social supports will be provided in a warm and safe environment to individuals who do not need further hospitalization. The length of stay for this program is dependent upon an individual's need and is anticipated to be up to 30 days. At a minimum, staffing will include licensed clinicians, nursing coverage, behavioral health technicians, and a prescriber. Although the crisis diversion housing is not permanent, individuals experiencing a recent psychiatric hospitalization or relapse will receive the support they need from professionally trained and dedicated staff to continue their recovery in the community. Referrals to CDHs will be prioritized for individuals with complex behavioral health needs that require significant services and supports to return to the community and who have received crisis intervention services in a Crisis Receiving Stabilization Center, from Mobile Crisis Outreach Teams. Individuals may also be referred from DMHAS' Diversion Unit. The Crisis Diversion Homes will include linkages to peer supports, clinical services with a goal of community re-integration to permanent or long-term housing and supports for the person receiving services. DMHAS will not be using ARPA funds for capital expenditures.

E. Crisis Diversion Beds

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

F. Inpatient Diversionary Beds

The DMHAS contracts with inpatient providers to purchase bed-days in inpatient facilities, known as "Diversion" contracts. The purpose of the Diversion contracts is to afford individuals age 18 and older with an SMI who would otherwise be admitted to a state or county psychiatric hospital the opportunity to receive treatment in an inpatient setting, which may enable the individual to stabilize and be discharged to the community. The primary goal of the purchase of bed days is to avert admissions to state hospitals. Individuals who do not stabilize and require continued inpatient treatment may be transferred to a state or county hospital at the conclusion of their approved length of stay in the contracted Diversion bed. The hospitals that contract for Diversion beds maintain additional bed capacity that is not governed by their DMHAS Diversion contract, and serve a similar population in this additional capacity. DMHAS currently contracts for access of up to 52 beds at three private psychiatric facilities - Carrier, Hampton, and Northbrook that offer an alternative to state psychiatric hospitalization. In CY 2024 there were 806 admissions utilizing 19,850 bed days and 95% were diverted from a state hospitalization. In CY 2023 there were 707 admissions utilizing 17,250 bed days and 94% were diverted from a state hospitalization.

4. Peer Recovery Support

Peer Respite Beds

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

5. Acute Care Services

A. Designated Screening Centers (DSCs)

DSCs are designed to provide psychiatric emergency services including screening, assessment, crisis intervention, referral, linkage, and crisis stabilization services, 24 hours per day, 365 days per year, in every geographic area in the state. The SMHA funds 23 Designated Screening Centers (Screening and Screening Outreach) programs across the 21 Counties. According to the SMHA's Quarterly Contract Monitoring Report (QCMR) database of information self-reported by the screening programs, there were 74,755 episodes of care to these screening centers during SFY 2025. Of the 74,755, there were 61,306 adults served and 13,449 youth served.

B. Affiliated Emergency Services (AES)

AES provide for behavioral health staffing at emergency departments, including a mental health provider who is responsible for

the provision of emergency services to individuals in crisis presenting in hospital emergency departments. Emergency service includes mental health and social services provision or procurement and advocacy. Emergency services offer immediate crisis intervention services and service procurement to relieve the client's distress and to help maintain or recover his or her level of functioning. Emphasis is on stabilization, so that the client can actively participate in needs assessment and service planning. Emergency service is affiliated by written agreement with the geographic area Designated Screening Center. (N.J.A.C.10:31). There are 12 Affiliated Emergency Service programs which are located in the following counties: 3 in Hudson, 1 in Middlesex, 3 in Monmouth, 2 in Morris, 1 in Passaic and 2 in Union. AES programs serve both the adult and youth population. There were 25,255 individuals served in SFY 2025. Of the 25,755, there were 20,859 adults served and 4,896 youth served.

6. Disaster Response

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

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

Mental Health First Aid (MHFA) teaches participants how to identify and respond to signs of mental health and substance use concerns. The 8-hour course introduces participants to risk factors and warning signs of behavioral health crisis, builds understanding of their impact and provides an overview of common treatments. Through role-playing and videos, it demonstrates how to assess a mental health crisis, select interventions, provide initial help, and connect people to resources. Mental Health First Aid is evidence-based, evidence-informed and proactively updated. A number of research studies have shown that training in Mental Health First Aid results in better knowledge, attitudes, and support.

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

Both MHFA and QPR trainings and materials are provided at no cost to hosting agencies and the public.

B. MHBG BSCA (9/30/2023 - 9/29/2025)

The Disaster and Terrorism Branch (DTB) is in its second cycle of the Bipartisan Safer Communities Act (BSCA), we utilize this funding to expand the existing behavioral health services continuum in the aftermath of traumatic events that impact the psychological health of New Jersey residents. Outlined below are multiple initiatives that help support this work.

1) Disaster Response Crisis Counselor

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

Disaster response is always local and the DTB has cultivated successful working partnerships with the County Mental Health Administrators and the County Alcoholism and Drug Abuse Directors, who are responsible for the planning of behavioral health services in their counties. A subaward has been given to each interested county to fund recruitment, exercise drills, training activities as well as engagement efforts for Disaster Response Crisis Counselors.

The DTB continues to promote the DRCC program through dissemination of printed materials, podcasts, and timely webinars that focus on current responses, lessons learned and emerging trends in the field.

2) Learning Management System

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

3) Critical Incident Stress Management

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

4) Traumatic Loss Coalition

The DTB deploys DRCC's to work with all residents of New Jersey. However, when there is an incident primarily impacting youth and young adults, DTB works closely with New Jersey's Traumatic Loss Coalition (TLC). DTB has successfully strengthened this partnership through cross-training. To date, 417 responders have been certified in the "Managing Sudden Traumatic Loss" (MSTL) response model. Specifically, the goal is to:

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

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

5) BTAM Team Initiative

The NJ BTAM (Behavioral Threat Assessment and Management) Team is a centralized resource focused on the sharing of information, knowledge, and leveraging support of first responders and behavioral health professionals for the purpose of threat management. When first responders identify a community threat, the team convenes to provide consultation in reviewing individuals at risk for the potential of engaging in violence or other injurious activities and recommending intervention strategies to manage the risk of injury for individuals who pose a potential safety risk. The team includes representatives from several state and federal agencies and organizations including first responders, intelligence, education and behavioral health sectors. Each member of the team has advanced training in behavioral threat assessment and works collaboratively to prevent acts of violence through early identification, consultation, and management of individuals displaying concerning or threatening behavioral indicators. The team's goal is to decrease the number of incidents that occur by creating diversion pathways for at-risk individuals into programs for behavioral health or other services. DTB has played an integral role in the BTAM, with our Unit Director and Director of Training attending meetings weekly and sharing the mental health perspective on threat assessment.

6) Emergency Partnerships

The DTB works in coordination with the NJ Department of Human Services' Office of Emergency Management (OEM) in planning for the aftermath of a disaster. We have used the BSCA grant to conduct an Interagency Collaboration and Communication Workshop Series. The workshop series was successful, as it enhanced effective collaboration and communication strategies to better coordinate efforts during mass casualty events and disasters. By fostering collaboration and sharing best practices, we intend to improve future outcomes and decrease behavioral health challenges that can occur in the chaos of crisis response. Our most recently held event was entitled "Enhancing Behavioral Health Support in Mass Casualty Events", which focused on promoting effective communication and collaboration among Emergency Managers and partnering agencies during mass casualty or disaster incidents. We plan to collaborate with emergency partners to co-host exercise drills as well. By conducting disaster behavioral health exercises, DTB prepares members of the DRCC's and other crisis teams for their role in Reunification and Family Assistance Center operations. The overarching goal is to break down existing silos to prevent duplication of services and to educate partners about the importance of improving behavioral health outcomes in the immediate aftermath of a community crisis. The workshops include education and planning for all partners to address needs of individuals with serious mental illness and those living with substance use disorders.

C. teen Mental Health First Aid (6/15/2022 – 9/30/2025)

The Disaster & Terrorism Branch (DTB) has partnered with the Mental Health Association in New Jersey (MHANJ) to provide teen Mental Health First Aid (tMHFA) to high schools throughout NJ. tMHFA is designed for teens aged 15-18 or those students in grades 10-12. This course reviews typical adolescent development, common mental health challenges for youth, and teaches a 5-

step action plan for how to help young people in both crisis and non-crisis situations. tMHFA training gives teens the tools of awareness; assisting them with the ability to identify when they or their friends are experiencing emerging mental health challenges, worsening signs and symptoms, or experiencing a crisis. Because one in five teens will experience a mental health challenge by age 18 (National Council, 2023), the tMHFA model is an investment in our youth and those adults that are in regular contact or caring for them.

7. Governor's Mental Health Initiatives

A. tMHFA Expansion

The Division of Mental Health and Addiction Services' Disaster and Terrorism Branch (DTB) has expanded funding for teen Mental Health First Aid for the benefit of students and school personnel in several NJ high schools. Building on DTB's initial implementation and lessons learned of tMHFA in eighteen (18) New Jersey high schools, this expansion allowed the Mental Health Association in New Jersey (MHANJ) to broaden the project to include thirty-five (35) additional high schools offering multi-year support for teens, school staff and families; in total 63 high schools have joined the initiative. To add, youth serving organizations will be invited to join the project and partner with schools to support continued training and sustainability. The project will extend through two academic years with materials and consultation made available in the third year to imbed tMHFA into school curriculums for sustainability.

B. MHFA on College Campuses

The National Council of Mental Wellbeing, the facilitators of the Mental Health First Aid curriculum, have a module specifically for the higher education community which is utilized for this initiative. This training curriculum allows students, faculty, administrators and other school staff to identify risk and protective factors as well as to decrease the stigma of receiving needed behavioral health services. Mental Health First Aid (MHFA) is a way to identify and respond to behavioral health changes in our young adults. MHFA was designed to extend the concept of first aid training to behavioral health. MHFA teaches participants to recognize signs and symptoms, listen nonjudgmentally, and appropriately refer a person to supports and services. The Division of Mental Health and Addiction Services' Disaster & Terrorism Branch (DTB) will make MHFA available on college campuses throughout New Jersey. At this time, the program is not able to launch due to a procurement delays. Ultimately our goal is not only to train students, but each campus will be invited to nominate staff to become MHFA instructors in order to sustain the curriculum on campuses long-term.

C. Higher Education Peer Counseling

This initiative has been branded as "Campus Cares" and will host several psychoeducational sessions at multiple campuses in NJ including topics such as: Understanding Personal Boundaries, Addressing Loneliness, and Understanding Financial Stress. Although the Campus Cares sessions that were held reached students, DTB wants to reach more students across the State. DTB is currently in the process of procuring vendors to assist colleges/universities with their mental health/wellness goals.

8. Services to Veterans, Service members and their families.

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. According to the SMHA's USTF+ client data system 1,394 consumers admitted into and transferred into DMHAS supported services in SFY2024 self-identified as veterans, which represents 1.3% of unduplicated consumers admitted in that period of time³. These individuals 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. In prior communications between the SMHA and with the NJ Veterans Administration Healthcare System (VA) VANJ, and differences between their estimates and what was reported in the USTF system at the time, it may be supposed that the actual number of veterans served in SFY2024 is closer to 2,373. This variance may be because many active or former service members may not consider themselves as veterans (with regards to responding provider intake questions).

The SMHA has periodic meetings and communications with the NJ Healthcare System (VA) to enhance collaboration, particularly around acute care services. A SMHA representative continues communication with the NJ Department of Military and Veterans Affairs (DMAVA) and collaborates regarding needed services for New Jersey National Guard (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 point 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 to New Jersey's veterans is an area of focus. 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 has participated in the SAMHSA- supported Governor's Challenge to Prevent Suicide Among Service Members, Veterans and Their Families (SMVF), which is led by the New Jersey Department of Military and Veterans Affairs (DMAVA) in collaboration with the United States Department of Veterans Affairs (VA). The initiative has been working to develop and implement state-wide suicide prevention best practices for SMVF, using a public health approach. With the support of the governor, each state formed an interagency military and civilian team to develop a strategic action plan to advance the National Strategy for Preventing Veteran Suicide. The NJ Governor's Challenge team includes behavioral health and suicide prevention coordinators representing the state public/behavioral health agency, VA, and National Guard, veterans service organizations, as well as county level public entities and nonprofit organizations. The NJ initiative has three priority area workgroups that are developing and carrying out a plan to ensure that veterans are identified by service provider, that they are being screened and assessed for suicide risk and related needs, and that they receive lethal means counselling and safe firearm storage education. The goals of the priority area workgroups, along with a comprehensive list of resources for SMVF, and information about related initiatives, are on a dedicated DMAVA website SaveNJVets (<https://www.nj.gov/military/savenjvets/>).

9. 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 and virtual outpatient services at several outpatient locations in the Northern region of the state, with Masters level clinicians who are staff in Deaf Community and fluent in American Sign Language (ASL). They also provide 24/7 statewide consultation for psychiatric emergency services (Clinicians can be reached onsite during business hours by phone/Videophone) and after hours by calling our on-call service number). Consultation is also available to inpatient settings, and outpatient programs. ACCESS staff participates in the NJ training for Certified Psychiatric Screeners. The purpose for this is so that screeners are able to understand, navigate, and explain the state's screening process when working with an individual who is Deaf to ensure the Deaf client is assessed in an appropriate manner in accordance with NCLAS. Additionally, ACCESS provides onsite clinical consultation and liaison services to NJ's Short Term Care Facilities (STCFs), assisting with treatment and discharge planning for each deaf patient.

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

In the Southern Region, South Jersey Behavioral Health Resources (SJBHR) operates a 5-bed supervised community residence for deaf individuals with a mental illness who are either discharged from the state hospital, other inpatient setting, or are already reside in the community and could benefit from this service. Additionally, SJBHR operates a regional adult partial care program to serve this population.

NJ has the Statewide Inpatient Program (SIP) for the Deaf at Greystone Park Psychiatric Hospital in Morris Plains. The SSIP consists of a 25-bed locked inpatient unit in the main hospital building and an eight-bed capacity less restrictive residential cottage to prepare individuals for discharge. The SSIP is staffed with a professional clinical team skilled in ASL and Deaf community. Additionally, all paraprofessional SSIP staff are trained in ASL and providing services to the Deaf community. Registry of Interpreters for the Deaf (RID) certified ASL Interpreting staff are available for patient and staff interfaces, particularly clinical contacts.

The Statewide Deaf Advisory Committee (DAC) meets quarterly to review systems of care, as related to Deaf services and mental health in the State of New Jersey. Pursuant to Administrative Bulletin 5:07 [Section 504 of the Rehabilitation Act of 1973 (P.L. 93-112), and the Americans with Disabilities Act (ADA) (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.

Compliance with Anti-discrimination Laws

10. ARRIVE Together Community Resource

ARRIVE Together is a co-responder first responders and behavioral health professional co-responder model. It is a transformative and powerful model, de-escalating situations without use of force with a dramatic decrease in transport to the emergency

department.?

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

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

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

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

V. Initiatives funded under Covid Supplemental and ARPA

1. Coordinated Specialty Care (CSC) and CSC Community Integration- Covid Supplemental, ARPA and BSCA funding.

Since its inception in November 2016, NJ Coordinated Specialty Care (CSC) programs have gone through a rapid expansion. The initiative was covered statewide by three providers and designed to serve 105 clients annually. The CSC initiative was serving double the clients at 210 annually (70 per program) with some clients still receiving service after two years in the program. The three providers covered 7 counties each. This presented a challenge for providers covering the vast territory as well as for individuals receiving services because of the time spent traveling to the provider agency and the lack of access in the county of residence. The original teams could not serve individuals with affective psychosis and the teams were receiving many referrals and requests for services to those in need. Most outpatient programs did not specifically fit the programmatic needs of an individual discharged from a CSC program.

In 2023, NJ expanded its Coordinated Specialty Care (CSC) program for First Episode Psychosis to include Affective Psychosis. A stepped care approach (Community Integration or CI) was added to provide the opportunity for individuals to continue after the CSC two-year program and to remain engaged with their current team. There are currently five funded teams and a sixth region that is not currently covered. The staffing for each team has been increased to provide for a caseload of 200 in its first full year of operation (2025-2026), for 300 in year two (2027) and for 400 in year three and beyond (2028 and continuing). Individuals ages 15-35 are eligible for the CSC program that have an Early Serious Mental Illness diagnosis for less than or equal to 2 years at the time of admission to the CSC program. CSC-CI program are individuals 15 years of age and older with an ESMI diagnosis that is non-organic

The CSC program is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, family members as active participants. CSC provides comprehensive services that include evidence-based pharmacological treatment, supported employment and education services, individual and group psychotherapy, care management, family therapy, and recovery support in community and clinical settings. Services provided to individual clients in a CSC program usually do not exceed 2 years.

The CI program is designed to address the need for the CSC continuum of care. The Stepped-Care treatment approach is a "3 tier" system where clients can titrate up or down the level of service modality depending on their recovery and/or the need for additional services and supports. Individuals in the CI program will receive more or less intensive care and units of service in accordance with their assessed need and treatment plan. Individuals will continue to receive CI services from their current CSC clinicians, prescribers, Supported Employment and Education Staff and Certified Peer Recovery Staff, in accordance with assessed level of need in order to preserve continuity of care and support.

Coordinated Specialty Care and Community Integration treatment and supports are geared toward:

- reintegration of the client into the community,
- return to school/work,
- symptom stabilization,
- diversion from inpatient services
- a decrease of screening center utilization.
- decrease in duration of untreated illness

increase in medication adherence
increase in level of functioning
decrease hospital recidivism
integration of health and behavioral health via continuity of care between the CSC-CI APN and the client's primary care practitioner

2. Crisis Receiving Stabilization Centers- Funding from Covid Supplemental, ARPA, and BSCA

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

3. Crisis Diversion Homes- Covid Supplemental funding

The SMHA has identified gaps in its system of care that are attributable to extended emergency room stays. As such, the SMHA will be looking to bridge the gap between homelessness and permanent housing by developing two community-based Crisis Diversion Homes that are staffed 24/7. This is a transitional program providing services that are provided until the client is stabilized and community supports, services and permanent housing have been arranged. This will provide the client the opportunity to remain in the community with needed supports. Services provided by this program are on a temporary basis. Referrals will be prioritized for the Crisis Receiving Stabilization Centers and Mobile Crisis Outreach Teams. Referrals will be made thru DMHAS.

4. Psychiatric Emergency Screening Services (PESS) Peer Support Diversion: Funding from Covid Supplemental and from ARPA

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

5. CHLP - Community Health Law Project- Funding from the Covid Supplemental grant.

The Community Mental Health Law Project - Legal Assistance due to Covid/Housing Stability was funded by both COVID Supplemental Plan and ARPA plan. These resources will also be used to support legal needs of SMI persons receiving services that have arisen as a result of COVID, e.g., evictions. New Jersey and the federal government have eviction moratoriums in place related to COVID. Once the eviction moratorium is lifted, landlords will be able to commence eviction proceedings. Housing stability is an important component of recovery. The DMHAS will use funds to support legal services focused on housing stability to avert homelessness through eviction. DMHAS will use the MHBG COVID Supplemental to enter into a contract with an agency that is staffed to provide landlord/tenant legal services to individuals with SMI facing eviction. Services will be provided statewide. DMHAS will use ARPA grant funding to continue to fund the Community Mental Health Law Project for 1.5 years. The funding will not be used for rent.

6. CT-R or Recovery-Oriented Cognitive Therapy- Funding for CT-R from Covid Supplemental.

CTR, or Recovery Oriented Cognitive Therapy, has been funded through MHBG COVID Supplemental plan. CT-R training was given to mental health providers by the Beck Institute, which developed a Center of Excellence for CT-R with the funding. Guided by Dr. Aaron T. Beck's cognitive model, CT-R is an evidence-based practice that provides concrete, actionable steps to promote recovery and resiliency. Originally developed to empower individuals given a diagnosis of schizophrenia, CT-R applies broadly to individuals experiencing extensive behavioral, social, and physical health challenges. CT-R is highly collaborative, person-centered, and strength-based, and tailored to those who have a history of feeling disconnected from and distrustful of mental health professionals.

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

created of a COE website to publicize training opportunities, provide resources to providers across the state, and host CT-R training materials (guidelines, useful tools, videos)

recruited New Jersey nonprofit agencies that provide services to adult outpatients who have a primary diagnosis of a serious mental health condition

conducted a virtual kickoff for agencies from across the state

began to train (focus groups and the workshop) the first cohort of 7 programs

intensified recruitment efforts for a second and third cohorts of training on Community Support Services teams and Group Homes

created promotional materials to get the word out about the COE

set up incentivizing process to get money to trainees

provided technical support consultation to Peer Providers

Since the initial COE-CTR initiative, DMHAS has extended the program to address other settings, including older adults who receive services in nursing facilities. The Ct-R training is being provided on a pilot basis to a consultant and trainer organization that serves nursing homes with seriously mentally ill populations.

7. Teen Mental Health First Aid – Covid Supplemental funding and ARPA funding.

Since 2022, we have partnered with the Mental Health Association in New Jersey (MHANJ) to provide the National Council of Mental Wellbeing's Mental Health First Aid curriculum to high schoolers throughout our State. MHBG COVID Supplemental and ARPA funding has allowed us to expand the scope of this program multiple times. MHANJ has provided this training, referred to as teen Mental Health First Aid to sixty-three (63) high schools in the State of New Jersey, benefiting 12,006 students to date.

The teen Mental Health First Aid curriculum goal is to mitigate the need for hospitalizations and higher levels of care for the SED population by identifying those at high risk and creating safe interventions. The curriculum addresses the stigma that this vulnerable population can feel as they navigate the high school environment. Teen peers are taught to identify signs and symptoms of significant mental health disorders such as anxiety, depression, substance abuse, and psychosis. Additionally, safety planning with a trusted adult, and identifying resources are part of this evidence-based curriculum.

8. 988 Implementation – New Jersey has not established a methodology to estimate incidence of SMI among adults and will be requesting technical assistance. New Jersey has not established a methodology to estimate incidence of SMI among adults and will be requesting technical assistance. Funding from Covid Supplemental and ARPA.

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

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

B. Web-based Electronic Referral System and Crisis Management Module is funded with Covid Supplemental funding and ARPA funding.

Web-based Electronic Referral System Funding enabled DMHAS to procure a web-based data system that provides a registry for behavioral health beds and services to facilitate access for persons with SMI. The data system maintains information and communications on community and acute care referrals and provide the information needed to monitor referrals and intervene to facilitate placement and linkages to services. The electronic registry will assist in diverting admissions from emergency rooms and inpatient settings including state hospitals. The electronic registry is necessary to enhance movement along the continuum of DMHAS services. Eventually, data system will foster a continuum of community-based care that meets the needs of the individual where they live. The registry will contain a public facing portal for individuals to be able to request an appointment with a service provider.

C. Web-based Electronic Referral System - Crisis Management Module

The crisis management module expedites access to assessment and mobile outreach so that those in crisis can be linked to treatment if desired. Prospectively, the module will track their journey from crisis call to treatment and coordinate all stakeholders' information within a crisis management system. The module, combined with the referral system, will support collaboration between the state, first responders organizations, local community organizations, faith-based organizations, and other behavioral health stakeholders in their efforts to ensure the integrated delivery of appropriate, evidence-based, and family-centered services. The system provides a real-time connection between crisis call center professionals, crisis response teams, and treatment providers. The Service Availability dashboard displays the availability and location of mobile crisis teams, along with the directory and availability of behavioral health providers at two distinct dashboard tabs. Crisis teams are dispatched using GPS-enabled technology and can view the caller's intake information, accept the dispatch, and document their assessment and plan at the scene. The crisis teams can, in turn, use the Service Availability dashboard to find available crisis beds or refer for an outpatient assessment and treatment. The module's framework is based on SAMHSA's crisis management best practices and core elements of 1. No "Wrong Door" Access; 2. Regional Crisis Call Centers; 3. Mobile Crisis Team Response; and 4. Crisis Receiving Stabilization Facilities. The technology provides real-time situational awareness and connection to all crisis stakeholders so that crisis professionals can connect persons receiving services to care more quickly.

10. Performance Improvement -Evaluation of programs

Performance Improvement Evaluation is funded by ARPA. DMHAS is in negotiations with a provider to do the performance evaluation of the initiatives funded under the ARPA grant. The vendor is tasked with completing a performance evaluation that examines the development and implementation of the initiatives funded under ARPA. The vendor will interview DMHAS program leads as well as interview a sample of providers and identify potential best practices across initiatives that may be further implemented throughout the state. Areas of strength as well as potential areas in need of improvement in the mental health services system will be identified along with recommendations for the sustainability of the initiatives after ARPA funding has ended.

11. CSOC-Acute Care Services Capacity Improvement Program

Children's System of Care (CSOC) Acute Care Services Capacity Improvement Program is funded by ARPA.

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

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

12. Older Adults Expansion for 50+ yrs. Population

Older Adult expansion services is funded by ARPA. The IMPACT (Improving Mood, Promoting Access to Collaborative Treatment) and PEARLS (Program to Encourage Active, Rewarding Lives for Seniors) programs were replaced with an older adult expansion

initiative described below.

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

13. Peer Wellness Program

Peer Wellness Program was funded by COVID supplemental funding plan. The Mental Health Association in New Jersey, Inc (MHANJ) was awarded the Whole Health Learning Collaborative (WHLC) January 2023. The NJ Peer Connection (NJPC), which is the project's name, involved meetings with the leadership of all division-funded wellness centers and has started to meet in person to each wellness center for one-to-one technical assistance. Technical assistance is described as in person collaboration/conversation and an informal needs assessment between NJPC and Wellness Center staff and membership, gathering ideas for events, wellness center whole health initiatives past and/or present, current barriers/goals since COVID19, etc. NJPC has launched resource webinars through its United by Wellness (UBW) virtual platform who has existing membership comprised of wellness center staff and membership.

Beginning on 03/29/2023, the webinar/resource meetings were held twice a month for remaining 9 months of contract. In addition, MHANJ has been working with GoMo Health working on the creating the dashboard and implementation of the texting platform. MHANJ has additionally presented the whole health initiative of NJ Peer Connections at the 2023 COMCHO meeting. Lastly, NJ Peer Connections held its first Statewide event in May 2023.

The contract for the Whole Health Learning Collaborative to support the Community Wellness Centers was extended and continued until March 2025. This collaborative but will also feature utilized some of the same elements that made the project a success in 2024, but new centers were added to the collaborative, in addition to the returning from the prior year. The initiative's first in-person event was held at the Crowne Plaza in Edison, NJ. The all-day event included workshops, networking, vendors, and was a great success. The WHLC Team made in-person site visits with the newly contracted centers and virtual support was provided for the existing centers; in-person site visits were available for the existing centers upon request and monthly think tank sessions were also held.

14. Crisis Pilot Collaborative

First responder Crisis Pilot Collaborative is funded by the ARPA. A pilot program to be implemented between a DMHAS crisis diversion funded program such as Early Intervention Supportive Services (EISS) program or Crisis Receiving and Stabilization program, and a local first responders where individuals in crisis will be able to communicate with a clinician on the EISS or Crisis Receiving and Stabilization team via an IPAD for assistance and potentially avoid an emergency room admission or an inpatient psychiatric admission through this intervention. The use of electronic platforms such as Doxy.me is free for the minimum service. The budget includes a cost of 90 IPADs equipped with Wi-Fi + cellular connectivity.

15. Acute Care Systems Review Committee (SRC) Technical Assistance - the Acute Care TA program is funded by ARPA plan.

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

16. Screening Center Communication for Individuals that are Deaf and Hard of Hearing: is funded by ARPA

In support of the Screening Center Communication for Individuals who are Deaf and Hard of Hearing initiative, this funding will be used to purchase tablets and accessories for working with individuals who are deaf and hard of hearing during psychiatric emergency screening for two additional screening centers. The equipment will be used by staff who provide services to individuals with serious mental illness (SMI) who are deaf and hard of hearing.

17. Designated Screening Services (DSS): This initiative is funded by ARPA plan.

Designated Screening Services: In order to support the expansion of mobile crisis outreach and address systemwide needs of individuals with SMI, this proposal requests funding for 33 vehicles for 23 Designated Screening Services programs and technology, including tablets, hotspots, and related accessories (i.e., headsets) for the 23 DSS programs in New Jersey. This

investment directly supports the statewide goal of expanding mobile crisis capacity, decreasing unnecessary emergency department use, and improving timely access to behavioral health care in the community for individuals with SMI. The technology will be utilized by the staff serving individuals with SMI.

18. Mental Health Fee for Service (FFS) Program: This initiative is funded by ARPA.

The MH FFS Program pays provider agencies under contract with the DMHAS to deliver community-based mental health services on a fee-for-service basis. Payment through the MH FFS Program is prohibited when other sources of payment are available, such as Medicaid, Medicare, charity care, or private insurance. The mental health programs eligible for ARPA funding through the MH FFS Program will include the following outpatient programs:

Adult Community Mental Health Rehabilitation – community mental health rehabilitation services include assessment, development of a comprehensive service plan and implementation of the service plan through individual services coordination, training in daily living skills, and supportive counseling, intended to restore individuals with a serious mental illness to their maximum level of functioning. Activities are designed to develop, strengthen, and maintain the knowledge, behaviors, adaptive, and coping skills in all areas of life. Skill development is provided in areas of self-care maintenance, illness self-management, accessing and utilizing community resources, and social interaction. Interventions include counseling, crisis intervention, medication education, health care monitoring and oversight.

Outpatient - mental health services provided in a community setting. Services include psychiatric evaluation, medication monitoring, individual therapy, group therapy and family therapy.

Partial Care - individualized, outcome oriented, structured, non-residential program offered in a non-hospital setting. The program includes active treatment and psychiatric rehabilitation.

Integrated Case Management Services - individualized, collaborative and flexible outreach service designed to engage, support and integrate individuals with serious mental illness into the community of their choice and facilitate their use of available resources and supports in order to maximize independence. Provided primarily in the consumer's natural environment. ICMS services include, but are not limited to assessment, service planning, service linkage, ongoing monitoring, ongoing clinical support and advocacy.

Programs of Assertive Community Treatment (PACT) - comprehensive, integrated rehabilitation, treatment and support services for individuals with serious and persistent mental illness, who have repeated psychiatric hospitalizations and who are at serious risk of psychiatric hospitalization. Provided in the consumer's home or other natural setting by a multi-disciplinary treatment team. PACT is the most intensive program element in the continuum of ambulatory community mental health care.

Community Support Services (CSS) - mental health rehabilitation services that assist individuals with serious mental illness and severe mental health needs to attain the skills necessary to achieve and maintain their valued life roles in employment, education, housing, and social environments.

Reimbursement is limited to non-profit provider agencies under DMHAS contract to provide treatment, rehabilitative and support services to individuals with a serious mental illness (SMI).

19. Consumer Connections: This initiative is funded by ARPA.

Consumer Connections is the consumer training component of the Mental Health Association of New Jersey. They provide individuals who have lived experience with access to the Certified Peer Recovery Staff (CPRS) training, which is critical to providing a strong peer work force in the state.

SSA

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

DMHAS is the Single State Authority (SSA) for substance use disorder treatment and services in New Jersey. Between the Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant and other federal and state resources. The SSA provides services across the continuum of care, which includes prevention, early intervention, treatment and recovery support.

In FFY 2025, the SSA funded: a) 21 county-based prevention coalitions (provided by 19 prevention agencies) serving all of NJ's counties for the provision of prevention programs with a focus on environmental strategies, b) over 30 community-based prevention providers that offer a variety of evidence-based curricula for children, adolescents, older adults, and families, c) two state institutions of higher education that provide early intervention services (Rutgers University and The College of New Jersey), e) housing continuum including four recovery-based housing residences with case management and supportive services for individuals with an opioid use disorder (OUD) who are homeless or at risk of homelessness, and Oxford houses f) a Women's Intensive Supportive Housing (WISH) program, g) two Intensive Supportive Housing (ISH) programs, h) 24-hour Addictions Hotline

services, i) 23 recovery support centers, j) Mobile Medication Units k) 21 Opioid Overdose Recovery Programs, l) 21 Support Teams for Addiction Recovery, m) 20 Older Adult Education Programs, n) three Family Support Centers, o) a Telephone Recovery Support program, p) an addictions workforce training and development initiative, q) 21 county governments for the provision of services throughout the continuum of care, r) funding through a Request for Letter of Intent (RLI) for all county jails to incorporate or enhance Medication Assisted Treatment (MAT) as well as case management services for individuals who are incarcerated in county jails who have an Opioid Use Disorder (OUD) at the jail, s) 5 Integrated Opioid Treatment and Substance Exposed Infants programs, t) 7 regional Maternal Wraparound programs, and u) an Intensive Recovery Treatment Support program. Legal and navigation services and temporary shelter housing with case management and housing subsidies will be implemented in FFY 2026.

DMHAS utilizes the American Society of Addiction Medicine (ASAM) principles in client placement. Within its treatment continuum, ASAM levels of care range from Early Intervention, Withdrawal Management (ambulatory and residential), Outpatient, Intensive Outpatient, Residential (Short-term, Long-term, Halfway House), Partial Care and Opioid Maintenance. As of July 31, 2025, there were 287 licensed substance use disorder treatment provider agencies accounting for 363 Standard and 349 Intensive Outpatient sites, 190 Partial Care sites, 50 Opioid Treatment Program (OTP) sites, 30 Halfway House sites, 49 Long-Term Residential sites, 57 Short-Term Residential sites, 17 Ambulatory Detox sites, 53 Residential Detox sites and 2 Extended Residential sites. A significant achievement is that there is an OTP in 19 of NJ's 21 counties. Bergen, Hunterdon, Salem are the counties with no OTPs.

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 use disorder, 4) the substance use treatment needs of people who are deaf, hard of hearing or disabled; women who are pregnant or have dependent children; 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) 2024, there were 81,217 substance use disorder treatment admissions and 78,797 discharges reported to the SSA through its New Jersey Substance Abuse Monitoring System (NJSAMS). Of these admissions, 45,914 were unduplicated. There were 15,323 fee-for-service (FFS) admissions. For primary drug at admission, 36% reported heroin and other opiates and 42% reported alcohol. Data for CY 2024 indicate that only 15% of Methadone is planned and 10% of Buprenorphine in treatment for clients admitted to treatment, yet heroin and other opiates are the primary drugs for 36% of admissions entering New Jersey's addiction treatment system. Most admissions were to outpatient care (21%), followed by intensive outpatient care (20%). Regarding age, 1% were under 18 years old, 2% were 18-21 years old, 14% were 22-29 years old, 66% were 30 to 54 years old and 18% were over 55 years old. Clients who did not have insurance at admission increased (15%). Those who had Medicaid was 71%.

The SSA's primary population served are individuals who are indigent and in need of substance use disorder treatment. Priority is given to certain groups of those in need: persons who inject drugs (PWID), pregnant women and women with dependent children, and individuals with/or at risk of HIV or TB. Other groups in need of services include individuals with the following: co-occurring mental illness; homelessness; deaf, hard of hearing or disabled; older adults; military service, and intoxicated drivers.

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

State Government

The SSA strives to promote the prevention and treatment of substance use disorder, support the recovery of individuals affected by the chronic disease of addiction, and promote the use of evidence-based practices. The SSA is responsible for regulating, monitoring, planning and funding substance abuse prevention, early intervention, treatment and recovery support services in New Jersey. In addition, the SSA assists with training the addiction treatment, prevention and recovery workforce. The SSA provides leadership and collaborates with providers, consumers, families, and other stakeholders to develop and sustain a system of client-centered care that is accessible, accountable to the public and grounded in best practices that yield measurable results. The SSA monitors substance use disorder treatment provider agencies for quality assurance and compliance with required assessment and treatment protocols and for other contractual requirements.

County Government

In New Jersey, county governments also play an important part in the overall functioning of the public behavioral health system. Since 1983, a portion of the proceeds of the state's alcoholic beverages tax has been dedicated to the production and implementation of county comprehensive plans in all 21 counties. The plans correlate county resources to the needs of individuals with alcohol and drug use disorders. Originally, the scope of these plans was limited to the needs of individuals with an alcohol use disorder. In 1989, both the scope of the county plans and corresponding financial resources for which the counties were made responsible expanded to include the needs of individuals with drug use disorder. Additionally, in the same year, a

governor's advisory council was established to coordinate the actions of all departments and divisions of state government with regard to substance abuse and to oversee locally driven prevention efforts by municipal alliances.

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

The SSA's current county planning activities focus on the 2024-2027 planning cycle. New Jersey implemented its Medicaid Waiver (1115) in 2023, which established a managed behavioral health care organization. The counties will continue to provide the state with a critically important monitoring and feedback from their programs. Additionally, the county plans will direct greater attention to the problems of citizens dually afflicted with both substance use disorder and mental health illness. The county Mental Health Administrators were invited to participate in the community-based planning certificate program DMHAS sponsored in 2013 and the comprehensive planning process with the hope that, over time, both the substance abuse and mental health planning processes and products will integrate under a single county comprehensive, behavioral health plan. Currently, the County Alcoholism and Drug Abuse Directors and County Mental Health Administrators continue to have several joint Director meetings every year. As of April 2025, 18 County governments out of 21 have combined mental health and addictions into one department.

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 is offered in the community and the SSA awards funding either through cost-based contracts to 146 SUD treatment agencies, and fee-for-service contracts to 145 SUD treatment agencies that provide a continuum of treatment. Of these, 47 agencies had both a cost-based and fee-for-service contract. It provides funding to 42 SUD prevention agencies. It also provides awards to the 21 County Governments.

County Government. The SSA collaborates with the 21 counties of New Jersey in a joint state and county comprehensive behavioral health planning process intended to: 1) coordinate system development and service delivery at state and local levels, and 2) unify community-based planning for prevention and treatment. Chapter 51 of the Laws of 1989, C.26:2BB-12 et seq, amended Chapter 531 of the Laws of 1983 that had established the "Alcohol, Education, Rehabilitation and Enforcement Fund" (AEREF) and the county comprehensive planning requirement for participation in the AEREF program. The amended statute established 1) the Governor's Advisory Council on Alcoholism and Drug Abuse, GCADA, and 2) the county Local Advisory Committee on Alcoholism and Drug Abuse, LACADA, known under the 1983 Act simply as the citizen advisory committee. The AEREF is a non-lapsing, revolving trust fund into which approximately \$11 million are deposited annually from a tax on the sale of alcoholic beverages. Approximately \$10.3 million from the AEREF plus an additional \$6.9 million in supplemental funds from the state treasury are distributed per statutory formula to the counties each year, for a total of approximately \$17.6 million for CY 2025.

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 DMHAS Office of Planning, Research, Evaluation and Prevention is responsible for overseeing the AEREF county comprehensive planning program.

Governor's Council on Substance Use Disorder (GCSUD). The SSA works collaboratively with the Governor's Council on Substance Use Disorder on various addiction prevention related projects, including participation in the Prevention Collaborative Process. The Prevention Collaborative: 1) helps counties identify and implement a greater number of evidence-based prevention programs, 2) supports counties in the use of environmental approaches to prevention at the county and municipal levels, and 3) encourages counties to develop and operationalize community-based recovery support systems of care. The plan also provides direction in the development of future prevention funding opportunities made available by the SSA.

Through the Municipal Alliance Program, the GCSUD 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. GCSUD's Municipal Alliance Program provides 320 grants to 425 municipalities throughout New Jersey, with the majority of grants averaging between \$5,000 - \$10,000. The primary CSAP strategy utilized by the alliances is education, followed by alternatives, which provide social, athletic and recreational activities as an alternative to situations in which alcohol and drug use might occur. The majority of programming is delivered in communities and schools served by the alliances. In 2022, DMHAS awarded \$1 million (from the BG

Supplement) to GCSUD for the development of a statewide Youth Leadership program. In 2023, DMHAS awarded an additional \$1.5 million to GCSUD to expand the work of the municipal alliances and increase their use of evidence-based programs and strategies.

Local Advisory Committee on Alcoholism and Drug Abuse. The SSA works collaboratively with the county Local Advisory Committees on Alcoholism and Drug Abuse (LACADAs) that “assist county government in development of the annual county comprehensive plan” required for participation in the Alcohol, Education, Rehabilitation and Enforcement” Fund (AEREF) of 1983 and 1989.

The LACADAs are also required to establish a County Alliance Steering Subcommittee (CASS), which is the county-level planning body for each county’s Municipal Alliances (MAs) that are funded and overseen by the Governor’s Council on Alcoholism and Drug Abuse (GCADA). The MAs are coalitions of municipal level residents and other stakeholders who volunteer to conduct data analysis and prevention service inventories as the basis for adopting a set of local prevention priorities and recommending these to the LACADAs.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

[1] Martin Lepage, Michael Bodnar, Lisa Buchy, Ridha Joober, and Ashok Malla. Early Medication Adherence and Insight Change in First-Episode Psychosis, *Clinical Schizophrenia & Related Psychoses* (2010)

[2] Vijaya Raghavan, Greeshma Mohan, Subhashini Gopal, Mangala Ramamurthy, and Thara Rangaswamy. Medication adherence in first-episode psychosis and its association with psychopathology, *Indian J Psychiatry* (2019)

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

[4] <https://nj.gov/humanservices/dmhas/initiatives/olmstead/>

[5] Be advised that the actual volume of veterans served is likely larger; the possible variance is due to the widespread adaptation & use of the USTF+ system—several agencies are still not diligently using this system on a consistent basis.

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

1. 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 and one out of every three children. DHS serves older New Jerseyans, individuals and families with low incomes; people with developmental disabilities, or late-onset disabilities; people who are blind, visually impaired, deaf, hard of hearing, or deaf-blind; parents needing child care services, child support and/or healthcare for their children; people who are dealing with addiction and mental health issues; and families facing catastrophic medical expenses for their children. Through DHS' eight divisions, it provides numerous programs and services designed to give eligible individuals and families the help they need for economic and health challenges. They include health insurance through NJ FamilyCare or Medicaid, food assistance through NJ SNAP, independent living supports, personal care services, and much more.

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

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

Between 2017-2018, DMHAS went through two major reorganization processes. On June 29, 2017, former Governor Christie filed an executive reorganization plan with the State Legislature transferring the institutions and programs under DMHAS and its staff that support the provision of mental health and addiction services from the Department of Human Services (DHS) to the Department of Health (DOH). The plan stated that "transferring the provision of mental health and

addiction services to DOH is necessary to improve health care, remove bureaucratic obstacles to the integration of physical and behavioral health care and effectively address substance abuse disorder as the public health crisis it is.” On August 28, 2017, DMHAS became part of DOH.

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

2. Mental Health Services

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

New Jersey’s has 21 counties and each 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 by the county’s Designated Screening Center (DSC) in accordance with state regulation (NJAC10:31-5.3(a)). The SRC is comprised of representatives from the county’s 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, a representative from the county Mental Health Board, community provider representation, Program for Assertive Community Treatment (PACT), Integrated Case Management Services (ICMS), family and consumer organizations, and a representative from the SMHA. The SRC is charged with the collection and review of service data as well as monitoring the provision of acute care services statewide. Each county has at least one Designated Screening Center with mobile outreach and 24-hour access. The county-based Designated Screening Centers generally determine who meets the commitment standard and requires inpatient treatment.

The community mental health system of services provides for eight levels of care: (1) prevention and early intervention; (2) crisis stabilization services <24 hours; (3) crisis stabilization and diversionary services > 24 hours; (4) acute care services; (5) peer recovery support; (6) family

support; (7) treatment and rehabilitative services; (8) county and state psychiatric hospitals. The SMHA contracts for statewide, regional and county/local behavioral health services. Statewide contracted services include services for populations such as: Crisis Assessment Response & Enhanced Services (CARES) program which provides consultation and training to our hospital and community providers regarding individuals dually diagnosed with a mental illness and developmental disability; Statewide Clinical Outreach Program for the Elderly (S-COPE) which provides consultation and training to nursing facilities and DMHAS residential providers who serve older adults (55 years of age and older) who are at risk of psychiatric hospitalization; and *ACCESS* which provides community-based behavioral health 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 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 Training Centers to provide training and information to providers regarding co-occurring services for individuals with a mental illness and substance use disorder and housing with enhanced supports for individuals with co-occurring medical needs, development disorders, substance use disorders.

According to its 2023 URS Data Table 3, & 14a, the SMHA served 338,007 unduplicated adult (age 18+ years) persons receiving services SFY 2023. There was a total of 338,007 individuals served in all settings in SFY 2023. Of the total number of unduplicated adult persons receiving services in SFY 2023, there were 317,698 (93.99%) served in community settings; 1,701 (0.5%) were served in State Psychiatric Hospitals, 18,241 (5.39%) were served in other psychiatric inpatient settings, and 675 (.19%) were served in the institutions under the Justice System. Of the total number of unduplicated adults (338,007) served in *all* settings by the SMHA in SFY 2023, 120,126 (35.53%) were reported to have SMI.

According to its 2024 URS Data Table 3, & 14a, the SMHA served 83,334 unduplicated adult (age 18+ years) persons receiving services SFY 2024. There was a total of 83,334 individuals served in all settings in SFY 2024. Of the total number of unduplicated adult persons receiving services in SFY 2024, there were 77,396 (92.87%) served in community settings; 1,693 (2.03%) were served in State Psychiatric Hospitals, 3,059 (3.67%) were served in other psychiatric inpatient settings, and 255 (.03%) were served in the institutions under the Justice System. Of the total number of unduplicated adults (83,334) served in all settings by the SMHA in SFY 2024, 30,098 (36.11%) were reported to have SMI. Please note that the numbers from URS SFY24 Table 3 are unduplicated within the same row or service setting, but can be duplicated between rows, e.g., the same client may be served in both state psychiatric hospitals and community mental health centers during the same year and thus would be reported in both rows.

SFY24 has decreased numbers comparing with SFY23, because SFY24 URS tables were only based on the data entered in a newly developed web-based data platform which does not have the full data volume as of yet. DMHAS began transitioning to this new client level data system, the USTF+, to conform to SAMHSA reporting requirements for the Mental Health Block Grant (MHBG) as well as to move to a more secure web-based application. DMHAS has been providing trainings for providers on the USTF+ as well as implemented a newsletter to inform providers of

any changes to the system on a regular basis as DMHAS strives to improve upon functionality and incorporate enhanced functionality. DMHAS has also implemented ongoing meetings with system administrators at the provider level to gather feedback and enhance compliance with reporting. Due to the transition from the USTF Legacy reporting system to the new web-based application, DMHAS has seen a decrease in reporting into the system as providers are trained. DMHAS has staff that are responding to help tickets in a timely manner to address client record-specific data entry issues. It should be noted however, that the Quarterly Contract Monitoring Report (QCMR) collects duplicated data across programs. In SFY 23, there was a total of 261,861 individuals served (of those served 242,279 were 18 and older) and in SFY 24, there were 270,263 individuals served (of those served 251,501 were 18 and older).

Persons diagnosed with a SMI are the statutory population for SMHA funded services. However, the SMHA also provides services to other individuals including persons with first episode psychosis, individuals in need of crisis services, access needs, older adults, individuals with co-occurring mental health and substance use disorders, hearing impairment, and co-occurring developmental disability.

Many of the activities of the SMHA focus on inter-organizational coordination and collaboration to improve access for statutory 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 (administers WorkfirstNJ, TANF, General Assistance, SNAP, Child Care services), and Division of Medical Assistance and Health Services (Medicaid). In addition, there is coordination with the DCF's Children's System of Care (CSOC) and Division of Child Protection and Permanency (DCP&P), Department of Health, Attorney General's Office of Alternative and Community Responses, Department of Community Affairs (housing/homeless) and the New Jersey Housing and Mortgage Financing Agency (NJMHFA). There is also coordination with the Division of Vocational Rehabilitation Services (DVRS) within the Department of Labor and Workforce Development, the Department of Corrections, the Department of Military and Veterans Affairs (DMAVA), and the Department of Education (DOC) and interbranch coordination with the Administrative Office of the Courts (AOC).

The Five Criteria in State Mental Health Plan

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

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

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

1. Prevention and Early Intervention Services

A. Coordinated Specialty Care (CSC), Coordinated Specialty Care, Community Integration (CSC CI)

The SMHA has utilized the CMHBG 10% set-aside funds for providing services to individuals with first episode psychosis (FEP) since FY 2017. A Request for Proposal was issued in June 2016 for three agencies to provide Coordinated Specialty Care (CSC) services for individuals with FEP. Oaks Integrated Care, Rutgers University Behavioral Health Care (RUBHC), and Care Plus Inc NJ, became operational on November 1, 2016 and 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 three programs began with a caseload of 35 each and doubled in size, reaching their capacity. Each agency had been covering 7 counties which presented as a challenge for providers in covering the vast territory as well as for the individual's receiving services because of the time spent traveling to the provider agency. The programs had also been receiving referrals and calls for early psychosis or "Affective Psychosis." which did not meet the FEP criteria at that time.

In 2023, DMHAS utilized the Substance Abuse and Mental Health Services Administration's (SAMHSA) Community Mental Health Block Grant (CMHBG) Early Serious Mental Illness 10% Set-Aside, CMHBG COVID-19 Supplemental Funding, and CMHBG ARPA (American Rescue Plan Act) funding to implement a Community Integration Program (CSC CI) designed to address the need for additional coverage in the state and the CSC continuum of care. A Request for Proposal was issued in November 2023 for six agencies to provide Coordinated Specialty Care (CSC) for the population with Early Serious Mental Illness (ESMI) and a Community Integration Program designed to address the need for the ESMI population along the continuum of care. DMHAS expanded from three awarded programs to five awarded programs, which are currently funded and operational. The five programs are: Rutgers University Behavioral Health Care which serves the Central Sub-Region 2 (Middlesex, Somerset & Union) and Southern Sub-Region 1 (Burlington, Camden, Gloucester & Salem). Legacy Treatment Services serves the Southern Sub-Region 2 (Atlantic, Cape May & Cumberland) and Care Plus NJ, Inc. serves Northern Sub-Region 1 (Bergen, Passaic, Essex & Hudson) and Northern Sub-Region 2 (Morris, Sussex, Hunterdon & Warren). Each provider agency has implemented a CSC program and a Coordinated Specialty Care Community Integration (CSC CI) program. In addition to expanding from 3 programs to 5 programs and adding a step-down component, NJ enhanced staffing of the CSC CI model in order to provide for an enhanced caseload of 200 per team for a combined caseload for CSC and step-

down (CI) in 2025 as well as future projected caseloads of 300 and 400. The CSC CI teams will be able to provide services to individuals with FEP or with affective psychosis. Individuals with affective psychosis were contacting the CSC teams but previously could not be served due to the restrictions in the admission criteria. The CSC teams can now provide services to individuals with ESMI.

New Jersey's CSC programs utilize a coordinated team approach emphasizing the importance of addressing each individual's unique goals, needs, and preferences through shared decision making and collaborative treatment planning. Services will utilize the evidence-based practice methods including, but not limited to, person-centered therapy, cognitive behavioral therapy (CBT), peer wellness coaching, trauma-informed care, individual resiliency training (IRT), psychoeducation, and supported employment and education. Program staff shall provide community outreach services, evidence-based pharmacological treatment, supported employment and education services, individual and group psychotherapy, case management, family therapy and multifamily psychoeducation, peer recovery and 24-hour-accessible recovery support.

The CI program provides continued treatment for the client after the client has completed the CSC program. The CI program will use the "Stepped-Care" treatment model for clients with an ESMI diagnosis. The Stepped-Care treatment approach is a "3 tier" system where clients can titrate up or down the level of service modality depending on their recovery and/or the need for additional services and supports. Individuals in the CI program receive more or less intensive care and units of service in accordance with their assessed need and treatment plan. Individuals will continue to receive CI services from their current CSC treatment team in accordance with assessed level of need in order to preserve continuity of care. Once admitted to the CSC, individuals can titrate up or down in the units of service and frequency of visits as needed and can remain in the CI program as long as clinically indicated.

New Jersey's CSC programs serve individuals between 15-35 years of age with an ESMI diagnosis (psychosis must be of non-organic etiology) for less than or equal to 2 years at the time of admission to the CSC program with or without previously receiving treatment. Those served in the CSC-CI program are individuals 15 years of age and older with an ESMI diagnosis that is non-organic. In Fiscal year 2024, the combined CSC CI program had treated 244 individuals. The expansion of the CSC program to include Coordinated Specialty Care Community Integration, significantly increased service capacity. In Fiscal year 2025, the combined CSC CI program had treated 568 individuals. To support this expansion, clinical staffing has increased from 6.0 FTEs to 12.0 FTEs, enabling the State to better address the growing demand for Early Serious Mental Illness (ESMI) services, including both initial interventions and step-down support. A data evaluation staff assists in data collection and evaluation. The agencies are required to submit: Quarterly Contract Monitoring Reports (QCMR); Quarterly Programmatic Progress Reports, and Quarterly Report of Expenditures (ROE) reports that tracks federal fiscal spending for each agency. The data evaluation staff reviews quarterly data to monitor the progress of all clients, to evaluate the CSC CI programs, and also to address all federal data evaluation and reporting requirements.

The New Jersey CSC CI programs have implemented and collected data that include four diagnostic outcomes: Suicidality, Quality of Life, Social & Global Functioning, and Severity of Depression. Additional measures include: client data, medication monitoring, psychiatric hospitalization, discharge information, length of stay, re-admission dates, and substance use. Provider agencies employ 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 CI programs. MIRECC GAF is the primary assessment tool used to determine symptom progress in the CSC CI client base. Scores are collected on a quarterly basis and compared against previous quarter scores. The Colombia Suicide Severity Index is used at intake, after each hospitalization, and on a discretionary basis to assess client suicidality. These measures have also been used by other RAISE programs outside New Jersey and proven to be sound measures for symptom severity among the FEP population. Clinical Global Impressions Rating Scale is used to measure severity of illness, global improvement and therapeutic response. WHODAS (World Health Organization Disability Assessment Schedule) is used to measure disability and functional impairment. BPRS (Brief Psychiatric Rating scale) is used to gather information about the presence and severity of psychiatric symptoms. ACES (Adolescent Childhood Experiences Scale) is given at the time of initial clinical assessment and for a 6-month treatment update.

Since the inception of the program in 2017 through June 30, 2025, the NJ CSC and CSC CI programs have received over 3,466 referrals, served 2,557 individuals, and provided 304,404 units of service. In SFY 2025, the CSC CI programs began reporting client level data via the Unified Services Transaction Form Plus (USTF+). According to the data reported via USTF+, 448 individuals were served in the CSC CI programs. 372 of the 448 individuals were prescribed antipsychotic medication. 81% (302) of the 372 individuals were adherent to their medication regimen. The CSC CI module is new to the USTF+ and the providers were trained in SFY 2025 to report the data. It is noteworthy that data reported via the Quarterly Contract Monitoring Report (QCMR) reveals that 568 individuals were served in SFY 2025. DMHAS will continue to work with providers to have the USTF+ data reconcile with the QCMR aggregate data. In SFY 2024, New Jersey made 5 awards for its CSC CI program, 3 of these awards were new programs. All CSC CI providers have been received 3 half-day trainings from OnTrack NY. The overall decrease in the adherence rate is expected to improve as the new programs develop. NJ saw a low rate of adherence in 2017 when the initial programs first opened and then saw an improvement overtime. NJ data is reported for all individuals enrolled in the CSC CI programs regardless of length of stay. A review of literature for early psychosis medication adherence reveals the following for good adherence: 85% at 1 month ^[2]; 69% at 6 months ^[1]; and 59.3% at 12 months ^[2]. NJ will be looking at the possibility of capturing data at these points in time for comparison with benchmark data. Additionally, a study from Yesien et al ^[3], found adherence rates are to vary from 40% to 60% in individuals with first episode psychosis.

CSC and CSC CI have provided a stable system for individuals with early psychosis to interact in the community through gainful employment, continuing education and return to school, and improved level of functioning for those who remain in care for a consistent period.

[1] Martin Lepage, Michael Bodnar, Lisa Buchy, Ridha Joobar, and Ashok Malla. Early Medication Adherence and Insight Change in First-Episode Psychosis, *Clinical Schizophrenia & Related Psychoses* (2010)

[2] Vijaya Raghavan, Greeshma Mohan, Subhashini Gopal, Mangala Ramamurthy, and Thara Rangaswamy. Medication adherence in first-episode psychosis and its association with psychopathology, Indian J Psychiatry (2019)

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

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

As a part of its work and effort to eradicate stigma, the Council posts training videos related to stigma awareness and messages of hope and recovery on its website. The council conducts outreach to schools, the media and other organizations. Community partnerships focus on collaboration with individuals to ensure that input, information and guidance in regarding messaging, and approach are accurate and appropriate. Staff from NJAMHAA coordinate the implementation of the Stigma Council activities. Outreach activity has been in the form of virtual webinars, conferences, in-person learning forms, and community events.

Communication with the Public through Correspondence and Phone Calls

One of the many functions of the Council is to keep the communication lines open with the stakeholders in New Jersey. This has been accomplished through a variety of avenues, including email correspondence and telephone conversations. Among the many ideas and subjects that have arisen through these interactions with stakeholders, several overarching themes have been prevalent. These include responses to inquiries as to how to get involved with the Council, including how to become a member of the Council; comments concerning Council work, efforts, and functions; general inquiries about the Council's goals and mission; requests to have information placed on the Council website; and even issues unrelated to the Council because the individuals did not know where else to turn. No matter what the communication may have been, someone from the Council promptly responded to each request with an acknowledgement of its receipt and guidance related to each request.

Stopping Stigma newsletter

- FY2025: Third issue in October 2024; the May 2025 issued
- FY2024: Launched in October 2023; second issue in May 2024

Each issue of this publication is sent electronically to 5,179 people, including state and federal legislators and policymakers; general and mental health trade associations; county mental health administrators; and 149 media outlets (print, radio and television; statewide, in the tri-state area and nationally; general and others specific to health/mental health). The newsletters are also

announced via press releases, posted and highlighted on the Stigma Council website, and among the materials at events, where many individuals have expressed interest in them.

Press Releases and Media Advisories

- FY2025: 2
- FY2024: 3

Each press release was sent to the 149 media outlets and posted on the Stigma Council website.

Stigma-Free Zone Learning Collaborative virtual sessions

- FY2025: 414 attendees across two events
- FY2024: 125 attendees across two events.

Additional In-person and Virtual Events

- FY2025: An in-person event, *Showcasing the New Jersey Governor's Council on Mental Health Stigma*, was held on July 16, 2025. The DMHAS Assistant Commissioner received recognition as a State Champion in the fight against stigma.
- FY2024: May 22, 2024, *Addressing the Youth Mental Health Crisis: Fostering Understanding and Partnerships to Further Support the Younger Generations*, virtual – 125 attendees; August 14, 2024, *Engaging Vulnerable Youth and Young Adults*, in person - 126 attendees

In FY 25, the Council hired a part time Outreach Coordinator. The Outreach Coordinator is responsible for educating the community on mental illness and ways to combat stigma related to it. The coordinator has brought a renewed energy to the Council and is working to engage stakeholders statewide on how to mobilize communities on mental health stigma related matters.

C. Suicide Prevention

Compared with the rest of the United States, New Jersey has low rates of deaths by suicide, consistently varying between lowest and second lowest in the nation (CDC, WISQARS). However, suicide rates in NJ are following national trends and have steadily risen over the years.

The last fully confirmed age adjusted rate was in 2022. New Jersey had an age-adjusted suicide rate of 7.65 deaths per 100,000 people (compared to 14.2 nationally). Known risk factors of suicide, which include mental illness, serious physical illness, chronic pain, alcohol and opioid use, gambling problems, loss, economic concerns, trauma, stress, and loneliness, and suicide risk was exacerbated by COVID-19. A CDC survey conducted in 2020 at the onset of the pandemic found that almost 11% of adults had seriously considered suicide in the last month and that the rates were significantly higher among respondents aged 18-24 years, certain ethnicities, unpaid caregivers for adults, and essential workers. We expect to see long term effects from the pandemic that will likely impact the rate of suicide attempts in the future.

There were 769 deaths by suicide in New Jersey in 2022 and 721 deaths in 2023 (not fully confirmed), making suicide the 15th leading cause of death that year. These represented a slight increase from 704 deaths by suicide in 2021. In New Jersey, the highest risk occurs between the ages of 55 and 59 years, when the rate of suicide was 13.1. The state ranks second nationally in rate of teenage suicide deaths, at 5.3 per 100,000. However, the rate of suicide deaths in age-group 15-24 had increased by 18% from 2020 to 2021. Firearms were the leading mechanism for suicide for men 55 and older and across all age-groups in 2021. Veterans and services members have high risk for suicide, and firearms are the major method of suicide in these populations. DMHAS has been working with the NJ Department of Military and Veterans Affairs (DMAVA) for the last few years on the SAMHSA Governors Challenge to Prevent Suicide in Service members, Veterans, and their Families, which is described in more detail below.

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

Suicide prevention will be addressed by the recent expansion of 988 and crisis services in N.J. In SFY25, the SMHA utilized approximately \$9.5 million from a combination of federal grant funds including the COVID Supplemental Act, ARPA, and the SAMHSA 988 State and Territory Improvement grant to contract with a marketing agency for a statewide high-profile public messaging campaign for 988. The SMHA now funds four (4) centers that together provide in-state response to calls, chats and texts through the 988 Suicide and Crisis Lifeline. The 988 Lifeline is a national hotline offering one-on-one support for mental health, suicide and substance-use related problems for anyone 24/7.

Together, the New Jersey 988 Lifeline centers respond to calls 24 hours a day, every day of the year from individuals who are seeking assistance or information for themselves, friends or relatives that may be at risk of suicide and in need of services. In Calendar Year 2024, NJ 988 Lifeline centers received a total of 84,406 calls, of which 67,503 answered in state (goal is for 90% answered in state). Geo-routing calls from the closest cell towers to the individual was recently added to give a general location of the caller. To further promote the Lifeline throughout New Jersey, the SMHA has translated and printed brochures in ten languages in N.J. for distribution.

The SMHA has been in the process of sunsetting the NJ Hopeline in order to further promote and expand the 988 Suicide and Crisis Lifeline in NJ. While the Hopeline number remains operational, marketing for the Hopeline has ended and callers are being encouraged to dial 988 instead.

In addition to the 988 Lifeline, 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

In 2019, the Medical Director’s Office spear-headed the implementation of the state’s suicide prevention initiatives. In 2025, the DMHAS reorganized suicide prevention efforts such that suicide prevention activities are shared between the DMHAS Medical Director’s office and the office overseeing 988 and crisis continuum services overseen by the Division. These efforts are assisted by the Suicide Prevention Advisory Committee. The membership of the Committee consists mostly of DHS, DCF, and DOH employees, as well as members from the state universities and persons with lived experience. There are other DMHAS offices that contribute to 988 and crisis continuum services as well as suicide prevention activities.

The Governor’s Office annually issues proclamations declaring Suicide Prevention Month and/or a Suicide Prevention Week in September. Each year, the Committee has convened an annual Suicide Prevention Conference, which has been held for the last nine years (except for being cancelled in 2020 because of COVID). The conference has grown in attendance every year. More than 1,800 people registered for the 2024 conference. Attendees included people with lived experience, person receiving services, medical professionals, social workers and community social service providers, educators, community health providers, hospital-based providers, community agencies, administrators, state representatives, and executive leadership. DMHAS also provides other training on suicide prevention throughout the year, and this is aided by the Division’s capability to provide CMEs (continuing medical education) for physicians to attend; CEs (continuing education) for other behavioral health disciplines are also being provided at the trainings through the Rutgers University Technical Assistance Center.

The state’s major suicide prevention initiative is to implement the Zero Suicide approach statewide in NJ and consolidate suicide-related activities under the combined offices. The Zero Suicide approach is based in the belief that suicide deaths for individuals under care within health care systems are preventable. The Zero Suicide Institute under the Education Development Center (EDC) is recognized as the leading proponent and training entity of this model. DMHAS offered 3 virtual Zero Suicide Academies in with the EDC 2020, and additional ones in 2021-2024. In 2025, Rutgers University Behavioral Health Care provided the trainings on the Zero Suicide approach. This is a signature training for health and behavioral health organizations seeking to dramatically decreasesuicides among those in their care. Using the Zero Suicide framework, participants of the health care system learn how to incorporate best and promising practices into their organizations and processes to improve care and safety for individuals at risk under their care. Funding for this project was included in the DMHAS’ budget for suicide prevention. In 2025, DMHAS began coordinating with DCF in promoting the Zero Suicide approach statewide.

DMHAS has participated in the Governor's Challenge to Prevent Suicide Among Service Members, Veterans and Their Families (SMVF), which is led by the New Jersey Department of Military and Veterans Affairs (DMAVA) in collaboration with the United States Department of Veterans Affairs (VA). The initiative has been working to develop and implement state-wide suicide prevention best practices for SMVF, using a public health approach. With the support of the governor, each state formed an interagency military and civilian team to develop a strategic action plan to advance the National Strategy for Preventing Veteran Suicide. Teams are encouraged to include suicide prevention coordinators representing the state public/behavioral health agency, VA, and National Guard. The NJ initiative has three priority area workgroups that are developing and carrying out a plan to ensure that veterans are identified, screened and assessed for suicide, risk factors and related needs, and that lethal means counselling and safe firearm storage education are provided to them.

In response to the fact that firearms are the most common means of suicide death and firearm access significantly increases the risk for suicide, DMHAS has partnered with the Rutgers University School of Public Health's Gun Violence Research Center (GVRC) to address suicide by firearm and to promote firearm safe storage and decreased access. The GVRC has developed and presented in numerous webinars for DMHAS, and has initiated several projects that try to promote community awareness of lethal means safety and the risks of unsecured firearm access; the most recent GVRC initiative involves the training of clergy and of key community members, such as barbers and hairdressers, who can raise awareness and influence the public on the risks of unsecured firearms and suicide in the community. Other GVRC initiatives have involved training of healthcare providers on suicide and lethal means and the development of an online firearm storage map. In SFY26, the plan is to fund the Rutgers-GVRC to implement The Armory Project (TAP) approach in N.J. The TAP will facilitate safe, voluntary, out-of-home storage with vetted firearm dealers to help prevent suicide.

The goal is that this proven initiative will more effectively remove firearm access to veterans and other members of the public who are at risk of suicide. This allows for involuntary removal of firearms on a temporary basis during an episode of mental health crisis or other need, and it complements the state's availability of involuntary firearm removal through the police and judiciary by use of the states' Extreme Risk Protective Order (ERPO) law. DMHAS is actively working with the Office of the Attorney General to promote the ERPO alternative, which has been proven to save lives.

All community behavioral health programs contracted by the Department of Human Services (DHS) and/or licensed by the Department of Health (DOH) are required to report unusual incidents regarding individuals they serve, including self-injury and suicide. The DMHAS agencies report these incidents to the DHS Unusual Incident Reporting and Management System (UIRMS). DMHAS requires providers to intensely analyze each of these events to assess opportunities for improvement in their systems and processes. The reports of the providers are reviewed for patterns and trends among agencies. DMHAS regularly confers with the epidemiology office in DOH, which regularly receives and analyzes data from the Violent Death Reporting System (VDRS),

which is a public health reporting system managed by the CDC that provides detailed and timely surveillance system of all violent fatalities DOH also receives NJ data from other systems that capture non-fatal suicide attempts of those receiving treatment through emergency room visits and inpatient hospitalizations. There are also pilot initiatives to develop county-level suicide fatality review teams that will examine complex factors that could have contributed to the suicide deaths of adult individuals. DCF has had a longstanding Child Fatality and Near Fatality Review Board that is independent of the department and that reviews child fatalities and near fatalities to identify their causes and the implications of these deaths to services that are being provided.

2. Crisis Stabilization Services < 24 hours

A. Call Centers

988 Implementation was funded by State Appropriations, the COVID Supplemental Plan and the American Rescue Plan Act (ARPA). New Jersey originally had five (5) call centers that provided services for the 988 Suicide and Crisis Lifeline. These centers received certification by Vibrant Emotional Health (Vibrant) for meeting the minimum clinical, operational and performance standards.

In April 2022, DMHAS was awarded approximately \$2.5 million from the SAMHSA 988 Capacity Building Grant to prepare Lifeline centers for the anticipated increase in call, chat, and text volume due to the transition to 988. As of September 2022, following the State's procurement process, funding from a combination of federal grants including the SAMHSA 988 Capacity Building Grant, Mental Health/Substance Abuse Block Grants and American Rescue Plan Act, totaling \$3.7 million was awarded to the five (5) NJ Lifeline centers.

In December 2022, NJ DMHAS was awarded an additional \$1 million through the SAMHSA 988 Capacity Building Supplemental Grant. Of this award, approximately \$340,000 was awarded to four (4) of the five (5) 988 Lifeline centers in New Jersey based on their existing contract amounts (one center declined additional funding).

With these original contracts, 988 Lifeline centers were able to expand their capacity to meet the growing demand. Comparing calendar year data from 2021 to 2023, NJ experienced a significant increase in call volume while increasing calls answered. From 2021 to 2023, call volume increased 36% and centers were able to respond to 38% more calls.

Original contracts from these funding opportunities were scheduled to end April 2024 in alignment with the project period of the SAMHSA 988 Capacity Building Grant. To maintain center funding and in turn, statewide 988 operations, NJ DMHAS applied for and received a No Cost Extension on these funds from SAMHSA and was able to extend contracts until September 2024.

In September 2023, NJ DMHAS was awarded the SAMHSA 988 State and Territory Improvement Grant. This grant provides NJ DMHAS with approximately \$12 million over the course of three

(3) years (Sept 2023 – Sept 2026) for projects such as increasing the workforce to support the growing 988 demand and continuing both statewide and messaging about 988.

Additionally, funding of \$12.8 million was allocated in the State Fiscal Year 2023 (SFY23) budget toward the expansion of the 988 Lifeline network. In January 2023, using approximately \$1.9 million of these state appropriations, NJ DMHAS published a Request for Proposals (RFP) soliciting applications to establish a Managing Entity (ME) for the New Jersey 988 Suicide and Crisis Lifeline system. Carelon Behavioral Health was awarded this contract.

Among the NJ 988 ME's responsibilities are to:

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

NJ DMHAS prioritized the spending of \$10 million in state appropriations to enhance NJ 988 call, chat and text services. Using state appropriations, an RFP to award \$10 million in State funds was published in March 2024 with the goal of expanding 988 Lifeline center capacity sufficiently to answer 90% of state-based calls, chats and texts. In September 2024, approximately \$7 million from this State-funding opportunity was awarded to two (2) of the five (5) original 988 Lifeline centers. One (1) of the five (5) original centers decided to end their 988 Lifeline services on July 31, 2024. The other two (2) centers that did not receive awards remained committed to providing 988 Lifeline services but struggled to identify replacement funds to maintain their operations. NJ DMHAS, using a portion of SAMHSA grant funds, was able to provide contract extensions to these two (2) centers to continue these necessary services at their current levels.

In March 2025, with the remaining state funding and approximately \$1.3 million from the SAMHSA Improvement Grant, NJ DMHAS published a Request for Letters of Interest (RLI) to provide ongoing funding to these two (2) centers for the purposes of not only maintaining their current level of operations but expanding their services to contribute towards the goal of achieving a 90% in-state answer rate. Final awards were issued June 2025. The goal is to reach a minimum of 90% in-state answer rate with no more than 10% of calls being routed to the national backup system. Comparing data from CY 2023 to CY 2024, NJ saw a 36% increase in call volume while answering 36% more calls. Looking at Vibrant data from SFY24, NJ had a 78% in-state answer rate. In the first eight (8) months of SFY25, NJ increased its in-state answer rate to 82%. NJ 988 Lifeline centers continue to recruit and onboard staff to expand the capacity for responding to calls, chats and texts. Increased funding based on demand and the identification of additional ongoing funding streams are vital to reaching and maintaining this goal.

To establish a “no wrong door” philosophy for 988, NJ DMHAS has been working closely with multiple agencies in New Jersey’s system of acute care and crisis response. Agencies include the Department of Children and Families’ (DCF) Children’s System of Care (CSOC)/PerformCare (serving children and adolescents), ReachNJ (substance use treatment resources and referrals), The Department of Human Services’ Division of Developmental Disabilities (DDD), and NJ211. NJ DMHAS has established warm transfers between 988 and these partner agencies. These transfers are used after an initial assessment determines staff on other call lines could be helpful to the individual in crisis.

NJ DMHAS has also been working closely with its partners within the 9-1-1 system to establish bi-directional warm transfer protocols and procedures between 9-1-1 and 988. Once these are in place, whether an individual calls 988 or 9-1-1, they will be connected to the most appropriate professional and level of care. This plan is consistent with the no wrong door approach and will allow emergency personnel (first responder, emergency medical services and fire fighters) to handle situations that need their skills, equipment and expertise. Predating 988, the Hopeline transferred calls to 911 as necessary. 988 continues to transfer calls directly to 911.

B. Mobile Crisis Outreach Response Teams (MCORTs)

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

MCORTs support individuals 18 or older by de-escalating crises, providing linkage to ongoing community services, and follow-up support. MCORTs collaborate with family members or loved ones to assist and support the individual in crisis when appropriate. The goals of the Mobile Crisis Outreach Response Team program are:

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

MCORTs are dispatched by the NJ 988 Managing Entity, Carelon, after a 988 Lifeline Center determines a community-based response, without emergency responders, is necessary and appropriate. MCORT is a voluntary service and the individual must provide consent prior to dispatch.

For the MCORT program, the state has been divided into nine (9) Regions based on geography and population. This information was also used to determine the minimum number of teams to

operate in each Region. One of the goals of the MCORT program is to provide an in-person response within one-hour of the initial dispatch.

In October 2023, NJ DMHAS published an RFP to award approximately \$16 million in state funds to up to nine (9) agencies establish a total of 62 MCORTs across the 21 NJ counties, based on the regional system identified above. Through this procurement process, four (4) agencies were awarded contracts to operate MCORTs in eight (8) of the nine (9) regions while Region 9 went unawarded. In May 2024, NJ DMHAS posted an additional RFP to establish an MCORT program in Region 9. The successful bidder was awarded a contract in September 2024.

On March 3, 2025, MCORT services were launched statewide with limited hours of operation. On August 11, 2025, MCORT services expanded to full 24/7 availability. From March 3rd through July 31st, MCORT completed 247 dispatches. In SFY 2025, there were 148 individuals served by MCORT and 197 units of service.

In December 2024, DMHAS received approval of its Medicaid State Plan Amendment (SPA) requesting for MCORT to be Medicaid-supported under Section 1947 of the U.S. Social Security Act. The SPA will provide an enhanced match for 3 years, then move to a standard 50% reimbursement through the federal medical assistance percentage (FMAP) for MCORT services.

C. Crisis Receiving Stabilization Centers

DMHAS has made awards to five provider agencies to develop crisis receiving stabilization centers (CRSCs) which will advance the development of the crisis continuum in NJ based on the National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit with utilizing funding from the mental health block grant 5% set aside, Covid Supplemental funding from the MHBG and SUPTRS grants and ARPA funding from the MHBG and SUPTRS grants. When this program is implemented and the centers are in operation, commencing late 2025 / early 2026, they will provide onsite crisis services for up to 24 hours to individuals 18 years of age and older with a mental illness, substance use disorder or co-occurring disorder and in need of immediate crisis intervention and stabilization for a behavioral health crisis.

CRSC offers a no-wrong-door access to crisis stabilization, operating much like a hospital emergency department (ED) that accepts all walk-ins, first responders drop offs, and fire department drop offs. The individuals served in the program will receive community-based treatment and supportive services 24 hours a day, 7 days a week, every day of the year, with the goal of mitigating the need to use the ED to access community-based services and preventing unnecessary or inappropriate hospitalization and provide short-term (less than 24 hour) community-based services to individuals experiencing a suicidal, mental health or substance use crisis. Individuals will be available to walk-in for immediate crisis response services.

The objective is to develop an appropriate alternative to the use of local hospital emergency services and in-patient psychiatric hospitalization, by providing crisis services and placement support for those in need of permanent housing. The goal of these programs is to decrease the utilization of local hospital emergency services, designated screening centers, and in-patient psychiatric hospitalization while maintaining crisis stabilization treatment. The program will also

result in cost savings through the decrease in avoidable ED visits, inpatient admissions, first responder engagement, and 911 calls.

These facilities include access to trained staff who can provide assessment, crisis stabilization, intensive supports, engagement, psychoeducation, identification of strengths, collaborative problem solving, and individualized crisis planning. Services will be offered in a safe, clean, community-based environment conducive to the recovery process. Medication management, administration, and education will also be offered. Medication-Assisted Treatment will also be available at the CRSCs. Clinical staff in the program will strive to stabilize individuals and address mental health needs. The program will offer continuity of care promoting continued stability and ensuring linkages are arranged that meet the needs of the individual.

3. Crisis Stabilization and Diversionary Services > 24 hours

A. Crisis Diversion Homes

Crisis Diversion Homes (CDHs) are funded by the ARPA plan. In order to bridge the gap between homelessness and permanent housing, DMHAS has awarded two crisis diversion homes with 5 beds, each home will be staffed 24 hours a day, every day of the year. This program will provide community-based stabilization in a home-like setting and is not long term or permanent housing. The length of stay for this program is dependent upon an individual's need and is anticipated to be up to 30 days. At a minimum, staffing will include licensed and credentialed clinicians, nursing staff, behavioral health technicians, and a prescriber. Although the crisis diversion homes are not permanent, individuals experiencing a recent psychiatric hospitalization or relapse will receive the support they need from professionally trained and dedicated staff to continue their recovery in the community in a home-like environment. The services and supports will be prioritized for individuals who are referred from Crisis Receiving Stabilization Centers (CRSCs) and from Mobile Crisis Outreach Response Teams (MCORTs).

This additional level of care in the crisis continuum will help decrease the number of individuals in local emergency departments and emergency screening, while also serving as a referral source for crisis receiving and stabilization facilities for individuals with complex behavioral health needs that require significant services and supports to avert hospitalization and successfully return to the community. Additionally, referrals may come from community inpatient programs as a step-down from short-term acute inpatient services providing the opportunity to further stabilize the client and connect the client with services and supports depending upon availability. The Crisis Diversion Homes will include linkages to peer supports, clinical services, and housing with a goal of community re-integration to permanent or long-term housing and supports for the person receiving services.

B. Crisis Diversion Beds

The DMHAS contracts with mental health providers to provide 14 crisis beds in three different homes. These are residential settings that are staffed 24 hours a day 7 days a week. The homes focus on providing a recovery oriented residential setting for individuals to help avoid a mental health crisis or hospitalization. The length of stay in these homes is designed to be short term, and typically less than 30 days. The homes focus on rehabilitative skill development, crisis planning, and individual recovery goals. Additionally, DMHAS contracts with a provider for a fourth home consisting of 5 beds to provide crisis housing and services for individuals that are dually diagnosed with a mental illness and a developmental disability.

C. Peer Respite Beds

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

D. 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 avert admissions to state hospitals. Individuals who do not stabilize and require continued inpatient treatment may be transferred to a state or county hospital at the conclusion of their approved length of stay in the contracted Diversion bed. The hospitals that contract for Diversion beds maintain additional bed capacity that is not governed by their DMHAS Diversion contract and serve a similar population in this additional capacity.

DMHAS currently contracts for access of up to 52 beds at three private psychiatric facilities including Carrier, Hampton, and Northbrook that offer an alternative to state psychiatric hospitalization. Most contracts specify a cost per bed-day of \$745.08. The actual spending in calendar year CY 2024 was \$11,575,372.00. There were 809 admissions utilizing 19,850 bed days and 95% were diverted from a state hospitalization. In CY 2023 there were 707 admissions utilizing 17,250 bed days and \$9,192,839.30 and 94% were diverted from a state hospitalization.

4. Acute Care Services. The SMHA currently funds and regulates a variety of acute mental health care programs for individuals with acute mental health needs and for those experiencing psychiatric crises. They include Designated Screening Centers (DSC),

Affiliated Emergency Services (AES), Early Intervention Support Services (EISS), Involuntary Outpatient Commitment (IOC), and Short Term Care Facility (STCF) beds.

A. Designated Screening Centers (DSC).

The SMHA funds 23 Designated Screening Centers (Screening and Screening Outreach) programs across the 21 Counties. The Screening and Screening Outreach Program is designed to provide psychiatric emergency services including screening, assessment, crisis intervention, referral, linkage, and crisis stabilization services, 24 hours per day, 365 days per year, in every geographic area in the state. According to the SMHA's Quarterly Contract Monitoring Report (QCMR) database of information self-reported by the screening programs, there were 71,175 episodes of care to these screening centers during SFY 2024 and 74,755 episodes of care in in SFY 2025.

B. 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 2024, the state's 12 Affiliated Emergency Service Programs delivered 27,070 episodes of crisis care (3 Hudson, 1 Middlesex, 3 Monmouth, 2 Morris, 1 Passaic and 2 Union Counties) and received \$4.85 million in funding. There were 25,755 episodes of care delivered in SFY 2025.

C. 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 \$24.5 million and serve all 21 counties. In SFY24, there were 17,739 individuals served and 17,161 in SFY 2025.

D. Involuntary Outpatient Commitment (IOC).

DMHAS now funds eighteen Involuntary Outpatient Commitment (IOC) programs that serve all twenty-one New Jersey Counties. Annualized funding is \$6.5 million to support these programs, which have an aggregate statewide service capacity to serve 575 persons. During SFY 2024, a total of 1,080 persons were served in IOC, with an average active ongoing caseload of 420. There were

1,048 served in SFY 2025. 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.

E. Short Term Care Facilities (STCFs).

In order to meet the needs of individuals who require involuntary in-patient psychiatric services, the SMHA currently designates 410 Short Term Care Facility (STCF) beds. The SMHA has allocated \$24.6 million in subsidies for STCF beds. Each designated bed receives a \$60K per annum subsidy to support the enhanced staffing and programming required by the designation. There are currently 410 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 2024, the state’s System Review Committee database indicates that the occupancy rate for STCF beds was 76%.

- ***5. Peer Recovery Support***

The Office of Office of Advocacy and Peer Services (formerly named the Office of Consumer Affairs) in the Medical Director’s unit has a key role in ensuring that individuals with mental illness, substance use disorder, or a co-occurring disorder receive a continuum of prevention, early intervention, treatment and recovery support services delivered by a well-trained workforce. The Manager of the Office of Advocacy and Peer Services is a person with lived experience who leads the unit; oversees peer-run community wellness centers, respite programs, and other peer support programs; as well as contracts for peer training and other services. The manager retired after over 20 years of state service and DMHAS will be looking to fill this position. DMHAS continues to look for opportunities to integrate individuals with lived experience into the workforce. One example is the integration of peers in mobile crisis outreach teams and CRSCs. Additionally, DMHAS has posted guidelines for organizations considering the integration of individuals with lived experience into their workforce. The manager of the Office of Advocacy and Peer Services is a member of the DMHAS Divisions Executive Staff committee and is involved in leadership activities with providers. Feedback from the peer provider community is received directly in virtual meetings that are held bi-monthly with peer providers, who share accomplishments and ideas, ask questions or raise concerns with each other and with DMHAS staff.

The manager of the Office of Advocacy and Peer Services supervises a full-time staff person with lived experience of substance use and/or co-occurring mental health issues and so provides feedback to DMHAS staff overseeing co-occurring and SUD services–DMHAS Ombudsman and as coordinator of a Secret Shopper program. The staff person shares other role in the Advocacy

and Peer Services unit; including the Ombudsman and Secret Shopper services. The Ombudsman receives complaints or concerns about provider services, while the Secret Shopper program involves peers making calls to agency providers while presenting typical client scenarios. She also sits on panels that review and score RFPs and other proposals made to DMHAS and is currently recruiting for a larger pool of potential peer candidates to help conduct these reviews.

Division of Mental Health and Addiction Services (DMHAS) Office of Advocacy and Peer Services (formally Consumer Affairs); has direct oversight of most mental health peer-operated services delivered in the New Jersey community. This Peer run office is supervised by the Division's Office of the Medical Director.

The office employs two individuals with lived expertise within the office. One peer, who has been part of DMHAS since 2011 serves as the manager of the office and as the Division's Mental Health Ombudsman. The managers purview includes the Community and Hospital based Wellness Centers, the Peer Respite program, CHOICES (Smoking Cessation), Peer training for mental health, Peer operated Warmline, NJ Mental Health Cares information line. The other lived expertise person has been with the Division for one year and is in a full-time role. She has been a tremendous addition to the Office of Advocacy and Peer Services and has made great connections with the peer workforce across New Jersey.

DMHAS works in tandem with people having lived experience, family members, providers and other stakeholders, to promote recovery and wellness for persons managing a mental illness, substance use challenge or co-occurring issues, through a sequence of prevention, early intervention, treatment and recovery services provided by a well-trained and skilled workforce.

State-wide Consumer Advisory Committee (SCAC) meets quarterly on a virtual platform through TEAMs. Virtual meetings are facilitated by the Office of Advocacy and Peer Services personnel. SCAC membership consists of the 22 Community Wellness Center peer managers, three hospital-based Wellness Center peer managers. These meetings generally include a presence by Executive leadership, including the DMHAS Medical Director and the Division's Deputy Assistant Commissioner. There DMHAS Office of Community Services Regional staff also attend the meeting.

DMHAS shares recent updates with the attendees and answers individual questions. The Community Wellness Center peer managers are asked to share updates about their centers and discuss needs of the community members they serve. Topics include individual accomplishments, community challenges, concerns and ideas, and participants are comfortable asking questions and learning innovative skills from their fellow Peers.

The SCAC members have provided the Division of Mental Health and Addiction Services with feedback that they find the quarterly meetings helpful, but they would like some of the meetings to be in person. The Division benefits from hearing from these front-line service providers to better understand the community's needs.

In 2024, DMHAS rebid the Community Wellness Centers (CWCs) and added funding dollars to provide more competitive salaries for the Center's Peer workforce, to enhance programing and expand community outreach. Many centers have added marketing strategies and provide a vast

variety of community outreach. There have also been many centers adding additional satellite sites. These services take trained staff members into their communities to work with individuals who may not get to the centers or that don't know about the services offered at the Wellness Centers. Each Community Wellness Center is expected to be open at minimum 25 hours at the primary location. Those hours of operation must include two nights and one weekend day.

As the world has moved beyond the pandemic, DMHAS has made certain all centers are returning to in person activities, as well as still providing some virtual recovery groups to their participants who had gotten used to the virtual model. These combined services hybrid centers allow more participants to engage in activities offered. The centers are an essential part of their individual community. Many operate in the structure of a "home" with living rooms, kitchens, game rooms, libraries, rooms with exercise equipment and craft rooms, to name a few. They are a place where participants can engage in social interactions, by sitting in a cozy welcoming space and having conversations with each other. They can eat together and build the ties of a family environment.

Wellness Centers provide a space that is non-stigmatizing and always works to be respectful of one another's similarities and understanding of each other's differences. Members can play a game of pool or air hockey, as well as chess or board games. The centers offer wellness and recovery groups and other group activities such as healthy cooking classes or arts and crafts. Outside trips are taken regularly to places like the grocery store, food pantries or Walmart. Staff from the centers also go into the communities and bring wellness-related activities with them, as well as marketing items to introduce people who have lived experience or have family members with mental health or co-occurring needs to available services and other resource opportunities. They visit other types of Human Services centers, Veteran's centers, libraries and churches and will sometimes hold scheduled wellness-focused groups or similar activities at these locations.

The peer staff represented within DMHAS Office of Advocacy and Peer Services make frequent visits across the State to better support the varieties of activities that people sharing their lived experience provide to the Community. It is also an opportunity to share the impact of peer work and engage to support each other. Site visits have included both community-based and hospital-based Wellness Centers, 988 call centers, Peer Warmline call center and Mobile Community Outreach Team (MCORT) work sites. As new centers (provider agencies) have opened their doors, the Office of Advocacy and Peer Services staff have attended these Grand Opening events. It has brought joy and support to work in a collaborative manner and for the community service providers to be aware that their services are appreciated and supported by the Division of Mental Health and Addiction Services.

Currently, DMHAS Office of Advocacy and Peer Services is working on a plan to have a state-wide, yearly, in person SCAC meeting that would allow the peer Wellness Center managers engage and network face-to-face. The Whole Health Learning Community Initiative, funded by DMHAS, has already started this multi-agency engagement across the Wellness Centers. The initiative has created an environment of comradery and built wonderful collaborations between providers. Plans are being made to invite the peer managers of the Substance Use Recovery Centers to come together with the Office of Advocacy and Peer Services staff and share their lived experience to initiate quarterly meetings for Substance Use peer programs.

A long-term objective of this office is to allow both groups of peer managers to gather collectively and meet their counterparts who operate DMHAS Substance Use Recovery Centers and Community Wellness Centers. This will build an environment that supports seamless transitions from one service center to the other, for participants in need of Community-based services from either or both operating community service centers.

RFP Reviews. As part of the internal DMHAS Request for Proposal review process, DMHAS includes staff members with lived experience to sit on all of the reconciliation committees to review and score any proposals that are submitted to the DMHAS. Peers use the value of lived experience, as current and/or past recipients of mental health services and/or co-occurring services, to bring their unique perspective to the review meetings. The awareness that peers bring to the review teams has impacted other staff's viewpoints when scoring proposals, creating an understanding that leads to open discussion, which may impact scoring decisions and final awards. The Division has included Peers in the review process for over fourteen years.

Community members with lived experience and family members of persons receiving services, also participate in the RFP process, in the capacity of consultants. These community members review proposals and submits a written and oral summary of each proposal to the RFP team lead. The representatives are compensated for their input. The team lead discusses each review with the community member, and responses are shared with the DMHAS internal review committee before each proposal is scored. The perspective of the community members is shared and considered, as part of the overall process.

DMHAS Mental Health Ombudsman is a DMHAS staff person with lived experience. The Ombudsman responds to callers who use the Division of Mental Health and Addiction Services (DMHAS) Ombudsman Line, which is a non-crisis line, that is monitored Monday through Friday from 9:00am to 5:00pm. The line accepts recorded messages 24/7. It is important for the Ombudsman to develop trust with the caller to allow the caller to feel comfortable being open and honest about their call. For this, the Ombudsman must possess learned engagement strategies which they use to work with the caller. The Ombudsman begins the conversation by letting the caller know it is the formal complaint line for DMHAS services. A process is in place to resolve most issues in a swift, confidential and effective manner.

This role requires outstanding communication and interpersonal skills, knowledge of resources of other professionals, problem solving skills and the ability to be empathetic. The DMHAS Ombudsman role is filled by a Peer with lived Mental Health service experience, who is also a family member of a person(s) who has received Mental Health and co-occurring services.

DMHAS Secret Shopper Initiative, at the Assistant Commissioner's directive, the Office of Advocacy and Peer Services introduced the DMHAS Secret Shopper Program. The purpose of this project was to generate feedback about how our provider agencies are responding to calls made by persons who pose as clients. The program has provided the Division with valuable information to learn about some of the experience when calling a provider, the availability of appointments and challenges that client can receive trying to access services.

The Program currently has two community-based callers. One caller with mental health lived experience and one impacted by mental illness and substance use disorder were hired to the initiative, and they split the phone calls between MH agencies and SUD agencies. Each participant is issued a State allotted cell phone to use when making calls to providers. This is important because they are asked to leave a message for a call back when they reach an answering machine. Each participant also receives an email account connected to the Division's network. The Secret Shopper sends a synopsis of each call to the Initiative Supervisor at the end of each month. A total requirement of 15 outreach calls per month are expected per participant. In past periods the expectations were higher and it was found to be an overwhelming demand on the individuals. They are paid by the State as consultants for their services.

The feedback from such calls to agencies is tracked and monitored. In the past the agencies received a letter detailing the Shopper's experience. There is a plan to once again alert provider agencies of the outcome of each of these calls. The initiative has no intention to create blame for a problematic call. The Secret Shopper Initiative has been used to enhance services and to make systemic awareness of a DMHAS expectation to demonstrate respect, knowledge and to offer support an individual seeking services for any behavioral health related condition.

Some issues identified by the Secret Shoppers have included:

- Calls being answered by an answering machine rather than speaking to a live person.
- Long wait times to get an appointment for emergent issues.
- Having to call another number to make an appointment.

An outcome of this project, was that a pro-active group of providers met with DMHAS Executive Leadership to try to resolve some of the concerns expressed to DMHAS. One of these concerns was the regular use of answering machines and calls not being returned in a timely manner or not returned at all. The agencies didn't like this practice either, however, the providers communicated that they could no longer afford the cost of having a receptionist available to take calls.

Both groups brainstormed and some resolutions were discussed and implemented. The agencies stated that using an answering machine was necessary due to staffing and funding constraints.

Some more issues identified by the Secret Shoppers included:

- Answering systems were malfunctioning or went to random unmonitored mailboxes.
- Agencies went out of business or merged, and the directory numbers were no longer valid.

Block Grant funded Community-based Peer-operated Service Providers

Legacy Treatment Services

Legacy Treatment Services operates **Crosswinds**, a peer-run mental health crisis respite center in Toms River, NJ. This program provides crisis respite services for 7-14 days for adults who need a supportive residential environment to work towards wellness and recovery and avoid psychiatric re-hospitalization. The program has several peers on staff who work with consumers to develop WRAPs and PADs and run peer support groups. Consumers have access to staff on a 24/7 basis to receive needed supports, while working to be linked with essential services, such as housing,

financial assistance, physical health care and mental health care. The program also has peers in substance use recovery on staff who can assist consumers who have both mental health and substance use concerns work towards their own recovery. The success of the program is such that consumers have graduated from the program and worked to obtain peer certificates to come back as volunteers or employees in Crosswinds.

Legacy also operates several programs that have peer staff available to provide support. **Kairos House**, a similar residential program to Crosswinds, also employs peer workers on staff to provide support. Crisis programs include **988 Mobile Crisis Outreach Response Teams**, in which a certified peer is part of a response team for in-person community crisis outreach. The **Screening and Crisis Intervention Program (SCIP)** employs peers to provide support for in-person outreach, emergent case management, and follow-up supports to those experiencing psychiatric crisis. **Involuntary Outpatient Commitment** programs employ peer case managers who use their own story of wellness and recovery to connect with consumers who are court-ordered to outpatient mental health treatment.

Community Support Services has peers on staff specifically to work with individuals developing WRAP plans and Psychiatric Advance Directives. Lastly, the **Outpatient** department has peers on staff to provide individual peer to peer sessions to those who receive therapy and medication management.

Consumer Parent Support Network

The purpose of the Consumer Parent Support Network is to support parents with a diagnosis of a mental illness in their parenting efforts and to promote the healthy functioning within their families.

The Consumer Parent Support Network uses traditional case management, combines it with support groups, education and advocacy, using mentors. Each program participant has the opportunity to select from a variety of support services that can strengthen their role as a parent. Our Parent Support staff assists with needed referrals and case management. Our Parent Advocates are both parents and people with lived experience. They can help a person negotiate the challenges of parenting by acting as a mentor, sounding board and source of encouragement.

Mental Health Association of Essex and Morris

Mental Health Association of Essex And Morris (MHA E&M) embeds peer led services throughout several programs within the agency as it recognizes the importance of the ability to connect with the individuals served through shared life experience.

The Forensic Peer Support Staff for Decreasing Recidivism provides off-site and in-home, hands-on support to mental health individuals playing a role in supporting these individuals from start to finish. Peer support helps individuals transition out of the justice system and build stability in their mental health and everyday lives, increasing socialization and successful tenure in the community. Peer Support Staff offers guidance, encouragement, and advocacy to keep participants

engaged and connected to needed resources. The Peer Support staff co-facilitate peer groups which helps the individual receiving services develop coping skills and navigate the ups and downs of recovery. Sharing the lived experience of navigating mental health challenges and a similar history provides participants with motivation, builds hope, establishes trust, and creates an ability to relate to one another.

Peers with lived experience are employed at the Community Wellness Centers provide appropriate. They partner with community providers for available services and coordinate resource events at the Community Wellness Centers. Lived experience professionals share life experiences, provide engagement and promote skill-building services, creating a collaborative and caring relationship, that focuses on strengths-based, person-centered services. Additionally, the Lived Experience Professionals (LEP) provides support in recovery planning through evidenced-based practices, such as Motivational Interviewing, and through advocacy. LEP are equipped to assist with managing crisis and de-escalation and promoting the integration of physical and mental health wellness which nurtures growth and development.

The Peer Support Staff employed in the Mobile Crisis Outreach Response Team (MCORT) provide evidence-based crisis services, to an individual identified by 988, who is experiencing a mental health or substance use disorder crisis in the community and is agreeable to an outreach. The person in the community who is experiencing a crisis can get non-clinical support from Outreach Team. The MCORT teams have a peer worker who offers support beyond the resolution of any immediate crisis. The peer team member can follow up on the person, making connections to social services and other services that may increase early intervention access. When appropriate there is collaboration with family members, friends or loved ones to assist and support individuals in crisis on an as-needed basis.

MHANJ Peer to Peer Support Line is a peer-operated warm line that offers emotional support, hope, encouragement and resources to callers. Peer to peer Support line is staffed by people who have lived experience with mental health challenges who provide supportive communication with callers who share mental health challenges. The warmline provides telephone peer support to individuals with mental health difficulties, in lieu of using more traditional emergency psychiatric services. All Peer Line staff receive specialized training and have monthly team meetings to discuss caller issues and receive additional support.

Catholic Charities of Greater Trenton

Riverbank Community Wellness Center

Since its inception in 1997, the Riverbank Community Wellness Center (RCWC) has been at the forefront of the Community Wellness Center initiative, significantly impacting the lives of individuals dealing with mental health and co-occurring issues.

A key aspect of the RCWC is its peer-led model, which involves staff members who have first-hand experience with mental health and substance use challenges. The center offers a wide range of life skills, training and educational programs that focus on self-care and help decrease social isolation. RCWC empowers its members to lead healthier and more balanced lives. Monthly groups are tailored to address the specific needs of individuals, including those with mental health concerns, co-occurring challenges like, substance use, chronic medical issues, aging, and individuals experiencing homelessness.

Positioned as a central resource hub, the RCWC is dedicated to helping individuals navigate the complexities of mental health services and co-occurring challenges. A team of trained peer counselors is available to assist members in accessing vital resources, such as housing assistance, SNAP benefits, health insurance, tax preparation aid, and vocational support. Additionally, the center collaborates with the South Jersey Food Bank, collecting 300 pounds of food every two months, which includes fresh produce and nutritious items for community meals that are served three times a week. There is also a food pantry available to members and the public at any time for those in need.

In late 2024, the RCWC was awarded a new contract from DMHAS, which has facilitated an expansion of services. As a result, the center has extended its operating hours at our Burlington location to five days a week, in addition to providing services one night a week at two satellite sites, one in Browns Mills and one in Maple Shade. Furthermore, the acquisition of a 15-passenger van enables transportation for up to 40 members to and from various center activities, enhancing accessibility for those in the community.

The RCWC is pleased to report that for the grant year 2024-25, as of March 24, 2025, it has welcomed nearly 150 consumers, providing 813 self-help activities and 428 wellness and recovery activities to them.

Riverbank Transportation & Roads to Recovery

Since 2001, the peer operated Riverbank Transportation program (RBT) has been offering rides to individuals with mental health challenges who aspire to pursue employment or education but face difficulties accessing public transportation. Recognizing that transportation often poses a significant obstacle to achieving vocational goals, RBT serves as a reliable and cost-effective alternative to rideshare options, playing an essential role in promoting independence. The program averages 75 rides per month and charges \$2.00 per journey.

Roads to Recovery (RTR) is another peer-run transportation initiative that provides rides for participants of community recovery groups like Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Gamblers Anonymous. This service caters to co-occurring peers, located within a ten-mile radius of Westampton and is offered at no cost. In 2024, RTR facilitated nearly 100 rides for those engaged in their recovery efforts. However, due to financial constraints and staffing shortages, the RTR program has been temporarily put on hold until further notice.

It is worth mentioning that both RBT and RTR are peer-operated programs employing three part-time drivers along with one dispatcher, which allows them to achieve their own recovery

objectives. Additionally, we take pride in noting that all bi-annual satisfaction surveys conducted among RBT and RTR consumers indicate complete satisfaction with the services provided.

Center for Family Services

Better Future Community Wellness Center (BFCWC) is a peer-run, peer-operated wellness center providing support, connection and recreation for adults with mental health issues who seek community, friends, social outlets, and relaxation. It provides a warm and welcoming environment where individuals can access needed community-based social services, receive peer support, and be informed about mental health, substance use disorder, and co-occurring issues in a supportive environment. No individual is denied full access to or participation in services or activities. This safe and non-restrictive environment provides all participants with a sense of hope and allow them to come together to engage in peer-to-peer support and be offered social, educational and recreational opportunities to address individual needs.

Better Future Community Wellness Center provides members with meaningful activities to decrease co-occurring substance use and mental health issues in a place where they will feel accepted and valued. It is equipped with trained, compassionate staff and community-based resources in a safe environment, consumers receive welcoming, non-institutional services from peers with similar experiences who are in recovery. Social connection can influence an individual's educational attainment, workplace satisfaction, economic prosperity, and overall feelings of well-being and life fulfillment. Social isolation and loneliness have repeatedly been linked to negative physical and mental health outcomes across studies nationwide. Risk factors associated with social isolation include living in rural and/or urban areas where resources are limited, having a chronic physical or mental illness, and lack of transportation, among others. BFCWC goal is to bridge this gap and offer non-restrictive, peer support for consumers with long-term physical and mental health conditions in various locations to significantly improve their quality of life and knowledge, skills and confidence to manage their health and physical functioning.

The BFCWC is a vital community-based initiative aimed at empowering adults who are recipients of mental health services to take control of their well-being, foster resilience, and support one another on their journey to recovery. It is operated by peers who have experience with mental health challenges and can provide one-on-one or group support to program participants. The center offers regular workshops and educational sessions covering a variety of topics such as stress management, emotional regulation, mindfulness, and self-care. There are also organized social events, group outings, and recreational activities that foster a sense of community and provide opportunities for social interaction and recreation. The center holds various support groups facilitated by peers that focus on specific mental health conditions or common challenges, providing a space for sharing and mutual support. This program plays a significant role in decreasing stigma, fostering recovery, and promoting well-being for all participants.

List of Services Offered (BFCWC)

Peer-operated wellness centers are community-based organizations run by individuals with lived experiences of mental health or substance use challenges. These centers provide various

interventions aimed at supporting recovery, wellness, and empowerment. Some common interventions include:

1. Peer Support Groups: - Facilitated by trained peers, these groups offer mutual support and shared experiences to help individuals manage their mental health or substance use challenges.
2. One-on-One Peer Support: - Personalized support sessions where peers offer guidance, encouragement, and resources based on their own recovery journeys.
3. Wellness and Recovery Education: - Workshops and classes focused on topics like stress management, coping skills, nutrition, exercise, mindfulness, and other wellness strategies.
4. Resource Navigation: - Assistance in connecting with community resources, such as housing, employment, healthcare, and social services.
5. Social and Recreational Activities- Organized events and activities to promote social interaction, decrease isolation, and build a sense of community.
6. Advocacy and Empowerment - Training and support for individuals to advocate for their own needs and rights, as well as to participate in broader advocacy efforts for systemic change.
7. Skill-Building Workshops: - Training sessions on practical skills such as financial management, job readiness, communication, and problem-solving.
8. Holistic Health Services: - Access to complementary therapies like yoga, meditation, art therapy, and other holistic practices that support overall well-being.
9. Outreach and Community Engagement: - Efforts to reach statutory populations and raise awareness about mental health and wellness within the broader community.

These interventions are designed to create a supportive environment where individuals can share experiences, gain new skills, and build a network of supportive relationships, all of which are crucial for sustaining long-term recovery and wellness

The Mental Health Association in New Jersey; Peer Services Across New Jersey Synopsis

ACWC: Atlantic Community Wellness Center “Individuals Concerted in Effort” has over four decades of experience in providing people access to meaningful activities in a place where individuals are accepted and valued. MHA staff have an intimate understanding of the value of social connections which contribute to members’ health, feeling of safety, prosperity, and ability to be resilient. ACWC became the first center to adapt to the need within the community and offer “center without walls” concept and modality of services which allowed greater access to people living throughout the county. The ACWC provides four core services, peer support activities, wellness recovery classes, training/education workshops, and community engagement. Peer support activities include supportive counseling, information/referral/linkages, end-to-end application & paperwork assistance, system navigation, promoting coping skills/selfcare,

boundary/limit setting, and others. Wellness Recovery Classes include topics such as healthy behaviors: physical activity & nutrition, health literacy & decreasing the use of substances (e.g., tobacco, alcohol, drugs, caffeine, sugar), social isolation/supports (community connections), healthy relationships/belonging, and Mental Health: Stress, Anxiety, Depression Management/Emotions, Grief/trauma, self-esteem/motivation/self-care. Training and education workshops focus on unmet needs including food/ housing/utility instability, financial resource strains, employment, and education. ACWC been an integral partner training first responders to produce better outcomes for our residents in crisis providing peer delivered training and perspective.

OCWC: Ocean County Community Wellness Center; Journey to Wellness (JTW), provides a holistic approach to mental wellness, offering free peer support and wellness services to individuals looking to enhance their mental health, well-being, and self-care. Through structured support groups, wellness coaching, skill-building workshops, and socialization activities, JTW fosters resilience, self-advocacy, and personal growth in a non-clinical, stigma-free environment. Staffed by individuals with lived experience of mental health and/or co-occurring challenges, JTW fosters an environment of understanding and empathy, allowing participants to connect with others who have similar journeys. Peer support staff serve as mentors and advocates, guiding participants in navigating their recovery paths while providing encouragement and motivation. Utilizing recovery-oriented, person-centered, and trauma responsible approaches, JTW creates a space where individuals can openly discuss their struggles and triumphs without fear of stigma, empowering community members to take charge of their mental health, build resilience, and cultivate a sense of belonging, ultimately contributing to a healthier and more connected community. JTW's mobile wellness unit, "Wellness on Wheels" (WOW Van) offers curbside wellness and support throughout Ocean County, truly embodying "meeting a person where they are at" in all ways possible, by providing access to information, referrals, wellness & support out in the community. By meeting people where they are, the WOW Van breaks down barriers and ensures that individuals who may not otherwise seek support can connect with peer specialists in a safe, non-judgmental environment. The WOW Van is deployed throughout the week and whenever needed, including scheduled community events and outreach efforts.

Ocean County Community Peer Recovery Center; ROADS Recovery Center Recovery, Opportunities, Acceptance, Dignity, and Support (R.O.A.D.S.) offers a supportive space where individuals are accepted & valued, regardless of stage, phase, or recovery pathway. ROADS provides participant-centered support encouraging individuals to be in the driver's seat of their own recovery. ROADS is designed to offer support, help prevent recurrence of SUD, and promote sustained recovery by being recovery-orientated, person-centered, trauma-informed, and focused on peer support. ROADS offers services that address the members' recovery, wellbeing, and unmet needs. ROADS follows SAMHSA's Recovery Oriented System of Care Principles & focuses services including food, housing, utilities, transportation, finance, substance use, mental health, & co-occurring, education/employment, social isolation/connections, healthy behavior, etc. ROADS also offers a community-driven approach, having strong partnerships across Ocean County to connect individuals with additional recovery resources.

UBW: United by Wellness was designed and built by MHANJ Peer Leadership Team to expand access to peer-to-peer support on a virtual platform for peers across New Jersey and beyond. Peer staff, interns and volunteers working with MHANJ's wellness centers, Individuals Concerted in Effort, and Journey to Wellness (JTW) combined resources along with other MHANJ to create a virtual wellness center that was launched in 2022. UBW currently provides free access to over 50 support groups weekly, which are offered 7 days a week to over 1800 current active members. A comprehensive array of groups offer support, wellness, spiritual, education, socialization, training, community meetings for both mental health and co-occurring individuals in recovery. UBW has recently expanded to partner with a Center for Independent Living to engage those with disabilities dealing with behavioral health challenges.

The Peer Recovery Warmline has been an integral part of NJ peer services since 2009. The warmline is fully staffed and supervised by experienced peer staff who provide support, education, advocacy and "personal peer to peer support" to the most isolated person in recovery. Utilizing WRAP (Wellness Recovery Action Planning) and IPS (Intentional Peer Support) models, the team operates 7 days a week, and volunteers to work all the holiday. Each year over 40,000 calls are answered each year. The PRW offers an optional text/chat component that provides daily text messages of support throughout the day and week. This provides another level of support and connection. **PRW operates as part of the MHANJ Call Center** that has multiple behavioral health lines – that provides easy access warm transfers to information and referral- through NJ Mental Health Cares- that also provides the PRW with a vast data base community recovery support services to share with peer warmline callers. In 2022, MHANJ advocated for peers to play a major role in crisis response. As a result, peers hired for the 988 call line facilitate easy warm transfers to PRW for 988 crisis callers. MHANJ continues to expand the role of peers in the operation of the call center – with many peers integrated across all our lines in partnerships with strong support, supervision, and clinical backup- proving their value to NJ's crisis response network.

Consumer Connections: Building a strong peer workforce has been the goal of MHANJ Consumer Connections since it was founded in 1997. Consumer Connections has been training peers to work in paid positions within New Jersey's mental health system for over 25 years. Over time, the program has evolved into a comprehensive workforce development initiative, supporting the growth of the Certified Recovery Support Practitioner (CRSP) credential, New Jersey's only mental health peer certification recognized by Medicaid. Consumer Connections continues to strengthen the peer workforce by providing all required CRSP training, including the 84-hour Core Training and WRAP Seminar I, offering scholarships for credentialing fees, and assisting peers throughout the credentialing process. Additionally, the program serves as a liaison to the state certification board, offers career counseling and vocational services to programming alumni, and delivers a full range of technical assistance and training to peer employers in mental health and co-occurring services within the adult system of care. Recognizing the importance of co-occurring capacity in the peer workforce, Consumer Connections is committed to expanding expertise in this area. To that end, the program provides Core Training graduates with access to the Certified Peer Recovery Specialist (CPRS) training, which leads to New Jersey's substance use disorder (SUD) peer credential. Consumer Connections has secured additional funding through ARPA federal

dollars to expand programming in 2025. This funding has enabled the program to increase the number of Core Trainings from three to five, WRAP Seminar I workshops from six to ten, and CPRS trainings from one to three. Additionally, this expansion has allowed the program to hire two additional full-time peer trainers, further strengthening training capacity. Funding to support CRSP credentialing scholarships has significantly increased the number of credentialed individuals in New Jersey, more than doubling the total within just one year. With continued funding and strong policy leadership, MHANJ has established a solid foundation to meet the evolving needs of New Jersey's peer workforce and to drive sustainable growth in the field. However, a significant challenge is that ARPA funding is a one-time allocation that will end in September 2025. It is already clear that there is sufficient demand to continue operating at this expanded capacity, but without sustained funding, it is uncertain how the program will be able to maintain its staffing levels and training capabilities beyond the third quarter of 2025.

The Whole Health Learning Collaborative: NJ Peer Connections is a program of the Mental Health Association in New Jersey, that is funded and designed to assist and support the 20+ Division funded Community Wellness Centers (CWC) in the state of New Jersey. This program unifies and unites all NJ CWCs for the cause of Whole Health Care by prioritizing the eight dimensions of wellness in all centers and the services provided to the community in which they serve. Whole Health is based on SAMHSA's 8 Dimensions of Wellness, which promotes mental health care is more than just psychological but covers many different aspects of life (social, spiritual, emotional, intellectual, vocational, financial, and physical health). In WHLC's 1st year of programming, WHLC assisted each CWC create wellness-based goals to implement whole health initiatives in their centers. All centers were given in-person and virtual technical assistance, a liaison for feedback with the Division, and communal support and education through regionalized events across the state. Each CWC was awarded Wellness Dollars to fund these initiatives and given an opportunity to share their successes and best implementation practices at the programs ended statewide event.

The regionalized events, offered in the North, Central, and Southern parts of the state, offered great educational and networking opportunities for all CWCs helping to create a network of support cross organizationally and statewide for the staff of the Wellness Centers. Educational workshops included: PADS, Choices, Recovery-Based Solutions, Creative Minds, Peer Advocacy, WRAP, Resource Sharing, and more. Due to its success, the Whole Health initiative was refunded through ARPA (until March 2025) funding to sustain the momentum and collaborative efforts of the centers and focus and prioritize the integration of the four newly awarded CWCs. This round of funding allowed for on-going in-person and virtual technical assistance to the newly awarded centers and other CWCs who needed assistance integrating their newly established goals and priorities resulting from the new CWC contracts. It also allowed for an additional two in-person regional events welcoming in the new Community Wellness Centers to the statewide community and in an effort to help each center reach its full potential. This program enhanced the CWCs by allowing them the opportunity to learn, network, and advocate for each other to better the people they serve. It can only be hoped this initiative can continue in some way in the future as this tie between all the CWCs is long overdue and extremely necessary in the success of the CWCs.

Hospital-based Wellness Centers

Collaborative Support Programs of New Jersey (CSPNJ). CSPNJ's Hospital Wellness Centers on the grounds of Greystone, Ancora, and Trenton Psychiatric Hospitals serve as essential, recovery-focused spaces led by individuals with lived experience. These centers provide peer support, wellness activities aligned with the 8 Dimensions of Wellness, and advocacy opportunities through COMHCO and the NJ Behavioral Health Planning Council. Programs such as the Hearing Voices Network, skill- building workshops, and the Hospital Cell Phone Project empower individuals to navigate their recovery journey with greater autonomy. We receive an average of 10 referrals to the HCPP monthly, effectively engaging and enrolling more than four-fifths of those interested. Recognizing the need for technology supports for discharged from State Psychiatric Hospitals and the challenges individuals with psychiatric conditions encounter in navigating the emerging technology-based healthcare system, State Psychiatric Hospitals partnered with DMHAS and its contracted provider Collaborative Support Programs of New Jersey (CSPNJ) to provide cell phones for patients upon discharge. From the inception of the program to the present, 200 patients discharged from Ancora, 150 patients discharged from GPPH, 200 patients discharged from TPH, and 5 patients discharged from AKFC received state funded cell phones that include data plans for unlimited talk and text for 6-months along with protective cases for the phones. Furthermore, the patients received training on the phones that were configured to have direct access to service notifications and appointment reminders. Additionally, CSPNJ collaborates with Community Wellness Centers to assist eligible individuals in applying for Lifeline cell phone services, helping ensure sustained connectivity beyond the initial six months. The approach empowers individuals receiving the phones, as they retain the ability to keep their phone number moving forward, which supports continuity and personal autonomy. In 2025, the project was expanded, and an additional 300 phones were purchased with state resources to replenish the supply for future hospital discharges. Additionally, CSPNJ's Program Aide roles and Unit Wellness Providers strengthen transition planning by participating in Life Management and Community Integration Meetings, offering advocacy in treatment team discussions, and expanding peer support sessions for those facing complex discharge challenges. Through structured wellness activities, peer support calls, and Health & Well-Being Surveys, CSPNJ ensures individuals receive personalized, continuous support that fosters a successful transition from hospitalization to independent living.

Recognizing the critical role of stable housing in recovery, CSPNJ has partnered with Ancora State Psychiatric Hospital to launch the Community Housing Options Tour, an innovative initiative that enhances discharge planning by connecting hospital staff and individuals served with real-world housing solutions. This program introduces participants, including supported housing providers, wellness center staff, and individuals preparing for discharge, to various housing models such as Residential Health Care Facilities, boarding homes, and independent supported housing. By improving understanding of recovery- oriented housing that emphasizes autonomy and community integration, this initiative strengthens collaboration between hospital discharge teams and community-based providers. As a result, there has been a marked increase in proactive engagement in discharge planning, leading to more successful transitions. Given the measurable success at Ancora, CSPNJ is expanding this initiative to Trenton Psychiatric Hospital, with plans underway to bring it to Greystone Park Psychiatric Hospital.

Looking ahead, CSPNJ is dedicated to scaling and strengthening its hospital wellness centers with innovative programming designed to enhance recovery outcomes and community reintegration. Planned initiatives include the relaunch of virtual Community Wellness Center groups, an employment pilot program incorporating Indeed job search training, and the expansion of Program Aide roles at Trenton Psychiatric Hospital. To foster engagement across centers, CSPNJ will introduce a statewide basketball tournament, expand Peer Gatherings featuring CSPNJ Wellness Institute workshops, and provide Peer Certification training for staff pursuing CPRS and CRSP credentials. To recognize member achievements, CSPNJ will implement a Certificate of Achievement program for vocational and wellness milestones. Additionally, contingent on funding, CSPNJ will organize community integration trips and conference opportunities, further reinforcing the organization's commitment to holistic recovery. With sustained investment, CSPNJ's hospital wellness centers will continue to serve as transformational spaces that empower individuals, decrease hospital recidivism, and build a bridge to lasting independence.

Wellness Respite Services

Respite is a safe, peer-run alternative to an inpatient psychiatric hospitalization and our services are at no cost to guests. Our Wellness Respite House is staffed 24 hours a day, 7 days a week by people who are trained and experienced in supporting others to transform a crisis into an opportunity for enhancing personal wellness and recovery. During the final quarter of the 2024 calendar year, all three of our respite houses averaged occupancy rates of over 98%.

The mission of our Wellness Respite Services is to provide an alternative to hospitalization which instills a sense of hope, empowerment, and fosters recovery and wellness to pursue valued life roles and personal goals. Each Respite House is a clean, safe, supportive, tranquil and non-judgmental environment in a residential community.

We offer intensive peer support and involvement in wellness activities to help guests to restore balance, and plan for adjustments when they return to their home, their associated valued roles, and their community activities. Guests meet with staff for one hour every day to learn coping skills for their wellness goals. Guests can stay at the house for a maximum of 10 days. If there is a waiting list or if a guest chooses to remain at home, we can provide wellness planning and intensive phone contact and outreach in the community for up to 10 days. After completing a Respite House stay or Intensive Outreach, all guests are offered up to 30 days of continued support through a follow up wellness plan and phone contact and outreach in the community for up to 30 days. Respite staff have developed a robust and intentional marketing plan designed to raise awareness among potential guests, families, service providers, and key community partners. Beyond traditional outreach, staff take an active and engaged role in the community, consistently promoting the lifesaving and life-changing support that Wellness Respite offers. For example, in 2025, Respite staff presented at the Whole Health event, sharing insights about Wellness

Respite's mission, services, and impact on the lives of those seeking alternatives to hospitalization. Thus, as of March 2025, we have supported over 3,950 guest stays. Lastly, despite limited capacity (15 beds), the impact is profound: 84.38% of Respite guests avoided hospitalization during their stay. And 91.62% felt valued and respected by peer staff; while 95.48% reported improved ability to manage their emotional and practical needs.

Community Wellness Centers

The Community Wellness Centers (CWC's) at CSPNJ provide a welcoming and supportive environment where individuals can access a range of peer-operated services to support their journey toward wellness. These centers are dedicated to fostering a sense of belonging and empowerment through personalized peer support, wellness activities, and community engagement. Whether in-person or virtual, peer mentors and support staff offer compassionate guidance, ensuring that every visitor has access to encouragement, advocacy, and resources that align with their unique needs. By centering services around the eight dimensions of wellness emotional, physical, social, intellectual, occupational, environmental, financial, and spiritual CWC promotes holistic well-being that extends beyond traditional healthcare models to over 16,000 unique members across our 15 locations.

The comprehensive services offered at CWC's go beyond immediate wellness support by addressing essential life needs. Through wellness groups, substance use support, and advocacy connections, members and visitors receive structured guidance tailored to their specific challenges. Linkages to crisis intervention, permanent housing, healthcare services, and community resources ensure that individuals have a strong support network during difficult times. The centers also assist with obtaining identification, applying for mainstream benefits, and navigating the complexities of services. These offerings create a foundation for self-sufficiency and stability, allowing individuals to regain control over their lives while feeling supported by a compassionate community.

What sets CWC's apart is the quality of care and dedication embedded in peer-operated services. Every interaction is rooted in lived experience, empathy, and a deep understanding of the challenges individuals face. Peer mentors not only provide resources but also foster meaningful connections that encourage self-advocacy and resilience. By emphasizing the uniqueness of each member's journey and integrating the eight dimensions of wellness into all services, CWC's ensures that every person who walks through its doors receives individualized, respectful, and comprehensive support. This person-centered approach makes the Community Wellness Centers a vital resource for those seeking to improve their well-being and transform their lives.

COMHCO

COMHCO continues to lead innovative and high-impact peer advocacy efforts across New Jersey, demonstrating the power of lived experience in shaping policy and service delivery. Over the past year, we have expanded engagement through monthly virtual membership meetings, providing real-time updates on critical issues such as Medicaid waivers, the integration of behavioral health services, and the expansion of involuntary commitment laws. Notably, we saw a significant increase in participation from individuals currently residing in state psychiatric hospitals, reflecting the success of our outreach and the growing demand for peer-led advocacy. Our quarterly leadership meetings have also strengthened peer involvement in county mental health boards and state and national stakeholder groups, ensuring that individuals directly affected by policies have a seat at the table. Additionally, our advocacy efforts have been instrumental in combating homelessness and promoting housing rights to support recovery.

A cornerstone of our work is the Annual Statewide Conference, which in 2024 brought together over 300 participants to engage in workshops on legal advocacy, voting rights, psychiatric advanced directives, and cross-disability advocacy. This event has become a vital platform for educating and empowering peers while fostering community connections. In preparation for our 2025 conference, we have implemented membership pulse surveys to ensure programming aligns with the needs and priorities of our community. In tandem with this, we have expanded our coalition to reach young adults, individuals with co-occurring substance use challenges, and statutory populations. These efforts are reinforced by our structural growth, with updates to our by-laws establishing a 13-person board with regional representation from all areas of the state.

In September 2024, COMHCO partnered with the National Disability Rights Network to host screenings of *Accessing Democracy* by Jack Rosen at the CSPNJ Annual Fall Fest and at local community wellness centers. This powerful film was part of a broader effort to promote civic engagement. During the same month, we collaborated with the REV UP campaign to increase voter registration and education, emphasizing bi-partisan voter education and accessibility for individuals with disabilities.

As part of our continued commitment to peer engagement, we will also be holding two statewide town halls to gather feedback from peers, as recommended during our monthly membership meetings. These town halls will serve as open forums for individuals to share their experiences and shape advocacy priorities. In addition, we will conduct workshops focused on telling your story and coalition building, equipping peers with tools to effectively share lived experiences and strengthen collaborative efforts across the state.

Looking ahead to the 2026–2027 funding period, COMHCO is committed to sustaining and expanding these initiatives to further elevate the voice and impact of peer advocacy. Our focus will be on strengthening our infrastructure, increasing accessibility to advocacy opportunities, and continuing to challenge policies that create stigma with behavioral health conditions.

SAMHSA funding will be critical in supporting these efforts, allowing us to enhance virtual engagement, develop new leadership pipelines, and expand peer-led initiatives that promote recovery, autonomy, and meaningful involvement in the community. By investing in peer-driven solutions, we can continue to drive systemic change and improve outcomes for individuals navigating behavioral health challenges in New Jersey.

Certification training for staff pursuing CPRS and CRSP credentials. To recognize member achievements, CSPNJ will implement a Certificate of Achievement program for vocational and wellness milestones. Additionally, contingent on funding, CSPNJ will organize community integration trips and conference opportunities, further reinforcing the organization's commitment to holistic recovery. With sustained investment, CSPNJ's hospital wellness centers will continue to serve as transformational spaces that empower individuals, decrease hospital recidivism, and build a bridge to lasting independence.

Prevention Resources

The Community Wellness Center (CWC) in Hunterdon provides individualized peer services focused on holistic well-being and personal empowerment. Each guest meets with a Peer Advocate to develop a personalized "wellness plan," setting goals and tracking progress across the Eight Dimensions of Wellness—physical, emotional, occupational, spiritual, financial, mental, environmental, and intellectual well-being. This tailored approach ensures that each person receives support that meets their specific needs while fostering personal growth and self-sufficiency.

Beyond individual plans, the CWC emphasizes a strong sense of community, where guests actively contribute by cooking for one another, offering support, and sharing resources. This community of mutual aid promotes dignity and pride while creating a welcoming, home-like atmosphere rather than a traditional service facility. The center operates six days a week, offering activities such as yoga, meditation, journaling, nutrition classes, and recreational programs.

Adding to the sense of community, the CWC offers Peer-led programming and services at several satellite locations; wellness classes at the *Fisherman's Mark* food bank in Lambertville, yoga and meditation at the *Hunterdon County libraries*, as well as wellness programming offered to the residents of *Veterans Haven North*, in Glen Gardner. The CWC also distributes food both on site and in the "Little Free Food Pantries" located throughout the town in conjunction with the *Flemington Food Pantry*. All programs and services are provided by a Peer, or an individual with lived experience in mental health.

CHOICES (Consumers Helping Others Improve their Condition by Ending Smoking) is an innovative peer outreach program dedicated to addressing tobacco use among individuals with mental illness in New Jersey. For two decades, CHOICES has been at the forefront of delivering education, resources, and motivation to smokers with mental illness. The program employs trained

mental health peer counselors, known as Consumer Tobacco Advocates (CTAs), who work tirelessly to support smokers in their journey toward a healthier lifestyle. The program was originally conceptualized to use peer counselors to reach out to smokers with serious mental illness living in the community. This approach was an advantage in reaching individuals who might not be motivated to talk to a health care provider.

Entering its 20th year, CHOICES has continued to evolve its approach to tobacco education and intervention. While the program maintains its core mission of providing educational presentations to consumers in mental health treatment across all levels of care, the 2024-2025 grant year has seen a significant expansion. This year, CHOICES introduced Learning About Healthy Living (LAHL) groups at four Community Wellness Centers, enhancing peer-led support and education. The centers include:

- Moving Forward CWC (New Brunswick)
- CARE Center (Neptune)
- Riverbank CWC (Burlington)
- Freedom Trail CWC (Somerville)

These biweekly groups meet for 12 sessions and provide structured education, linkage to tobacco treatment resources, referrals, and continued peer support. The LAHL curriculum, developed by CHOICES founder and medical director Dr. Jill Williams, an addiction psychiatrist, remains an essential tool in delivering impactful education, as well as a continuity of communication between the consumers attending the centers and the CHOICES team. The full curriculum is accessible [here](#).

During the 2024-2025 grant year (July 2024 to present), CHOICES reports the following metrics, which will increase by approximately 20-25% by the end of the grant period:

81 in-person and virtual visits to mental health treatment providers across New Jersey. (As of March 25, 2025)

- Engagement with 1,088 consumers who smoke, providing education and motivation for tobacco dependence treatment. (As of March 25, 2025)
- Two newsletters published and distributed to over 1,500 consumers and mental health agencies, reinforcing the importance of tobacco treatment.

Additional Programs Provided with the CHOICES Educational Site Visit and Carbon Monoxide Monitoring and Feedback:

2024-2025, St Clare's Inpt Unit, Broadway House, Booker BH, Donald Mays CWC, Camden CWC, Princeton House, Ancora Psychiatric Hospital, Essecare, SERV Annual Conference, UBHC Cherry Hill, Options, Up Your Alley, Broadway House, Greystone, Main Hospital, West Bergen Mental Healthcare, Future Dreams, Bergen County Wellness Center, Jewish Family Services of Atlantic and Cape May Counties, Greystone Wellness, Catholic Charities East Windsor, Mt Carmel Guild Cranford, Mt Carmel Guild Newark

Since its inception in 2005, CHOICES has built an impressive legacy:

- 2,098 community visits conducted, reaching over 61,935 individuals with mental illness who smoke.
- 13,490 individuals received individualized feedback sessions, including carbon monoxide monitoring and personalized discussions about the health and financial impact of smoking.

As CHOICES celebrates its 20th anniversary, it reflects on past achievements while planning for future growth. Program focus continues to include tobacco education, cannabis education, including structured healthy living groups will ensure continued relevance and effectiveness. The enthusiasm and engagement of CTAs has been instrumental in inspiring participants and fostering hope that positive behavior change is possible.

With ongoing dedication, CHOICES remains committed to supporting individuals with mental illness in achieving better health outcomes and promoting a tobacco-free future. The program's sustained impact highlights the power of peer-led initiatives in driving meaningful change within the mental health community.

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

A. 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 decreasing symptomatic behaviors of the family member with a serious mental illness. Families also learn patterns of communication and levels of environmental stimulation which have been demonstrated to decrease 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 decreasing symptomatic behaviors of the family member with a serious mental illness. Family psychoeducation is offered in each of New Jersey's 21 counties via the county IFSS Program. According to QCMR data reported by providers, 3,505 families received services provided by IFSS in SFY 2024 and 3,847 in SFY 2025.

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 families throughout the state has always provided a significant challenge for the IFSS programs. IFSS programs invest significant effort and energy in attempting to reach families in all regions. Visits occur on a regular basis to a wide variety of mental health programs.

IFSS staff also establishes contact with local churches and clergy as well as appearing at public meetings and events such as health fairs in their respective counties. Additionally, IFSS programs maintain a positive relationship with the New Jersey Chapter of the National Alliance on Mental Illness (NAMI NJ). NAMI NJ affiliate offices are located in each county.

NAMI NJ is contracted with the SMHA to provide support, education, advocacy and referral services to statutory populations.

B. Acute Family Support Programs (AFS)

The Acute Care Family Support Project is a service embedded in the emergency room. The service is available to families with an adult member experiencing a psychiatric crisis and being assessed in a Screening Center or Affiliated Emergency Service. They provide onsite or offsite support to the family while their loved one is being assessed, educate them regarding services/treatment in an acute care setting, including the commitment process, and link them to existing family support in the community. Family may also include significant others and primary caretakers. In 2022, there were ten programs serving residents of eleven counties, which include Atlantic, Bergen, Burlington, Camden, Cape May, Essex, Hunterdon, Middlesex, Monmouth, Passaic, Union. Due to COVID-19 restrictions on hospital units, there was a decreased activity in these programs through 2024 and 2,607 individuals were served. In SFY 25, there were 3,495 individuals served in AFS.

7. Treatment and Rehabilitative Supports

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

A. 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, 2 Camden, 1 Cape May, 1 Cumberland/Salem, 1 Essex, 1 Gloucester, 1 Hudson, 1 Hunterdon, 1 Mercer, 2 Middlesex, 1 Morris, 1 Ocean, 1 Passaic, 1 Somerset, 1 Union and 1 Warren) in order to create quick access to intensive outpatient services for individuals seeking access to treatment through the acute mental health system. These new programs are designed to create dedicated

access for person receiving services referred from emergency rooms and other acute settings. In SFY 2024 there were 3,069 individual receiving services and 2,608 in SFY 2025.

B. Program of Assertive Community Treatment (PACT).

Program of 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 individuals with SMI. The program is designed to meet the needs of individuals 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 statutory population, PACT teams offer highly individualized services, employ a low staff-to-individual ratio, conduct the majority of their contacts in natural community settings (e.g., individual's residence), and are available to help individuals address psychiatric crises 24 hours a day. Service intensity is flexible and regularly adjusted to individuals' needs. Per the evidence-based model, individuals are eligible for PACT for an indeterminate period as clinically needed.

Most New Jersey PACT teams are staffed with eight to ten full-time equivalent direct care staff and can serve between 70-75 individuals at any point in time. There are 31 PACT teams in New Jersey. PACT services are available in all 21 counties of the state. The SMHA contracts with 10 different non-profit agencies that operate these teams. Since state fiscal year 2010, the SMHA has expanded twenty of the 31 teams with additional staffing. As an Evidence-Based Practice (EBP), Assertive Community Treatment is endorsed by SAMHSA. PACT will continue to be integral to enhancing the network of community mental health services. According to QCMR data reported by providers, there were 2,440 persons receiving PACT services in SFY 2024 and 2,361 in SFY 2025.

C. 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 statutory 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 statutory 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 persons receiving services to mental health services in their agency such as, outpatient or partial care programs. All PATH programs link individuals to behavioral health and co-occurring services, entitlements and housing (emergency, transitional and permanent) within their communities. In SFY 2024, there were 1,562 persons served by PATH and 1,699 in SFY 2025.

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, and strategies to reach the statutory population.

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

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

Individuals eligible for services may have challenging behaviors related to frequent untreated mental illness or lengthy hospitalizations and homelessness. This may include a history of non-engagement with services, refusal to leave a hospital setting, active substance use disorder, lack of financial benefits, forensic history 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 integration, housing stability, wellness, recovery, and resiliency. Illness management, socialization, work readiness and employment, peer support, and other skills that foster increased self-direction and personal responsibility for one's life are also addressed. Person receiving services are expected to be full partners in identifying and directing the types of support

activities that would be most helpful to maximize successful community living. This includes use of community mental health treatment, medical care, self-help, employment and rehabilitation services, and other community resources, as needed and appropriate. According to QCMR data reported by providers, there were 5,765 persons served in SFY 2024 and 5,842 person receiving services in CSS in SFY 2025.

E. Residential Services. DMHAS-licensed supervised residential options offer on-site staff support and assistance with activities of daily living according to client needs. Housing opportunities include supervised apartments, and group homes. Additionally, residences may address particular needs: of individuals with serious mental illness and/or co-occurring substance use disorders, short-term Respite Care, Crisis, and Deaf/Blind. These group homes provide different levels of staffing based on the license for the particular homes ranging from In SFY 2024 there were 2,658 persons served in residential services and 2,701 in SFY 2025.

F. Supported Employment (SE). The Division of Mental Health and Addiction Services (DMHAS) provides evidence-based practice (EBP) supported employment services since 1988. SE is provided statewide for adults (18 years of age and older) with serious mental illness and/or co-occurring mental illness and substance use disorders by assisting with choosing, obtaining and retaining integrated employment in jobs of their choice within their skill and credential set. The services are provided through 20 fee-for-service (FFS) contracted community mental health provider organizations. In SFY 2024 there were 1,549 individuals served in SE and 1,412 served in SFY 2025.

G. Supported Education (SEd). DMHAS has also provided SEd services since 2006. SEd services are available to individuals with serve mental illness and/or co-occurring disorders who either want or are currently matriculating in post-secondary education. Through four FFS contracted community provider organizations, Sed is accomplished throughout reach services aimed to assist people with reach their postsecondary academic goals. Services are individualized and flexible based on student choice and career goals. In SFY 2024 there were 165 served in SEd and 187 served in SFY 2025.

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

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

IMR is provided at Ann Klein Forensic Center (AKFC). The program delivers a structured, step-by-step process that equips individuals with the essential information and skills needed to set and achieve their personal recovery goals. It is conducted in a group format at AKFC, ensuring a supportive and collaborative environment. AKFC is proud to offer this program to our patients. The nurses (facilitators) were trained with a one-hour online introductory course, followed by an in-class discussion led by a consultant from Rutgers University on the IMR module. The registered nursing staff (RNs) participated in training focused on the module's content and delivery. We hold four sessions weekly—two in the morning and two in the evening—each lasting 60 minutes and designed for AKFC patients. Currently, two licensed practical nurses (LPNs) have completed the online course and will soon attend the in-class discussion for a new module. Additionally, the STU operated by Ann Klein Forensic Center incorporates IMR in their individualized treatment modalities for residents, prioritizing interventions that alleviate barriers to discharge and support resident goal.

Ancora Psychiatric Hospital (APH)

The Ancora program under the leadership of the social work administration in collaboration with psychiatric rehabilitation provides IMR in group treatment and as a support to discharge planning. IMR is incorporated in transition of care at an on-grounds cottage designed for skills practicing in preparation for discharge.

Trenton Psychiatric Hospital (TPH)

At Trenton Psychiatric Hospital, the psychosocial rehabilitation teams provide IMR through Group and Individual therapy in various iterations and complexes over the campus. There are various offerings about IMR programming with robust IMR group offerings in each of the four complexes. IMR Happy Life curriculum is an example of adaptation of the evidenced IMR principals with an emphasis on belief in recovery, providing an ability to better understand the mental health lived experience. Relapse prevention and coping skills are provided as part of IMR curriculum, and individualized IMR sessions are provided to support treatment goals and individual skill building. IMR curriculum specific to the individual needs of patients who are on Conditional Extension Pending Placement (CEPP), is provided to meet the unique needs of long-term patients transitioning back to community life.

Greystone Park Psychiatric Hospital (GPPH)

Greystone Park Psychiatric Hospital utilizes an interdisciplinary approach for IMR interventions through a nurse led model, providing both group and individual sessions. Additionally Social Work leads IMR interventions including a unique IMR program designed for deaf and hard of hearing patients.

The New Jersey Division of Mental Health and Addiction Services (DMHAS) continued to emphasize the incorporation of Illness Management and Recovery (IMR) into the foundation of principles and practices of a recovery-oriented, person-centered system of community mental health services. IMR implementation continues to be supported by state regulations concerning New Jersey's partial care/partial hospital (PC/PH) systems and community support services programs (CSS). As part of outpatient mental health agencies' contractual agreements with DMHAS, IMR providers are asked to track persons receiving IMR services and whether or not IMR was delivered via group and/or individual sessions.

Through a contract with Rutgers UBHC-Technical Assistance Center (TAC), DMHAS provides the following services for agencies across the state and within a given fiscal year:

1. Three 2-day IMR introductory trainings (with a focus on programmatic implementation)
2. IMR post-training consultation sessions for individual agencies (via onsite, virtual and/or telephone)
3. Supplemental IMR trainings to support implementation
4. Monthly IMR Roundtables (virtual consultations for IMR-trained and contracted community provider network).

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

IMR virtual and in-person training by the Rutgers UBHC TAC continued in FY 2024 despite the ongoing impact of staff turnover and position vacancies. The total number of IMR practitioners trained in FY 2024 was 112. Thirty-seven IMR Practitioners received training from 16 Community Support Services Programs. Another 75 IMR Practitioners received training from 44 Partial Care/Partial Hospital Programs.

Data on service recipients is limited to a degree since some agencies did not submit FY 2024 IMR data. However, those who did submit reports noted that, for Community Supportive Services (CSS), 147 clients received IMR services. For Partial Care / Partial Hospital programs, 4,916 clients received services. Combined, for FY 2024, the TAC received reports of 5,063 clients receiving IMR services. This is despite only 22% of CSS programs and 40% of Partial Care / Partial Hospital programs reporting.

During FY 2024, the TAC held monthly IMR virtual Roundtables in order to provide continuing support for staff/ agencies seeking to enhance their implementation efforts. For FY 2024, 73 staff from 19 agencies, including direct IMR practitioners, supervisors and clinical directors participated in the 90-minute Round Table discussions.

In September of 2024, in collaboration with DMHAS, the Rutgers TAC held a 20th Anniversary event commemorating 20 years of IMR training and implementation in New Jersey. The event included a talk by Kim Meuser and Susan Gingrich who discussed the past and future of IMR both in New Jersey and worldwide.

Crisis Intervention Team. DMHAS funds a CIT Center of Excellence through Legacy Treatment Center. The Center facilitated the development of new county CIT efforts. Presently nineteen of twenty-one counties as well as the NJ State Police provide training to first responders, dispatcher and mental health staff in CIT. These counties offer the training to other counties and municipalities as well as their own. For calendar year 2025 to date, there have been 27 40-hour classes, 4 one-day dispatcher programs, 2 NJ virtual training classes, 3 advance trainings and 3 academy one day trainings.

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

Re-entry Services (Intercepts 4-5) The SMHA has offered Re-entry services (Forensic Case Management) from county correctional facilities since 2000. Programs have between 1 to 2 case managers who interview and enroll potential candidate while in jail, provide pre-release planning and then successful linkage and coordination to mental health and other social/community services. No psychiatric or treatment services are directly provided by the programs but rather link existing mental health services. Counties include: Atlantic, Bergen, Burlington, Camden, Cumberland, Essex, Gloucester, Hudson, Monmouth, Morris (also included some county funding), Middlesex, Mercer (also included county funding), Passaic, Ocean, and Union.

Veterans Prosecutor Program was established through legislative action in 2017. Operated by local prosecutor offices, it affords a veteran with lower-level charges an opportunity to access treatment services with access to treatment services. This program is potentially available in every county, however, the referral rate is low. The SMHA was actively involved in the implementation and in supporting training as well as providing mental health and support services for those veterans who are not eligible for VA services.

Chief Justice's Mental Health Committee: The Chief Justice of the NJ Supreme court through the Acting Administrative Director revitalized this committee in December of 2019. The committee is co-chaired by the Commissioner of the Department of Human Services and a Presiding Judge. The Asst. Commissioner for the SMHA as well as a senior manager and other staff are represented on the committee. The collaborative includes a pilot, training, and data and treatment subcommittees. Through a collaborative effort, the committee will examine points of intersect between person receiving services and the judiciary and how mental health services may be accessed as well as examine best practices and potential pilot programs.

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

J. Integrated Case Management Services. ICMS works collaboratively with the person receiving services, their family/significant others (as appropriate) and other collateral contacts to assesses the individual's strengths and needs; develop a service plan based on this assessment; refer and link individuals to needed services, including medical and dental services; and monitor engagement in services. In SFY 2024, there were 4045 individuals served and in SFY 2025 there were 3,847 served with ICMS services.

K. Outpatient Services. Outpatient services include counseling interventions provided by trained clinicians to individuals living in the community who require non-immediate care that can be delivered on a scheduled basis. Interventions may include individual, group, and family therapy; medication counseling and maintenance, assessment and testing, outreach services, and referral. In SFY 2024 there were 85,623 individuals served in outpatient and 75,608 in SFY 2025.

L. Partial Care. Rehabilitation services are provided within partial care and include engagement strategies that are designed to connect with individuals in order to enter into therapeutic relationships supportive of the individual's recovery. Activities assist a person receiving services to identify, achieve and retain personally meaningful community integration and other personal goals over time which help the person resume normal functioning in valued life roles in self-chosen community environments. In SFY 2024 there were 6,300 served in partial care and 5,802 served in SFY 2025.

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

- Coping skills, adaptive problem solving, and social skills training that teach individuals strategies to self-manage symptoms;
- Psycho-education that provides factual information, recovery practices, including evidence-based models,
- Development of a comprehensive relapse prevention plan that offers skills training and individualized support;

- Medication self-management, behavioral tailoring, simplifying a consumer's medication regimen, and motivational interviewing assist and support person receiving services in adhering to their medication regimens;
- Wellness activities that are consistent with the consumer's self-identified recovery goals. Wellness activities may address common physical health problems, such as tobacco dependency, alcohol use, sedentary lifestyle and lack of physical exercise, and overeating and/or poor nutrition including connection to primary medical and dental services;
- Skill development needed for consumer-chosen community environments, facilitating consumer-directed recovery and re-integration into valued community living, learning, working and social roles by developing critical competencies and skills; and
- Age-appropriate learning activities which are directly tied to the learning of daily living or other community integration competencies such as financial literacy, learning basic computer literacy, and recognition of directions and safety warnings.

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

The multidisciplinary clinical team and advocates within the facility for management of behavioral issues for individuals who would not benefit from inpatient psychiatric stays. S-COPE equips staff by sharing best practices and offering trainings. S-COPE also gets referrals from screening/crisis to follow up with patients upon discharge back to their nursing homes. All assessments and treatment recommendation offered are consistent with promising practices and/or evidence-based practices. S-COPE staff develop reports on their consultations, and it's contracted for intakes, consultation calls, both telephonic and on-site annually.

S-COPE staff also provides training to crisis/screeners, primarily to nursing homes. All trainings are developed by the S-COPE team and trainings topics can be suggested by providers that they serve. N. Legal Services. Legal assistance provided to mental health clients, either through agency referrals or self-referral, by a network of DMHAS-funded legal service agencies. Assistance may include advice and guidance, case coordination, and court representation for issues such as government entitlements, housing, evictions, employment, etc. In SFY 2024, there were 2025 served by Legal Services and 1900 served in SFY 2025.

O. Certified Community Behavioral Health Program (CCBHC) New Jersey has 7 Demonstration CCBHC providers. The CCBHC is required to provide 9 Core Services, including crisis, ambulatory treatment, mental health care for veterans, peer and family support, case management (TCM), primary care screening and monitoring, screening diagnosis and risk assessment.

Psychiatric rehabilitation services are also one of the nine required services. The CCBHC agencies provide rehabilitative services through direct service or through an agreement with the designated collaborative organization. This includes supportive employment, supportive education, independent living skills, medication management and transitional services for individuals who have and are moving back into the community. There were 21,994 persons served by CCBHC.

8. State and County Psychiatric Hospitals

A. State Hospitals

The Department of Health (DOH) operates four adult psychiatric hospitals. The care at the hospitals serves people with persistent and severe mental illness who need intensive, inpatient care and treatment. Effective August 20, 2018, the Division of Mental Health and Addiction Services (DMHAS) was transferred to the Department of Human Services, while state psychiatric hospitals remained under the supervision of the Department of Health. The State Mental Health Authority (SMHA) previously operated the state hospitals until this reorganization. The SMHA and the Department of Health continue to work collaboratively to facilitate discharges from the state hospitals as well as increasing diversionary efforts which provide opportunities for individuals to live, work, and learn within their community. The development of supportive housing in 2006, the Olmstead settlement agreement in 2008, the Olmstead unit in 2009, and subsequent expansion of diversion staff, have contributed to a decrease in state hospital census. The state regional psychiatric hospital census has decreased from 2,109 in SFY 2006 to 982 in SFY 2025, a decrease of 53.44%. The data from SFY 2006 to SFY 2025 excludes Ann Klein Forensic Center (AKFC) and includes Hagedorn Psychiatric Hospital (HPH) for SFY 2006. HPH was subsequently closed on 6/14/12. The end of year census for Ann Klein Forensic Center (AKFC) for SFY 2025 was 189. The state regional psychiatric hospital admissions have decreased by 80% from 2,938 in SFY 2006 to 587 in SFY 2025 (excluding AKFC and including HPH).

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

Ancora Psychiatric Hospital (APH) has 515 CMS certified beds as an adult inpatient facility that offers a multidisciplinary team approach for the development and implementation of care. Ancora also has cottages on grounds, of which one is available to the state hospital as a training cottage. The remaining cottages are occupied by community providers. Ancora meets the needs of its mentally ill clients in the areas of admissions, acute and chronic psychiatric units, gero-psychiatric units, a sub-acute medical unit, and a secure care unit (forensic). The mission of APH is to provide quality comprehensive psychiatric, medical, and rehabilitative services that encourage maximum patient independence and movement towards community living with an environment that is safe

and caring. In SFY 2025, Ancora began work with Rowan School of Medicine to augment staffing and increase medical educational opportunities for staff to advance best practices in evidenced based treatment.

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

Trenton Psychiatric Hospital (TPH), located in West Trenton, Mercer County, primarily serve the residents of central New Jersey. Trenton Psychiatric Hospital has 400 CMS certified beds, as well as cottages on the grounds. TPH provides a holistic approach to patient care from initial assessment and the treatment of the human response to current and potential mental health problems. TPH ensures its patients (and their families) competent, compassionate care as patients individualized care goals are reached. In 2023, TPH started its first clinic (Steppingstone Substance Use Disorder (SUD) Clinic) in the Marquand building providing the cottages, substance use treatment, on day program treatment model. A second SUD clinic, RISE & SHINE opened in January 2025. TPH has collaborated with Northern and Southern Centers of Excellence in establishing Addiction Programs at TPH, arranging Continuing Medical Education (CME).

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

B. County Hospitals

The SMHA supports three county operated psychiatric facilities that operate as part of the continuum of services. These facilities are located in Bergen, Essex, and Hudson counties. Effective 10/15/2024 the ownership of Union County's Cornerstone was transferred to a private owner and ceased to be a county psychiatric hospital.

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

The county hospital census has decreased by 5.3% from 569 in SFY 2010 to 539 in SFY 2025. During this same time, the county hospital admissions decreased by 10% from 6,264 in SFY 2010 to 5,439 in SFY 2025. DMHAS began collecting data from the county hospitals in SFY 2010.

9. Olmstead Initiatives

Over the last few years, the SMHA has been successful in its delivery of services to individuals in the state psychiatric hospitals as well as in the community. Much of this success is due to the implementation of various initiatives resulting from the Olmstead Lawsuit. In April 2005, New Jersey Protection and Advocacy, Inc., now known as Disability Rights of New Jersey (DRNJ) filed suit against the New Jersey DHS on behalf of psychiatric patients who were found to no longer meet commitment standards, but for whom no appropriate placement was available. The official term for the status assigned is Conditional Extension Pending Placement (CEPP). The SMHA issued its initial Olmstead Plan known as the Home to Recovery CEPP Plan in January 2008.

Although the Olmstead Settlement agreement was the result of a lawsuit initiated in 2005, this Settlement resulted in an investment in the mental health system for needed community, residential and other services. The Olmstead Settlement agreement can be viewed at:

http://www.state.nj.us/humanservices/dmhas/initiatives/olmstead/olmstead_settlement_agreement.pdf, The settlement agreement included performance indicators for improved community integration, each with its own individual measures for every year covered by the Settlement Agreement. The performance indicators were:

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

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

As per the Administrative Bulletin 5:11 persons receiving services in state psychiatric hospitals are assigned to community service providers who have the option of either accepting the person receiving services or requesting additional supports from DMHAS. In addition to community providers, state psychiatric hospitals have the option within their discharge planning process of collaborating with community service providers to request additional supports for the person receiving services in their potential new living situations outside the institutions. Such requests and other efforts toward successful discharge are to be documented within the Individual Needs for Discharge Assessment (INDA). Assignments are based on hospital treatment team recommendations as well as the individual's preferences. The assigned provider is expected to participate in treatment team meetings. The early involvement of community providers in the treatment planning process fosters familiarity between provider and the person receiving services, allowing for immediate planning on the part of the provider to prepare to meet the individualized needs of each person receiving services upon discharge into their care. This preparation is critical to ensuring that the person receiving services is provided with necessary community supports and thereby maximizes his/her chances of sustained community tenure. It is born out of high-level interagency collaboration.

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

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

The Home to Recovery II Plan includes outcomes geared toward monitoring sustainability of the Division's community integration efforts. These outcomes include but are not limited to enhanced utilization of Supportive Housing, expansion of CSS opportunities, a decrease in census; fewer admissions to state hospitals; and a decrease in the number of individuals on CEPP. The average state hospital census for the 4 regional state hospitals in SFY 2008 (year of the settlement agreement) was 1,951 and there was an average of 2,763 admissions that year. The CEPP census on 6/30/2008 was 938. The percentage of individuals on CEPP of the total census was 49.9% on 6/30/2008. Additionally, there were four regional hospitals in SFY 2008 as Hagedorn Psychiatric Hospital closed in SFY 2012. The average state hospital census for the three regional state hospital in SFY 2025 was 982 (a decrease of 49.67% from 2008), there were an average of 587 admissions (decrease of 78.75% from 2008), and the CEPP census on 6/30/25 was 195 (decrease of 79.2% from 2008). The percentage of individuals on CEPP of the total census was 19.9% on 6/30/2025 (decrease of 60.12% from 2008). In SFY 2008, there were 3,051 individuals receiving services in supportive housing. In 2024, there were 5,765 individuals served by CSS and 5,842 served in SFY 2025.

A. Validation of Vacancy Tracking Systems. The Bed Enrollment Data System (BEDS) was developed in 2013 for the furtherance of deliverables to the Olmstead lawsuit settlement agreement with Disability Rights NJ¹ to facilitate the communication of accurate information between state hospitals and community residential providers regarding bed needs and available housing inventory. The system has replaced the process of cold calls to agencies and the utilization of quickly outdated paper tracking sheets. In the Spring of 2021 BEDS was updated to contain

¹ <https://nj.gov/humanservices/dmhas/initiatives/olmstead/>

functional improvements, including search features and the addition of short-term care facility (STCF) beds, to give the SMHA a better view of the acute care system.

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

Beginning in 2023, DMHAS has utilized Covid Supplemental and ARPA funding to procure a web-based data system for tracking referrals and vacancies for beds and services, including status of the referrals, disposition, and communication regarding the referrals. Additionally, the database has a crisis management module for call center intakes and mobile outreach dispatch. The crisis management module went live on March 3, 2025.

B. Enhancements to Community Capacity. From 2010 through 2014, DMHAS was charged with the creation of 695 beds expressly for the community placement of person receiving services on CEPP status in the regional state hospitals and 370 beds to be created for person receiving services who are already in the community and at high-risk for hospitalization and/or homelessness. This equates to a total of 1,065 placements to be created over the five-year period covered by the settlement. The SMHA met and exceeded this goal, creating 1,436 new placements. Of these, 941 were set aside for the discharge of CEPP person receiving services from state hospitals (exceeding the settlement goal of 695 by 246 or 35%), and 495 were reserved for persons receiving services at risk of hospitalization (exceeding the goal of 370 by 125 or 33.78%). In total, the SMHA exceeded its goals for placement creation by 34.83%, which amounts to 371 placements above its required deliverable. The Division continued creating new placements for the SMI populations, reaching a total of 1,808 new placements by the end of SFY 2016, with 1,274 reserved for CEPP discharges and 534 set aside for persons receiving services at risk of hospitalization. There were 1,060 number of new placements created from SFY 2017 to SFY 2025. This would also include recycled subsidies and multiple re issuance of subsidies. DMHAS will be funding approximately 40-60 new subsidies in SFY 2026.

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

D. 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 DCEO. Follow-up on systems raised by ICRC and discussion of resolution strategies are discussed. In addition, policy or systems that may involve collaboration with another Division or state Department, are discussed at these meetings and elevated to Olmstead leadership to address. Olmstead staff also use these meetings to update the hospital leadership on any new administrative bulletins, requests for proposals, updates or changes to the vacancy tracking system, and/or trends identified in the data.

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

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

G. State Hospital infrastructure modernization. The SMHA has embarked on multi-year technology initiative to modernize technology systems such as the State's Oracle database for hospital census management, and the expansion of the state hospital based developed Provider Order Entry System (POES). These efforts provide a singular data footprint for both DMHAS and the state psychiatric hospitals to share various aspects of data pursuant to CEPP management.

H. State Hospital and Community Training

The SMHA, through DMHAS' Olmstead unit provided level of care trainings to the treatment teams at each of the three regional state hospitals. The Olmstead unit staff facilitated discussions on community treatment options and social service programs to support individualized discharge planning. Training was also provided to Community Support Services providers.

Recently the state hospitals have begun formative discussions with the community providers on collaborative discharge planning through on-site events such as provider open houses and expanded in-reach along with hospital tours of community provider agencies.

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

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

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

According to figures released by the United States Census Bureau, the 2024 adult population of New Jersey was 7,448,667. The size of the New Jersey child population was 2,052,184. 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 2024 was 402,228. Using the upper SMI limit of 7.1%, the estimated number of adults with SMI in New Jersey in 2024 was 528,855. Accordingly, using the lower SMI limit of 3.7%, the estimated number of SMI adults in New Jersey in 2024 was 275,600.

According to URS Table 2a, a total of 93,572 unduplicated persons ages 18 and over received services in programs provided or funded by the SMHA in FY 2024. SMHA served 34,750 unduplicated adults with SMI (refer to URS data table 14a) in FY 2024. That was 8.64% of the total estimated adults with SMI in New Jersey receiving services (402,228). The objective of the SMHA is to continually increase the number of adults with SMI that may receive emergency mental health services and non-emergency community mental health services. Also shown in URS data table 14a and 14b, out of the total 34,750 unduplicated adult with SMI served by SMHA in FY 2024, 17,107 (49.3%) were ethnic minorities. SMHA will ensure that all statutory populations continue to have access to mental health services in New Jersey. New Jersey has not established a methodology to estimate incidence of SMI among adults and will be requesting technical assistance.

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.

1. Services to Homeless Populations

DMHAS operates Projects for Assistance in Transition from Homelessness (PATH) program using a combination of federal and state funds. The statutory population is homeless adults or those at risk of homelessness who have a serious mental illness, including those with co-occurring

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

substance use disorders who are not currently engaged in and are resistant to mental health and other community support services.

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

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

In SFY 2024, the PATH programs in New Jersey provided outreach to 2,559 individuals and served a total of 1,562 persons. There were 638 program participants that were linked to mental health services, 92 to substance use treatment services, 166 to primary health/dental care, 368 to financial services, 299 to temporary housing/shelter, 250 to long term housing and 292 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. In SFY 2025, the PATH programs in New Jersey provided served a total of 1,699 persons.

Services provided under the certified (community behavioral health clinic) CCBHC initiative are available to all who meet programmatic criteria. 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. In Year 6 (2022-2023) only 1.6% of CCBHC clients were experiencing homelessness. CCBHC services include case management services designed to assist clients in addressing homelessness or who need services. The CCBHCs also include one provider agency, AtlantiCare Behavioral Health, that serves a rural population in Southern New Jersey.

2. Services to Rural Populations

The SAMHSA 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 pocket of Atlantic County to be apart of the CCBHC's demonstration project funded by CMS. The CCBHCs offer services within a holistic framework, thereby closing a treatment gap that frequently results in inadequate service provision for individuals with co-existing social, physical and behavioral health care needs. New Jersey's CCBHCs offer, through direct services or through affiliation 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.. The CCBHC Demonstration Program was extended to September 2025.

Currently, the New Jerseys Division of Medical Assistance and Health Services (Medicaid) in collaboration with DMHAS and the Department of Children and Families is developing a Medicaid State Plan Amendment to enable the CCBHC Demonstration providers, including Atlanticare, to sustain the CCBHC after the Demonstration ends in September 2025.

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

3. Services to Older Adults: Statewide Clinical Outreach Program for the Elderly (SCOPE)

Seeing a need to assist long-term care providers serve older adults with behavioral problems, DMHAS awarded a contract for a program to provide clinical consultation, assessment, treatment and intervention to older adults who were residents of nursing homes and were at risk for psychiatric hospitalization. Trinitas Regional Medical Center in Elizabeth, New Jersey was the recipient and has been administering this Statewide Clinical Outreach Program for the Elderly (S-

COPE), which is fully funded by DMHAS and has been in operation since April, 2012. Older adults (55+) residing in nursing homes and state-funded residential care facilities are seen by S-COPE's multidisciplinary team consisting of a geriatric psychiatrist (consultant), geriatric advanced practice nurse, and licensed clinical social workers, who are available 24 hours/7 days a week for telehealth or on-site consultations. S-COPE also provides training to nursing facilities on assessing and managing challenging behaviors in their residents

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.

1. State funding/training

The Division of Mental Health and Addiction Services (DMHAS) is dedicated to community--based mental health services and is advancing community supports for individuals 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 2025, State appropriations for mental health community providers were \$421million. A significant portion of which has been dedicated to 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 eight 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 many providers and clients to Fee for Service reimbursement, and away from fixed cost or overall cost reimbursement contracts. DMHAS believes that the combination of more attractive Medicaid rates and the transition to a direct Fee for Service reimbursement approach for non-Medicaid services (with enhanced rates), will lead to greater access for clients and a more transparent, accountable and efficient behavioral health service delivery system. DMHAS continues its commitment to consumers and providers, by ensuring reimbursement opportunities to providers when staff resources are deployed. DMHAS reimburses MH FFS contracted providers for non-Medicaid covered services. This reimbursement accomplishes two important things: 1. these ancillary but critical services support consumers' community tenure and 2. it limits reimbursements to the services provided.

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 2025 was approximately \$5.7 million. In addition, DMHAS hosts quarterly meetings and webinars that served as training opportunities for the provider community. DMHAS staff deliver these trainings, which are funded by our State General Fund appropriations.

Goals

While New Jersey currently has cost-based contracts and fee-for-service arrangements with approximately 118 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 22 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 \$38 million for state fiscal year 2025. 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.

2. Federal funding

The Division leveraged other sources of funding to support community mental health services. In addition to the Mental Health Block Grant, the other primary sources of federal funding in SFY 2025 were the Projects for Assistance in Transition from Homelessness (PATH) grant, American Rescue Plan Act (ARPA), and the Bipartisan Safer Communities Act. The PATH grant provided \$2.2 million to support our contracts for that program. DMHAS was awarded \$39,121,366 in ARPA funds to expend by 9/30/25. These funds have been allocated for Crisis Services Crisis Receiving Stabilization Centers and 988 Implementation, Coordinated Specialty Care Community Integration, Psychiatric Emergency Screening Services Peer Recovery Services, Crisis Diversion Homes, Web-based Electronic Referral System and Crisis Management Module, , Community Health Law Project, Teen Mental Health First Aid, Co-Occurring SMI/IDD Initiative, Older Adult Expansion, Fee for Service, Designated Screening Services, Consumer Connections, and Criminal Justice Reform.

3. Staffing

As of June 30, 2025, the total staff in the New Jersey Division of Mental Health and Addiction Services (DMHAS) were 267, consisting of 205 full-time employees and 62 staff on a part-time or consultant basis. 17 staff are dedicated to Mental Health Block Grant (MHBG)-specific activities. Many other staff across the Division dedicate time and effort to mental health programs and contracts.

Overall, staff are dedicated to administrative and programmatic functions, including Community Services, Contract Monitoring, Planning and Evaluation, Olmstead and Diversion, Prevention, Housing and Treatment, and Legal and Finance. Primary responsibilities include program and

policy development, day-to-day oversight and monitoring of community providers, development of request for proposals, data analysis, information technology operations and administrative (fiscal/legal/management) support.

4. Mental Health Block Grant (MHBG) Expenditure plan

In State Fiscal Year 2026, DMHAS will continue to expend MHBG resources on prescribed and allowable activities. This reflects our commitments for Coordinated Specialty Care Community Integration for Early Serious Mental Illness including First Episode Psychosis (FEP) and Affective Psychosis (10% of the grant), Crisis services, including Crisis Receiving Stabilization Centers (5% of the grant), Behavioral Health Planning Council activities, Administrative functions (limited to 5% of the total grant), and resource, development, and training.

As always, the largest portion of our anticipated expenditures reflects community care programs for clients with Serious Mental Illness (SMI). While New Jersey currently has cost-based contracts and Fee for Service arrangements with 118 unduplicated agencies that provide eligible Community Mental Health services, to facilitate fiscal reporting and administration, and minimize the audit burden on our providers, DMHAS has allocated the available Block Grant funding to a select group of about 22 provider agencies who deliver services under Fee for Service arrangements. These agencies provide direct treatment services (including Outpatient, Residential, Partial Care and Case Management) to clients, most of whom have SMI. DMHAS Fiscal staff review data from our expenditure claiming system to allocate the funding appropriately.

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

A. Screener Certification: The SMHA contracts with Rutgers University Behavioral Healthcare technical assistance center to provide Screener Certification Courses for psychiatric emergency screening service staff. These courses, offered four times per year new staff, are comprised of eight full days of instruction and include training related to the wellness and recovery model, New Jersey's civil commitment statute, providing care in the most appropriate environment, suicide assessment, outreach with police and working with youth.

B. The Mental Health Awareness Training Grant: The goal of this initiative is to empower anyone working with adolescents and young adults, first responders, or veterans to increase their mental health awareness, equip them with resources on how to appropriately react to crisis and provide linkage to professional, peer, and self-help resources. Mental Health First Aid, Youth Mental Health First Aid, and Question. Persuade. Refer. (QPR) are the evidenced-based suicide prevention trainings that are being offered at no cost through this initiative.

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

Objective: 24 training sessions annually with an aim of 600 training participants.

Outcome: 768 training participants completed the 8-hour Mental Health First Aid course.

Objective: 48 training sessions annually with an aim of 960 training participants.

Outcome: 1,195 training participants completed the 2-hour Question. Persuade. Refer. course.

In the federal fiscal year 2024, there were 1,963 individuals trained Statewide under the MHAT grant, surpassing our goal of 1,560. Data indicators were submitted into SPARS (SAMHSA's Performance Accountability and Reporting System) on a quarterly basis as required. The following objective was surpassed with an outcome of 98%; Objective: 85% or more training participants will indicate an improvement of knowledge, attitudes and beliefs related to mental health prevention and promotion. To add, quarterly monitoring meetings continue to be completed with our assigned SAMHSA representative. Monthly flyers with training dates and zoom links are distributed to State and county partners and posted on the State website. Additionally, we are receiving and fulfilling more request for in person trainings.

We continue to offer these important suicide prevention trainings to school districts/personnel, case management organization, and the general public. At this time, the MHAT program is managed by our Training Coordinator under the supervision of the Grants Staff. To add, an administrative support staff was recently hired to assist the Training Coordinator with registering training participants.

C. Disaster Response Crisis Counselor Certification: The DRCC training curriculum was created in response to the need for a trained workforce to provide crisis counseling to NJ residents in the event of a community crisis or larger scale disaster response. The core courses for initial certification are:

1. Introduction to Disaster and Trauma Counseling: Basic Training for Disaster Response Crisis Counselors
2. Issues in Disaster Response and Recovery
3. Ethical Issues in Crisis Response
4. Key Concepts in Psychological First Aid
5. National Incident Management System (NIMS 700) /Incident Command System (ICS 100) Note: NIMS and ICS training are offered by FEMA and can be taken on-line.

In 2024, there were five (5) opportunities for individuals seeking certification to complete the required courses named above. Additionally, current DRCC's are expected to maintain their certification by attending recertification courses, last year fourteen (14) recertification courses were conducted by Disaster and Terrorism Branch staff.

As of March 2025, there are a total of 490 Active DRCC's in the 21 NJ counties: Atlantic (71), Bergen (71), Burlington (76), Camden (64), Cape May (49), Cumberland (44), Essex (72), Gloucester (55), Hudson (48), Hunterdon (41), Mercer (61), Middlesex (81), Monmouth (130), Morris (84), Ocean (100), Passaic (64), Salem (40), Somerset (69), Sussex (48), Union (78), Warren (38).

At this time, DMHAS is in the second cycle of a funding opportunity that assist County Mental Health Administrators recruit, engage and sustain their respective DRCC volunteer workforces.

Psychiatrist Residency Training and Psychiatric Advance Practice Nurses (APNs) Program
DMHAS has supported the training and hiring of psychiatrists and psychiatric Advanced Practice Nurses (APNs) in its contracted programs. The state has a significant need for more of these critical professionals and so has been involved in the development of programs to increase the numbers of psychiatrists and psychiatric APNs in the state. Most of the state's support in past years has been focused on increasing the numbers of Psychiatric APNs in community mental health programs serving individuals with serious mental illness. However, while the APN program is no longer being funded, beginning in 2022, DMHAS has received funding provided by the state legislature to support the training of adult psychiatry residents and of child and adolescent psychiatry (CAP) fellows in the state.

The legislative funding has had the goal of increasing the number of adult and child psychiatrists who are practicing in the state. The state funding of positions in psychiatric training programs has been provided since SFY 2023, when one new resident in each of the then 11 residency programs was funded. In SFY 2024, two residents per program were funded, as were two CAP fellows in the state's two CAP Fellowship programs. In SFY2025, the funding had been decreased but still supported new residents and CAP Fellows in most of the programs. In the years that the initiative has been in place. The funding has supported a total of 64 new resident positions and 7 new CAP fellowship positions.

These programs are overseen out of the DMHAS Medical Director's office. One requirement of the residency and CAP training programs for new residents is a focus on public and community psychiatry. As such, all programs are required provide training on a public and community psychiatry curricula, and to provide trainees with experience in settings that expose them to services for vulnerable clients with serious mental illness and substance use receiving services in community-based settings. these populations. Another related aspect of the legislative funding is to provide a program that promotes interest among medical students in the field of psychiatry. The state has used funding to support two separate but related initiatives in SFY2024 and SFY2025. The two initiatives have outreached New Jersey medical students and invited them to participate in a variety of activities and educational forums on psychiatry practice.

While DMHAS no longer has a program that directly funds psychiatric APN positions, the Division supports the role of psychiatric APNs in the provision of services in contracted clinics and providers. As licensed independent practitioners, psychiatric 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 can 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). Psychiatric APNs were also a large proportion of the practitioners who prescribed medication for opioid use disorder (MOUD) to address the overdose crisis, and they remain critical prescribers in this role.

Under the COVID emergency relaxation of state licensing regulations, APNs did not have to have a collaborative agreement with a physician to prescribe, and they were also able to prescribe buprenorphine with a DATA waiver. However, the Data or X waiver is no longer a requirement for prescribing buprenorphine. Also, Executive order 112 removing the APN requirement for a

collaborative agreement may end and bring back the requirement for a collaborative practice agreement. While the capability to use telehealth during the pandemic has eased the prescriber shortage in the state workforce, psychiatric APNs continue to have a critical role in providing mental health services.

NJ Higher Education Student Assistance Authority (HESAA) to address the critical shortage of behavioral healthcare providers, the Behavioral Healthcare Provider Loan Redemption Program offers loan redemption to eligible providers in exchange for up to six years of service. Eligible behavioral healthcare providers included psychiatrists, licensed psychologists, licensed social workers, licensed clinical social workers, psychiatric nurse mental health clinical specialists, board certified behavior analysts, licensed clinical alcohol and drug counselors, licensed professional counselors, and licensed associate counselors. The program will provide up to \$50,000 to redeem an eligible participant's cumulative outstanding student loan balance in exchange for every two full-time years of service at an approved site, for a total of \$150,000 in loan redemption in exchange for up to six years of service.

E. 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, Tobacco Cessation, wellness and recovery programs, and Illness Management and Recovery training.

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

1. State Government

The Division of Mental Health and Addiction Services in New Jersey (DMHAS) is a Division under the New Jersey Department of Human Services. The DMHAS serves as the Single State Agency (SSA) for Substance Abuse and the State Mental Health Authority (SMHA) as designated by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). The mission of the Division of Mental Health and Addiction Services is to promote opportunities for adults with serious mental illness to maximize their ability to live, work, socialize, and learn in communities of their choice. This is accomplished through a comprehensive system of care, including psychiatric inpatient settings and community-based support services comprised of partnerships among the DMHAS, other State agencies, consumers, families, providers, and mental health advocates, with the understanding that adults with serious mental illness are entitled to dignified and meaningful lives. This mission is realized in both new and existing Division programs by application of the following operating principles: Services are to be delivered by means of a comprehensive system of care, which emphasizes the most appropriate settings to promote the highest level of functioning; There must be continuity of care and coordination of services within the State and between the public and private sectors; The range of services within the system of care must respond to the needs of the individual consumers ; The Division must

assure appropriate, high quality care for the State's most severely disabled citizens in State psychiatric hospitals and for the less disabled citizens in community programs

The Division oversees the provision of a broad range of community mental health and addiction services throughout the State, and contracts with various entities to provide and support community-based prevention, early intervention, treatment, education and recovery services, including for at-risk. It contracts with approximately 320 agencies for a wide range of [community mental health services](#) that assist consumers living in the community; and supports and monitors a wide variety of [substance use treatment](#) and [prevention](#) services providers designed to decrease the misuse of alcohol and other drugs through effective evidence-based treatment.

The Division monitors and participates in the provision of community for quality assurance and improvement, training, program development, evaluation, management, information systems, fiscal and systems planning, and compliance with required assessment and treatment protocols and contract requirements.

The Division coordinates and manages addiction treatment services delivery for criminal justice programs through collaboration with other state entities, including the Administrative Office of the Courts, Department of Corrections and State Parole Board. It is responsible for the Statewide [Intoxicated Driving Program](#), which schedules individuals convicted of driving under the influence for detention, screening, evaluations, education, and treatment referral and oversees the [Intoxicated Driver Resource Centers](#) (IDRCs).

The Division contracts with community agencies to provide screening services in order to decrease inappropriate inpatient or outpatient commitments and avoid unnecessary incarcerations. The Division designates funds and, with the Department of Health, regulates the provision of mental health services at inpatient units in acute care hospitals known as short term care facilities, as well as the assessment, referral, commitment, and crisis intervention functions of [screening centers](#).

Through the Division's [Disaster and Terrorism Branch](#), the Division works with Federal, State and local emergency management to coordinate and provide disaster crisis counseling.

2. County Government

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

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

1. Department of Human Services, Division of Medical Assistance and Health Services (DMAHS).

DMHAS, the SMHA in the Department of Human Services, and the Medicaid Division, DMAHS, have 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 goals.

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

The DMHAS and DMAHS are collaborating on several initiatives that are part of the New Jersey approved Medicaid Comprehensive Waiver. These include: transitioning of services for person receiving services with the dual diagnosis of Intellectual/Developmental Disorders and Managed Long Term Services and Supports (MLTSS); collaboration related to the carve-in of managed psychiatric inpatient services, including the waiver of IMD private hospitals; and the development of Behavioral Health Home (BHH) Services. The state's 7 BHH programs in N.J. exist in 4 counties and offer a wide variety of health promotion and wellness activities in addition to connecting individuals to the care they need. BHH staff provide care coordination for clients' medical needs and help them to make and keep appointments, take prescribed medication plans, find transportation, plan healthy meals, and set exercise routines, among other services. Four site visits were held in July; these sites were All Access Mental Health, Catholic Charities, Stress Care, and Meridian. The visit focused a chart review on metabolic syndrome documentation. Vantage, Behavioral Crossroads, and CarePlus will be reviewed at a later time.

7 Current Providers: All Access Mental Health- Mercer County, Catholic Charities-Mercer County, CarePlus-Bergen County, Vantage-Bergen County

Stress Care-Monmouth County

Meridian Hospitals Corp-Monmouth County, Behavioral Crossroads- Atlantic County

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 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 integration 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.

Integration of Behavioral Health into Managed Care Organizations (MCOs).

The NJ Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), and DMHAS have a united goal of furthering the State's efforts to support whole person care. Traditionally, many behavioral health (BH) services are excluded from the managed care delivery system and are instead delivered on a fee-for-service basis. Over the course of the 1115 demonstration renewal period, New Jersey conducted a systematic review of all behavioral health services to assess, on a service-by-service basis, whether it was appropriate and feasible to integrate such services into managed care. This process review occurred in phases, involved close consultation with stakeholders and the public, and was conducted over a few years. The State has hosted a series of sessions to share the details of implementation and solicit feedback from stakeholders, NJ FamilyCare (Medicaid) members, communities served, and the overall healthcare community.

DMHAS joined DMAHS in fall of 2023 as NJ began planning to integrate the management of Medicaid funded behavioral health services into the five managed care organizations. It was decided that the process would be rolled out in Phases with Ambulatory services for youth and adults integrated January 13, 2025. Phase Two II will include Residential and opioid treatment program services and will be implemented no earlier than January July 2026. Some services such as children's SUD services include in the Children's System of Care will be reviewed and considered for a Phase III roll out with the goal date for that is not yet undetermined.

DHS engaged the services of Boston Consulting Group to work with our two divisions to develop a smooth and orderly implementation informed by behavioral health providers, advocates, and individuals with lived experience. It was the DHS primary goal that no Medicaid enrollee experience an interruption of services. To that end, there has been significant stakeholder input

including, separate provider, family and advocate, and enrollee focus groups, as we began the process. As implementation policies and procedures began, we relied on stakeholder advisory groups. In addition, the DHS staff at both divisions have presented and solicited input at multiple provider meetings, at conferences, and in other forums.

To prepare providers and enrollees for the launch of Phase I Integration, DHS held monthly trainings on a variety of topics. Whenever relevant, the MCOs presented at these meetings to train providers and enrollees on their individual systems and requirements. Phase I of the Integration was launched on January 13, 2025. All training materials and a Provider Manual are on the divisions' websites. An email address and hotline for all concerns and problems were developed and distributed. Currently, the DHS staff from both divisions participate in daily huddles where we review provider, enrollee, and MCO feedback and concerns. DHS reviews data including but not limited to, provider networks, numbers of prior authorizations, timeliness of payments and individuals enrolled. DHS holds individual and group MCO meetings to address issues.

NJ was also a recipient of a CCBHC Demonstration Grant, which includes a variety of services such as screening and referral for physical health needs and Health and Wellness services. Currently, seven CCBHCs are in operation (as of 7/1/17) as a part of the Demonstration Grant. Medicaid has been a partner throughout, having developed the Prospective Payment System that NJ is utilizing for this project. SMHA continues to partner with Medicaid to monitor and assist in the ongoing implementation of the CCBHC. DMHAS also works with Department of Children and Families (DCF) on implementation of the CCBHC. Currently, DMHAS and NJ Medicaid are working to sustain the CCBHC model in NJ. Currently NJ Medicaid, and DCF are collaborating on the develop a Medicaid State Plan Amendment to sustain the CCBHC after the Demonstration ends September 2025.

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

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

Department of Human Services, Division of Developmental Disabilities (DDD). SMHA Olmstead staff collaborate with DDD staff regarding the discharge planning of individuals dually diagnosed with both intellectual developmental disabilities and mental illness (DD/MI) who are being treated the state psychiatric hospitals. DDD has also hired full time Transitional Case Managers (TCMs)

that are assigned to each respective state hospital. The DDD TCMs have primary responsibilities at the state hospitals focusing on securing placement for the state hospital DD/MI population who meet level of care for Community Care Program (CCP) residential placement, working collaboratively with hospital staff to address any discharge barriers that may be present, and coordinating support services for DD/MI individuals who do not meet level of care for the CCP. 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 management occur to address systems level issues and barriers to community re-integration. Staff from DDD are also members of the Behavioral Health Planning Council. The SMHA has developed an RFP process to promote the development of community-based supportive housing opportunities and other support services for person receiving services with co-occurring mental health and developmental disabilities.

2. Department of Children and Families.

Interdivisional and interdepartmental collaboration between DMHAS and the DCF CSOC is frequent. Leadership from each Department/Division have collaborated on grants and other initiatives to enhance the continuum of services for youth and those transitioning to the adult service system. Staff from CSOC attend monthly Behavioral Health Planning Council meetings to better coordinate services.

3. DMHAS Medical Director's Behavioral and Primary Health Integration Office.

The SMHA Medical Director's Office has an Integration unit with the goal of promoting integration between behavioral health agencies and primary health care providers. The main goal of the initiative is to provide persons receiving services with mental health and/or substance use disorders (SUDs) increased access to primary care and to improve collaboration between behavioral health agencies and primary health care providers in order to promote and improve general health, including the treatment and prevention of infectious diseases. The Division of Medical Assistance and Health Services (DMAHS) and the office are working closely on a number of initiatives to provide case management, increase medication assisted treatment, and ensure collaboration between behavioral health and primary care practitioners. Behavioral health homes and certified community behavioral health clinics (CCBHCs) are specific initiatives that the integration office is overseeing.

Also, the office has just finished overseeing a five-year grant-funded initiative called 'Promoting Integration in Primary and Behavioral Health Care, or PIPBHC, which had provided integrated treatment for HIV and Hepatitis C in primary care clinics to clients referred from opioid treatment programs and syringe access programs. One accomplishment of this work has been to successfully lobby for the removal of the Medicaid requirement for an infectious disease consultant to manage treatment of individuals receiving direct-acting antivirals for hepatitis C; this has allowed primary care practitioners to initiate Hepatitis C medications and increase access to this treatment. This 5-year grant ended in March of 2025, with outcome data showing that the integrated care model increased access to and completion of treatment for infectious diseases such as hepatitis C, as well as improved outcomes for those with HIV. DMHAS was awarded a second PIPBHC grant in August 2024, which promotes the collaborative care management (CoCM) model of integrated

primary and behavioral healthcare. This grant focuses on delivering behavioral health screening, assessment and treatment in three primary care clinics for individuals with co-occurring medical needs.. The grant aims to build capacity by working by providing virtual psychiatric consultation and by training to the clinics' medical staff to collaborate with onsite behavioral health clinicians on clients' care.

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

Although much work has been done to develop a set of regulations that integrate these services, work in this area continues. DMHAS continues its work with the Department of Health licensing office to develop integrated ambulatory regulations with the goal of streamlining the regulations and increasing integration of behavioral health and primary care services. The goal is to develop a single, unified regulation that will remove current barriers and allow integrated services to operate seamlessly. DOH has announced that the draft integrated or 'Single Rule' regulations will be publish for public comment in late April, 2025.

4. NJ Housing and Department of Community Affairs (DCA).

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

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

The NJ SMHA relies on Community Support Services (CSS) as its standard for community integration in providing housing and mental health services. CSS is a rehabilitative service intended to increase consumer choice in the types and sources of mental health services that they receive. It is also intended to involve the individual in the development of an individualized

rehabilitation plan (IRP) designed to improve the chances of those diagnosed with mental illness to maintain valued life roles in employment, education, housing, and social environments. The SMHA reports 5,765 individuals served by Community Support Services (CSS) in SFY 2024 and 5,842 individuals served in SFY 2025.

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 receipt. The SHC will provide apartment inspections within five days of the consumer's submitted complete packet. The SHC will also make rental payments by the payment due date for all individuals with a subsidy managed by the SHC.

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

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

IV. Description of Regional, County and Local Entities that Provide Behavioral Health Services; How These Systems Address the Population Needs

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

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

The population in NJ is varied in its makeup. Staff providing services must ensure consumer access. Mental health agencies are required to adhere to licensing standards that require professional credentials and well-trained staff. 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 meet the needs of the population. Several programs and the populations that they serve are described below. By virtue of setting (e.g., hospital emergency departments), coverage (e.g., rural entities), admissions practices, and regulatory protections, acute mental health care programs serve all individuals who satisfy eligibility requirements.

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 well-trained and capable of meeting the needs of clients. Additionally, the grantee is required to ensure that there is a training strategy related to access, quality, and outcomes. Supported Employment and Supported Education are provided throughout the state.

1. DMHAS Services to Statutory Populations

The SMHA provides services to adults with SMI and children with SED with block grant funding. Persons receiving services include those who are at risk of hospitalization and homelessness, population experiencing early psychosis (First Episode Psychosis (FEP) and affective psychosis), persons receiving services in need of SE/SEd, individuals in crisis or receiving emergency services, older adults 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, where mental health Criteria 1 and 4 were addressed. Additional services to specific populations are described below.

2. First Episode Psychosis (Non-Affective) and Affective Psychosis

First Episode Psychosis (FEP) refers to the early stages of someone experiencing psychotic symptoms or a psychotic episode. The Coordinated Specialty Care (CSC) program is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, family members as active participants. CSC provides comprehensive services that include evidence-based pharmacological treatment, supported employment and education services, individual and group psychotherapy, care management, family therapy, and recovery support in community and clinical settings. Services provided to individual clients in a CSC program usually do not exceed 2 years. The population served by CSC are individuals between the age of 15-35 who have experienced psychotic symptoms for less than two years and their psychosis

is non-organic. There were 244 individuals served in SFY 2024 and 568 served SFY 2025 with the expansion of the program. NJ originally funded three teams. A need was identified for an increase of available services to individuals with FEP, for access to services for individuals with affective psychosis, as well as for step-down services for those completing the CSC program.

Due to this increased need for services, NJ expanded its Coordinated Specialty Care (CSC) program for First Episode Psychosis to include Affective Psychosis with the start of the Coordinated Specialty Care Community Integration Program (CSC CI). Affective Psychosis is manifest by symptoms of psychosis that are present with mood episodes and most typically involve bipolar disorders or major depressive disorder. Bipolar disorders are defined by the experience of manic and depressive episodes. The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; APA, 2013). The CSC CI also provides the stepped-care approach to provide the opportunity for individuals in CSC to remain engaged with their current team. The Stepped-Care treatment approach is a “3 tier” system where clients can titrate up or down the level of service modality depending on their recovery and/or the need for additional services and supports. CSC-CI program serves individuals 15 years of age and older with an ESMI diagnosis that is non-organic. There are currently five funded CSC CI teams and a sixth region that is not currently covered. In SFY 2024, 189 individuals were served in the CSC program with an additional 55 individuals served in CI program. DMHAS utilized Mental Health Block Grant, Covid Supplemental and ARPA funding to develop these services.

3. Crisis Continuum

A. Crisis Call Centers 988 Implementation. The 988 crisis call centers (also known as contact centers) were funded by both the COVID Supplemental Plan and the American Rescue Plan Act (ARPA). New Jersey originally had five (5) call centers that provided services for the 988 Suicide and Crisis Lifeline. These centers received certification by Vibrant Emotional Health (Vibrant) for meeting the minimum clinical, operational and performance standards. As of September 2022, following the State’s procurement process, funding from a combination of federal grants including the SAMHSA 988 Capacity Building Grant, Mental Health/Substance Abuse Block Grants and ARPA, totaling \$3.7 million was awarded to the five (5) NJ Lifeline centers.

With these original contracts, 988 Lifeline centers were able to expand their capacity to meet the growing demand. Comparing calendar year data from 2021 to 2023, NJ experienced a significant increase in call volume while increasing calls answered. From 2021 to 2023, call volume increased 36% and centers were able to respond to 38% more calls. In state fiscal year (SFY) 2024, Lifeline centers received 75,664 incoming calls and answered 59,533 for a statewide 79% answer rate. Calls not answered in NJ were handled by Vibrant’s network of national backup centers.

One (1) of the five (5) original contact centers ended their Lifeline services as of July 31, 2024. Contracts with the remaining four (4) centers using these funds ended in September 2024 and were replaced by new contracts using state appropriations and SAMHSA 988 State and Territory Improvement Grant funds. New Jersey now has four (4) Lifeline centers of which all four (4) respond to calls originating in New Jersey and three (3) also respond to chats and texts originating in-state.

B. Mobile Crisis Outreach Response Teams (MCORTs)

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

On March 3, 2025, MCORT services were launched statewide operating weekdays from 7am to 3pm. On March 31st, 2025, MCORT expanded its hours to weekdays from 7am to 7pm. The week of August 11, 2025 MCORT expanded hours to 24 hours per day, every day of the year.

C. Crisis Receiving Stabilization Centers (CRSCs)

CRSCs are currently in the developmental stages and will be established with the mental health block grant 5% crisis set-aside. Covid Supplemental and ARPA funding have been used in the planning, development, staffing, and purchase of equipment and supplies (subject to and limited by federal guidance issued by SAMHSA on July 29, 2025) that are needed to stand up the facilities. The DMHAS has awarded five crisis receiving stabilization centers (CRSCs) which will advance the development of the crisis continuum in NJ based on the National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit. The population served includes individuals who are 18 years of age and older with a primary SMI and/or SUD experiencing acute symptoms that could interfere with community tenure. DMHAS will be using the “no wrong door” concept and partnering with community crisis responders. Services will be available 24 hours per day, 7 days per week, 365 days a year and include access to trained staff who can provide assessment, crisis stabilization, intensive supports, engagement, psychoeducation, identification of strengths, collaborative problem solving, and individualized crisis planning. Services will be offered in a safe, clean, community-based non-hospital environment conducive to the recovery process. Medication management, administration, and education will also be offered. Medication-Assisted Treatment will also be available at the CRSCs. The program will offer continuity of care promoting continued stability and ensuring linkages are arranged that meet the needs of the individual. The goal of this program is to decrease the utilization of local hospital emergency services, designated screening centers, and in-patient psychiatric hospitalization while maintaining crisis stabilization treatment. DMHAS has awarded five agencies to develop up to five centers statewide.

D. Crisis Diversion Homes (CDH)

Crisis Diversion Homes are funded with ARPA funds and will be established for the purpose of offering temporary transitional housing for up to 30 days, within a 24-hour supervised setting. DMHAS has contracts with providers to stand up two crisis diversion homes, each with 5 beds and are staffed 24/7. CDHs will serve individuals 18 years of age or older with an SMI or a co-occurring substance use disorder, forensic involvement, or co-occurring developmental disability. This program will provide community-based stabilization in a home-like setting and is not long term or permanent housing. Therapeutic and social supports will be provided in a warm and safe environment to individuals who do not need further hospitalization. The length of stay for this program is dependent upon an individual's need and is anticipated to be up to 30 days. At a minimum, staffing will include licensed clinicians, nursing coverage, behavioral health technicians, and a prescriber. Although the crisis diversion housing is not permanent, individuals experiencing a recent psychiatric hospitalization or relapse will receive the support they need from professionally trained and dedicated staff to continue their recovery in the community. Referrals to CDHs will be prioritized for individuals with complex behavioral health needs that require significant services and supports to return to the community and who have received crisis intervention services in a Crisis Receiving Stabilization Center, from Mobile Crisis Outreach Teams. Individuals may also be referred from DMHAS' Diversion Unit. The Crisis Diversion Homes will include linkages to peer supports, clinical services with a goal of community re-integration to permanent or long-term housing and supports for the person receiving services. DMHAS will not be using ARPA funds for capital expenditures.

E. Crisis Diversion Beds

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

F. Inpatient Diversionary Beds

The DMHAS contracts with inpatient providers to purchase bed-days in inpatient facilities, known as "Diversion" contracts. The purpose of the Diversion contracts is to afford individuals age 18 and older with an SMI who would otherwise be admitted to a state or county psychiatric hospital the opportunity to receive treatment in an inpatient setting, which may enable the individual to stabilize and be discharged to the community. The primary goal of the purchase of bed days is to avert admissions to state hospitals. Individuals who do not stabilize and require continued inpatient treatment may be transferred to a state or county hospital at the conclusion of their approved length of stay in the contracted Diversion bed. The hospitals that contract for Diversion beds maintain additional bed capacity that is not governed by their DMHAS Diversion contract, and serve a similar population in this additional capacity. DMHAS currently contracts for access of up to 52 beds at three private psychiatric facilities -- Carrier, Hampton, and Northbrook that offer an alternative to state psychiatric hospitalization. In CY 2024 there were 806 admissions utilizing 19,850 bed days and 95% were diverted from a state hospitalization. In CY 2023 there were 707 admissions utilizing 17,250 bed days and 94% were diverted from a state hospitalization.

4. Peer Recovery Support

Peer Respite Beds

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

5. Acute Care Services

A. Designated Screening Centers (DSCs)

DSCs are designed to provide psychiatric emergency services including screening, assessment, crisis intervention, referral, linkage, and crisis stabilization services, 24 hours per day, 365 days per year, in every geographic area in the state. The SMHA funds 23 Designated Screening Centers (Screening and Screening Outreach) programs across the 21 Counties. According to the SMHA's Quarterly Contract Monitoring Report (QCMR) database of information self-reported by the screening programs, there were 74,755 episodes of care to these screening centers during SFY 2025. Of the 74,755, there were 61,306 adults served and 13,449 youth served.

B. Affiliated Emergency Services (AES)

AES provide for behavioral health staffing at emergency departments, including a mental health provider who is responsible for the provision of emergency services to individuals in crisis presenting in hospital emergency departments. Emergency service includes mental health and social services provision or procurement and advocacy. Emergency services offer immediate crisis intervention services and service procurement to relieve the client's distress and to help maintain or recover his or her level of functioning. Emphasis is on stabilization, so that the client can actively participate in needs assessment and service planning. Emergency service is affiliated by written agreement with the geographic area Designated Screening Center. (N.J.A.C.10:31). There are 12 Affiliated Emergency Service programs which are located in the following counties: 3 in Hudson, 1 in Middlesex, 3 in Monmouth, 2 in Morris, 1 in Passaic and 2 in Union. AES programs serve both the adult and youth population. There were 25,255 individuals served in SFY 2025. Of the 25,755, there were 20,859 adults served and 4,896 youth served.

6. Disaster Response

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

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

Mental Health First Aid (MHFA) teaches participants how to identify and respond to signs of mental health and substance use concerns. The 8-hour course introduces participants to risk factors and warning signs of behavioral health crisis, builds understanding of their impact and provides an overview of common treatments. Through role-playing and videos, it demonstrates how to assess a mental health crisis, select interventions, provide initial help, and connect people to resources. Mental Health First Aid is evidence-based, evidence-informed and proactively updated. A number of research studies have shown that training in Mental Health First Aid results in better knowledge, attitudes, and support.

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

Both MHFA and QPR trainings and materials are provided at no cost to hosting agencies and the public.

B. MHBG BSCA (9/30/2023 - 9/29/2025)

The Disaster and Terrorism Branch (DTB) is in its second cycle of the Bipartisan Safer Communities Act (BSCA), we utilize this funding to expand the existing behavioral health services continuum in the aftermath of traumatic events that impact the psychological health of New Jersey residents. Outlined below are multiple initiatives that help support this work.

1) Disaster Response Crisis Counselor

In 2007, DTB began the Disaster Response Crisis Counselor (DRCC) Certification Program. DRCC's are trained and background-checked volunteers who are deployed to a county or Statewide in the immediate aftermath of a community crisis. With the help of BSCA funding, DTB has increased the numbers and scope of the DRCC program in order to have a more enhanced crisis taskforce teams for specific response types such as mass casualty events, impacting

individuals in rural communities, those with severe mental illness, and those who are deaf and hard of hearing, etc. The development of such unique task force teams to deploy to incidents of mass casualties and, requires coordination with law enforcement, medical examiner offices and healthcare systems. The preparation of DRCC teams to respond to more complex anticipated and no-notice events is a vital part of response efforts.

Disaster response is always local and the DTB has cultivated successful working partnerships with the County Mental Health Administrators and the County Alcoholism and Drug Abuse Directors, who are responsible for the planning of behavioral health services in their counties. A subaward has been given to each interested county to fund recruitment, exercise drills, training activities as well as engagement efforts for Disaster Response Crisis Counselors.

The DTB continues to promote the DRCC program through dissemination of printed materials, podcasts, and timely webinars that focus on current responses, lessons learned and emerging trends in the field.

2) Learning Management System

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

3) Critical Incident Stress Management

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

4) Traumatic Loss Coalition

The DTB deploys DRCC's to work with all residents of New Jersey. However, when there is an incident primarily impacting youth and young adults, DTB works closely with New Jersey's Traumatic Loss Coalition (TLC). DTB has successfully strengthened this partnership through cross-training. To date, 417 responders have been certified in the "Managing Sudden Traumatic Loss" (MSTL) response model. Specifically, the goal is to:

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

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

5) BTAM Team Initiative

The NJ BTAM (Behavioral Threat Assessment and Management) Team is a centralized resource focused on the sharing of information, knowledge, and leveraging support of first responders and behavioral health professionals for the purpose of threat management. When first responders identify a community threat, the team convenes to provide consultation in reviewing individuals at risk for the potential of engaging in violence or other injurious activities and recommending intervention strategies to manage the risk of injury for individuals who pose a potential safety risk. The team includes representatives from several state and federal agencies and organizations including first responders, intelligence, education and behavioral health sectors. Each member of the team has advanced training in behavioral threat assessment and works collaboratively to prevent acts of violence through early identification, consultation, and management of individuals displaying concerning or threatening behavioral indicators. The team's goal is to decrease the number of incidents that occur by creating diversion pathways for at-risk individuals into programs for behavioral health or other services. DTB has played an integral role in the BTAM, with our Unit Director and Director of Training attending meetings weekly and sharing the mental health perspective on threat assessment.

6) Emergency Partnerships

The DTB works in coordination with the NJ Department of Human Services' Office of Emergency Management (OEM) in planning for the aftermath of a disaster. We have used the BSCA grant to conduct an Interagency Collaboration and Communication Workshop Series. The workshop series was successful, as it enhanced effective collaboration and communication strategies to better coordinate efforts during mass casualty events and disasters. By fostering collaboration and sharing best practices, we intend to improve future outcomes and decrease behavioral health challenges that can occur in the chaos of crisis response. Our most recently held event was entitled "Enhancing Behavioral Health Support in Mass Casualty Events", which focused on promoting

effective communication and collaboration among Emergency Managers and partnering agencies during mass casualty or disaster incidents. We plan to collaborate with emergency partners to co-host exercise drills as well. By conducting disaster behavioral health exercises, DTB prepares members of the DRCC's and other crisis teams for their role in Reunification and Family Assistance Center operations. The overarching goal is to break down existing silos to prevent duplication of services and to educate partners about the importance of improving behavioral health outcomes in the immediate aftermath of a community crisis. The workshops include education and planning for all partners to address needs of individuals with serious mental illness and those living with substance use disorders.

C. teen Mental Health First Aid (6/15/2022 – 9/30/2025)

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

7. Governor's Mental Health Initiatives

A. tMHFA Expansion

The Division of Mental Health and Addiction Services' Disaster and Terrorism Branch (DTB) has expanded funding for teen Mental Health First Aid for the benefit of students and school personnel in several NJ high schools. Building on DTB's initial implementation and lessons learned of tMHFA in eighteen (18) New Jersey high schools, this expansion allowed the Mental Health Association in New Jersey (MHANJ) to broaden the project to include thirty-five (35) additional high schools offering multi-year support for teens, school staff and families; in total 63 high schools have joined the initiative. To add, youth serving organizations will be invited to join the project and partner with schools to support continued training and sustainability. The project will extend through two academic years with materials and consultation made available in the third year to imbed tMHFA into school curriculums for sustainability.

B. MHFA on College Campuses

The National Council of Mental Wellbeing, the facilitators of the Mental Health First Aid curriculum, have a module specifically for the higher education community which is utilized for this initiative. This training curriculum allows students, faculty, administrators and other school staff to identify risk and protective factors as well as to decrease the stigma of receiving needed behavioral health services. Mental Health First Aid (MHFA) is a way to identify and respond to behavioral health changes in our young adults. MHFA was designed to extend the concept of first aid training to behavioral health. MHFA teaches participants to recognize signs and symptoms, listen nonjudgmentally, and appropriately refer a person to supports and services. The Division of

Mental Health and Addiction Services' Disaster & Terrorism Branch (DTB) will make MHFA available on college campuses throughout New Jersey. At this time, the program is not able to launch due to a procurement delays. Ultimately our goal is not only to train students, but each campus will be invited to nominate staff to become MHFA instructors in order to sustain the curriculum on campuses long-term.

C. Higher Education Peer Counseling

This initiative has been branded as “Campus Cares” and will host several psychoeducational sessions at multiple campuses in NJ including topics such as: Understanding Personal Boundaries, Addressing Loneliness, and Understanding Financial Stress. Although the Campus Cares sessions that were held reached students, DTB wants to reach more students across the State. DTB is currently in the process of procuring vendors to assist colleges/universities with their mental health/wellness goals.

8. Services to Veterans, Service members and their families.

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. According to the SMHA's USTF+ client data system 1,394 consumers admitted into and transferred into DMHAS supported services in SFY2024 self-identified as veterans, which represents 1.3% of unduplicated consumers admitted in that period of time³. These individuals 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. In prior communications between the SMHA and with the NJ Veterans Administration Healthcare System (VA) VANJ, and differences between their estimates and what was reported in the USTF system at the time, it may be supposed that the actual number of veterans served in SFY2024 is closer to 2,373. This variance may be because many active or former service members may not consider themselves as veterans (with regards to responding provider intake questions).

The SMHA has periodic meetings and communications with the NJ Healthcare System (VA) to enhance collaboration, particularly around acute care services. A SMHA representative continues communication with the NJ Department of Military and Veterans Affairs (DMAVA) and collaborates regarding needed services for New Jersey National Guard (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 point 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 to New Jersey's veterans is an area of focus. The SMHA's Anti-Stigma Council has partnerships with federal and state military and veteran's organizations and spearheads initiatives such as the

³ Be advised that the actual volume of veterans served is likely larger; the possible variance is due to the widespread adaptation & use of the USTF+ system—several agencies are still not diligently using this system on a consistent basis.

“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 has participated in the SAMHSA- supported Governor’s Challenge to Prevent Suicide Among Service Members, Veterans and Their Families (SMVF), which is led by the New Jersey Department of Military and Veterans Affairs (DMAVA) in collaboration with the United States Department of Veterans Affairs (VA). The initiative has been working to develop and implement state-wide suicide prevention best practices for SMVF, using a public health approach. With the support of the governor, each state formed an interagency military and civilian team to develop a strategic action plan to advance the National Strategy for Preventing Veteran Suicide. The NJ Governor’s Challenge team includes behavioral health and suicide prevention coordinators representing the state public/behavioral health agency, VA, and National Guard, veterans service organizations, as well as county level public entities and nonprofit organizations. The NJ initiative has three priority area workgroups that are developing and carrying out a plan to ensure that veterans are identified by service provider, that they are being screened and assessed for suicide risk and related needs, and that they receive lethal means counselling and safe firearm storage education. The goals of the priority area workgroups, along with a comprehensive list of resources for SMVF, and information about related initiatives, are on a dedicated DMAVA website SaveNJVets (<https://www.nj.gov/military/savenjvets/>).

9. 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 and virtual outpatient services at several outpatient locations in the Northern region of the state, with Masters level clinicians who are staff in Deaf Community and fluent in American Sign Language (ASL). They also provide 24/7 statewide consultation for psychiatric emergency services (Clinicians can be reached onsite during business hours by phone/Videophone) and after hours by calling our on-call service number). Consultation is also available to inpatient settings, and outpatient programs. ACCESS staff participates in the NJ training for Certified Psychiatric Screeners. The purpose for this is so that screeners are able to understand, navigate, and explain the state’s screening process when working with an individual who is Deaf to ensure the Deaf client is assessed in an appropriate manner in accordance with NCLAS. Additionally, ACCESS provides onsite clinical consultation and liaison services to NJ’s Short Term Care Facilities (STCFs), assisting with treatment and discharge planning for each deaf patient.

ACCESS operates residential services in Passaic County. These include an eight bed 24-hour supervised community residence for deaf individuals with mental illness who have been discharged from a New Jersey state hospital or its equivalent, a four-bed supervised residence, and two, three bed semi-supervised apartments. ACCESS also provides assistance for individuals who are deaf and hard of hearing with mental health diagnosis that are living in the community in

supportive housing apartments. Two additional community programs managed by ACCESS are located in the Northern Region of the state that provide services to the deaf and hard of hearing population with mental health issues. Integrated Case Management Services (ICMS) provides a staff member to work with this identified population in the community, and the Partial Care program in Paterson has services for persons with SMI who are deaf and hard of hearing.

In the Southern Region, South Jersey Behavioral Health Resources (SJBHR) operates a 5-bed supervised community residence for deaf individuals with a mental illness who are either discharged from the state hospital, other inpatient setting, or are already reside in the community and could benefit from this service. Additionally, SJBHR operates a regional adult partial care program to serve this population.

NJ has the Statewide Inpatient Program (SIP) for the Deaf at Greystone Park Psychiatric Hospital in Morris Plains. The SSIP consists of a 25-bed locked inpatient unit in the main hospital building and an eight-bed capacity less restrictive residential cottage to prepare individuals for discharge. The SSIP is staffed with a professional clinical team skilled in ASL and Deaf community. Additionally, all paraprofessional SSIP staff are trained in ASL and providing services to the Deaf community. Registry of Interpreters for the Deaf (RID) certified ASL Interpreting staff are available for patient and staff interfaces, particularly clinical contacts.

The Statewide Deaf Advisory Committee (DAC) meets quarterly to review systems of care, as related to Deaf services and mental health in the State of New Jersey. Pursuant to Administrative Bulletin 5:07 [Section 504 of the Rehabilitation Act of 1973 (P.L. 93-112), and the Americans with Disabilities Act (ADA) (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.

0. Compliance with Anti-discrimination Laws

10. ARRIVE Together Community Resource

ARRIVE Together is a co-responder first responders and behavioral health professional co-responder model. It is a transformative and powerful model, de-escalating situations without use of force with a dramatic decrease in transport to the emergency department.

In most jurisdictions, mental health professionals accompany plain clothes officers in unmarked police vehicles to respond to 9-1-1 calls for service relating to mental or behavioral health crises, although each county may employ a slightly different framework of interaction between the mental health and first responders based on what would best serve the community. Different health care providers around the state have signed on to work with first responders on this effort, which is designed to form relationships between individuals needing help and first responders and mental

health professionals, in order to de-escalate situations and transition away from 1 first responders relying on emergency rooms or use of force.

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

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

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

V. Initiatives funded under Covid Supplemental and ARPA

1. Coordinated Specialty Care (CSC) and CSC Community Integration- Covid Supplemental, ARPA and BSCA funding.

Since its inception in November 2016, NJ Coordinated Specialty Care (CSC) programs have gone through a rapid expansion. The initiative was covered statewide by three providers and designed to serve 105 clients annually. The CSC initiative was serving double the clients at 210 annually (70 per program) with some clients still receiving service after two years in the program. The three providers covered 7 counties each. This presented a challenge for providers covering the vast territory as well as for individuals receiving services because of the time spent traveling to the provider agency and the lack of access in the county of residence. The original teams could not serve individuals with affective psychosis and the teams were receiving many referrals and requests for services to those in need. Most outpatient programs did not specifically fit the programmatic needs of an individual discharged from a CSC program.

In 2023, NJ expanded its Coordinated Specialty Care (CSC) program for First Episode Psychosis to include Affective Psychosis. A stepped care approach (Community Integration or CI) was added to provide the opportunity for individuals to continue after the CSC two-year program and to remain engaged with their current team. There are currently five funded teams and a sixth region that is not currently covered. The staffing for each team has been increased to provide for a caseload of 200 in its first full year of operation (2025-2026), for 300 in year two (2027) and for 400 in year three and beyond (2028 and continuing). Individuals ages 15-35 are eligible for the CSC program that have an Early Serious Mental Illness diagnosis for less than or equal to 2 years at the time of admission to the CSC program. CSC-CI program are individuals 15 years of age and older with an ESMI diagnosis that is non-organic

The CSC program is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, family members as active participants. CSC provides comprehensive services that include evidence-based pharmacological treatment, supported employment and education services, individual and group psychotherapy, care management, family therapy, and recovery support in community and clinical settings. Services provided to individual clients in a CSC program usually do not exceed 2 years.

The CI program is designed to address the need for the CSC continuum of care. The Stepped-Care treatment approach is a “3 tier” system where clients can titrate up or down the level of service modality depending on their recovery and/or the need for additional services and supports. Individuals in the CI program will receive more or less intensive care and units of service in accordance with their assessed need and treatment plan. Individuals will continue to receive CI services from their current CSC clinicians, prescribers, Supported Employment and Education Staff and Certified Peer Recovery Staff, in accordance with assessed level of need in order to preserve continuity of care and support.

Coordinated Specialty Care and Community Integration treatment and supports are geared toward:

- o reintegration of the client into the community,
- o return to school/work,
- o symptom stabilization,
- o diversion from inpatient services
- o a decrease of screening center utilization.
- o decrease in duration of untreated illness
- o increase in medication adherence
- o increase in level of functioning
- o decrease hospital recidivism
- o integration of health and behavioral health via continuity of care between the CSC-CI APN and the client’s primary care practitioner

2. Crisis Receiving Stabilization Centers- Funding from Covid Supplemental, ARPA, and BSCA

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

in-patient psychiatric hospitalization, while maintaining crisis stabilization treatment and linkage to community services.

3. Crisis Diversion Homes- Covid Supplemental funding

The SMHA has identified gaps in its system of care that are attributable to extended emergency room stays. As such, the SMHA will be looking to bridge the gap between homelessness and permanent housing by developing two community-based Crisis Diversion Homes that are staffed 24/7. This is a transitional program providing services that are provided until the client is stabilized and community supports, services and permanent housing have been arranged. This will provide the client the opportunity to remain in the community with needed supports. Services provided by this program are on a temporary basis. Referrals will be prioritized for the Crisis Receiving Stabilization Centers and Mobile Crisis Outreach Teams. Referrals will be made thru DMHAS.

4. Psychiatric Emergency Screening Services (PESS) Peer Support Diversion: Funding from Covid Supplemental and from ARPA

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

5. CHLP - Community Health Law Project- Funding from the Covid Supplemental grant.

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

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

6. CT-R or Recovery-Oriented Cognitive Therapy– Funding for CT-R from Covid Supplemental.

CTR, or Recovery Oriented Cognitive Therapy, has been funded through MHBG COVID Supplemental plan. CT-R training was given to mental health providers by the Beck Institute, which developed a Center of Excellence for CT-R with the funding. Guided by Dr. Aaron T. Beck's cognitive model, CT-R is an evidence-based practice that provides concrete, actionable steps to promote recovery and resiliency. Originally developed to empower individuals given a diagnosis of schizophrenia, CT-R applies broadly to individuals experiencing extensive behavioral, social, and physical health challenges. CT-R is highly collaborative, person-centered, and strength-based, and tailored to those who have a history of feeling disconnected from and distrustful of mental health professionals.

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

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

Since the initial COE-CTR initiative, DMHAS has extended the program to address other settings, including older adults who receive services in nursing facilities. The Ct-R training is being provided on a pilot basis to a consultant and trainer organization that serves nursing homes with seriously mentally ill populations.

7. Teen Mental Health First Aid – Covid Supplemental funding and ARPA funding.

Since 2022, we have partnered with the Mental Health Association in New Jersey (MHANJ) to provide the National Council of Mental Wellbeing's Mental Health First Aid curriculum to high schoolers throughout our State. MHBG COVID Supplemental and ARPA funding has allowed us to expand the scope of this program multiple times. MHANJ has provided this training, referred to as teen Mental Health First Aid to sixty-three (63) high schools in the State of New Jersey, benefiting 12,006 students to date.

The teen Mental Health First Aid curriculum goal is to mitigate the need for hospitalizations and higher levels of care for the SED population by identifying those at high risk and creating safe interventions. The curriculum addresses the stigma that this vulnerable population can feel as they navigate the high school environment. Teen peers are taught to identify signs and symptoms of significant mental health disorders such as anxiety, depression, substance abuse, and psychosis. Additionally, safety planning with a trusted adult, and identifying resources are part of this evidence-based curriculum.

8. 988 Implementation – New Jersey has not established a methodology to estimate incidence of SMI among adults and will be requesting technical assistance. New Jersey has not established a methodology to estimate incidence of SMI among adults and will be requesting technical assistance. Funding from Covid Supplemental and ARPA.

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

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

B. Web-based Electronic Referral System and Crisis Management Module is funded with Covid Supplemental funding and ARPA funding.

Web-based Electronic Referral System Funding enabled DMHAS to procure a web-based data system that provides a registry for behavioral health beds and services to facilitate access for persons with SMI. The data system maintains information and communications on community and acute care referrals and provide the information needed to monitor referrals and intervene to facilitate placement and linkages to services. The electronic registry will assist in diverting admissions from emergency rooms and inpatient settings including state hospitals. The electronic registry is necessary to enhance movement along the continuum of DMHAS services. Eventually, data system will foster a continuum of community-based care that meets the needs of the individual where they live. The registry will contain a public facing portal for individuals to be able to request an appointment with a service provider.

C. Web-based Electronic Referral System - Crisis Management Module

The crisis management module expedites access to assessment and mobile outreach so that those in crisis can be linked to treatment if desired. Prospectively, the module will track their journey from crisis call to treatment and coordinate all stakeholders' information within a crisis management system. The module, combined with the referral system, will support collaboration between the state, first responders organizations, local community organizations, faith-based organizations, and other behavioral health stakeholders in their efforts to ensure the integrated delivery of appropriate, evidence-based, and family-centered services. The system provides a real-time connection between crisis call center professionals, crisis response teams, and treatment providers. The Service Availability dashboard displays the availability and location of mobile

crisis teams, along with the directory and availability of behavioral health providers at two distinct dashboard tabs. Crisis teams are dispatched using GPS-enabled technology and can view the caller's intake information, accept the dispatch, and document their assessment and plan at the scene. The crisis teams can, in turn, use the Service Availability dashboard to find available crisis beds or refer for an outpatient assessment and treatment. The module's framework is based on SAMHSA's crisis management best practices and core elements of 1. No "Wrong Door" Access; 2. Regional Crisis Call Centers; 3. Mobile Crisis Team Response; and 4. Crisis Receiving Stabilization Facilities. The technology provides real-time situational awareness and connection to all crisis stakeholders so that crisis professionals can connect persons receiving services to care more quickly.

10. Performance Improvement -Evaluation of programs

Performance Improvement Evaluation is funded by ARPA. DMHAS is in negotiations with a provider to do the performance evaluation of the initiatives funded under the ARPA grant. The vendor is tasked with completing a performance evaluation that examines the development and implementation of the initiatives funded under ARPA. The vendor will interview DMHAS program leads as well as interview a sample of providers and identify potential best practices across initiatives that may be further implemented throughout the state. Areas of strength as well as potential areas in need of improvement in the mental health services system will be identified along with recommendations for the sustainability of the initiatives after ARPA funding has ended.

11. CSOC-Acute Care Services Capacity Improvement Program

Children's System of Care (CSOC) Acute Care Services Capacity Improvement Program is funded by ARPA.

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

The proposed project is to create a statewide consultation and technical assistance center (Center) dedicated to psychiatric screening centers and CCIS units that will assume a systems and direct practice approach to improving the quality of care for youth with acute behavioral health needs. The Center will be charged with conducting a multi-systemic needs assessment of each agency to distill training and consultation needs from "door to discharge" that will serve in enhancing the work force and the delivery of quality care for youth with co-occurring disorders. Equally important, the needs assessment will identify system barriers that impede the delivery of services. Information gathered through the assessment will be used to develop an agency specific and

statewide training and consultation curriculum. Similarly, information gathered related to system barriers will be utilized to inform the evolution of state-driven policies and contractual requirements. Following the review of the needs assessment data, the Center will design and offer agency specific and statewide training and technical assistance that will be complemented by subject matter experts in areas such as best practices in supporting and treating youth with IDD challenges with acute psychiatric needs and their family. In addition to providing training and consultation, the Center will concurrently develop structured forums for screening centers and CCIS units to consistently communicate with New Jersey Department of Health (DOH), DMHAS and Department of Children and Family (DCF) with an agenda that elicits acute care service system strengths and challenges and nurtures collaboration. In addition, a best practice forum will be created amongst agency medical directors and led by the DCF Medical Director. Best practice forums will serve in unifying medical directors across the state and provide an opportunity to highlight and discuss optimal treatment strategies in acute care settings. Progress towards curriculum and forum goals will be monitored quarterly and will include gathering and reviewing data related to workforce confidence and consumer satisfaction. The work plan will be revised as needed through an iterative process. The work of the Center will serve in complementing an initiative funded through the Garrett L Smith grant aimed at supporting emergency departments in linking youth who present as suicidal and their families to services and supports. The project will be implemented over a three-year period.

12. Older Adults Expansion for 50+ yrs. Population

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

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

13. Peer Wellness Program

Peer Wellness Program was funded by COVID supplemental funding plan. The Mental Health Association in New Jersey, Inc (MHANJ) was awarded the Whole Health Learning Collaborative (WHLC) January 2023. The NJ Peer Connection (NJPC), which is the project's name, involved meetings with the leadership of all division-funded wellness centers and has started to meet in person to each wellness center for one-to-one technical assistance. Technical assistance is described as in person collaboration/conversation and an informal needs assessment between NJPC and Wellness Center staff and membership, gathering ideas for events, wellness center whole health initiatives past and/or present, current barriers/goals since COVID19, etc. NJPC has

launched resource webinars through its United by Wellness (UBW) virtual platform who has existing membership comprised of wellness center staff and membership.

Beginning on 03/29/2023, the webinar/resource meetings were held twice a month for remaining 9 months of contract. In addition, MHANJ has been working with GoMo Health working on the creating the dashboard and implementation of the texting platform. MHANJ has additionally presented the whole health initiative of NJ Peer Connections at the 2023 COMCHO meeting. Lastly, NJ Peer Connections held its first Statewide event in May 2023.

The contract for the Whole Health Learning Collaborative to support the Community Wellness Centers was extended and continued until March 2025. This collaborative but will also feature utilized some of the same elements that made the project a success in 2024, but new centers were added to the collaborative, in addition to the returning from the prior year. The initiative's first in-person event was held at the Crowne Plaza in Edison, NJ. The all-day event included workshops, networking, vendors, and was a great success. The WHLC Team made in-person site visits with the newly contracted centers and virtual support was provided for the existing centers; in-person site visits were available for the existing centers upon request and monthly think tank sessions were also held.

14. Crisis Pilot Collaborative

First responder Crisis Pilot Collaborative is funded by the ARPA. A pilot program to be implemented between a DMHAS crisis diversion funded program such as Early Intervention Supportive Services (EISS) program or Crisis Receiving and Stabilization program, and a local first responders where individuals in crisis will be able to communicate with a clinician on the EISS or Crisis Receiving and Stabilization team via an IPAD for assistance and potentially avoid an emergency room admission or an inpatient psychiatric admission through this intervention. The use of electronic platforms such as Doxy.me is free for the minimum service. The budget includes a cost of 90 IPADs equipped with Wi-Fi + cellular connectivity.

15. Acute Care Systems Review Committee (SRC) Technical Assistance - the Acute Care TA program is funded by ARPA plan.

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

16. Screening Center Communication for Individuals that are Deaf and Hard of Hearing: is funded by ARPA

In support of the Screening Center Communication for Individuals who are Deaf and Hard of Hearing initiative, this funding will be used to purchase tablets and accessories for working with individuals who are deaf and hard of hearing during psychiatric emergency screening for two additional screening centers. The equipment will be used by staff who provide services to individuals with serious mental illness (SMI) who are deaf and hard of hearing.

17. Designated Screening Services (DSS): This initiative is funded by ARPA plan.

Designated Screening Services: In order to support the expansion of mobile crisis outreach and address systemwide needs of individuals with SMI, this proposal requests funding for 33 vehicles for 23 Designated Screening Services programs and technology, including tablets, hotspots, and related accessories (i.e., headsets) for the 23 DSS programs in New Jersey. This investment directly supports the statewide goal of expanding mobile crisis capacity, decreasing unnecessary emergency department use, and improving timely access to behavioral health care in the community for individuals with SMI. The technology will be utilized by the staff serving individuals with SMI.

18. Mental Health Fee for Service (FFS) Program: This initiative is funded by ARPA.

The MH FFS Program pays provider agencies under contract with the DMHAS to deliver community-based mental health services on a fee-for-service basis. Payment through the MH FFS Program is prohibited when other sources of payment are available, such as Medicaid, Medicare, charity care, or private insurance. The mental health programs eligible for ARPA funding through the MH FFS Program will include the following outpatient programs:

- Adult Community Mental Health Rehabilitation – community mental health rehabilitation services include assessment, development of a comprehensive service plan and implementation of the service plan through individual services coordination, training in daily living skills, and supportive counseling, intended to restore individuals with a serious mental illness to their maximum level of functioning. Activities are designed to develop, strengthen, and maintain the knowledge, behaviors, adaptive, and coping skills in all areas of life. Skill development is provided in areas of self-care maintenance, illness self-management, accessing and utilizing community resources, and social interaction. Interventions include counseling, crisis intervention, medication education, health care monitoring and oversight.
- Outpatient - mental health services provided in a community setting. Services include psychiatric evaluation, medication monitoring, individual therapy, group therapy and family therapy.

- Partial Care - individualized, outcome oriented, structured, non-residential program offered in a non-hospital setting. The program includes active treatment and psychiatric rehabilitation.
- Integrated Case Management Services - individualized, collaborative and flexible outreach service designed to engage, support and integrate individuals with serious mental illness into the community of their choice and facilitate their use of available resources and supports in order to maximize independence. Provided primarily in the consumer's natural environment. ICMS services include, but are not limited to assessment, service planning, service linkage, ongoing monitoring, ongoing clinical support and advocacy.
- Programs of Assertive Community Treatment (PACT) - comprehensive, integrated rehabilitation, treatment and support services for individuals with serious and persistent mental illness, who have repeated psychiatric hospitalizations and who are at serious risk of psychiatric hospitalization. Provided in the consumer's home or other natural setting by a multi-disciplinary treatment team. PACT is the most intensive program element in the continuum of ambulatory community mental health care.
- Community Support Services (CSS) - mental health rehabilitation services that assist individuals with serious mental illness and severe mental health needs to attain the skills necessary to achieve and maintain their valued life roles in employment, education, housing, and social environments.

Reimbursement is limited to non-profit provider agencies under DMHAS contract to provide treatment, rehabilitative and support services to individuals with a serious mental illness (SMI).

19. Consumer Connections: This initiative is funded by ARPA.

Consumer Connections is the consumer training component of the Mental Health Association of New Jersey. They provide individuals who have lived experience with access to the Certified Peer Recovery Staff (CPRS) training, which is critical to providing a strong peer work force in the state.

Q1:

SSA

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 citizens who are most in need, or about one of every five New Jersey residents. DHS serves individuals and families with low incomes, people with mental illnesses and/or substance use disorders,

developmental and intellectual disabilities, late-onset disabilities, blind, visually impaired, deaf, hard of hearing, or deaf-blind, and aging individuals. In addition, the Department serves parents needing childcare services, child support and/or healthcare for their children, as well as families facing catastrophic medical expenses for their children. DHS has the following Divisions, Commission, and Office: Division of the Deaf and Hard of Hearing; Division of Developmental Disabilities; Division of Disability Services; Division of Family Development, Division of Medical Assistance and Health Services (Medicaid); Division of Aging Services; Division of Mental Health and Addiction Services (DMHAS); Commission for the Blind and Visually Impaired; and Office of New Americans. DHS provides many support systems for the families of children served by the Department of Children and Families (DCF).

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

On June 29, 2012, Governor Chris Christie signed a bill that further reorganized DCF into a single point of entry for all families with children, youth and young adults living with either developmental disabilities or substance use disorders, or both. This realignment of substance use treatment and developmental services is intended to improve 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 use 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 use and co-occurring disorders treatment at all levels of service in an efficient and coordinated manner from the statewide and regional level to the local levels, thus enhancing access to services, coordination of services, alignment of policies and contracts, and workforce development efforts.

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

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 use 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 inpatient, residential and ambulatory treatment programs and facilities.

DHS/ DMHAS is working with DOH licensing office to comment on ambulatory regulations that impede integrating services, with the goal of streamlining the regulations and increasing integration of services. The plan is to develop a single, unified ambulatory care regulation that will allow integrated services to operate seamlessly. The draft rule was released for comment on April 21, 2025 and allows for a 60-day comment period.

An integrated rule will establish licensure and operational standards for the development of an integrated licensing system by which an outpatient facility that provides healthcare services, including primary care and reproductive health services; behavioral health services, including ambulatory mental health treatment, substance use disorder and/or other addiction treatment services; opioid treatment program services and/or any combination of these services. The proposed regulatory structure includes facility standards for healthcare and behavioral healthcare services including opioid treatment program services (draft issued by NJ Department of Health) and program standards for behavioral healthcare, including opioid treatment program services (issued by the NJ Department of Human Services, Division of Mental Health and Addiction Services). The draft standards proposes regulatory and policy reform that streamlines the application process for greater standardization of regulations across service types, providers greater flexibility for best practice and innovation and will support funding reform that will support the provision of integrated services.

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

Division of Medical Assistance and Health Services (DMAHS).

1. NJ FamilyCare's Comprehensive Demonstration Waiver.

NJ FamilyCare's Comprehensive Demonstration ("The Waiver") was renewed on March 30, 2023 and continues to include an Opioid Use Disorder (OUD)/Substance Use Disorder (SUD) continuum which provides authority for the New Jersey Department of Human Services' Division of Medical Assistance and Health Services (DMAHS), to serve individuals with a substance use disorder or opioid use disorder in a full continuum of care. The continuum matches beneficiaries with the most appropriate services to meet their needs 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 program standards. Beneficiaries have access to high quality, evidence based, OUD and SUD treatment services ranging from acute withdrawal management, ongoing chronic care in cost effective settings, and care for comorbid physical and mental health conditions.

The New Jersey has waiver authority to:

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

The Comprehensive Demonstration is a five-year demonstration and is now valid through the end of June 2028. As part of the waiver requirements New Jersey is expected to continue reporting data as part of the SUD Monitoring Protocol and track progress toward the Demonstration's goals.

2. Presumptive Eligibility

The SSA, in collaboration with NJ FamilyCare, has established and is expanding mental health and SUD service providers who are able to enroll consumers needing treatment services in 24 -72 hours through presumptive eligibility (PE). PE allows a certified provider to enter information directly in the FamilyCare enrollment application that is then checked, and a temporary Medicaid number assigned. The application goes through verification, and if successful, a permanent Medicaid number is assigned. As of July 14, 2025, 267 behavioral health provider agencies have been certified to take PE applications.

3. Integration of Behavioral Health into Managed Care Organizations (MCOs).

The NJ Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), and DMHAS have a united goal of furthering the State's efforts to support integrated, whole person care. Traditionally, many behavioral health (BH) services are excluded from the managed care delivery system and are instead delivered on a fee-for-service basis. Over the course of the 1115 demonstration renewal period, New Jersey conducted a systematic review of all behavioral health services to assess, on a service-by-service basis, whether it was appropriate and feasible to integrate such services into managed care. This process review occurred in phases, involved close consultation with stakeholders and the public, and was conducted over a few years. The State has hosted a series of sessions to share the details of implementation and solicit feedback from stakeholders, NJ FamilyCare (Medicaid) members, communities served, and the overall healthcare community.

DMHAS joined DMAHS in fall of 2023 as NJ began planning to integrate the management of Medicaid funded behavioral health services into the five managed care organizations. It was decided that the process would be rolled out in Phases with Ambulatory services for youth and adults integrated January 1, 2025. Phase II will include Residential and opioid treatment program services and will be implemented no earlier than July 2026. Some services such as children's services include in the Children's System of Care will be reviewed and considered for a Phase III roll out with a goal date that is not yet determined.

DHS engaged the services of Boston Consulting Group to work with our two divisions to develop a smooth and orderly implementation informed by behavioral health providers, advocates, and individuals with lived experience. It was the DHS primary goal that no Medicaid enrollee experience an interruption of services. To that end, there has been significant stakeholder input including, separate provider, family and advocate, and enrollee focus groups, as we began the process. As implementation policies and procedures began, we relied on stakeholder advisory groups. In addition, the DHS staff at both divisions have presented and solicited input at multiple provider meetings, at conferences, and in other forums.

To prepare providers and enrollees for the launch of Phase I Integration, DHS held monthly trainings on a variety of topics. Whenever relevant, the MCOs presented at these meetings to train

providers and enrollees on their individual systems and requirements. Phase I of the Integration was launched on January 1, 2025. All training materials and a Provider Manual are on the divisions' websites. An email address and hotline for all concerns and problems were developed and distributed. Currently, the DHS staff from both divisions participate in daily huddles where we review provider, enrollee, and MCO feedback and concerns. DHS reviews data including but not limited to, provider networks, numbers of prior authorizations, timeliness of payments and individuals enrolled. DHS holds individual and group MCO meetings to address issues.

Work on Phase II of the integration is beginning with the benefit of lessons learned from the Phase I implementation.

Division of Medical Assistance and Health Services and Department of Children and Families.

DMHAS was selected to be one of the eight Certified Community Behavioral Health Clinic (CCBHC) demonstration states. The NJ CCBHC demonstration providers began services in July 2017. This project is a collaboration between the Department of Human Services' Division of Medical Assistance and Health Services (DMAHS) and DMHAS and the Department of Children and Families (DCF). NJ has been working with our partners at the DCF Children's System of Care (CSOC) in an effort to improve the CCBHC provider capacity to increase the numbers of children served.

There are seven behavioral health providers that are part of NJ's demonstration and that have been certified as CCBHCs by the DMHAS. The Federal Demonstration was extended to September 2025. DMHAS and DCF are working with our sister agency, DMAHS to develop a Medicaid State Plan that will sustain the service. In addition, in NJ, there were 11 providers in 2022, 6 providers in 2021, and 9 providers in 2020 who were awarded SAMHSA CCBHC expansion grants.

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

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

DMHAS developed a Memorandum of Agreement with DCF to provide services for the Partnership for Success grant that DMHAS was awarded in 2018 but ended in August 2023.

New Jersey State Parole Board. Memorandum of Agreement (MOA) exists 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.

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

On December 21, 2021, an extension and modification MOA between NJSPB and DMHAS to expand Intensive Outpatient Treatment Services (IOTSS) in order to provide rapid access to mental health services to parolee clients in need of mental health or co-occurring mental health and SUD treatment through the Mutual Agreement Program (MAP). Access to IOTSS is intended to provide an option for Designated Screening Programs and other acute care and hospital referral sources to assure that appropriate, intensive, community based, recovery-oriented outpatient services. Through IOTSS Parolee with an exacerbation of the symptoms of mental illness and/or a co-occurring substance abuse disorder receives comprehensive assessments, Wellness and Recovery Action Plans (WRAPS), Medication Administration and Education, Individual Therapy, Structured Group Therapy, Illness Management and Relapse Prevention Groups.

Department of Corrections. Since 2017, DMHAS has collaborated with the Department of Corrections (DOC) to provide Intensive Recovery Treatment Support (IRTS) pre- and post-release services to a cohort of eligible individuals with substance use disorder. Services are provided by staff from Rutgers University Behavioral Healthcare. Funding is braided so no pre-release services are funded with SUPTRS; DOC state funds are used for services provided pre-lease and supplies not permitted by SUPTRS.

In October 2020, NJ Governor signed legislation for the decreased sentences and early release of certain NJ state prison inmates incarcerated for non-violent offences. The law was effective in early November 2020. Through January 2021, almost 3,000 inmates were released. Approximately 800 of these individuals had an Opioid Use Disorder diagnosis and 364 enrolled in the IRTS program. Two additional IRTS teams were developed to serve them. early release of certain NJ incarcerated (compassionate release) to decrease the number of incarcerated individuals in the prisons during COVID. The law was effective in early November 2020. Through January 2021, almost 3,000 individuals incarcerated in prison were released. Approximately 800 of these individuals had an Opioid Use Disorder diagnosis and 364 enrolled in the IRTS program. Two additional IRTS teams were developed to serve them.

IRTS links eligible individuals to recovery services necessary to support wellness and successful community re-integration. It helps individuals address issues such as health/wellness, treatment adherence, employment, housing, and opportunities and skills to enhance the individual's ability to participate in meaningful life activities. IRTS teams can provide services to a maximum of 840 participants for up to six months prior to release and up to 12 months post release. To date, 5,792 individuals have been referred to the program.

State Police. Between 2014-2022, the Regional Operations Intelligence Center operated by the New Jersey State Police developed and operated the Drug Monitoring Initiative (DMI), to address the pervasive use of heroin, opiates, and the violent crimes and burglaries that are directly correlated with this nationwide crisis. The DMI was a nationally recognized program with a robust multi-state drug intelligence capability that collects and analyzes law enforcement and healthcare data in order to help law enforcement and public healthcare experts develop strategies to combat drug activity in their jurisdictions. Some highlights of the initiative are:

- The incorporation of public health guidance into the drug monitoring intelligence process
- The ability to coordinate the collection, analysis, and mapping of drug incidents statewide
- The expedited analysis of drug seizures to better direct criminal investigations and health resources
- Training law enforcement, fire service, and emergency medical service personnel statewide

DMHAS made frequent use of data provided by DMI for prevention needs assessment and planning.

Department of Education. The SSA will continue to coordinate with the Department of Education (DOE) to develop school health goals and priorities. The primary focus of this interdepartmental group is to decrease risky behaviors and promote the adoption of health enhancing behaviors. Additionally, the DOE will continue to participate in DMHAS' State Epidemiological Outcomes Workgroup (SEOW) to review survey instruments that can be jointly used to collect data required by both entities, and to coordinate schedules for administering student surveys so as to minimize duplication of data collection efforts.

In 2024, the DOE asked DMHAS to take over the administration of the YRBS High School Survey from the Centers for Disease Control and Prevention (CDC). DMHAS was required to apply for the five-year grant issued by the CDC, which was awarded to DMHAS in July 2024. DMHAS has been working closely with DOE through this transition period.

Department of Health. DMHAS collaborates with its partners at DOH in several areas and across a variety of offices. A major initiative DMHAS worked with DOH on was devising new proposed rules creating a single, integrated license for outpatient health care facilities. This reform will cut historical red tape and enable providers to deliver integrated primary care, mental health, and addiction treatment services. This comprehensive, whole-person approach is proven to deliver improved health outcomes and better patient experience. The proposed new rules address longstanding obstacles and a complex regulatory regime that have impeded health care providers' ability to offer coordinated physical and behavioral health services. The proposed rules were

released on April 21, 2025, for public comment. The public comment period was for sixty (60) days. DOH is still under review of those comments.

Division of HIV, STD and TB Services (DHSTS). DMHAS collaborated with DHSTS on a project with the National Alliance of State and Territorial AIDS Directors (NASTAD) and the JSI Research & Training Institute, Inc. (JSI). They were provided one-time funds to support activities related to the Strengthening Systems of Care for People with HIV and Opioid Use Disorder (SSC) project. Funds were meant to support time-based activities focused on enhancing systems of care for people with HIV and OUD and in alignment with state technical assistance plans developed for the project. Funding was made available to support technical assistance (TA), training, and capacity development activities of New Jersey, one of the nine states selected to participate. JSI was funded by the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) Projects of National Significance to work with nine states and provide technical assistance (TA) on strengthening systems of care to address OUD and HIV treatment, care, and recovery needs. DMHAS and DOH were partners in this project and met monthly with the consultants. The SSC conducted their initial site visit in February 2020 and concluded the monthly technical assistance meetings in August 2022. The two Departments worked on a TA plan with JSI and the final sustainability plan containing six goals was completed and provided to DMHAS and DOH in September 2022.

Stigma and its effects contribute to the syndemics of HIV and OUD, acting as an obstacle to care for people seeking services. An area to be explored will be data sharing among the two Departments to determine the number of individuals in SUD treatment who have HIV and the number of individuals who have HIV that are in SUD treatment. The information will be utilized by both Departments to help improve health outcomes for this population by better engaging individuals to seek either HIV or SUD treatment.

Office of Primary Care and Rural Health. DMHAS works with the Manager of the DOH Office of Primary Care and Rural Health on enhancing integrated care at the state's FQHCs, which includes working collaboratively on an RFP in 2025 to build integrated behavioral health into an additional FQHC. In November 2024, DMHAS presented at the 3rd Annual New Jersey Rural Health Conference hosted by the Department of Health to discuss the Travel Reimbursement and Invoicing Program (TRIP) that was developed to remove transportation as an obstacle to accessing health and behavioral health services. The presentation was part of a session on "Innovative Methods of Healthcare Delivery".

Office of Communicable Disease Services. DMHAS works with Office of Communicable Disease Services in efforts to address Hepatitis C and other communicable diseases common to those with a SUD and the DOH Office of Certificate of Need and Licensure to streamline and make effective the state's provider licensure requirements.

Office of Population Health. During calendar years 2020-2022, DMHAS collaborated with the DOH Office of Population Health on its ORO project. The goal of the project was to decrease the number of opioid prescriptions written in the ED and, instead, use alternative non-opioid pharmacological and non-pharmacological (nerve blocks, massage, etc.) approaches addressing, DMHAS issued one-year awards to 11 hospitals and in 2022 made four additional awards.

DMHAS managed the program, and the DOH developed a learning collaborative in which awardees were required to participate. During 2020-2022, 114,817 patients received the ORO protocol, and 1,006 providers were trained by May 2021.

Office of Population Health. The New Jersey Department of Health (NJDOH) is in the development phase of the [Healthy New Jersey 2030](#) (HNJ2030) State Health Improvement Plan to promote, strengthen, and evaluate the State's efforts to improve the health and well-being of all people. The Office oversees the statewide health assessment and health improvement plan. DMHAS was a member of the Healthy New Jersey (HNJ) Action Teams between 2022-2023 and will be participating in the re-convened the HNJ Advisory Council to evaluate and prioritize the strategies that were proposed. The teams have been reorganized based on the 2025 SHIP Priority Areas: Access to Quality Care, Healthy Communities, and Healthy Living. DMHAS will serve on the Healthy Living Action Team.

Division of Disaster Preparedness, Resiliency and Emergency Medical Services (DPREMS). DMHAS has been collaborating with DPREMS for years. DMHAS works with this Division's Office of Data Analytics, Resources, and Infrastructure to receive information on EMS transports of individuals who were reversed from an overdose with naloxone to emergency departments. This allows DMHAS to better monitor the performance of our OORP programs that provide recovery support to these individuals at the specific hospitals where they are located. The OORP program is in 75% of NJ Acute care hospitals.

DOH Office of Women's Health (OWH). DMHAS has formed a new partnership with the DOH Office of Women's Health. The Office for Women's Health (OWH) is dedicated to protecting and strengthening women's health in New Jersey by fostering healthy families and communities. OWH promotes evidence-based healthcare services with a focus on accessibility, innovation, and integration to empower women to live long, healthy, and autonomous lives. The New Jersey Maternal Data Center aims to assure data regarding maternal health and related outcomes are transparent to policy makers, consumers, and relevant stakeholders in New Jersey, through dissemination of data visualizations focused on the maternal health ecosystem.

In partnership with the OWH and the Department of Human Services (DHS) Division of Mental Health and Addiction Services (DMHAS), this project aims to develop a comprehensive spatial analysis and mapping initiative focused on substance use disorder (SUD) among the maternal health population. Utilizing data from the Maternal Data Center and matched hospital discharge and birth certificate records, the project will map treatment access points, including Maternal Wrap-Around (MWRAP), Intensive Outpatient Treatment for Substance Exposed Infants (IOT-SEI),⁵ and Medication-Assisted Treatment (MAT) programs, alongside key maternal and infant health outcomes. This visualization will identify geographic gaps in treatment and prevention services, particularly in the critical postpartum period, to support interventions and improve maternal and infant health outcomes.

Other DOH Offices. As a SAMHSA Prescription Drug Abuse Policy Academy State, NJ applied for a unique technical assistance opportunity in 2014 through the SAMHSA supported NCSACW to address the multi-faceted problems of NAS and SEI. NJ DMHAS as the lead State agency, partnered with DCF and DOH, and submitted a successful application (no funding attached). The

IDTA goal was to develop uniform policies/guidelines that address the entire spectrum of NAS and SEI from pre-pregnancy, prevention, early intervention, assessment and treatment, postpartum and early childhood. The IDTA provided technical assistance to NJ to strengthen collaboration and linkages across multiple systems such as addictions treatment, child welfare, and medical communities to improve services for pregnant women with opioid and other substance use disorders and outcomes for their babies. The Core Team included over 60 individuals representing multiple State Departments and Divisions, community stakeholders, treatment providers, and the medical community. Three goals were established (1) Increase perinatal SEI screening at multiple intervention points (2) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women screening positive on the 4P's (Parents, Partner, Past and Present) Plus get connected for a comprehensive assessment by establishing formal warm-handoffs and other safety net measures; (3) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women delivering SEIs and their babies and any other eligible children, receive early support services for which they are eligible. Workgroups were formed. The Labor, Delivery and Engagement (Infants) workgroup developed the Birthing Hospital Survey with input from the medical community and perinatal cooperatives. The survey was disseminated statewide in 2017 to labor and delivery hospitals. The survey sought to understand how pregnant women with SUD and SEI, treated, and triaged with partners at discharge and if NAS was explored. The results were intended to guide Departments in establishing statewide guidelines for best practice; aid in the development of cross system models to ensure families get access to services; establish education needs on issues of SEI and NAS and identify high risk areas. In an effort to increase access to SUD treatment and decrease unmet treatment needs of pregnant and parenting women with an OUD and based on the survey findings, DMHAS engaged Rutgers Robert Wood Johnson Medical School to provide technical assistance and training through the Extension for Community Healthcare Outcomes (ECHO) Program. DMHAS Office of Treatment and Recovery Supports continues to support the ongoing Maternal Child Health-Pregnant and Parenting Women with Opioid Use Disorder ECHO series.

New Jersey was awarded another round of In-Depth Technical Assistance (IDTA) through the National Center on Substance Abuse and Child Welfare's (NCSACW) 2023: "Advancing Collaborative Practice and Policy: Promoting Healthy Development and Family Recovery for Infants, Children, Parents, and Caregivers Affected by Prenatal Substance Exposure". The Department of Health is the lead State Department and NJ state representatives include the Departments of Children and Families, Human Services, and the Governor's Office. The state team includes an individual with lived experience. The DMHAS Women's Treatment Coordinator represents the Department of Human Services. The overall goal is to increase awareness of pregnant women and SUD, through increased education and maximizing messaging through the perinatal work force; increase awareness and access to treatment, Plans of Safe Care, and improving screenings in hospitals and healthcare providers. Four goals have been established:

- Conduct a statewide landscape analysis of resources available to individuals with a SUD and understand how referrals are made to appropriate resources and levels of care;
- Address gaps in the SUD system of care to establish comprehensive and fluid collaborative approach among state agencies, healthcare providers, and community-level and non-profit organizations to address substance use during and after pregnancy;
- By 2025, create and execute a state-wide prenatal Plans of Safe Care process that enables community and clinical partners to formally support a birthing woman;

- Support birthing hospitals in updating their protocol related to screening and referring pregnant women with SUD; and subsequently engaging in a comprehensive approach to implementing Plans of Safe Care in New Jersey.

Division of Medical Assistance and Department of Health. DMHAS participated on the Maternal and Child Health Policy Innovation Program (MCH PIP) Alumni Policy Academy from August 2023 through April 2024 convened by the National Academy for State Health Policy (NASHP) with support from the Health Resources and Services Administration, Maternal and Child Health Bureau (HRSA-MCH). State partners include DHS with Medicaid as the lead agency, DMHAS and representatives from the DOH and DCF. The overall goal is to improve maternal health outcomes by addressing obstacles (e.g., transportation, child-care, language/low literacy, discrimination) to accessing maternity care; effective referral processes for health-related social needs of pregnant and parenting women. DMHAS maternal child health initiatives (IOT-SEI and MWRAP) provide intensive case management, recovery supports, and services to assist pregnant and parenting women with SUD and co-occurring to access care, address obstacles to help improve maternal health outcomes.

DMHAS participates in a multi-department SUD Health Information Technology (HIT) Plan Workgroup between these two Departments. The Workgroup was formed to promote interoperability between behavioral health and physical health providers caring for SUD/ODI individuals, the State of New Jersey. A total of \$5.4 million in funding was allocated for a milestone-based SUD provider incentive program. The program is now administered by the Department of Human Services, after execution of an MOA that transferred the administration from the Department of Health. It is described more fully under system improvements.

NJ Department of Military and Veterans Affairs (DMAVA). The United States Department of Veterans Affairs (VA) partnered with the Substance Abuse and Mental Health Services Administration (SAMHSA) to continue the Governor's Challenges to Prevent Suicide Among Service Members, Veterans and Their Families (SMVF). For the *Governor's Challenge*, New Jersey and other participating states are working to develop and implement state-wide suicide prevention best practices for SMVF, using a public health approach. New Jersey began participation in the 2021 Governor's Challenge cohort, and the Division continues to participate in these meetings with DMAVA. DMHAS is part of an interagency military and civilian team to develop a strategic action plan to advance the National Strategy for Preventing Veteran Suicide. Teams are encouraged to include suicide prevention coordinators representing the state public/behavioral health agency, VA, and National Guard. DMHAS initially was co-leading the Governors Challenge along with the NJ Department of Military and Veterans Affairs (DMAVA) and continues to actively participate. This team has produced a state plan to address suicide, and more recently has been meeting to implement goals and objectives in three priority areas set forth by SAMHSA and the VA to prevent suicide for SMVF. The three Priority Area workgroups which are: 1) Identifying SMVF and Screening for Suicide Risk, 2) Promoting Connectedness and Care Transitions, and 3) Lethal Means Safety and Safety Planning.

For Priority Area 1, a goal that has been developed is to conduct another SMVA Needs Assessment Survey in CY 2025 (the last one was in 2022) to determine what supports providers need in serving Veterans. A second goal is to develop a "Have You Served Campaign". As part of this campaign,

an effort will be made to help identify American Indian Veterans in New Jersey. A third goal is to develop an “Ask the Question” website following the model developed by New Hampshire. A meeting was held with the DMAVA web designer in July 2025 to begin providing an outline for the website. A goal for completion of the website was set for December 2025. The “Ask the Question” is intended to educate service providers to better understand and providing support and care to military veterans.

Office of the Attorney General. ARRIVE Together is an initiative out of the Attorney General’s Office in partnership with DMHAS’ contracted providers that has been in effect since 2021 and expanded in 2023 to all 21 NJ counties. ARRIVE Together is a program that pairs law enforcement officers with mental health professionals to respond to behavioral health crises. The goal is to provide immediate support, de-escalate situations, and connect individuals in crisis with appropriate mental health services. This collaborative approach aims to improve outcomes for those experiencing mental health crises and enhance the safety of both the individuals in crisis and the responding officers. DMHAS continues to partner with the Attorney General’s Office of Alternative Community Response throughout the implementation of this key initiative.

Department of Labor. The New Jersey Department of Labor and Workforce Development (NJDOL) Pathways to Recovery Initiative launched in 2019 connects residents impacted by the opioid crisis to employment and offers supportive services in job readiness, skill building and obtaining industry recognized credentials. NJDOL announced in March 2025 the availability of an additional \$5 million in grant funding for organizations to offer training, employment, and retention services for individuals in recovery. Eligible applicants—including nonprofits, for-profits, government entities, and higher education institutions connected to mental health or opioid treatment centers—can receive up to \$1 million over 24 months starting June 1, 2025. Since its inception, the program has expanded statewide, forged over 1,550 employer partnerships, and supported more than 4,150 participants.

NJ Higher Education Student Assistance Authority In June of 2024, the Department collaborated with the Department of Children and Families and Higher Education Student Assistance Authority to launch the Home and Community Based Services (HCBS) Provider Loan Redemption Program. The program provided eligible workers with up to \$50,000 in loan relief in exchange for one year of service at an approved HCBS location and is funded with \$17.5m in funding from the American Rescue Plan Act.

- o Eligible professions included psychiatrists, social workers, registered nurses, alcohol and drug counselors, marriage and family therapists, and numerous other HCBS positions providing healthcare, behavioral health, and social services to individuals with medical needs, mental health conditions, and disabilities.
- o 448 individuals enrolled in the loan redemption program, selected from over 1,000 applicants, with the largest groups of participants being registered nurses, licensed social workers, DCF care managers, and licensed professional and associate counselors.

Law and Public Safety. The Office of Alternative and Community Responses (OACR) within the Department of Law and Public Safety (LPS) strives to, among other things, incorporate public health strategies into public safety responses to the opioid and addiction crises. The Opioid Policy

and Response Bureau (OPRB) within OACR provides funding for Operation Helping Hands (OHH), which supports programs in which law enforcement officers play an active role in identifying individuals with substance use disorders (SUD) and together with community partners serve as an entry point to treatment and/or recovery support services. DMHAS and the Office of Alternative and Community Response (OACR) are meeting concerning naloxone distribution and better coordination of services with the goal of continued sustainability. Another goal is to better align where naloxone is distributed and where actual overdoses are occurring.

Q3:

SSA

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

DMHAS is the Single State Authority (SSA) for substance use disorder treatment and services in New Jersey. Between the Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant and other federal and state resources. The SSA provides services across the continuum of care, which includes prevention, early intervention, treatment and recovery support.

In FFY 2025, the SSA funded: a) 21 county-based prevention coalitions (provided by 19 prevention agencies) serving all of NJ's counties for the provision of prevention programs with a focus on environmental strategies, b) over 30 community-based prevention providers that offer a variety of evidence-based curricula for children, adolescents, older adults, and families, c) two state institutions of higher education that provide early intervention services (Rutgers University and The College of New Jersey), e) housing continuum including four recovery-based housing residences with case management and supportive services for individuals with an opioid use disorder (OUD) who are homeless or at risk of homelessness, and Oxford houses f) a Women's Intensive Supportive Housing (WISH) program, g) two Intensive Supportive Housing (ISH) programs, h) 24-hour Addictions Hotline services, i) 23 recovery support centers, j) Mobile Medication Units k) 21 Opioid Overdose Recovery Programs, l) 21 Support Teams for Addiction Recovery, m) 20 Older Adult Education Programs, n) three Family Support Centers, o) a Telephone Recovery Support program, p) an addictions workforce training and development initiative, q) 21 county governments for the provision of services throughout the continuum of care, r) funding through a Request for Letter of Intent (RLI) for all county jails to incorporate or enhance Medication Assisted Treatment (MAT) as well as case management services for individuals who are incarcerated in county jails who have an Opioid Use Disorder (OUD) at the jail, s) 5 Integrated Opioid Treatment and Substance Exposed Infants programs, t) 7 regional Maternal Wraparound programs, and u) an Intensive Recovery Treatment Support program. Legal and navigation services and temporary shelter housing with case management and housing subsidies will be implemented in FFY 2026.

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The SSA's primary population served are individuals who are indigent and in need of substance use disorder treatment. Priority is given to certain groups of those in need: persons who inject drugs (PWID), pregnant women and women with dependent children, and individuals with/or at risk of HIV or TB. Other groups in need of services include individuals with the following: co-occurring mental illness; homelessness; deaf, hard of hearing or disabled; older adults; military service, and intoxicated drivers.

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

State Government

The SSA strives to promote the prevention and treatment of substance use disorder, support the recovery of individuals affected by the chronic disease of addiction, and promote the use of evidence-based practices. The SSA is responsible for regulating, monitoring, planning and funding substance abuse prevention, early intervention, treatment and recovery support services in New Jersey. In addition, the SSA assists with training the addiction treatment, prevention and recovery workforce. The SSA provides leadership and collaborates with providers, consumers, families, and other stakeholders to develop and sustain a system of client-centered care that is accessible, accountable to the public and grounded in best practices that yield measurable results. The SSA monitors substance use disorder treatment provider agencies for quality assurance and compliance with required assessment and treatment protocols and for other contractual requirements.

County Government

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

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

The SSA's current county planning activities focus on the 2024-2027 planning cycle. New Jersey implemented its Medicaid Waiver (1115) in 2023, which established a managed behavioral health care organization. The counties will continue to provide the state with a critically important monitoring and feedback from their programs. Additionally, the county plans will direct greater attention to the problems of citizens dually afflicted with both substance use disorder and mental health illness. The county Mental Health Administrators were invited to participate in the community-based planning certificate program DMHAS sponsored in 2013 and the

comprehensive planning process with the hope that, over time, both the substance abuse and mental health planning processes and products will integrate under a single county comprehensive, behavioral health plan. Currently, the County Alcoholism and Drug Abuse Directors and County Mental Health Administrators continue to have several joint Director meetings every year. As of April 2025, 18 County governments out of 21 have combined mental health and addictions into one department.

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 is offered in the community and the SSA awards funding either through cost-based contracts to 146 SUD treatment agencies, and fee-for-service contracts to 145 SUD treatment agencies that provide a continuum of treatment. Of these, 47 agencies had both a cost-based and fee-for-service contract. It provides funding to 42 SUD prevention agencies. It also provides awards to the 21 County Governments.

County Government. The SSA collaborates with the 21 counties of New Jersey in a joint state and county comprehensive behavioral health planning process intended to: 1) coordinate system development and service delivery at state and local levels, and 2) unify community-based planning for prevention and treatment. Chapter 51 of the Laws of 1989, C.26:2BB-12 et seq, amended Chapter 531 of the Laws of 1983 that had established the “Alcohol, Education, Rehabilitation and Enforcement Fund” (AEREF) and the county comprehensive planning requirement for participation in the AEREF program. The amended statute established 1) the Governor’s Advisory Council on Alcoholism and Drug Abuse, GCADA, and 2) the county Local Advisory Committee on Alcoholism and Drug Abuse, LACADA, known under the 1983 Act simply as the citizen advisory committee. The AEREF is a non-lapsing, revolving trust fund into which approximately \$11 million are deposited annually from a tax on the sale of alcoholic beverages. Approximately \$10.3 million from the AEREF plus an additional \$6.9 million in supplemental funds from the state treasury are distributed per statutory formula to the counties each year, for a total of approximately \$17.6 million for CY 2025.

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 DMHAS Office of Planning, Research, Evaluation and Prevention is responsible for overseeing the AEREF county comprehensive planning program.

Governor’s Council on Substance Use Disorder (GCSUD). The SSA works collaboratively with the Governor’s Council on Substance Use Disorder on various addiction prevention related

projects, including participation in the Prevention Collaborative Process. The Prevention Collaborative: 1) helps counties identify and implement a greater number of evidence-based prevention programs, 2) supports counties in the use of environmental approaches to prevention at the county and municipal levels, and 3) encourages counties to develop and operationalize community-based recovery support systems of care. The plan also provides direction in the development of future prevention funding opportunities made available by the SSA.

Through the Municipal Alliance Program, the GCSUD 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. GCSUD's Municipal Alliance Program provides 320 grants to 425 municipalities throughout New Jersey, with the majority of grants averaging between \$5,000 - \$10,000. The primary CSAP strategy utilized by the alliances is education, followed by alternatives, which provide social, athletic and recreational activities as an alternative to situations in which alcohol and drug use might occur. The majority of programming is delivered in communities and schools served by the alliances. In 2022, DMHAS awarded \$1 million (from the BG Supplement) to GCSUD for the development of a statewide Youth Leadership program. In 2023, DMHAS awarded an additional \$1.5 million to GCSUD to expand the work of the municipal alliances and increase their use of evidence-based programs and strategies.

Local Advisory Committee on Alcoholism and Drug Abuse. The SSA works collaboratively with the county Local Advisory Committees on Alcoholism and Drug Abuse (LACADAs) that “assist county government in development of the annual county comprehensive plan” required for participation in the Alcohol, Education, Rehabilitation and Enforcement” Fund (AEREF) of 1983 and 1989.

The LACADAs are also required to establish a County Alliance Steering Subcommittee (CASS), which is the county-level planning body for each county's Municipal Alliances (MAs) that are funded and overseen by the Governor's Council on Alcoholism and Drug Abuse (GCADA). The MAs are coalitions of municipal level residents and other stakeholders who volunteer to conduct data analysis and prevention service inventories as the basis for adopting a set of local prevention priorities and recommending these to the LACADAs.

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

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

On June 29, 2012, Governor Chris Christie signed a bill that further reorganized DCF into a single point of entry for all families with children, youth and young adults living with either developmental disabilities or substance use disorders, or both. This realignment of substance use treatment and developmental services is intended to improve 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 use 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 use and co-occurring disorders treatment at all levels of service in an efficient and coordinated manner from the statewide and regional level to the local levels, thus enhancing access to services, coordination of services, alignment of policies and contracts, and workforce development efforts.

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

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 use 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 inpatient, residential and ambulatory treatment programs and facilities.

DHS/ DMHAS is working with DOH licensing office to comment on ambulatory regulations that impede integrating services, with the goal of streamlining the regulations and increasing integration of services. The plan is to develop a single, unified ambulatory care regulation that will allow integrated services to operate seamlessly. The draft rule was released for comment on April 21, 2025 and allows for a 60-day comment period.

An integrated rule will establish licensure and operational standards for the development of an integrated licensing system by which an outpatient facility that provides healthcare services, including primary care and reproductive health services; behavioral health services, including ambulatory mental health treatment, substance use disorder and/or other addiction treatment services; opioid treatment program services and/or any combination of these services. The proposed regulatory structure includes facility standards for healthcare and behavioral healthcare services including opioid treatment program services (draft issued by NJ Department of Health) and program standards for behavioral healthcare, including opioid treatment program services (issued by the NJ Department of Human Services, Division of Mental Health and Addiction Services). The draft standards proposes regulatory and policy reform that streamlines the application process for greater standardization of regulations across service types, providers greater flexibility for best practice and innovation and will support funding reform that will support the provision of integrated services.

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

Division of Medical Assistance and Health Services (DMAHS).

1. NJ FamilyCare's Comprehensive Demonstration Waiver.

NJ FamilyCare's Comprehensive Demonstration ("The Waiver") was renewed on March 30, 2023 and continues to include an Opioid Use Disorder (OUD)/Substance Use Disorder (SUD) continuum which provides authority for the New Jersey Department of Human Services' Division of Medical Assistance and Health Services (DMAHS), to serve individuals with a substance use disorder or opioid use disorder in a full continuum of care. The continuum matches beneficiaries with the most appropriate services to meet their needs and provides an efficient use of resources grounded in evidence-based practice. This includes services provided in residential treatment settings that qualify as an Institute for Mental Disease (IMD) consistent with key benchmarks from nationally recognized, SUD-specific program standards. Beneficiaries have access to high quality, evidence based, OUD and SUD treatment services ranging from acute withdrawal management, ongoing chronic care in cost effective settings, and care for comorbid physical and mental health conditions.

The New Jersey has waiver authority to:

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

The Comprehensive Demonstration is a five-year demonstration and is now valid through the end of June 2028. As part of the waiver requirements New Jersey is expected to continue reporting data as part of the SUD Monitoring Protocol and track progress toward the Demonstration's goals.

2. Presumptive Eligibility

The SSA, in collaboration with NJ FamilyCare, has established and is expanding mental health and SUD service providers who are able to enroll consumers needing treatment services in 24 -72 hours through presumptive eligibility (PE). PE allows a certified provider to enter information directly in the FamilyCare enrollment application that is then checked, and a temporary Medicaid number assigned. The application goes through verification, and if successful, a permanent Medicaid number is assigned. As of July 14, 2025, 267 behavioral health provider agencies have been certified to take PE applications.

3. Integration of Behavioral Health into Managed Care Organizations (MCOs).

The NJ Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), and DMHAS have a united goal of furthering the State's efforts to support integrated, whole person care. Traditionally, many behavioral health (BH) services are excluded from the managed care delivery system and are instead delivered on a fee-for-service basis. Over the course of the 1115 demonstration renewal period, New Jersey conducted a systematic review of all behavioral health services to assess, on a service-by-service basis, whether it was appropriate and feasible to integrate such services into managed care. This process review occurred in phases, involved close consultation with stakeholders and the public, and was conducted over a few years. The State has hosted a series of sessions to share the details of implementation and solicit feedback from stakeholders, NJ FamilyCare (Medicaid) members, communities served, and the overall healthcare community.

DMHAS joined DMAHS in fall of 2023 as NJ began planning to integrate the management of Medicaid funded behavioral health services into the five managed care organizations. It was decided that the process would be rolled out in Phases with Ambulatory services for youth and adults integrated January 1, 2025. Phase II will include Residential and opioid treatment program services and will be implemented no earlier than July 2026. Some services such as children's services include in the Children's System of Care will be reviewed and considered for a Phase III roll out with a goal date that is not yet determined.

DHS engaged the services of Boston Consulting Group to work with our two divisions to develop a smooth and orderly implementation informed by behavioral health providers, advocates, and individuals with lived experience. It was the DHS primary goal that no Medicaid enrollee experience an interruption of services. To that end, there has been significant stakeholder input including, separate provider, family and advocate, and enrollee focus groups, as we began the process. As implementation policies and procedures began, we relied on stakeholder advisory groups. In addition, the DHS staff at both divisions have presented and solicited input at multiple provider meetings, at conferences, and in other forums.

To prepare providers and enrollees for the launch of Phase I Integration, DHS held monthly trainings on a variety of topics. Whenever relevant, the MCOs presented at these meetings to train providers and enrollees on their individual systems and requirements. Phase I of the Integration

was launched on January 1, 2025. All training materials and a Provider Manual are on the divisions' websites. An email address and hotline for all concerns and problems were developed and distributed. Currently, the DHS staff from both divisions participate in daily huddles where we review provider, enrollee, and MCO feedback and concerns. DHS reviews data including but not limited to, provider networks, numbers of prior authorizations, timeliness of payments and individuals enrolled. DHS holds individual and group MCO meetings to address issues.

Work on Phase II of the integration is beginning with the benefit of lessons learned from the Phase I implementation.

Division of Medical Assistance and Health Services and Department of Children and Families. DMHAS was selected to be one of the eight Certified Community Behavioral Health Clinic (CCBHC) demonstration states. The NJ CCBHC demonstration providers began services in July 2017. This project is a collaboration between the Department of Human Services' Division of Medical Assistance and Health Services (DMAHS) and DMHAS and the Department of Children and Families (DCF). NJ has been working with our partners at the DCF Children's System of Care (CSOC) in an effort to improve the CCBHC provider capacity to increase the numbers of children served.

There are seven behavioral health providers that are part of NJ's demonstration and that have been certified as CCBHCs by the DMHAS. The Federal Demonstration was extended to September 2025. DMHAS and DCF are working with our sister agency, DMAHS to develop a Medicaid State Plan that will sustain the service. In addition, in NJ, there were 11 providers in 2022, 6 providers in 2021, and 9 providers in 2020 who were awarded SAMHSA CCBHC expansion grants.

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

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

DMHAS developed a Memorandum of Agreement with DCF to provide services for the Partnership for Success grant that DMHAS was awarded in 2018 but ended in August 2023.

New Jersey State Parole Board. Memorandum of Agreement (MOA) exists 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.

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

On December 21, 2021, an extension and modification MOA between NJSPB and DMHAS to expand Intensive Outpatient Treatment Services (IOTSS) in order to provide rapid access to mental health services to parolee clients in need of mental health or co-occurring mental health and SUD treatment through the Mutual Agreement Program (MAP). Access to IOTSS is intended to provide an option for Designated Screening Programs and other acute care and hospital referral sources to assure that appropriate, intensive, community based, recovery-oriented outpatient services. Through IOTSS Parolee with an exacerbation of the symptoms of mental illness and/or a co-occurring substance abuse disorder receives comprehensive assessments, Wellness and Recovery Action Plans (WRAPS), Medication Administration and Education, Individual Therapy, Structured Group Therapy, Illness Management and Relapse Prevention Groups.

Department of Corrections. Since 2017, DMHAS has collaborated with the Department of Corrections (DOC) to provide Intensive Recovery Treatment Support (IRTS) pre- and post-release services to a cohort of eligible individuals with substance use disorder. Services are provided by staff from Rutgers University Behavioral Healthcare. Funding is braided so no pre-release services are funded with SUPTRS; DOC state funds are used for services provided pre-lease and supplies not permitted by SUPTRS.

In October 2020, NJ Governor signed legislation for the decreased sentences and early release of certain NJ state prison inmates incarcerated for non-violent offences. The law was effective in early November 2020. Through January 2021, almost 3,000 inmates were released. Approximately 800 of these individuals had an Opioid Use Disorder diagnosis and 364 enrolled in the IRTS program. Two additional IRTS teams were developed to serve them. early release of certain NJ incarcerated (compassionate release) to decrease the number of incarcerated individuals in the prisons during COVID. The law was effective in early November 2020. Through January 2021, almost 3,000 individuals incarcerated in prison were released. Approximately 800 of these individuals had an Opioid Use Disorder diagnosis and 364 enrolled in the IRTS program. Two additional IRTS teams were developed to serve them.

IRTS links eligible individuals to recovery services necessary to support wellness and successful community re-integration. It helps individuals address issues such as health/wellness, treatment adherence, employment, housing, and opportunities and skills to enhance the individual's ability to participate in meaningful life activities. IRTS teams can provide services to a maximum of 840 participants for up to six months prior to release and up to 12 months post release. To date, 5,792 individuals have been referred to the program.

State Police. Between 2014-2022, the Regional Operations Intelligence Center operated by the New Jersey State Police developed and operated the Drug Monitoring Initiative (DMI), to address the pervasive use of heroin, opiates, and the violent crimes and burglaries that are directly correlated with this nationwide crisis. The DMI was a nationally recognized program with a robust multi-state drug intelligence capability that collects and analyzes law enforcement and healthcare data in order to help law enforcement and public healthcare experts develop strategies to combat drug activity in their jurisdictions. Some highlights of the initiative are:

- The incorporation of public health guidance into the drug monitoring intelligence process
- The ability to coordinate the collection, analysis, and mapping of drug incidents statewide
- The expedited analysis of drug seizures to better direct criminal investigations and health resources
- Training law enforcement, fire service, and emergency medical service personnel statewide

DMHAS made frequent use of data provided by DMI for prevention needs assessment and planning.

Department of Education. The SSA will continue to coordinate with the Department of Education (DOE) to develop school health goals and priorities. The primary focus of this interdepartmental group is to decrease risky behaviors and promote the adoption of health enhancing behaviors. Additionally, the DOE will continue to participate in DMHAS' State Epidemiological Outcomes Workgroup (SEOW) to review survey instruments that can be jointly used to collect data required by both entities, and to coordinate schedules for administering student surveys so as to minimize duplication of data collection efforts.

In 2024, the DOE asked DMHAS to take over the administration of the YRBS High School Survey from the Centers for Disease Control and Prevention (CDC). DMHAS was required to apply for the five-year grant issued by the CDC, which was awarded to DMHAS in July 2024. DMHAS has been working closely with DOE through this transition period.

Department of Health. DMHAS collaborates with its partners at DOH in several areas and across a variety of offices. A major initiative DMHAS worked with DOH on was devising new proposed rules creating a single, integrated license for outpatient health care facilities. This reform will cut historical red tape and enable providers to deliver integrated primary care, mental health, and addiction treatment services. This comprehensive, whole-person approach is proven to deliver improved health outcomes and better patient experience. The proposed new rules address longstanding obstacles and a complex regulatory regime that have impeded health care providers' ability to offer coordinated physical and behavioral health services. The proposed rules were released on April 21, 2025, for public comment. The public comment period was for sixty (60) days. DOH is still under review of those comments.

Division of HIV, STD and TB Services (DHSTS).

DMHAS collaborated with DHSTS on a project with the National Alliance of State and Territorial AIDS Directors (NASTAD) and the JSI Research & Training Institute, Inc. (JSI). They were provided one-time funds to support activities related to the Strengthening Systems of Care for People with HIV and Opioid Use Disorder (SSC) project. Funds were meant to support time-based activities focused on enhancing systems of care for people with HIV and OUD and in alignment with state technical assistance plans developed for the project. Funding was made available to support technical assistance (TA), training, and capacity development activities of New Jersey, one of the nine states selected to participate. JSI was funded by the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) Special Projects of National Significance (SPNS) to work with nine states and provide technical assistance (TA) on strengthening systems of care to address OUD and HIV treatment, care, and recovery needs. DMHAS and DOH were partners in this project and met monthly with the consultants. The SSC conducted their initial site visit in February 2020 and concluded the monthly technical assistance meetings in August 2022. The two Departments worked on a TA plan with JSI and the final sustainability plan containing six goals was completed and provided to DMHAS and DOH in September 2022.

Stigma and its effects contribute to the syndemics of HIV and OUD, acting as an obstacle to care for people seeking services. An area to be explored will be data sharing among the two Departments to determine the number of individuals in SUD treatment who have HIV and the number of individuals who have HIV that are in SUD treatment. The information will be utilized by both Departments to help improve health outcomes for this population by better engaging individuals to seek either HIV or SUD treatment.

Office of Primary Care and Rural Health. DMHAS works with the Manager of the DOH Office of Primary Care and Rural Health on enhancing integrated care at the state's FQHCs, which includes working collaboratively on an RFP in 2025 to build integrated behavioral health into an additional FQHC. In November 2024, DMHAS presented at the 3rd Annual New Jersey Rural Health Conference hosted by the Department of Health to discuss the Travel Reimbursement and Invoicing Program (TRIP) that was developed to remove transportation as an obstacle to accessing health and behavioral health services. The presentation was part of a session on "Innovative Methods of Healthcare Delivery".

Office of Communicable Disease Services. DMHAS works with Office of Communicable Disease Services in efforts to address Hepatitis C and other communicable diseases common to those with a SUD and the DOH Office of Certificate of Need and Licensure to streamline and make effective the state's provider licensure requirements.

Office of Population Health. During calendar years 2020-2022, DMHAS collaborated with the DOH Office of Population Health on its Opioid Red. Options in the Emergency Department (ORO) project. The goal of the project was to decrease the number of opioid prescriptions written in the ED and, instead, use alternative non-opioid pharmacological and non-pharmacological (nerve blocks, massage, etc.) approaches addressing, DMHAS issued one-year awards to 11 hospitals and in 2022 made four additional awards. DMHAS managed the program, and the DOH developed a

learning collaborative in which awardees were required to participate. During 2020-2022, 114,817 patients received the ORO protocol, and 1,006 providers were trained by May 2021.

Office of Population Health. The New Jersey Department of Health (NJDOH) is in the development phase of the *Healthy New Jersey 2030* (HNJ2030) State Health Improvement Plan to promote, strengthen, and evaluate the State's efforts to improve the health and well-being of all people. The Office oversees the statewide health assessment and health improvement plan. DMHAS was a member of the Healthy New Jersey (HNJ) Action Teams between 2022-2023 and will be participating in the re-convened the HNJ Advisory Council to evaluate and prioritize the strategies that were proposed. The teams have been reorganized based on the 2025 SHIP Priority Areas: Access to Quality Care, Healthy Communities, and Healthy Living. DMHAS will serve on the Healthy Living Action Team.

Division of Disaster Preparedness, Resiliency and Emergency Medical Services (DPREMS). DMHAS has been collaborating with DPREMS for years. DMHAS works with this Division's Office of Data Analytics, Resources, and Infrastructure to receive information on EMS transports of individuals who were reversed from an overdose with naloxone to emergency departments. This allows DMHAS to better monitor the performance of our OORP programs that provide recovery support to these individuals at the specific hospitals where they are located. The OORP program is in 75% of NJ Acute care hospitals.

DOH Office of Women's Health (OWH). DMHAS has formed a new partnership with the DOH Office of Women's Health. The Office for Women's Health (OWH) is dedicated to protecting and strengthening women's health in New Jersey by fostering healthy families and communities. OWH promotes evidence-based healthcare services with a focus on accessibility, innovation, and integration to empower women to live long, healthy, and autonomous lives. The New Jersey Maternal Data Center aims to assure data regarding maternal health and related outcomes are transparent to policy makers, consumers, and relevant stakeholders in New Jersey, through dissemination of data visualizations focused on the maternal health ecosystem.

In partnership with the OWH and the Department of Human Services (DHS) Division of Mental Health and Addiction Services (DMHAS), this project aims to develop a comprehensive spatial analysis and mapping initiative focused on substance use disorder (SUD) among the maternal health population. Utilizing data from the Maternal Data Center and matched hospital discharge and birth certificate records, the project will map treatment access points, including Maternal Wrap-Around (MWRAP), Intensive Outpatient Treatment for Substance Exposed Infants (IOT-SEI),⁵ and Medication-Assisted Treatment (MAT) programs, alongside key maternal and infant health outcomes. This visualization will identify geographic gaps in treatment and prevention services, particularly in the critical postpartum period, to support interventions and improve maternal and infant health outcomes.

Other DOH Offices. As a SAMHSA Prescription Drug Abuse Policy Academy State, NJ applied for a unique technical assistance opportunity in 2014 through the SAMHSA supported NCSACW to address the multi-faceted problems of NAS and SEI. NJ DMHAS as the lead State agency, partnered with DCF and DOH, and submitted a successful application (no funding attached). The IDTA goal was to develop uniform policies/guidelines that address the entire spectrum of NAS

and SEI from pre-pregnancy, prevention, early intervention, assessment and treatment, postpartum and early childhood. The IDTA provided technical assistance to NJ to strengthen collaboration and linkages across multiple systems such as addictions treatment, child welfare, and medical communities to improve services for pregnant women with opioid and other substance use disorders and outcomes for their babies. The Core Team included over 60 individuals representing multiple State Departments and Divisions, community stakeholders, treatment providers, and the medical community. Three goals were established (1) Increase perinatal SEI screening at multiple intervention points (2) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women screening positive on the 4P's (Parents, Partner, Past and Present) Plus get connected for a comprehensive assessment by establishing formal warm-handoffs and other safety net measures; (3) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women delivering SEIs and their babies and any other eligible children, receive early support services for which they are eligible. Workgroups were formed. The Labor, Delivery and Engagement (Infants) workgroup developed the Birthing Hospital Survey with input from the medical community and perinatal cooperatives. The survey was disseminated statewide in 2017 to labor and delivery hospitals. The survey sought to understand how pregnant women with SUD and SEI, treated, and triaged with partners at discharge and if NAS was explored. The results were intended to guide Departments in establishing statewide guidelines for best practice; aid in the development of cross system models to ensure families get access to services; establish education needs on issues of SEI and NAS and identify high risk areas. In an effort to increase access to SUD treatment and decrease unmet treatment needs of pregnant and parenting women with an OUD and based on the survey findings, DMHAS engaged Rutgers Robert Wood Johnson Medical School to provide technical assistance and training through the Extension for Community Healthcare Outcomes (ECHO) Program. DMHAS Office of Treatment and Recovery Supports continues to support the ongoing Maternal Child Health-Pregnant and Parenting Women with Opioid Use Disorder ECHO series.

New Jersey was awarded another round of In-Depth Technical Assistance (IDTA) through the National Center on Substance Abuse and Child Welfare's (NCSACW) 2023: "Advancing Collaborative Practice and Policy: Promoting Healthy Development and Family Recovery for Infants, Children, Parents, and Caregivers Affected by Prenatal Substance Exposure". The Department of Health is the lead State Department and NJ state representatives include the Departments of Children and Families, Human Services, and the Governor's Office. The state team includes an individual with lived experience. The DMHAS Women's Treatment Coordinator represents the Department of Human Services. The overall goal is to increase awareness of pregnant women and SUD, through increased education and maximizing messaging through the perinatal work force; increase awareness and access to treatment, Plans of Safe Care, and improving screenings in hospitals and healthcare providers. Four goals have been established:

- Conduct a statewide landscape analysis of resources available to individuals with a SUD and understand how referrals are made to appropriate resources and levels of care;
- Address gaps in the SUD system of care to establish comprehensive and fluid collaborative approach among state agencies, healthcare providers, and community-level and non-profit organizations to address substance use during and after pregnancy;
- By 2025, create and execute a state-wide prenatal Plans of Safe Care process that enables community and clinical partners to formally support a birthing woman;

- Support birthing hospitals in updating their protocol related to screening and referring pregnant women with SUD; and subsequently engaging in a comprehensive approach to implementing Plans of Safe Care in New Jersey.

Division of Medical Assistance and Department of Health. DMHAS participated on the Maternal and Child Health Policy Innovation Program (MCH PIP) Alumni Policy Academy from August 2023 through April 2024 convened by the National Academy for State Health Policy (NASHP) with support from the Health Resources and Services Administration, Maternal and Child Health Bureau (HRSA-MCH). State partners include DHS with Medicaid as the lead agency, DMHAS and representatives from the DOH and DCF. The overall goal is to improve maternal health outcomes by addressing obstacles (e.g., transportation, child-care, language/low literacy, discrimination) to accessing maternity care; effective referral processes for health-related social needs of pregnant and parenting women. DMHAS maternal child health initiatives (IOT-SEI and MWRAP) provide intensive case management, recovery supports, and services to assist pregnant and parenting women with SUD and co-occurring to access care, address obstacles to help improve maternal health outcomes.

DMHAS participates in a multi-department SUD Health Information Technology (HIT) Plan Workgroup between these two Departments. The Workgroup was formed to promote interoperability between behavioral health and physical health providers caring for SUD/ODI individuals, the State of New Jersey. A total of \$5.4 million in funding was allocated for a milestone-based SUD provider incentive program. The program is now administered by the Department of Human Services, after execution of an MOA that transferred the administration from the Department of Health. It is described more fully under system improvements.

NJ Department of Military and Veterans Affairs (DMAVA). The United States Department of Veterans Affairs (VA) partnered with the Substance Abuse and Mental Health Services Administration (SAMHSA) to continue the Governor's Challenges to Prevent Suicide Among Service Members, Veterans and Their Families (SMVF). For the *Governor's Challenge*, New Jersey and other participating states are working to develop and implement state-wide suicide prevention best practices for SMVF, using a public health approach. New Jersey began participation in the 2021 Governor's Challenge cohort, and the Division continues to participate in these meetings with DMAVA. DMHAS is part of an interagency military and civilian team to develop a strategic action plan to advance the National Strategy for Preventing Veteran Suicide. Teams are encouraged to include suicide prevention coordinators representing the state public/behavioral health agency, VA, and National Guard. DMHAS initially was co-leading the Governors Challenge along with the NJ Department of Military and Veterans Affairs (DMAVA) and continues to actively participate. This team has produced a state plan to address suicide, and more recently has been meeting to implement goals and objectives in three priority areas set forth by SAMHSA and the VA to prevent suicide for SMVF. The three Priority Area workgroups which are: 1) Identifying SMVF and Screening for Suicide Risk, 2) Promoting Connectedness and Care Transitions, and 3) Lethal Means Safety and Safety Planning.

For Priority Area 1, a goal that has been developed is to conduct another SMVA Needs Assessment Survey in CY 2025 (the last one was in 2022) to determine what supports providers need in serving Veterans. A second goal is to develop a "Have You Served Campaign". As part of this campaign,

an effort will be made to help identify American Indian Veterans in New Jersey. A third goal is to develop an “Ask the Question” website following the model developed by New Hampshire. A meeting was held with the DMAVA web designer in July 2025 to begin providing an outline for the website. A goal for completion of the website was set for December 2025. The “Ask the Question” is intended to educate service providers to better understand and providing support and care to military veterans.

Office of the Attorney General. ARRIVE Together is an initiative out of the Attorney General’s Office in partnership with DMHAS’ contracted providers that has been in effect since 2021 and expanded in 2023 to all 21 NJ counties. ARRIVE Together is a program that pairs law enforcement officers with mental health professionals to respond to behavioral health crises. The goal is to provide immediate support, de-escalate situations, and connect individuals in crisis with appropriate mental health services. This collaborative approach aims to improve outcomes for those experiencing mental health crises and enhance the safety of both the individuals in crisis and the responding officers. DMHAS continues to partner with the Attorney General’s Office of Alternative Community Response throughout the implementation of this key initiative.

Department of Labor. The New Jersey Department of Labor and Workforce Development (NJDOL) Pathways to Recovery Initiative launched in 2019 connects residents impacted by the opioid crisis to employment and offers supportive services in job readiness, skill building and obtaining industry recognized credentials. NJDOL announced in March 2025 the availability of an additional \$5 million in grant funding for organizations to offer training, employment, and retention services for individuals in recovery. Eligible applicants—including nonprofits, for-profits, government entities, and higher education institutions connected to mental health or opioid treatment centers—can receive up to \$1 million over 24 months starting June 1, 2025. Since its inception, the program has expanded statewide, forged over 1,550 employer partnerships, and supported more than 4,150 participants.

NJ Higher Education Student Assistance Authority In June of 2024, the Department collaborated with the Department of Children and Families and Higher Education Student Assistance Authority to launch the Home and Community Based Services (HCBS) Provider Loan Redemption Program. The program provided eligible workers with up to \$50,000 in loan relief in exchange for one year of service at an approved HCBS location and is funded with \$17.5m in funding from the American Rescue Plan Act.

- o Eligible professions included psychiatrists, social workers, registered nurses, alcohol and drug counselors, marriage and family therapists, and numerous other HCBS positions providing healthcare, behavioral health, and social services to individuals with medical needs, mental health conditions, and disabilities.
- o 448 individuals enrolled in the loan redemption program, selected from over 1,000 applicants, with the largest groups of participants being registered nurses, licensed social workers, DCF care managers, and licensed professional and associate counselors.

Law and Public Safety. The Office of Alternative and Community Responses (OACR) within the Department of Law and Public Safety (LPS) strives to, among other things, incorporate public health strategies into public safety responses to the opioid and addiction crises. The Opioid Policy

and Response Bureau (OPRB) within OACR provides funding for Operation Helping Hands (OHH), which supports programs in which law enforcement officers play an active role in identifying individuals with substance use disorders (SUD) and together with community partners serve as an entry point to treatment and/or recovery support services. DMHAS and the Office of Alternative and Community Response (OACR) are meeting concerning naloxone distribution and better coordination of services with the goal of continued sustainability. Another goal is to better align where naloxone is distributed and where actual overdoses are occurring.

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 is offered in the community and the SSA awards funding either through cost-based contracts to 146 SUD treatment agencies, and fee-for-service contracts to 145 SUD treatment agencies that provide a continuum of treatment. Of these, 47 agencies had both a cost-based and fee-for-service contract. It provides funding to 42 SUD prevention agencies. It also provides awards to the 21 County Governments.

County Government. The SSA collaborates with the 21 counties of New Jersey in a joint state and county comprehensive behavioral health planning process intended to: 1) coordinate system development and service delivery at state and local levels, and 2) unify community-based planning for prevention and treatment. Chapter 51 of the Laws of 1989, C.26:2BB-12 et seq, amended Chapter 531 of the Laws of 1983 that had established the “Alcohol, Education, Rehabilitation and Enforcement Fund” (AEREF) and the county comprehensive planning requirement for participation in the AEREF program. The amended statute established 1) the Governor’s Advisory Council on Alcoholism and Drug Abuse, GCADA, and 2) the county Local Advisory Committee on Alcoholism and Drug Abuse, LACADA, known under the 1983 Act simply as the citizen advisory committee. The AEREF is a non-lapsing, revolving trust fund into which approximately \$11 million are deposited annually from a tax on the sale of alcoholic beverages. Approximately \$10.3 million from the AEREF plus an additional \$6.9 million in supplemental funds from the state treasury are distributed per statutory formula to the counties each year, for a total of approximately \$17.6 million for CY 2025.

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 DMHAS Office of Planning, Research, Evaluation and Prevention is responsible for overseeing the AEREF county comprehensive planning program.

Governor’s Council on Substance Use Disorder (GCSUD). The SSA works collaboratively with the Governor’s Council on Substance Use Disorder on various addiction prevention related projects, including participation in the Prevention Collaborative Process. The Prevention Collaborative: 1) helps counties identify and implement a greater number of evidence-based prevention programs, 2) supports counties in the use of environmental approaches to prevention at the county and municipal levels, and 3) encourages counties to develop and operationalize community-based recovery support systems of care. The plan also provides direction in the development of future prevention funding opportunities made available by the SSA.

Through the Municipal Alliance Program, the GCSUD 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. GCSUD’s Municipal Alliance Program provides 320 grants to 425 municipalities throughout New Jersey, with the majority of grants averaging between \$5,000 - \$10,000. The primary CSAP strategy utilized by the alliances is education, followed by alternatives, which provide social, athletic and recreational activities as an alternative to situations in which alcohol and drug use might occur. The majority of programming is delivered in communities and schools served by the alliances. In 2022, DMHAS awarded \$1 million (from the BG Supplement) to GCSUD for the development of a statewide Youth Leadership program. In 2023, DMHAS awarded an additional \$1.5 million to GCSUD to expand the work of the municipal alliances and increase their use of evidence-based programs and strategies.

Local Advisory Committee on Alcoholism and Drug Abuse. The SSA works collaboratively with the county Local Advisory Committees on Alcoholism and Drug Abuse (LACADAs) that “assist county government in development of the annual county comprehensive plan” required for participation in the Alcohol, Education, Rehabilitation and Enforcement” Fund (AEREF) of 1983 and 1989.

The LACADAs are also required to establish a County Alliance Steering Subcommittee (CASS), which is the county-level planning body for each county’s Municipal Alliances (MAs) that are funded and overseen by the Governor’s Council on Alcoholism and Drug Abuse (GCADA). The MAs are coalitions of municipal level residents and other stakeholders who volunteer to conduct data analysis and prevention service inventories as the basis for adopting a set of local prevention priorities and recommending these to the LACADAs.

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

Primary Prevention (Criterion 2)

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

1. Universal: where media messages and written information are provided statewide to all citizens;

2. Selective: where programs of information and skill development are provided to groups of individuals at some risk; and
3. Indicated: where programs of information, skill development and behavioral change are promoted to identify individuals most at risk.

Employing the five-step Strategic Prevention Framework (SPF) developed by SAMHSA's Center for Substance Abuse Prevention (CSAP) as well as DMHAS' Addiction Prevention Strategic Planning, the SSA plans prevention and early intervention services in the state, awards funding to providers through RFPs and funds 21 county-based prevention coalitions as well as more than 60 community-based programs that offer a variety of evidence-based prevention curricula for children, adolescents, older adults, and families. The SSA monitors contracts, provides on-going technical assistance to contracted provider agencies, and oversees outcome evaluations for each program. All DMHAS-funded coalitions and programs focus their efforts on addressing the prevention priorities identified in the Prevention Strategic Plan:

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

DMHAS funds over 60 curriculum-based prevention programs in community settings throughout the State. DMHAS-funded providers develop an annual work plan for each program they are delivering and submit a quarterly report that provides information about progress towards achieving annual program deliverables. Examples of curriculum-based programs include: Strengthening Families, Botvin's LifeSkills, I Can Problem Solve, and Too Good for Drugs. In SFY 2024, over 100,000 individuals were served through the delivery of individual and family programs.

Providers also use the Prevention Outcomes Management System (POMS), which is the DMHAS' online prevention data reporting system to submit basic socio-demographic information about program participants.

Since 2012, when DMHAS established its system of county 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, 2018, and 2023, county coalitions utilize resources to address tobacco prevention. Coalitions have used PFS funds for services to older adults and returning veterans when warranted. DMHAS was awarded a PFS five-year grant in September 2023 in which 14 of the 21 DMHAS-funded county coalitions were eligible to receive funding as subrecipients (did not receive a community PFS award from SAMHSA). The 14 coalitions will use PFS funding to address underage tobacco prevention. In addition to the 14 DMHAS-funded coalitions, 5 (also DMHAS-funded) received community-based PFS awards, and, as such were ineligible for RFS funding from DMHAS.

College Campuses. This initiative, which began in 2009, awarded state funds to Rutgers University and The College of New Jersey to enable them to provide recovery support and environmental

prevention strategies to help and support students who have a substance use disorder (SUD) diagnosis as well as those who intermittently abuse alcohol and other drugs (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 decrease the supply of and demand for AODs by making them less available and their use less acceptable within the campus environment. With State Opioid Response, BG Supplement and ARPA funds, additional state colleges and universities implemented on-campus programs for students in recovery or those who seek a substance-free college experience. The new institutions were Rutgers University – Newark, Ocean County Community College, Ramapo College, Rowan University (main campus), and Richard Stockton University. College Recovery Programs have served more than 500 students in recovery and held more than 5,000 events in SFY 2024.

Alternative Approaches to Pain Management for Older Adults (AAPMS). The Alternative Approaches to Pain Management is a comprehensive educational program specifically focused on providing older adults with practical information regarding (1) the appropriate use of non-opioid analgesic pain medication and (2) non-pharmacological approaches to dealing with acute and chronic pain. The goal of the project is to decrease the overuse, misuse and abuse of prescription opioid medications within this population. Programs utilize current evidence-based treatment guidelines for non-pharmacological treatment modalities. The “efficacy” of the educational program on participants’ knowledge about and understanding of alternative approaches to pain management is assessed by means of a pre and post-test. Most of the providers who are delivering the AAPMOA program use the evidence-based Wellness Initiative for Senior Education (WISE) program. WISE is a wellness and prevention program for older adults, which is designed to help them celebrate healthy aging, make healthy lifestyle choices and avoid substance abuse. It provides educational services to older adults on topics including medication management, stress management, depression, and substance misuse. Created by the New Jersey Prevention Network and implemented locally by prevention agencies across the country, WISE promotes health through education concerning high-risk behaviors in older adults.

Providing information about the risks associated with prescription pain medications is a component of these trainings. However, the primary focus is on providing information and answering questions about proven, non-pharmacological means of addressing pain. Providers do not deliver actual services, but offer information about alternative approaches and information regarding how and where to access such services as: physical therapy, chiropractic care, yoga, massage therapy, etc.

During this period, the Alternative Approaches to Pain Management for Older Adults program trained 12,000 people (10,000 older adults, 1700 caregivers, and 300 healthcare providers).

College Recovery Services. DMHAS provides funding to five state institutions of higher education. The funding enables them to offer students in recovery from a substance use disorder (SUD), students at-risk of developing a SUD, and students not in recovery who choose not to use alcohol and drugs, a supportive community (including housing) that promotes physical, psychological, social, and spiritual health. By providing this support, it is easier for a student who is in recovery to thrive in the college setting and work toward his/her/their academic goals.

The colleges/universities are Rutgers University New Brunswick and Newark campuses, The College of New Jersey, Rowan University and Richard Stockton University. During this reporting period:

- 1458 students received individual and/or group recovery support services
- 65 students resided in recovery housing
- in excess of 18,000 students participated in campus-wide or large-scale substance-free activities/events
- 94% reported (past 30-day) abstinence from substance use
- 70% reported being employed
- 100% of students reported satisfactory academic standing
- 100% of students reported no criminal justice involvement
- 100% of students reported stable housing (on or off campus)
- 100% of students reported satisfaction with the services they receive through the collegiate recovery program
- 100% reported social connectedness with peers, family, friends and/or coworkers
- 60% of students reported need for mental health resources, all of whom were either engaged with a lead counselor or were linked to a community mental health program.

Student Athletes. A major component of New Jersey’s SPF Rx project focuses on decreasing the prevalence of opioid use among young athletes. A toolkit called “Tackling Opioids through Prevention for Athletes” (TOP) was developed by the New Jersey Prevention Network for use by providers. Literature suggests that when young athletes are prescribed opioid pain relievers for sports-related injuries, there is a risk of addiction and medication misuse. The 19 county coalitions that were established by DMHAS use the TOP to provide education regarding this issue to coaches, parents, prescribers, and young athletes. In SFY 2023, 5,200 individuals were served, and in SFY 2024 6,871 participated in the trainings.

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 (NJPN) 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. These programs were combined and offered to families at weekly Military Family Nights (MFN). Both programs are designed to enhance protective factors to support military members and their families in making responsible parenting and individual choices regarding drug and alcohol use. NJPN developed a program based on the evidence-based curriculum, WISE (Wellness Initiative for Senior Education), NJPN made adaptations to create “WISE for Vets” to serve the older adult veteran population. Using these additional funds, NJPN was able to provide Coping with Work and Family Stress for reservists and first responders

Services for At-Risk Youth. Since 2009, the SSA has funded the North Jersey Community Research Initiative to continue and expand their existing programs for high-risk youth 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 decreasing rates of substance use among participants and that participants were highly satisfied with the services that were provided. In late 2022/early 2023, DMHAS issued an RFP to expand these services. Awards were made to two SUD prevention agencies to provide these services in the central and southern regions of the state. Over 400 youth and their parents/caregivers have participated in these programs.

Gambling. DMHAS contracts with Council on Compulsive Gambling NJ to provide numerous prevention services related to gambling. The areas of focus are:

Public Awareness: Information Dissemination, Enhance Access

The goal is to create greater awareness of the risk factors of problem and disordered gambling, and the availability of support, treatment, and hope for residents of New Jersey. Activities include:

- Outreach through traditional media, digital and electronic, and social media (billboards, radio-based public service announcements, video awareness messages, Podcasts, online media posts, the Council's website, etc.).
- Geo-fencing technology utilized to 'drop' promotional 'Pins' at or around New Jersey casinos, racetracks, Giants Stadium, the Meadowlands, and at sports betting events in an effort to provide access to those in their place of addiction.
- Distribution of informational brochures/pamphlets, infographics, articles, new videos, promotional items.
- Public Service Announcements, radio commercials, press releases, advertising and awareness for the 24/365 800-Gambler helpline for how to access help and resources for problem gambling.
- Physical Billboards displayed in several locations throughout New Jersey including in Atlantic City on the Atlantic City expressway, at the Meadowlands Racetrack on Route 3, and in Cranbury on New Jersey Turnpike South.

Information and Referral: Problem Identification & Referral

- Utilize and maintain the 800-GAMBLER helpline to serve New Jersey residents experiencing problems due to gambling. The Council maintains round the clock phone calls, text messaging, and website chat services in English and essentially any language in an effort to increase and expand accessibility to help with problem gambling. "Intake" call data includes: the type of gambling, finances, family issues, referrals, co-occurring issues. Intake callers will be asked if they would like the name and contact information for a licensed, certified gambling treatment counselor in their geographic area and provided with same where needed.

Education: Provide Information, Provide Support, Building Skills

The goal is to conduct outreach and provide presentations and training to broad representation of individuals, groups, and communities, professionals, laypeople, and the faith-based community to enhance the breadth, reach, and sustainability of gambling awareness and messages. Outreach and education are delivered to:

- Faith-based Communities to increase awareness and impart the message of support, treatment and hope for problem/disordered gamblers.
- Older Adult/Senior Population serving older adult and community organizations where problem gambling among the elderly is addressed.

- Adolescent/Young Adults serving high-school and college students addressing problem and underage gambling.
- Evidence-based, -preferred, or –Informed Programs conducted in multiple rounds/cycles of the Cognitive Perspective Restructuring (CPR) program. The CPR program addresses the consequences of risky behavior(s) and its aim is to prevent the onset of addiction.
- College/University IRB -approved survey. The Council enters into an agreement with an entity with expertise in research methods and technology to collect gambling data from college or university students.
- Casino and Sportsbook Operator Customer Service Training. In collaboration with established partners, the Council provides information about the dangers of problem gambling, the warning signs to look for, and ensure that customer service representatives are aware of resources for help that are available.
- Other At-risk Populations Presentations. The Council engages the corrections system, in-patient facilities, outpatient facilities, and other agencies and/or entities that serve at-risk populations.

Program & Policy Development: Community-based Process

The goal is outreach through meetings with government entities to provide information, participation, and resources to develop, refine, or implement programs related to problem gambling. Outreach includes:

- Meetings with government entities including municipal, county and state agencies and engagement at quarterly meetings of the Governor’s Council on Alcohol & Drug Abuse, and engage in meetings statewide with probation, parole, criminal justice offices, courts, and jails.
- Engagement with business and grass-roots entities through meetings with hospitals, for-profit and not-for-profit businesses, and restaurants, casinos, NJ Racetracks & gambling establishments, the NJ Lottery, employee assistance programs, homeless shelters, advocacy organizations, and other businesses.
- Meetings with professional and treatment organizations that serve residents of New Jersey including the Association for Addiction professionals and those that provide treatment and/or professional services (e.g., substance use, mental health, co-occurring). Essentially, including efforts to increase recognition of gambling as a co-occurring disorder.
- Attendance at statewide DMHAS-funded county prevention coalitions.
- Maintain a Responsible Gambling Workgroup and hold quarterly meetings of this group to discuss issues that pertain to the gambling industry, such as pending legislation, regulations, and policy issues impacting gambling in New Jersey. Meetings are also used for networking, information dissemination, and discussion of best practices to address and prevent problem gambling from multiple and varying perspectives.

Public Awareness Campaigns

Stigma and MOUD. DMHAS, in partnership with the Department Human Services (DHS), Office of Public Relations, secured a vendor that delivered a public awareness campaign to help decrease stigma and discrimination around the use of Medications for Opioid Use Disorder (MOUD). The campaign was initially launched in the Spring of 2020 with SOR 1.0 grant funds and refreshed its campaign multiple times with SOR 2.0 and 3.0 grants. Various forms of messaging including TV ads, radio commercials, social media and billboards have been utilized.

Anti-Stigma and Enhanced Naloxone. DMHAS used SUPTRS COVID-19 Supplemental funds for a public awareness campaign in 2024. This campaign focused on decreasing SUD stigma and connecting New Jersey residents to SUD treatment and recovery supports. Also, the campaign sought to help prevent overdose deaths by informing the public on the use of naloxone. Each time these campaigns run there is a significant and dramatic increase in call volume to the ReachNJ 24/7 hotline number.

DMHAS secured two new media vendors in 2025 with the issuance of two Requests for Engagements to the NJ Treasury's contracted media vendor list. The two new vendors will launch the following campaigns.

Anti-Stigma and Enhanced Naloxone. These multifaceted media campaigns funded through the ARPA grant were launched July 2025. The campaigns aimed at decreasing stigma surrounding SUD in New Jersey and inform the public about the importance of having access to naloxone to help with overdoses and save lives. Specifically, the campaign seeks to decrease stigma surrounding SUD diagnoses and treatment and increase the number of New Jersey residents who become connected to SUD treatment and recovery services and supports. Also, it seeks to help prevent overdose deaths.

Audiences include individuals with SUDs and their families. DMHAS' contracted media vendor will promote anti-stigma messaging to the general population, individuals with SUDs and their families, general practitioners, emergency room physicians, pain management specialists, pharmacists, mental health and SUD providers. Also, the Vendor will assist with promoting public awareness to populations such as older adults, high school and college athletes, and prescribers etc.

In July 2025, we launched the NJ Anti-Stigma campaign to de-stigmatize drug usage, plus encourage people struggling with addiction to seek help and access treatment resources. The theme is "Addiction Wasn't My Choice. Getting Help Is."

In July 2025, we also launched the NJ Naloxone campaign to normalize the use of Naloxone and decrease any hesitation to obtain it. "You could save a life" is the theme.

New creatives will be developed promoting the importance of having access to Naloxone and how it can save a life to the general public. It will also message individuals taking high-dose opioid medications, those using both opioids and benzodiazepines and people who use illicit opioids, e.g., heroin. The new anti-stigma campaign is tagged "There's More to the Story", while the naloxone campaign is tagged "In Your Hands", which emphasizes "you can save a life".

ReachNJ/Anti-Stigma/MOUD/Fentanyl. This multifaceted media campaign, funded through SOR 4.0 grant, launched on Monday, May 12, 2025. Spanning a wide range of media platforms, the campaign was designed to increase awareness, decrease stigma, and connect individuals to treatment resources.

The ReachNJ Anti-Stigma advertising campaign launched on May 12, 2025, and concludes on September 29, 2025. Every media tactic carries a clear call-to-action (CTA) directing New Jersey

residents to call 844-REACHNJ or visit ReachNJ.gov for information and support. The campaign's primary objective is to raise awareness of the resources available to individuals and families struggling with addiction or substance use disorder (SUD). It is tagged "Your Story, Your Addiction, Your Recovery".

Since launch, the campaign has executed more than 50 distinct media tactics, delivering:

- Over 4,600 OOH placements
- Tens of thousands of TV and radio advertisements
- Hundreds of millions of digital impressions

This comprehensive effort has generated record-breaking engagement.

The Fentanyl advertising campaign launched on July 7th and is scheduled to conclude on September 29, 2025. The campaign intends to increase awareness amongst teens and young adults about the threats of fentanyl and to increase knowledge of fentanyl and fentanyl-laced substances such as illicit and counterfeit pills and powders. A variety of approaches are used such as TV and radio ads, bus and train wraps, posters, messaging on Facebook, YouTube, Instagram, Tik Tok, Snapchat and the web. The fentanyl campaign is tagged "Stay in the Picture". Since this is the first time this campaign has run, it was important that it increased awareness among teens and young adults about the threats of fentanyl, while also helping parents of children ages 13-24 understand the risks of this dangerous drug. The media strategy provided broad coverage across the state of New Jersey, both traditionally through Out-of-Home (OOH) placements such as digital billboards, bus shelters, and transit, and digitally on programmatic, streaming video, social, Google and YouTube.

Discretionary Grants

Strategic Prevention Enhancement (SPE). In 2011, New Jersey received a State Prevention Enhancement from CSAP. New Jersey's State Prevention Enhancement 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 misuse 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) decrease underage drinking among persons aged 12 to 20; and 2) decrease 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 misuse among adults age sixty and

older; and serves military families with prevention education, addressing military community risk levels, striving to alleviate the risk factors, and enhancing the protective factors to support military members and their families in making responsible parenting and individual choices in regards to drug and alcohol use.

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

DMHAS utilized these SPF-PFS fund to update of the Statewide Prevention Inventory, an inventory of all existing substance abuse prevention interventions in NJ that was produced under NJ's SPE grant. The goal of this task was to provide information on existing prevention efforts and their focus so that service gaps could be identified, and duplication avoided in ongoing strategic planning efforts.

DMHAS was awarded a third Partnership for Success grant that began in October 2023. The project aims to: 1) Decrease youth underage drinking, vaping/use of e-cigarettes, and marijuana use and by youth and young adults ages 12-25 throughout NJ; 2) Increase knowledge about the effects of underage drinking, vaping/use of e-cigarettes, and marijuana use among youth and families throughout NJ; 3) Implement programming that addresses misinformation provided by social media about alcohol and drug use; and 4) Initiate or expand prevention programming for populations identified by each county coalition's needs assessment. DMHAS will fund 14 of its 21 County Prevention Coalitions (not awarded the community SPF-PFS grant) to address alcohol and underage drinking, marijuana and vaping in their respective counties: Atlantic, Burlington, Camden, Cumberland, Gloucester, Mercer, Middlesex, Monmouth, Passaic, Salem, Somerset, Sussex, Union, and Warren. A change of project scope was approved by SAMHSA in February 2025 to narrow the focus of the PFS grant to the prevention of underage tobacco use by conducting intensive education for tobacco retailers.

The DMHAS-funded county coalitions began their tobacco merchant education and outreach programs in the 3rd Quarter of the PFS grant year (FFY 2025). In total, they reached 237 merchants to provide personalized contact with the tobacco and vaping retailers providing materials, information and updates to state laws, local ordinances and general public health education to these businesses and their employees who have interactions with local youth, law enforcement and county health officials. The coalitions also interacted with their local communities via health/wellness fairs, tabling events, school resource programs, family expo events, and community luncheons. Additionally, they provided tobacco, vaping and cannabis education and materials to local FQHCs and healthcare providers. In total, they directly interacted with and reached approximately 7,020 individuals at community-based events in the 3rd quarter. After participating in the social media content training at the New Jersey Prevention Network about ways to better engage with youth, the collations tallied their impact from posts, videos and reels. Over 9,000 social media impressions were recorded from the coalitions' posts on various social

media platforms such as Instagram, Facebook, and TikTok. They are to post at least once per week with varying content that comports with the PFS goals.

Strategic Prevention Framework for Prescription Drugs (SPF-Rx). In September 2016, NJ was awarded a Strategic Prevention Framework for Prescription Drugs 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 address 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 identify communities and populations needing services, education or other interventions.

The service 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 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 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, identify locales for naloxone distribution to prevent drug overdoses. These reports will also be the basis for a public awareness campaign and for training of providers and the health care community on addictions and the risks of opioid prescribing.

In 2021, DMHAS was awarded a second five-year SPF-Rx grant to continue its work with Young Athletes and the other projects described above. A major component of New Jersey's SPF Rx project focuses on decreasing the prevalence of opioid use among young athletes. A toolkit called "Tackling Opioids through Prevention for Athletes" (TOP) was developed by the New Jersey Prevention Network for use by providers. Literature suggests that when young athletes are prescribed opioid pain relievers for sports-related injuries, there is a risk of addiction and medication misuse. The 21 county coalitions that were established by DMHAS use the TOP to

provide education regarding this issue to coaches, parents, prescribers, and young athletes. In SFY 2023, 5,200 individuals were served, and in SFY 2024, 6,871 participated in the trainings.

One component of this initiative is using New Jersey PMP data to identify patterns of Benzodiazepine, Buprenorphine, Opioid, and Stimulant (Schedule II-IV) usage among New Jersey residents to help direct localized prevention strategies. A dashboard with interactive data visualizations, condenses millions of rows of data into intuitive graphs and charts which highlight change over time and points of relative contrast making it easy for viewers to analyze the data and locate specific areas of concern. Color coded heat maps for dispensation rate show how the drug usage is geographically distributed without being masked by differences in county population and can be used in conjunction with maps of cities or local age distributions to inform the distribution plan. Similarly, the combination age and gender charts pie chart magnifies differences among smaller groups that would otherwise not be visible; while more women used stimulants than men in 2023, isolating this to individuals under 18 shows that far more teenage boys used stimulants than teenage girls. The tables used in the PowerBI dashboard were sourced from NJPMP dispensation data which was cleaned and processed through SAS and Excel. Every component, the dashboard, master excel sheet, and SAS programs have all been modularly set up such that the dashboard can be readily updated each year based on new PMP data. Note that the filters need to be consistently maintained and annual population info (US Census) is released the following spring.

State Targeted Response to the Opioid Crisis (STR). In May 2017, SAMHSA awarded New Jersey \$12,995,621 annually for two years for its State Targeted Response to the Opioid Crisis project. As one component of this project, DMHAS awarded funding for prevention services programs to older adults in five counties. Awardees designed and implemented a comprehensive educational program specifically focused on providing older adults with practical information regarding non-pharmacological approaches to dealing with acute and chronic pain. The goal of the project was to decrease the overuse, misuse and abuse of prescription opioid medications within this population. An additional five programs were added through a No Cost Extension (NCE). Since this grant has ended, these services are being continued through the subsequent SOR grants that were awarded.

State Opioid Response 2018 (SOR 1). In September 2018, SAMHSA awarded State Opioid Response (SOR) funds to New Jersey for two years. With these funds, DMHAS developed an additional five Alternative Approaches to Pain Management for Older Adults programs, described above. Additionally, funds were used to purchase 3,200 locking bags that people can use to prevent unauthorized access to their medications, and 40,000 Detera drug disposal kits were purchased and distributed throughout the state by the DMHAS-funded prevention coalitions.

State Opioid Response 2020 (SOR 2). Using State Opioid Response (SOR 2) funds, the Alternative Approaches to Pain Management for Older Adults (AAPMOA) programs was further expanded, and now includes 20 of 21 NJ counties, since one county did not apply for this funding.

Program providers have implemented a comprehensive educational program specifically focused on providing older adults with practical information regarding (1) the appropriate use of non-opioid analgesic pain medication and (2) non-pharmacological approaches to dealing with acute

and chronic pain. The goal of the project is to decrease the overuse, misuse and abuse of prescription opioid medications within this population. Programs utilize current evidence-based treatment guidelines for non-pharmacological treatment modalities. The “efficacy” of the educational program on participants’ knowledge about and understanding of alternative approaches to pain management is assessed by means of a pre and post-test. Most of the providers who are delivering the AAPMOA program use the evidence-based Wellness Initiative for Senior Education (WISE) program. WISE is a wellness and prevention program serving older adults, which is designed to help them celebrate healthy aging, make healthy lifestyle choices and avoid substance abuse. It provides educational services to older adults on topics including medication management, stress management, depression, and substance misuse. Created by the New Jersey Prevention Network and implemented locally by prevention agencies across the country, WISE promotes health through education concerning high-risk behaviors in older adults. Since the program was launched in 1996, prevention programs presented by WISE facilitators have reached over 650,000 individuals.

Providing information about the risks associated with prescription pain medications is a component of these trainings. However, the primary focus is on providing information and answering questions about proven, non-pharmacological means of addressing pain. Providers do not deliver actual services, but offer information about alternative approaches and information regarding how and where to access such services as: physical therapy, chiropractic care, yoga, massage therapy, etc.

SOR funds have also been used to purchase Detera Drug Disposal kits and medication lock boxes. These materials are provided to the DMHAS-funded prevention coalitions who, in turn, distribute them throughout their communities. In late 2020, DMHAS purchased 7,500 Detera kits and 2,500 lock boxes.

SOR 2 funds were also used to purchase 8,000 Detera kits to distribute to the DMHAS prevention coalitions. DMHAS also purchased 28,400 kits for our partners at the NJ Attorney General’s Coordinator for Addiction Responses and Enforcement Strategies (“NJ CARES”), and the Division of Consumer Affairs (“DCA”). Eighty (80) hospice and long-term care facilities received drug disposal kits. The kits provide the facilities with a safe and easy way to dispose of leftover medications, preventing opioids from being diverted or misused after they are no longer needed for a patient.

State Opioid Response 2022 (SOR 3). SOR 3 funding was used to continue the four on-campus prevention/recovery programs in NJ public colleges, universities, and community colleges. Under 2015 NJ Public Law, four-year public institutions of higher education, in which at least 25% of the undergraduate students live in on-campus housing, are mandated to establish substance abuse recovery housing and support programs by fall 2019. The intent of the SOR on-campus recovery program is to expand recovery support opportunities at public institutions that have not yet developed recovery programs, as well as at those not meeting the legislative requirements.

Funding was also used to purchase additional medication lock boxes and Detera kits. These items were distributed by the Prevention Regional Coalitions to individuals who need to secure opioid

medications or deactivate such medications thereby preventing drug misuse. Detera kits were also be provided to other groups such as hospices and pharmacies.

DMHAS used funds to update its information packets that police, EMS and health care practitioners can provide to overdose victims and their families. The packets include information about treatment and recovery resources for addiction that can help individuals and their family members.

State Opioid Response 2024 (SOR 4). SOR 4 funds were distributed to DMHAS' prevention coalitions to enable them to provide education to schools and community groups on the pervasiveness of fentanyl. The Older Adult program described above continued. To date, over 19,000 older adults, caregivers, and healthcare professionals have participated in the trainings. Funds were also used to continue the Alternative Approaches to Pain Management for Older Adults program and to fund the continuation of college recovery services as described above.

Other Funding Through the SUPTRS Block Grant

SUPTRS COVID-19 Supplemental FY 2021. DMHAS was awarded approximately \$45M in COVID-19 Supplemental Block Grant funding in March 2021, which ended in March 2025. Funding was allocated to enhance prevention services. It was used to develop Prevention Hubs in each of NJ's 21 counties. The DMHAS-funded system of prevention agencies became Prevention Hubs where individuals, local government entities, community organizations, youth, families and community members can obtain information and resources, get connected to outreach events, and do brief screenings and/or be connected to needed services. The Prevention Hubs' staff were trained to be a warm line to direct people to needed prevention resources and services or other interventions or support, as needed. The 21 Prevention Hubs created a one-stop shop to: (1) promote effective planning, monitoring, and oversight of efforts to deliver substance use disorder (SUD) prevention services; (2) provide support for local entities promotion prevention, including schools, law enforcement, and community-based organizations; (3) maximize efficiency in local prevention efforts by leveraging the current infrastructure and capacity; (4) address prevention funding and support gaps expanded by COVID-19; (5) ensure prevention resources are available in all 21 counties.

DMHAS contracted with the New Jersey Prevention Network to serve as the lead agency across the state and oversee the strategic coordination of Prevention Hub services. This model allows local impacts to be strengthened with the consistent messaging and comprehensive reach to every county. The local Prevention Hub can ensure that the needs of each county it serves are addressed.

To ensure the implementation of evidence-based prevention strategies, interventions and programs, key stakeholders and organizations need a one-stop source that supports needed prevention services to build resiliency, increase protective factors and decrease risk factors related to behavioral health issues. NJ has long-established prevention agencies that serve their communities. These organizations employ expert staff knowledgeable and skilled in the use of the Strategic Prevention Framework and implementation of best practices. Many of these agencies have been de facto Prevention Hubs supporting schools, government, faith-based communities, healthcare setting, and consumers, such as youth adults while also supporting provider

organizations in the implementation of policies, practices and programs that focus on decreasing the negative impact of substance misuse through the lifespan.

The Prevention Hubs are tasked with additional activities as a result of BG supplemental funding and further incorporate evidence-based tools for screening into their programs. Some of the planned tools involve Universal ACE's (Adverse Childhood Experiences) and SBIRT screening. In addition, DMHAS makes available a program called PreVenture which is an evidence-based prevention program that uses personality interventions to promote mental health and skill development and delay youth substance use. PreVenture is designed to help at-risk youth ages 12-17 learn useful coping skills, set long term goals, and channel their personality towards achieving them. It focuses on at-risk youth and introduces motivational pathways and coping skills based on the individual's personality. PreVenture can be implemented in school/non-school and online settings. PreVenture has been shown to decrease drug use, alcohol use and likelihood of binge drinking by 50%, delay initiation and frequency of cannabis use, decrease conduct problems and decrease risks for mental health struggles, such as anxiety and depression. A link for further information about NJ's Prevention Hubs can be found at: <https://www.njpreventionhub.org>.

New Jersey is expanding web-based/mobile tools for risk messaging for adolescents and young adults and to enhance social media utilization. DMHAS provided funds to the New Jersey Prevention Network to enable them to work with the Public Good Project, which has expertise in health messaging, campaign development and effective use of social media and other technology to reach high risk youth. Messaging will be utilized by the Prevention Hubs to maximize strategic local reach.

The Strengthening Families Program (SFP) is an evidence-based curriculum the state currently utilizes that has been expanded to address the needs of communities within NJ's counties. Once families are engaged they tend to stay connected to larger supports. The connection between families and the community increases the likelihood of positive experiences that can combat ACEs (Adverse Childhood Experiences). Family programming has become an intervention point for families to engage them in services that foster resilience. Through Strengthening Families, the state makes transportation available, connects individuals to additional financial supports and health resources like COVID Vaccine centers. This program provides families with meals, support and family activities and engagement. This support directly creates better health outcomes for children by addressing Economic Stability, Education, Food and Community and Prosocial Engagement. The population of focus for this SUPTRS Supplemental-funded delivery of SFP is families that are involved with the justice system.

DMHAS also identified a need to increase recovery and prevention programs for colleges and universities in NJ. An RFP was issued in July 2022 to provide supportive, substance-free living environments and services for college students in recovery. Three colleges (Rowan University, Ocean County Community College, and Rutgers University Newark) were awarded a contract in September 2022 to provide individual and group substance abuse recovery-oriented strategies, provide assessment, academic, and relapse prevention services to students, and other appropriate services.

While DMHAS addresses marijuana prevention through its County Coalitions, NJ is strengthening the prevention of underage marijuana use and marijuana abuse with SUPTRS Supplemental resources.

DMHAS (with colleagues from Montclair State University's Center for Research and Evaluation on Education and Human Services) created a coordinated, state-wide, scientifically designed digital data collection tool (survey) for the 18- to 25-year-old population. This is a population for which the state lacks information on drug use behaviors and trends.

DMHAS provided SUPTRS Supplemental funds to the Governor's Council on Substance Use Disorder (GCSUD) for the development of a statewide Youth Leadership Program. This is a unique partnership opportunity for state government agencies to work collaboratively to service communities across New Jersey, particularly DMHAS and GCADA, the two leading providers of prevention programming and education in the state. Recipients of the Youth Leadership funding are the 21 counties in New Jersey who will then distribute the funding to the Municipal Alliances in their respective counties. The Municipal Alliances are comprised of local volunteers engaged in addressing substance use and misuse through prevention programming in their communities. In Fiscal Year 2024, there were 320 Municipal Alliances in 425 municipalities across all 21 counties. Prevention programming was planned for approximately 1,700,000 participants statewide - over 400,000 youth, 30,000 older Americans, and 1,200,000 community-wide event participants, reaching millions of New Jerseyans. The Municipal Alliance Program is an inextricable part of communities across the state, engaging all parts of the community: families who have lost loved ones, those trying to save them, educators, students, parents, seniors, coaches, athletes, clergy and communities of faith, veterans, law enforcement, chambers of commerce, county officials and community members.

The programs and services described above can be categorized according to the CSAP Prevention Strategies as such:

- Education: Strengthening Families Program
- Environmental (Policy): Coalitions and prevention agencies guide and influence the development of policies that address underage marijuana use in their communities
- Environmental (Community Norms): Public Good Project
- Information Dissemination: Large-scale public messaging provided by Prevention Hubs
- Alternatives: Substance-free recreational and/or sports activities provided by Prevention Hubs to their communities
- Problem Identification and Referral: The Prevention Hubs will utilize a screening process to determine if an individual's behavior can be modified through SUD primary prevention education activities or services.
- Community-Based Process: Prevention Hubs will promote effective planning, monitoring, and oversight of efforts to deliver substance use disorder (SUD) prevention services, and provide support for local entities promotion of prevention, including schools, law enforcement, and community-based organizations.

SUPTRS ARPA FY 2021. DMHAS was awarded approximately \$38.9 million of ARPA funding in May 2021, which is available until September 2025. It continues many of the SUPTRS Supplemental funded programs that were described in the previous section. DMHAS also

continues to work with the New Jersey Prevention Network as the lead agency across the state that oversees the strategic coordination of prevention services. New Jersey will continue web-based/mobile tools for risk messaging for adolescents and young adults and enhance social media utilization. Youth Peer leadership programs, the Prevention Warm-Line and marijuana prevention programs will continue.

Prevention activities continue to address over-the-counter medication use. Social media, such as TikTok, is fueling challenges to use these products. Social media challenges and over-the-counter medications can lead to deadly overdoses. Strengthening Families will be expanded for women in our treatment programs and expanded to other groups in need of such programming. Coalitions will provide evidence-based or evidence-informed vaping prevention programs to youth in schools or alternative locations.

Suicide Prevention. DMHAS Suicide Prevention Committee implements the Adult Suicide Prevention Plan in accordance with and guided by the 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action, published by the U.S. Department of Health and Human Service Office of the Surgeon General and National Action Alliance for Suicide Prevention. In addition, the Suicide Prevention Committee used the New Jersey Youth Suicide Prevention Plan and other States' suicide prevention plans as references. The NJ Adult Suicide Prevention Plan contains strategies and actions in addition to crisis responses for specific concerns of adult New Jersey citizens; addressing current NJ needs and activities and linking up-to-date science for prevention with practical application in the field. The plan and the action steps go beyond organizations and agencies and stress the importance of everyone's contribution to keeping all individuals in the state safe, in addition to conveying hope and recovery. Although NJ's rate of suicide has been the lowest or second lowest in the nation, DMHAS believes that every suicide is unacceptable and can potentially be prevented, especially for people under care. The plan recognizes several at-risk populations, such as individuals with mental health and substance abuse, a suicidal and/or trauma history, 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.

Individuals with SUD are at risk for suicide, which is a finding well documented in research studies. Substance use is a risk factor for both fatal and nonfatal overdoses, suicide attempts, and death by suicide. Compared with the general population, individuals with alcohol dependence and persons who use drugs have a 10–14 times greater risk of death by suicide, respectively, and approximately 22% of deaths by suicide have involved alcohol intoxication. One study found that opiates were present in 20% of suicide deaths, marijuana in 10.2%, cocaine in 4.6%, and amphetamines in 3.4%. Among the reported substances, alcohol and opioids are associated with the greatest risks of suicidal behavior.

In regard to suicide risk in persons using substances, DMHAS has placed a focus on making all SUD and co-occurring providers aware of these risks in their clients. For several years, DMHAS has supported training and technical assistance to behavioral health agencies so that they can adopt the Zero Suicide approach, which is a SAMHSA-endorsed and evidence-based model of care that has seven main components that have been shown effective in decreasing suicide deaths and

suicide attempts in a variety of systems and settings. DMHAS receives funding from the state legislature every year for its suicide prevention initiatives. The DMHAS funded training in the Zero Suicide model is offered to outpatient and residential services providers, although the majority who attend are providers of mental health or co-occurring disorder services. In response to the need for Zero Suicide training directed to SUD providers, future plans include training sessions directed to them.

DMHAS first partnered with the Education Development Center (EDC) to host three Zero Suicide Academies in the Fall of 2020. Zero Suicide is a commitment to suicide prevention in health and behavioral health care systems and is also a specific set of strategies and tools. The foundational belief of Zero Suicide is that suicide deaths for individuals under care within health and behavioral health systems are preventable. Following the three Academies, DMHAS partnered with EDC further to offer nine months of Community of Practice sessions to the participants of the academy for technical assistance and follow-up during their first year of implementation. DMHAS has expanded their partnership with EDC to offer additional academies in the fall of 2023 and in 2024. In 2025, DMHAS contracted with Rutgers Technical Assistance Center after a required procurement process and this agency provided two Zero Suicide Academies. The plan is for them to continue to do so in the near future.

DMHAS has been implementing 9-8-8, a national three-digit dialing code for the National Suicide Prevention Lifeline. DMHAS was awarded a grant to support its implementation. DMHAS partnered with the five Lifeline call centers and other key stakeholders in the state to ensure a smooth transition to the 9-8-8 system in July 2022. Since this date, calls to the new Suicide and Crisis Lifeline have increased and DMHAS has developed additional crisis services in accordance to the best practices in the SAMHSA National Guidelines for a Behavioral Health Coordinated System of Crisis Care; these include Mobile Crisis Outreach and Response Teams and crisis receiving and stabilization centers, among other crisis programs and initiatives.

Notably, the 988 crisis call line and related crisis services now address all behavioral health crises; in addition to suicide and mental health crises, these now serve those individuals with needs that involve substance use. The following services address the needs of those at suicide risk or who are experiencing other behavioral health crises: The 988 Suicide and Crisis Lifeline, the new three-digit dialing code for individuals experiencing suicidal, mental health, and/or substance use crisis. It is part of a larger crisis care continuum being developed in New Jersey known as the 988 system. This system is being set up with the guiding principle that there will always be someone to call, chat, or text; someone to respond; and somewhere to go.

NJ P.L. 2025, C.112 signed into law by Governor Murphy on July 22, 2025, requires student identification cards to have information on mental health and suicide crisis resources beginning this upcoming school year. This law applies to a public school that includes any of the grades seven through 12 and that issues student identification cards, and institutions of higher education that issue student identification cards. The new law permits the information included on the identification cards to be determined by the Commissioner of DHS, in consultation with the Commissioner of DOE and the Secretary of Higher Education. DHS Commissioner Adelman issued guidance to NJ educators on August 20, 2025, that information listed on the back of applicable student identification cards shall include: "Suicide & Crisis Lifeline Call or Text 988."

DMHAS also holds annual all-day conferences on suicide prevention that routinely provides training for all behavioral health staff, including those at addiction agencies. In 2024, the annual conference has had over eighteen hundred registrants and had sessions related to suicide and substance use, as well as on the topic of suicide and problem gambling. The annual suicide prevention conference is on September 10, 2025, which makes it the tenth year that this conference is being held.

Since 2015, DMHAS has initiated and collaboratively developed a Proclamation, signed by the Governor proclaiming September as Suicide Prevention Month (2015) or Week (2016 - 2022), and in April 2019, DMHAS started a single Suicide Prevention Unit to spearhead multiple suicide prevention initiatives in the State. The unit is in the Medical Director's office, but there is an advisory committee and staff from other offices in the Division who are also involved. Together, they plan the annual conference, Zero Suicide trainings and other projects, including those with the Rutgers University School of Public Health's Gun Violence Research Center (Rutgers-GVRC).

DMHAS has partnered with the Rutgers-GVRC to develop webinars covering a range of suicide prevention topics (e.g. firearm suicide prevention across settings). The intent was to reach broad audiences from health care providers, parents, gun owners, law enforcement, service members and veterans, and adolescents. Webinars represent a quick and scalable intervention that could reach stakeholders both within and beyond New Jersey. Two webinars in total were created, one for healthcare practitioners, and one for the general public which have been put on the DMHAS public website. In 2024, the Rutgers-GVRC has developed a freely available online map of locations across New Jersey willing to consider temporary and legal storage of personal firearms to disseminate the map broadly and to examine the experiences of participating sites in the months following the development and dissemination of the map. In 2025, the Rutgers-GVRC developed a project to train barbers and hairdressers on addressing firearm safety as a component of lethal means counseling.

DMHAS has also partnered with the NJ Academy of Family Physicians to focus on attracting the primary care community to suicide prevention training because 45% of those who died by suicide saw their primary care provider within a month of their death. As the professional association specifically for family physicians in New Jersey, NJAFP represents nearly all family physicians in New Jersey and can directly communicate with 6,500 primary care physicians and residents. This project developed six accredited podcasts to discuss suicide prevention training and resources, support, and electronic health records. The podcasts currently remain available on the NJAFP website.

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

DMHAS, in partnership with the DHS, Office of Public Relations, secured a vendor that delivered a public awareness campaign to help decrease stigma and discrimination around the use of MAT for Opioid Use Disorder (OUD). The campaign was initially launched in the Spring of 2020 and refreshed its campaign in the Spring of 2021. Various forms of messaging including TV ads, radio commercials, social media and billboards have been utilized.

Two anti-stigma public awareness campaigns were relaunched in 2025 after DMHAS secured two new vendors through a competitive bidding process. One campaign is funded by the SOR grant funds and the other is funded by SUPTRS ARPA funds.

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

Drug Free Communities Support Program. The Drug-Free Communities (DFC) Support Program is the nation's leading effort to mobilize communities to prevent and decrease substance use among youth. Created in 1997 by the Drug-Free Communities Act, administered by the White House Office of National Drug Control Policy (ONDCP), and managed through a partnership between ONDCP and CDC, the DFC program provides grants to community coalitions to strengthen the infrastructure among local partners to create and sustain a decrease in local youth substance use.

The DFC program is aimed at mobilizing community leaders to identify and respond to the drug problems unique to their community and change local community environmental conditions tied to substance use. Twenty-seven community coalitions in New Jersey receive funding to strengthen collaboration among local partners and create an infrastructure that decreases youth substance use. Additionally, extensive prevention programming and education is provided by other state agencies such as: Department of Education's Office of Student Support Services, Department of Children and Families, the Juvenile Justice Commission, Department of Health, the Division of Highway Safety, and law enforcement agencies.

Sober Truth on Preventing Underage Drinking. The purpose of Sober Truth on Preventing Underage Drinking (STOP Act) funding is to prevent and decrease alcohol use among youth and young adults ages 12-20 in communities throughout the United States. The program aims to: (1) address norms regarding alcohol use by youth, (2) decrease opportunities for underage drinking, (3) create changes in underage drinking enforcement efforts, (4) address penalties for underage use, and/or (5) decrease negative consequences associated with underage drinking (e.g., motor vehicle crashes, sexual assaults). In addition, grantees build on strategic plans that were developed under a Drug Free Communities (DFC) award utilizing the strategic prevention framework model

which aims to address underage drinking behaviors. New Jersey is home to eight STOP Act grantees.

Policy Academy. In 2014, New Jersey was one 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 misuse. 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 reach 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, 2. Utilizing existing or developing new social marketing and public information campaigns that reach 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, the Governor's Council on Substance Use Disorder's (GCSUD) Municipal Alliances, and CDC-funded Drug-Free Community coalitions in New Jersey around this issue is invaluable, and remains a major focus of their work.
- 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 persons 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. The goal of the OORP is to help these individuals find their way to recovery from an OUD.

Alcohol Strategic Plan and Policy Academy. Despite New Jersey's comprehensive array of prevention, treatment, and recovery services for alcohol use disorder (AUD), the state continues to face rising rates of unhealthy alcohol use, particularly among youth, older adults, and women. The COVID-19 pandemic exacerbated these trends, with alcohol surpassing heroin as the most reported substance in treatment admissions. Systemic challenges persist, including limited

utilization of medication-assisted treatment (MAUD), a need for wider adoption of services for alcohol use, and fragmented coordination among systems of care. These gaps are compounded by stigma, limited provider participation in trainings, and underutilized early intervention services. New Jersey seeks to break down service silos and strengthen collaboration across state agencies, healthcare providers, and communities to build capacity for a more integrated, and effective alcohol care continuum.

To address these challenges, DMHAS developed an Alcohol Policy Strategic Plan to identify populations most in need of services and determine the most effective ways to address those needs. College students, older adults, and persons being released from state and county correction facilities were identified. Additionally, increasing the use of medication to treat alcohol use disorder was identified as a priority goal.

In the fall of 2025, NJ-DMHAS was selected to participate in a Policy Academy focused on addressing alcohol use and alcohol use disorder. This initiative is a joint effort of SAMHSA's Center for Substance Abuse Prevention (CSAP) and Center for Substance Abuse Treatment (CSAT) in partnership with NASADAD to help states identify and address critical gaps to improve coordination and integration across the substance use continuum of care, spanning primary prevention, early intervention, treatment and recovery. A key goal of the Policy Academy is to have a holistic focus on improving state and local systems that address alcohol use and alcohol use disorders through integration, collaboration, and coordination across the continuum of care, including treatment with effective medications for alcohol use disorder. Participation in the Academy has enabled DMHAS to further develop its Alcohol Policy Strategic Plan.

Opioid Overdose Recovery Program. (OORP). Request for Proposals (RFP) was issued in June 2015 to develop an Opioid Overdose Recovery Program (OORP) to respond to individuals reversed from opioid overdoses and treated at hospital emergency departments as a result of the reversal. This new two-year initiative funded by DMHAS, the Governor's Council on Alcoholism and Drug Abuse (GCADA) and the Department of Children and Families (DCF) funded programs in Atlantic, Camden, Essex, Monmouth and Ocean Counties. Since then, using monies appropriated by the Governor, as well as STR and SOR funds, the program is now provided in all 21 NJ counties – and in 73 percent of hospital EDs throughout the state. The Opioid Overdose Recovery Program utilizes recovery specialists and patient navigators to engage individuals reversed from an opioid overdose to provide non-clinical assistance, recovery supports and appropriate referrals for assessment and substance use disorder treatment. The recovery specialists and patient navigators also maintain follow-up with these individuals. It is expected that, at minimum, recovery specialists will be accessible and on-call from Thursday evenings through Monday mornings. This new initiative commenced in the fall of 2015. Additional OORP RFPs were released. As of June 30, 2025, 31,814 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.

Opioid Reduction Options (ORO). Funded through SAMHSA's State Opioid Response grants and Governor Murphy's initiative to address the opioid epidemic in New Jersey, DMHAS issued an RFP to increase awareness and focus on non-opioid pain management strategies, decrease the use of opioids in Emergency Departments (EDs) and the subsequent prescribing of opioids at ED discharge. Funding was available for FFY 2019 and FFY 2020. According to a 2015 study of

opioid prescribing in a cross section of U.S. EDs, 17% of discharged patients received an opioid prescription; DMHAS sought a decrease 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, analgesia. The CERTA concept optimizes the following medication classes in place of opioids: Cox-1, 2, 3 inhibitors, *N*-methyl-D-aspartate ("NMDA") receptor antagonists, sodium channel blockers, nitrous oxide, inflammatory cytokine inhibitors and *gamma*-Aminobutyric acid ("GABA") agonists/modulators. Specific agents include NSAIDs and acetaminophen, ketamine, lidocaine, nitrous oxide, corticosteroids, benzodiazepines and gabapentin.

Three tiers were established which have different levels of expectation: Gold, Silver, and Bronze. Hospitals could apply for one of the tiers and were required to participate in a Learning Community tailored to the tier. In July 2019, DMHAS granted ORO awards to 11 hospitals, 10 Gold and 1 Silver. A new RFP was released in March 2021. Awards were made in May 2021 to four hospitals, 3 Gold and 1 Silver tier. The ORO program ended in 2023.

Secondary Prevention

Opioid Overdose Prevention Program (OOPP). 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 use disorder treatment programs, as well as those individuals engaged with local syringe access programs. Another priority is educating, training and distributing naloxone to family members, friends and loved ones who are in contact with individuals at risk for an opiate overdose.

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

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

The program provides education to individuals at risk for an opioid overdose, their families, friends and loved ones to recognize signs of an opioid overdose and includes the distribution of naloxone kits and information on how to access treatment, including Medication Assisted Treatment, which

is the best practice for someone living with an opioid use disorder. Federal funding received through STR and SOR helped to expand these trainings and distribution of kits to populations including, but not limited to, residential substance use disorder treatment agencies, schools, jails, prisons, fire departments, homeless shelters, offices of emergency management and HIV clinics. In addition to distributing naloxone, as of August 2022, the OOPPs can now also provide Fentanyl Test Strips (FTS), as an overdose protection strategy, to those who request during the trainings.

In March 2025, the agency providing trainings to the southern region of the State closed. The State is in the process to procure funding for another agency or agencies to continue trainings for this region. Currently, the State funds another provider through the Opioid Overdose Prevention Network (OOPN) which will provide trainings for this region.

Discretionary Grants

Prevent Prescription Drug/Opioid Overdose-Related Deaths (PDO). In September 2016, DMHAS was awarded a PDO grant from SAMHSA for \$1 million annually for five years to implement the Opioid Overdose Prevention Network (OOPN) initiative. DMHAS partnered with Rutgers University, Robert Wood Johnson Medical School, for the development and implementation of a comprehensive prescription drug/opioid overdose prevention program for this project which includes Naloxone training and distribution. The project reached over 3,000 individuals through training and distributed a minimum of 2,500 naloxone kits annually. The initiative served programs that served individuals including: agencies and organizations working with justice-involved populations and re-entry programs; healthcare professionals; pharmacists; syringe access programs; community health centers; individuals who underwent an overdose reversal and women's substance use disorder providers.

Our project implemented an Early Warning and Rapid Response System (EWRRS) that allows an extensive network of practitioners and community workers in a variety of healthcare settings (e.g., FQHCs, EDs, hospitals) who will be informed when their communities are affected. The alerts will also mobilize opioid overdose prevention practitioners who can provide emergency response training and distribute naloxone to at-risk individuals and their families, as well as disseminate information about addiction treatment services to the local communities that are affected. This program was in operation through August 30, 2023.

In June 2023, SAMHSA awarded a second five-year PDO grant to DMHAS which will continue the work of the OOPN. Training is provided to first responders, high need areas identified by the PDO-NJ initiative, and other groups including: agencies and organizations working with justice involved populations and re-entry programs; healthcare professionals; pharmacists; syringe access programs; community health centers; women's SUD providers; the Opioid Overdose Recovery Program that serves high risk individuals who have undergone a naloxone reversal; colleges; and outreach to the National Guard, military bases and construction trades in adopting opioid overdose response programs as part of their standard workplace safety protocols. Trainings will be provided virtually and in-person when possible, webinars and development of on-line training materials. Using a combination of in-person and virtual training, PDO-NJ will train an estimated 3,600 individuals annually, with a total of 18,000 over the five-year grant period. The OOPN program is described more fully below.

Opioid Overdose Prevention Network (OOPN).

New Jersey's first Prescription Drug Overdose project, which began in the fall of 2016 (known as the Opioid Overdose Prevention Network - OOPN) implemented an Early Warning and Rapid Response System (EWRRS) that enables an extensive network of practitioners and community workers in a variety of healthcare settings (e.g., FQHCs, EDs, hospitals) to receive information when their communities are affected by an increase in opioid overdoses. The alerts mobilize opioid overdose prevention practitioners to 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. A key aspect of the project involves extensive training using a variety of formats and development of a naloxone distribution plan specific to this initiative. In partnership with the Robert Wood Johnson School of Medicine at Rutgers University (RWJ), a minimum of 3,000 individuals annually is trained to recognize an overdose and immediately take steps to address it – including administering naloxone (the overdose reversal medication). As a component of the training, the project distributes a minimum of 2,500 naloxone kits annually. While the initiative reaches a broad spectrum of the adult (18 years or older) population in NJ, it also reaches out to programs serving individuals including: agencies and organizations working with justice-involved populations and 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.

In addition to the community-based trainings, RWJ developed a training of trainers for recovery specialists who work in DMHAS' Opioid Overdose Recovery Program (OORP) and Support Teams for Addiction Recovery (STAR). In the training, recovery specialists learn how to teach the clients they work with to respond to an overdose. The clients also receive naloxone kits as part of the training. Data for the reporting period (CY 2024) was as follows:

Community-based trainings

- 4073 kits distributed
- 4042 unique individuals trained

Trainings for Recovery Specialists

- 2326 kits distributed
- 28 unique individuals trained

Data from our OOPN program provides preliminary information on the role community-based naloxone distribution programs can play in preventing overdose deaths and indicates that lives can be saved through naloxone distribution and overdose prevention training. Few studies have described the outcomes of a naloxone distribution program and little is known about the circumstances in which naloxone kits are used and the behavior of those administering the naloxone. Frederiks, K., Everett, M., Gilmore Powell, K., et al. (*Reported outcomes from a community naloxone training and distribution program*, Drug and Alcohol Dependence Reports 15, 2025) collected data on naloxone kits that were reported as used during an opioid overdose, between January 2018 and June 2022. A total of 15,953 people attended 1,667 naloxone trainings and 16,429 kits were distributed. Report information was received for 191 kits. Naloxone was administered by police (37%), strangers (26%), family members (14%), friends (6%), or a staff

member in a social service or clinical setting (12%) or an unknown individual (5%). Almost all who overdosed (90%) were revived. This result of 90% success rate is reassuring in the current opioid environment, with stronger formulations such as fentanyl having become more available, and concerns having been raised about the efficacy of current naloxone dosing for opioid overdose reversal.

Naloxone Saturation Policy Academy. SAMHSA, in collaboration with the Association of State and Territorial Health Officials (ASTHO) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD), sponsored a 2024 Naloxone Saturation Policy Academy which was open to 10 states. DMHAS was a successful applicant and participated in the academy with a state team of six attending the in-person meeting in April.

It allowed state teams the opportunity to continue to build on evidence-based and innovative strategies to expand access to naloxone and other opioid overdose reversal medications across their communities and high-risk populations. The agenda included successful state models and evidence-based and innovative strategies to expand access to naloxone and other opioid overdose reversal medications across settings and high-risk populations. In addition, the agenda focused on topics most requested by states, such as funding considerations to reach populations in need, using data to inform saturation efforts, and partnerships across governmental agencies and non-governmental organizations.

DHS Naloxone Direct Program. Naloxone Direct (formerly called Naloxone Distribution Program) is a DHS naloxone distribution initiative that allows local government agencies, first responders, community service providers and other eligible entities to make requests for naloxone through an online portal. The purpose of the program is to provide naloxone to first responders and other eligible agencies for the purposes of: general distribution in the community, emergency administration for a suspected opioid overdose, and to make “leave behind” naloxone available for distribution by first responders to individuals post-overdose. Registered agencies are able to log into the portal and request naloxone 4mg nasal spray by the case (each case contains 12 two-dose cartons). Approved naloxone requests received through the portal are sent to the State’s approved vendor, who then ships the medicine directly to the agency. Since its inception in June 2022, the Naloxone Direct Program has distributed over 513,000 cartons of naloxone statewide.

Current eligible agencies include: law enforcement, EMS, Fire, county correctional facilities, local health departments, prevention agencies, libraries, shelters, re-entry agencies, institutes of higher education, county prosecutor's offices, family support services, mobile outreach vehicles, mental health agencies, K-12 schools, food banks, and substance use disorder treatment and recovery support agencies.

DHS Naloxone 365 Program. Naloxone 365 is a DHS naloxone distribution initiative for individuals in the community. Launched in January 2023, DHS partnered with its Medicaid division and the NJ Board of Pharmacy to develop and implement this unique program. Individuals 14 years or older may obtain naloxone anonymously and at no-cost to them at participating pharmacies across New Jersey. Anonymity, easy access, and free naloxone are the three cornerstones of the Naloxone 365 program. Individuals are not required to present a prescription

for naloxone, nor are they asked to provide identification, personal information, or their insurance. They can simply walk into a participating pharmacy and ask the pharmacist for naloxone and they will receive a carton of naloxone 4mg nasal spray (2 doses per carton) for free. Pharmacies must complete the NJ Board of Pharmacy's Naloxone Pilot Agreement to participate in the program. Once signed up, participating pharmacies would procure naloxone through their normal network of wholesalers. After dispensing naloxone to an individual, pharmacies bill for reimbursement using the NJMMIS/Medicaid billing code by following the instructions in the pilot program agreement. Pharmacies are reimbursed for naloxone at the current Medicaid rate. This program is funded using federal grant dollars. Since its launch in January 2023, the Naloxone 365 program has distributed over 138,000 cartons of naloxone statewide. To date, there are 665 pharmacies participating in the program. Individuals can locate participating pharmacies and pertinent information on naloxone by visiting www.StopOverdoses.nj.gov.

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 2024, there were 241 admissions for Early Intervention services. This service is most commonly delivered to clients referred from DMHAS' Driving Under the Influence (DUI) program.

Early Intervention Support Services (EISS). Early Intervention Support Services (EISS) are community-based treatment alternatives for adults with acute psychiatric symptoms, as well as individuals who have co-occurring conditions. It is a walk-in service that operates similar to an urgent care center for individuals who are experiencing a mental health crisis that does not require emergency room intervention or treatment. There is one EISS in each of New Jersey's 21 counties. New Jersey's EISS programs function as psychiatric urgent care clinics that offer adults access to crisis intervention services without having to rely on local hospital emergency departments. EISS programs provide rapid access to short-term, recovery oriented, crisis intervention services. Services include assess with mental illness. EISS providers used funding to hire co-occurring peer specialists for the EISS programs for activities including peer mentoring, coaching, resource connecting, group facilitation, and organizing recovery-oriented activities. Hiring of a Licensed Clinical Alcohol and Drug Counselor (LCADC) or Certified Alcohol and Drug Counselor (CADC) with these funds was permissible for programs without one under contract. The program was launched on January 1st, 2024. Twenty proposals were submitted and approved by county EISS providers, leading to allotment of a total \$3,574,195 to the SUD Service Enhancements. By the end of March 2025, 19 counties hired at least one SUD Direct Care staff member. In all, 2,207 assessments for prospective participants were completed, which resulted in 2,107 total unique SUD admissions to the program. A total of 5,590 hours of services were provided. The most common services provided were 3,409 case management sessions, 1,790 peer mentoring sessions, 398 ASAM LOC assessments, 255 individual therapy sessions, and 198 group facilitation sessions.

Intoxicated Driving Program (IDP) The New Jersey Intoxicated Driving Program (IDP) is responsible for the administration of post-conviction interventions for individuals convicted of alcohol or drug-related driving under the influence (DUI) offenses. Through a partnership between

the Department of Human Services (DHS), Administrative Office of the Courts (AOC), and the New Jersey Motor Vehicle Commission (NJMVC), the IDP (1) administers the state's post-conviction DUI offenses system, (2) approves and coordinates a network of county-based and regional Intoxicated Driving Resource Centers (IDRCs) that detain, educate, and screen consumers to determine the need for additional addictions treatment interventions, (3) recommends appropriate license action (suspensions and/or restorations) to the Motor Vehicle Commission, and (4) manages various other issues regarding documentation, general information and response to public inquiry.

Screening, Brief Intervention and Referral to Treatment (SBIRT). SBIRT was initially implemented by DMHAS in 2013 at the Henry J. Austin Health Center (HJAHC), a federally qualified health center (FQHC) with several locations throughout Trenton. HJAHC then expanded services to two partner emergency departments (EDs) in 2014. Services were further expanded to five additional NJ counties in 2016 through partnerships with Rutgers Robert Wood Johnson Medical Group and Rowan School of Osteopathic Medicine, Department of Family Medicine. SBIRT was delivered in broad healthcare settings including primary care clinics, federally qualified health centers, emergency departments, dental clinics, and a student wellness center. The project was in operation between 2013-2017 and a total of 55,990 unique individuals were pre-screened. SBIRT interventions were provided for more than 1,750 of these individuals.

In November 2021, a Memorandum of Agreement with the Rowan University, School of Osteopathic Medicine (SOM) was developed for Screening, Brief Intervention and Referral to Treatment (SBIRT) for persons receiving services at their internal medicine, family care, OB/GYN clinics, and at the Rowan University Student Health Center. Utilizing national best-practice standards for substance use screening, Rowan SOM has developed and implemented a fully sustainable, integrated SBIRT model as part of routine medical care. Additionally, Rowan SOM implemented annual, universal screening protocol, and office-based risk interventions, as part of patient intake services in all OB/GYN clinical settings. Initial funding was provided by COVID Supplemental and continued with ARPA. To date the program has screened over 60,000 unique individuals. Approximately 5 percent of persons pre-screened were using substances at dangerous or unhealthy rates.

NJ Connect for Recovery Call Line. The NJ Connect for Recovery (NJCR) Call Line was established by the Mental Health Association in New Jersey to support families and friends who are dealing with substance use disorders of their loved ones. The NJCR staff of family peer specialists and Certified Alcohol and Drug Counselors provide peer support, education, information, referral to community recovery support services, and advocacy to family members. This is a safe, confidential, and nonjudgmental service whose goal is to engage families in long term recovery supports for themselves. Services are available at no cost to the caller.

NJCR is part of the REACHNJ/IME network of support making and receiving direct warm transfers of calls, creating a seamless system to engage individuals in treatment and support families. NJCR additionally provides two-way text and messaging support to families that include wellness information and referrals. The NJCR Call Line operates seven days a week, 8am to 10pm at 855-652-3737, operates a website: www.njconnectforrecovery.org and a Facebook page provide access to services and family support information and resources.

NJCR also provides consultation and training to SUD and Co-Occurring Family Support groups across NJ. NJCR services include training in group facilitation, community recovery services and accessing treatment. Utilizing the Community Reinforcement and Family Training (CRAFT) and other model of family support, NJCR operates one virtual SUD Family Group meetings that provide access to local family counseling and support resources. Both are offered statewide on a weekly basis. In addition, NJCR offers education related to addiction, family strategies and the CRAFT model. NJCR is committed to collaborate and promote engagement with Regional Family Support Centers, Recovery Centers, ATLAS, and Intensive Family Support Services, as appropriate. The program maintains regular communication with its partner and actively seeks to identify and engage with families and other family support services and recovery services.

CY 2024 Data:

- Calls Received: 3137
- Calls from IME/ReachNJ (warm handoffs): 545
- NJCR Family Support Meetings: 39
- NJCR Family Support Participants: 674

ReachNJ Hotline. In February of 2017, Governor Chris Christie announced ReachNJ, the Addiction Helpline. The ReachNJ was continued through 2018 and was updated in 2019. ReachNJ provides screening, coordinated referrals, and care coordination. Reach NJ is available to all NJ residents including those with private insurance, those in need of financial assistance, children and young adults. Through this process, ReachNJ facilitates referrals to the agency most appropriate to meet the caller's needs.

NJ has embarked on a marketing campaign to increase awareness of the ReachNJ services. Recent data has demonstrated the effectiveness of the campaign. Some weeks NJ has seen increases in call volume of up to 400%.

ReachNJ has become a partner with the NJ DOH and Attorney General's Office to respond to disruptions in services when a prescribing physician's office or the physician's prescribing privileges are interrupted by the DEA or FBI. Patients are directed to call ReachNJ to find withdrawal management and other services. ReachNJ also refers callers to Recovery Support Services such a peer run Recovery Centers, Self Help, and Family Support Services.

In calendar year 2024 Reach NJ took approximately 16,970 calls from the public. This included calls from individuals seeking help to address their SUD, family and friends, providers with questions, and case management for individuals to assist them to manage their services and address obstacles to care. Reach made approximately 750 referrals that year.

988 Suicide and Crisis Lifeline. 988, the new three-digit dialing code for individuals experiencing suicidal, mental health, and/or substance use crisis, was established nationwide in July 2022. It is part of a larger crisis care continuum being developed in New Jersey known as the 988 system. This system is being set up with the guiding principle that there will always be someone to call, chat, or text; someone to respond; and a safe place to go.

Individuals with SUD are at risk for suicide, which is a finding well documented in research studies. Substance use is a risk factor for both fatal and nonfatal overdoses, suicide attempts, and death by suicide. Compared with the general population, individuals with alcohol dependence and persons who use drugs have a 10–14 times greater risk of death by suicide, respectively, and approximately 22% of deaths by suicide have involved alcohol intoxication. One study found that opiates were present in 20% of suicide deaths, marijuana in 10.2%, cocaine in 4.6%, and amphetamines in 3.4%. Among the reported substances, alcohol and opioids are associated with the greatest risks of suicidal behavior.

Data for CY 2024 indicated that a total of 90,692 contacts were made to the 988 call centers, of which 73,936 contacts were answered, a response rate of 81.5%. Data is tracked on referrals made and clients' primary presenting concerns for contacting 988. Of SUD-related referrals, 1,592 were recommended for ReachNJ or SUD treatment and 134 clients were recommended to contact their current SUD provider. 3,548 participants reported substance abuse / addiction was their primary concern. Over the year, 1,302 contactors identified as being in active substance use crises.

Funding was allocated from the SUPTRS COVID-19 Supplemental grant for implementation of the 988 Lifeline. Individuals with an SUD are susceptible to suicide and suicide attempts. Suicide is a leading cause of death among those that misuse substances (SAMHSA 2008). Deaths due to alcohol, drugs, and suicide have been on the rise for over the last two decades, doubling from 104,379 deaths in 2011 to 209,225 deaths in 2021 (Trust for America's Health 2023).

New Jersey originally had five (5) crisis call centers providing services for the 988 Suicide and Crisis Lifeline. These centers received certification by Vibrant Emotional Health (Vibrant) for meeting the minimum clinical, operational and performance standards and together they provide statewide coverage 24 hours a day, every day of the year.

In preparation for the transition to 988, NJ DMHAS was awarded approximately \$2.5 million from the SAMHSA 988 Capacity Building Grant to support Lifeline centers for the anticipated increase in call, chat and text volume. As of September 2022, following the State's procurement process, funding from a combination of federal grants including the SAMHSA 988 Capacity Building Grant, Mental Health/Substance Use Block Grants and American Rescue Plan Act (ARPA), totaling \$3.7 million was awarded to the five (5) NJ 988 Lifeline centers.

In December 2022, NJ DMHAS was awarded an additional \$1 million through the SAMHSA 988 Capacity Building Supplemental Grant. Of this award, approximately \$340,000 was awarded to four (4) of the five (5) 988 Lifeline centers in New Jersey. One center declined additional funding.

An additional \$12.8 million was allocated in State Fiscal Year (SFY) funds toward the expansion of the 988 Lifeline network to handle the increased volume of 988 calls, chats and texts. From these funds Caredon Behavioral Health (Caredon) was awarded a contract to act as the Managing Entity (ME) for the New Jersey 988 Suicide and Crisis Lifeline system. Among the ME's responsibilities are to collect and report 988 Lifeline center data, establish and maintain a comprehensive resource and referral database, and to dispatch Mobile Crisis Outreach Teams (MCORTs).

NJ DMHAS prioritized the spending of \$10 million in state appropriations to enhance NJ 988 call, chat and text services. Using state appropriations, an RFP to award \$10 million in State funds was published in March 2024 with the goal of expanding 988 Lifeline center capacity sufficiently to answer 90% of state-based calls, chats and texts. In September 2024, approximately \$7 million from this State-funding opportunity was awarded to two (2) of the five (5) original 988 Lifeline centers. As a result, one (1) of the five (5) original centers decided to end their 988 Lifeline services on July 31, 2024. The other two (2) centers that did not receive awards remained committed to providing 988 Lifeline services but struggled to identify replacement funds to maintain their operations. NJ DMHAS, using a portion of SAMHSA grant funds, was able to provide contract extensions to these two (2) centers to continue these necessary services at their current levels.

In March 2025, with the remaining state funding and approximately \$1.3 million from the SAMHSA Improvement Grant, NJ DMHAS published a Request for Letters of Interest (RLI) to provide ongoing funding to these two (2) centers for the purposes of not only maintaining their current level of operations but expanding their services to contribute towards a 90% in-state answer rate. Final awards are anticipated June 2025.

The goal is to reach a minimum of 90% in-state answer rate with no more than 10% of calls being routed to the national backup system. Comparing data from CY 2023 to CY 2024, NJ saw a 36% increase in call volume while answering 36% more calls. Looking at Vibrant data from SFY 2024, NJ had a 78% in-state answer rate. In the first eight (8) months of SFY 2025, NJ increased its in-state answer rate to 82%. NJ 988 Lifeline centers continue to recruit and onboard staff to expand the capacity for responding to calls, chats and texts. Increased funding based on demand and the identification of additional ongoing funding streams are vital to reaching and maintaining this goal.

2NDFLOOR. The Department of Children and Families (DCF) funds a program known as 2NDFLOOR. It is a confidential and anonymous youth helpline. In New Jersey, youth face various types of addiction that can impact their lives, from substance use disorders involving alcohol, marijuana, and prescription medications to behavioral addictions like gaming or social media. These addictions can affect mental health, relationships, and academic performance. It's crucial for young people to recognize the signs of addiction and seek help when needed. Resources are available throughout the state, including counseling, support groups, and educational programs, to empower youth to make healthier choices and overcome challenges.

Mobile Crisis Outreach Response Teams (MCORTs). Mobile Crisis Outreach Response Teams (MCORTs) have been established as the "Someone to Respond" for the NJ 988 system. Results from the 2022 National Survey on Drug Use and Health (NSDUH), found that one in four U.S. adults has a diagnosable mental, behavioral, or emotional disorder. Of these individuals, one in twelve also has a substance use disorder (SUD).

The state budget includes \$16 million for statewide MCORTs. These teams are designed to respond 24 hours a day, every day of the year to non-life-threatening mental health, substance use or suicidal crises in the community. MCORTs are comprised of a two-person unit in the field under remote supervision by a third professional from a centralized location. The professionals include trained peer support specialists, bachelor's level staff with related educational and professional experience (in the field), and master's level supervisors providing clinical consultation.

MCORTs support individuals 18 years of age or older by de-escalating crises, providing linkage to ongoing community services, and follow-up support. MCORTs collaborate with family members or loved ones to assist and support the individual in crisis when appropriate.

The goals of the Mobile Crisis Outreach Response Team program are:

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

MCORTs are dispatched by the NJ 988 Managing Entity, Carelon, after a 988 Lifeline Center determines a community-based response, without emergency responders, is necessary and appropriate. MCORT is a voluntary service and the individual must provide consent prior to dispatch. For the MCORT program, the state has been divided into nine (9) Regions based on geography and population. This information was also used to determine the minimum number of teams to operate in each Region. One of the goals of the MCORT program is to provide an in-person response within one-hour of the initial dispatch.

In October 2023, NJ DMHAS published an RFP to award approximately \$16 million in state funds to up to nine (9) agencies establish a total of 62 MCORTs across the 21 NJ counties, based on the regional system identified above. Through this procurement process, four agencies were awarded contracts to operate MCORTs in eight (8) of the nine (9) regions while Region 9 went unawarded. In May 2024, NJ DMHAS posted an additional RFP to establish an MCORT program in Region 9. The successful bidder was awarded a contract in September 2024.

On March 3, 2025, MCORT services were launched statewide operating weekdays from 7am to 3pm. On August 11, 2025, MCORT services expanded to full 24 hours a day, every day of the year availability. From March 3rd through July 31st, MCORT completed 247 dispatches. After implementing tracking of clients' primary consenting concerns on July 7th, through July 31st, MCORT data indicates 2 SUD clients were served since the start of the program.

In December 2024, DMHAS received approval of its Medicaid State Plan Amendment (SPA) requesting for MCORT to be Medicaid-supported under Section 1947 of the U.S. Social Security Act. The SPA will provide an enhanced match for 3 years, then move to a standard 50% reimbursement through the federal medical assistance percentage (FMAP) for MCORT services.

Crisis Receiving and Stabilization Centers (CRSCs). DMHAS has made awards to five provider agencies to develop crisis receiving stabilization centers (CRSCs) which will advance the development of the crisis continuum in NJ based on the National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit with utilizing funding from the mental health block grant 5% set aside, Covid Supplemental funding from the MHBG and SUPTRS grants and ARPA funding from the MHBG and SUPTRS grants. This program will provide services to individuals 18 years of age and older in need of immediate crisis intervention and stabilization for a behavioral health crisis. CRSC offers a no-wrong-door access to crisis stabilization, operating much like a hospital emergency department (ED) that accepts all walk-ins, law enforcement drop-offs, and fire

department drop offs. The individuals served in the program will receive community-based treatment and supportive services 24 hours a day every day of the year, with the goal of mitigating the need to use the ED to access community-based services and preventing unnecessary or inappropriate hospitalization and provide short-term (less than 24 hour) community-based services to individuals experiencing a suicidal, mental health or substance use crisis. Individuals will be available to walk-in for immediate crisis response services. The objective is to develop an appropriate alternative to the use of local hospital emergency services and in-patient psychiatric hospitalization, by providing crisis services and placement support for those in need of permanent housing. The goal of these programs is to decrease the utilization of local hospital emergency services, designated screening centers, and in-patient psychiatric hospitalization while maintaining crisis stabilization treatment. The program will also result in cost savings through the decrease in avoidable ED visits, inpatient admissions, police engagement, and 911 calls. These facilities include access to trained staff who can provide assessment, crisis stabilization, intensive supports, engagement, psychoeducation, identification of strengths, collaborative problem solving, and individualized crisis planning. Services will be offered in a safe, clean, environment conducive to the recovery process. Medication management for mental illness-related symptoms and substance use disorder, administration, and education will also be offered. Medication-Assisted Treatment and psychotropic medications will also be available at the CRSCs. Clinical staff in the program will strive to stabilize individuals and address mental health needs. The program will offer continuity of care promoting continued stability and ensuring linkages are arranged that meet the needs of the individual.

Shatterproof/Atlas. NJ had partnered with Shatterproof which is a national nonprofit organization dedicated to reversing the addiction crisis in the United States. The ATLAS Treatment Locator in NJ complements the NJ Treatment Directory and the NJREACH call center line. It is a tool that the public can use to determine which treatment facility is right for them or their loved one. It identifies addiction treatment providers' use of evidence-based best practices and publicly displays this information to support those in need and their loved ones in navigating to appropriate, quality care. Individuals can search for and compare treatment options using criteria that are important to them – such as location, particular services offered, and insurance accepted. Atlas is currently available in 14 states which includes New Jersey. It was funded for its first year in New Jersey by Horizon, and then the SUPTRS. Currently, NJ has issued a Request for Quotations (RFQ) which will use State funds for a vendor who can continue to provide a treatment locator that will allow users to compare providers based on measures and services important to them.

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. DMHAS has as contract that 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, individuals with criminal convictions, 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.

To screen for gambling problems, the Brief Biosocial Gambling Screen (BBGS) has been incorporated into DMHAS' administrative data collection system (NJSAMS). Data for CY 2024 indicated that 810 individuals, or 1%, of treatment admissions scored positive on one of the three BBGS items, indicating potential gambling related problems and the need for additional evaluation.

Conduct Disorder. Through the fall of 2021, DMHAS collaborated with University Behavioral Health Care (UBHC) at Rutgers University who implemented a substance abuse prevention study/intervention for children age 8-11 who display behaviors consistent with or meet diagnostic criteria for one of the diagnoses included in the definition of Conduct Disorders. Conduct disorders in youth are a significant predictor of the development of substance use disorders in adolescence and adulthood. DMHAS recognizes the need to identify, create and deliver innovative, quality outpatient services to those children at increased risk for the development of substance use disorders with the hope that these interventions will forestall or prevent their development. The project included an intensive clinical component in combination with the 14-week Strengthening Families Program. The study identified factors that were associated with the development of conduct disorders within the study population and suggested approaches and interventions that can minimize the likelihood of a young person developing a conduct disorder.

Overdose Prevention. The New Jersey legislature enacted the Overdose Prevention Act (P.L. 2021 c.152) with the specific purpose of ensuring that access to opioid antidotes be made as easily accessible and as widely available as possible, such that they are readily available at all times to administer when people are experiencing a suspected opioid overdose. In response to the legislation, the Department of Human Services, in partnership with other organizations, operationalized the legislation with the start-up of two initiatives, Naloxone Direct and Naloxone 365. Naloxone Direct is a naloxone distribution initiative, created in 2022, that allows local government agencies, first responders and other eligible entities to place orders for naloxone through an online portal. Naloxone 365 is a DHS naloxone distribution initiative for individuals in the community. Launched in January 2023, DHS partnered with the NJ Board of Pharmacy and the DHS' Division of Medical Assistance and Health Services (Medicaid) to develop and implement this unique program. Individuals 14 years or older may obtain naloxone at no-cost to them at participating pharmacies in NJ.

In January 2024, Governor Murphy signed into law bill S3957, which expanded exemptions from drug paraphernalia laws to also exempt certain supplies, including decriminalizing all test strips, including fentanyl test strips, xylazine test strips, and other drug-checking equipment. DMHAS uses federal and state funds to allow the purchase and distribution of testing strips at some contracted initiatives, including, but not limited to its Opioid Overdose Prevention Program (OOPP) and County Innovation Grants.

In addition to its widespread naloxone distribution efforts, the Division has made available a variety of supplies such as substance test kits, including fentanyl test strips and xylazine test strips, medication lock boxes and medication disposal kits. It also provides overdose reversal education and training services.

Currently, DMHAS is working on a procurement process to fund an agency to provide overdose prevention education, training, and supplies to licensed SUD and MH treatment agencies. The goal of the initiative is planned to decrease the risks of substance use disorders (SUDs) including fatal overdoses, drug-related infectious diseases, and skin and soft tissue infections. The initiative hopes to address the unmet need of people who use drugs by integrating access to both education and overdose prevention supplies in licensed treatment facilities, as well as promote safer drug use practices and access to life-saving care.

In January 2025, DMHAS hired a Technical Advisor develop a strategic plan to implement overdose prevention practices within its DMHAS operations. The primary responsibility of this new position is to inform the development of a comprehensive strategic plan designed to enhance the quality of care and improve access for those in need. Key to this role is facilitating multi-agency collaboration, involving critically assessing current operational processes, identifying obstacles to care, and examining existing funding mechanisms. A significant aspect of this role is identifying and integrating overdose prevention strategies into the plan, alongside evaluating and addressing workforce development needs.

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 on July 1, 2015, the IME has coordinated the addiction services for individuals, ensuring that they are delivered at the appropriate level for the applicable time required. Clients can either call the IME directly to be screened and receive a warm handoff to a provider, or they can go to/call a provider directly to be screened and continue services. If callers to the IME are amenable, the IME completes a full screen, both clinical and fiscal, and uses this information to make a referral to an SUD treatment agency with the funding and capacity to meet the caller's needs. The IME holds Affiliation Agreements with all of SUD treatment providers who receive state funding, federal funding and/or Medicaid. These agreements allow for coordination between the provider and the IME to increase caller engagement in care. This has allowed NJ to manage its resources across the continuum of care. The IME care coordination center's phone number is publicized as the addiction services hotline. The IME is publicized as ReachNJ in an on-going media campaign.

In 2020, New Jersey launched a real time bed management system in the NJSAMS. That system allows the IME to more accurately determine capacity and referrals for residential providers. That real time system also became available to the general public through the NJSAMS directory in June 2021.

The IME also offers 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.

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 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. All providers are required to be able to provide co-occurring services. Services provided at each level of care will meet or exceed current New Jersey licensure standards.

Outpatient. New Jersey's system continues to be based on the ASAM 3rd Addition levels of care and criteria. There is a Team at DMHAS who are actively reviewing the changes that will be needed to regulations, billing, and IT systems to become fully consistent with ASAM 4th Edition. Services provided at each level of care will meet or exceed current New Jersey licensure standards. Currently, New Jersey's level of care for outpatient treatment services is comprised of six levels. These are subject to change when NJ determines the changes needed to update the system to ASAM 4th addition

- 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.

The following is a brief description of the various substance use disorder treatment initiatives.

Substance Use Disorder Fee for Service (SUD FFS)

Through an open competitive bid, a Fiscal Agent Billing system contract was awarded to the Computer Sciences Corporation (CSC), now Gainwell Technologies in 2010. The contract was rebid in December 2024, and a contract was awarded to the incumbent, Gainwell Technologies, effective April 2025, to continue to provide services to the SSA's Substance Use Disorder (SUD) Fee for Service (FFS) Network to act as a Fiscal Agent to manage Authorization Authority for multiple separate Funding Sources (FS), create programming of benefit packages for SUD treatment and Enhancement Services, accept transmission of Provider Agency credentialing data, process claims, make payments, issue 1099s to network Provider Agencies, track service utilization Client data, and produce reports that will serve the DMHAS SUD FFS Initiatives network. The web-based system, nj-das.net, went live July 1, 2010 and continues today as the billing system for all of the SSA's SUD FFS Initiatives.

1. Driving Under the Influence Initiative (DUII);
2. Interim Services Initiative (ISI);
3. Medication-Assisted Treatment Initiative (MATI);
4. Mutual Agreement Program with State Parole Board (MAP/SPB);
5. New Jersey Statewide Initiative (NJSI) – Partially SUPTRS funded;
6. State Hospital Addictions Recovery and Education (SHARE);
7. South Jersey Initiative (SJI); and
8. Substance Abuse Prevention and Treatment Initiative (SAPTI).

Each Funding Initiative has a separate budget or Authorization Authority for the term of one State Fiscal Year (SFY) (July 1 – June 30). The total amount of funding available to support all these Initiatives was \$48,709,183 in SFY 2023, \$52,980,981 in SFY 2024, and \$66,420,400 in SFY 2025. The funding from SUPTRS to support the NJSI and SAPTI was \$20,296,609 in SFY 2023, \$30,735,807 in SFY 2024, and \$33,860,000 in SFY 2025. The amount of funding may vary from year to year based on available State, federal, and other resources. Funding amounts may also be adjusted within a given SFY based on available resources as informed by the Division's Fiscal Office.

The number of clients billed in the DMHAS SUD FFS initiatives for the past three fiscal years are as follows:

- 10,096 clients billed in SUD FFS in SFY 2023
- 12,547 clients billed in SUD FFS in SFY 2024
- 12,864 clients billed in SUD FFS in SFY 2025

The DMHAS FFS Network Initiatives claim volume for the same period is as follows:

- SFY 2023 – 556,054 with 8.56% denied.
- SFY 2024 – 651,134 with 7.45% denied.
- SFY 2025 – 701,976 with 6.8% denied.

* To ensure a predictable cash flow for providers, payment methodology transitioned from FFS to contract payments based on pre-COVID volume. Providers had to attest to keeping doors open

and continuing to take new admissions in order to be eligible for this payment methodology. In SFY 2022, payment methodology returned to FFS reimbursement for services provided.

Individuals eligible to access care through the SUD FFS Initiatives receive treatment either through a referral from the Interim Managing Entity (IME), an Initiative referral source, or directly at a licensed SUD treatment Provider Agency. Eligibility for funding through the SUD FFS Initiatives is based on clinical determination, program criteria, and income eligibility. An authorization is approval to access funds for reimbursement of Assessments, treatment, and Services rendered to an eligible individual. It is generated in NJSAMS prior to Services being rendered for an individual's anticipated Service needs based upon the treatment needs in the ASAM Levels of Care. Once the Authorization is generated in NJSAMS, the System automatically encumbers the funds required for each Service in the Authorization in the appropriate Funding Source or Initiative. A request for Authorization is transmitted by the Provider Agency to the IME through NJSAMS for IME-Managed Initiatives after NJSAMS determines the individual is financially and programmatically eligible and the Provider Site is approved for the requested Funding Source or Initiative. If conditions are met in NJSAMS, the IME will approve the Authorization request for the specific Client at a specific Provider Agency Site.

Providers then submit their claims through the Gainwell's nj-das.net system for reimbursement. Detailed service data is inputted which includes the CPT codes. Gainwell Technologies and the SSA have developed an automated interface with NJSAMS to link services data reported in NJSAMS which correspond to the claim for payment. All the billing data tables, approximately 124, are transferred to NJSAMS on a nightly basis to the SSA's server. This allows the SSA capability to analyze detailed encounter data. This information is easily linked to NJSAMS data so service utilization patterns can be analyzed by client characteristics and levels of care.

A. Federally Funded SUD FFS Treatment

As noted above, SUPTRS funding was used to support clients in the NJSI and SAPTI initiatives, but only for non-profit agencies. For-profit agency clients were funded with state resources. The funding from SUPTRS to support the NJSI and SAPTI was \$20,296,609 in SFY 2023, \$30,735,807 in SFY 2024, and \$33,860,000 in SFY 2025. The number of clients served in SFY 2025 that were funded by SUPTRS in these two initiatives were 5,482 (1,679 in SAPTI and 3,803 in NJSI). In addition, an additional \$9M was added to the SUD FFS in FY 2025 from the ARPA Supplemental grant. These two initiatives are further described below.

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

monitoring, urine drug screens, as well as an enhancement for Buprenorphine and Vivitrol, and recovery supports.

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

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

Prior to this initiative, agencies enrolled in the Block Grant initiatives were required to provide this service. In 2019 NJ DMHAS added language to Fee for Service (FFS) Network Annex A's to ensure all FFS funded treatment agencies provide Interim Services as an engagement service at all levels of care to ensure priority Pregnant and Parenting Women (PPW) consumers awaiting admission to their assessed level of care anywhere in the state could receive interim services within 48 hours at facilities closer to home. Interim services for PPW consumers are designed to decrease the adverse health effects of substance use, promote individual health, and decrease the risk of transmitting disease to sexual partners and their infants by providing individualized education, case management, referrals and MAT if needed, while awaiting admission. Statewide technical assistance on interim services was provided to all contracted providers.

The SOR grant currently funds this initiative. Individuals in regular ISI receive psychoeducation while they are awaiting admission to their assessed level of care. Individuals served in pre-admission ISI receive care management services to address obstacles to care including but not limited to housing, employment support, transportation, childcare, other recovery support services. For the period of September 30, 2024 to March 31, 2025, 112 individuals were admitted to preadmission ISI and secured a care management assessment. From those individuals, 20 identified that opioids were an issue via the Immediate Needs Profile (INP) and 8 individuals identified stimulants as an issue for them.

B. Non-Federally Funded SUD FFS Treatment

Mutual Agreement Program. The DHS/DMHAS oversees the Mutual Agreement Program (MAP), a Substance Use Treatment Project for individuals on parole implemented through Memoranda of Agreements between the DHS-DMHAS and the New Jersey State Parole Board (NJSPB). This funding is a combination of Medicaid and direct appropriations from DMHAS and funds transferred from NJSPB. These funds support a similar FFS network which offers the full continuum of care including long term and short-term residential care, halfway house, partial care,

detoxification, outpatient and intensive outpatient treatment, co-occurring services, psychotropic medication reimbursement, and MAT. With the advent of Medicaid reimbursement for treatment services and medication, the use of MAT for individuals on parole has expanded. It should be noted that MAT is offered at all NJ State Prisons.

South Jersey Initiative. This state funded fee-for-service initiative serves young adults (ages 18-24) from eight counties (Ocean, Atlantic, Burlington, Camden, Gloucester, Cape May, Salem and Cumberland). SFY 2023, the SJI eligibility criteria was expanded to include young adults ages 25 to 30 years old. This eligibility criteria change provides the opportunity to reach more young adults over the age of 24, and those who age out from their parents' insurance coverage who are in need of substance use disorder treatment (SUD). The SJI provides a continuum of care that includes methadone maintenance, detoxification, residential, halfway house, and outpatient treatment services.

Using Opioid Settlement funds, The Department of Children and Families will expand the South Jersey Initiative statewide. This initiative provides a "no wrong door" approach for youth aged 13 through 17 years who seek access to substance use treatment and continuum of care services. Utilizing a Fee for Service (FFS) model, the expansion will make outpatient, intensive outpatient, and short-term residential treatment programs more accessible statewide. The initiative will also offer early intervention services for youth who may not meet diagnostic criteria, but are engaging in substance use and may be at risk for dependence. Services, including family treatment, will be designed to provide support for youth as well as their parents and caregivers.

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). Individuals who are convicted of DUI and 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 decrease the incidence of recidivism and ultimately creating safer roads and waterways. There are over 200 licensed sites in the Driving Under the Influence Initiative (DUII) fee-for-service network providing all levels of substance use disorder treatment services.

State Hospital Addictions Recovery and Education (SHARE) The SHARE Program is a partnership with the DOH State Psychiatric Hospitals. It is designed to serve individuals with Co-occurring disorders who are admitted to one of the three state psychiatric hospitals and have been assessed for STR LOC and deemed appropriate to be treated in a community setting. Eligible Providers are licensed for Short Term Residential Level of Care and approved as a co-occurring licensed site with an Affiliation Agreement with one or more of the State Psychiatric Hospitals include: Ancora Psychiatric Hospital, Hammonton (South Jersey); Trenton Psychiatric Hospital, Trenton (Central Jersey); Greystone Psychiatric Hospital, Morris Plains (North Jersey).

Vivitrol Enhancement Network. Authorization to provide Vivitrol (injectable naltrexone) and related enhancement services in both residential and ambulatory settings through DMHAS Fee-for-Service (FFS) Network is predicated on licensing approval by the Department of Health,

Certificate of Need and Licensing (CN&L). In the Fee for Service Initiatives that offer the Vivitrol Enhancement Package, OP, IOP, PC and HWH Provider Sites must be approved for Medication Assisted Treatment (MAT) services by DOH CN&L. Opioid Treatment Programs (OTP), LTR, STR and IWM licensed sites are approved by meeting licensing requirements.

Those agencies contracted to provide Vivitrol must agree that the prescription and administration of the medication will be conducted by the appropriate medical personnel (Medical Director, Nurse Practitioner, Physician Assistant, Advanced Practice Nurse, or Registered Nurse) and that all counseling services will be provided in accordance with DOH and DCA regulation.

Agencies will ensure, and comply with, consumer choice and consent for this course of treatment. Staff shall provide the appropriate education regarding this medication and also discuss the options available for individuals with either an alcohol or opioid use disorder. A consumer information packet that is specific to injectable naltrexone pharmacology and developed by agency medical personnel shall be provided to the consumer by their counselor and verbally reviewed with the consumer at each level of care. The information packet shall include the benefits and the risks of the medication.

Buprenorphine Enhancement Network. DMHAS will continue the Buprenorphine Enhancement, similar to the one created for Vivitrol, that reimburses FFS Network providers for the provision of buprenorphine at their agencies. The Buprenorphine Enhancement Network was expanded in November 2022 to allow licensed SUD agencies to participate in the enhancement network with proper approval (MAT Waiver) issued by CN&L, depending on Level of Care (LOC). Licensed Opioid Treatment Programs (OTPs) and residential agencies with a medical provider are not subject to the requirement of approval of a MAT Waiver. In Fee for Service Initiatives that offer the Buprenorphine Enhancement Package, OP, IOP, PC and HWH Provider Sites must be approved for Medication Assisted Treatment (MAT) services by DOH CN&L. Opioid Treatment Programs (OTP), LTR, STR and IWM licensed sites are approved by meeting licensing requirements.

Contract-Based (Non-FFS) Treatment

SUPTRS Women's Set-Aside (PWWDC Criterion 3). The SSA provides funding through the women's set aside federal block grant to a statewide network of licensed substance use disorder (SUD) treatment providers in all modalities of care: outpatient, methadone outpatient, halfway house, short-term and long-term residential for substance use disorder treatment to pregnant women and parenting women. The women's set aside programs are designed to meet the specific needs of women such as gender specific SUD 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, childcare, 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). The IOT-SEI initiative focuses on three of the five major timeframes when intervention in the life of a SEI can decrease potential injury of prenatal substance exposure: the prenatal phase, the birth event, and neonatal phase. IOT-SEI provides an array of services for opioid dependent pregnant women, their infants and family ranging from substance use disorder treatment, prenatal and postpartum medical/obstetric services, care coordination, recovery-based living arrangements, wraparound services such as intensive case management and recovery support. Providers are required to develop Plans of Safe Care. The overall goal is intended to improve outcomes for pregnant women with opioid use disorder (OUD) their infant and families. This initiative promotes maternal health, improves birth outcomes and decrease the risks and adverse consequences of prenatal substance exposure. Five providers across the State are contracted to participate in this initiative.

Sonara Health. Nearly 100,000 people died from opioid overdoses in 2021, a 29% increase from 2020, of which 80% were caused by fentanyl. At a time when overdose fatalities are increasing at an alarming rate, SAMHSA reports less than 10% can access treatment. Remote observation of take-home methadone can help increase access to treatment. Methadone is a safe and effective treatment, but as an opioid and Schedule II drug, can only be prescribed and dispensed from an Opioid Treatment Program (OTP) - requiring daily, in person visits, which poses transportation challenges equally across urban and rural settings. Some OTPs are prone to limiting access to take-home methadone. Methodology to remotely observe take home methadone doses can help increase access, drive retention in treatment, and minimize diversion concerns. Remote observation is not new to public health and has long been employed by tuberculosis treatment teams where it increased adherence and treatment completion. Remote observation of take-home dosing adds the same level of direct supervision at an OTP to the take home regimen. Policymakers should support legislation that authorizes funding for remote observation of take-home methadone pilots.

COVID-19 pandemic data published in The Lancet Public Health showed that allowing more patients to have take home methadone - instead of daily, in person visits - benefited patients and OTPs. Specifically, researchers found:

- Improved patients' quality of life, including feelings of self-esteem and autonomy;
- Lessened burdens associated with daily, in person visits, such as travel and stress;
- Did not result in increased overdoses; and,
- Improved retention.

Additionally, clinicians reported they could provide more patient-centered care and their patients were more motivated to participate in treatment. As a result, SAMHSA issued proposed rules in December 2022 to permanently allow patients to receive up to 28 take-home doses after one month in treatment, and in April 2023 SAMHSA issued updated Methadone Take-Home Flexibilities Guidance that aligned with the proposed rule and would remain valid for one year from the end of the COVID-19 Public Health Emergency or the publication of the final rules, whichever occurs first.

Sonara Health is a HIPAA and 42 CFR Part 2 compliant digital health solution that is listed as an FDA Class I medical device. Sonara uses a web-based application to remotely observe patients who dose outside the clinic and was designed to specifically support a broad patient population at OTPs.

Sonara Health received \$250k in the SFY 2025 budget to start a pilot program in NJ in partnership with up to 8 outpatient clinics in the state. It has a technology that allows for patients to remotely engage in their treatment for Opioid Use Disorder recovery. Sonara's telemedicine and video directly observed therapy solutions enables treatment centers to increase access to life saving medication like methadone, while maintaining safety and treatment engagement that in person daily dosing offers.

The data is gathered from 8 OTPs currently enrolled in the pilot. The contract was extended through December 2026. The state legislature has also approved additional funding to support the expansion of this project.

Data collected includes:

- # of OTP patients onboarded and active
- # of doses accepted/rejected
- Travel/commute time
- Satisfaction scores associated with validated opioid withdrawal questionnaires
- Patient demographics

Data indicates:

- Enrollment and Activation: Enrolled 443 patients into Sonara since launch with 47 of those in June.
- Patient cravings are stable and withdrawal symptoms are reportedly improving patient-reported details
- 83% of patients experienced a decreased commute time, beneficial for those with long commutes.
- An NPS score of 77 placing Sonara in the "excellent" category, indicating high patient satisfaction.
- Positive feedback includes comments on increased privacy, convenience, and family time.
- 82% of patients reported Sonara changed their opinion of treatment.
- 43% of patients reported round a trip commute time of an hour or more to their treatment center.
- 52% of patients reported receiving take-home medication for the first time due to Sonara.
- 61% of patients are receiving more than 100mg of methadone.
- Increased Take-Home Doses: Sonara safely enabled the issuance of 2,792 doses in June and has recorded 7,580 doses since launch.
- High dose adherence: 97% of doses submitted by patients accepted by their care team and 76.8% of total doses recorded as prescribed in June (up 11.8% from May). We continue to see increasing compliance as patients and staff acclimate to the technology.

Discretionary Grants

SOR 1 Grant. SAMHSA released its initial State Opioid Response (SOR) grant opportunity for states and territories in June 2018; New Jersey was awarded funding in September 2018. The purpose of the initial SOR grant was to address the opioid crisis by increasing access to medication-assisted treatment using the three FDA-approved medications for the treatment of opioid use disorder, decreasing unmet treatment need, and decreasing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder (OUD) (including prescription opioids, heroin and illicit fentanyl and fentanyl analogs). A few initiatives implemented are listed below:

Through the SOR grant opportunity, the Department of Human Services, Division of Mental Health and Addiction Services (DMHAS), Department of Corrections (DOC) and the Department of Health (DOH) jointly initiated a program to expand the use of Medication-Assisted Treatment (MAT) for incarcerated individuals with opioid use disorders in all but one of the New Jersey County jails. The medications prescribed included methadone, buprenorphine, naltrexone and extended-release naltrexone (Vivitrol).

In addition, DMHAS provided funding to Cooper Medical School of Rowan University and Rutgers New Jersey Medical School, the two MAT State Centers of Excellence (COEs) to train health care prescribers to help them attain their buprenorphine waiver. Training not only covered the required curriculum to attain the waiver but also contained education on New Jersey specific resources which helped ease the pathway for prescribers to utilize buprenorphine in their practice.

The Building Capacity for Medication-Assisted Treatment (MAT) in Ambulatory Substance Use Disorder (SUD) Programs supports the development of medical capacity to provide MAT to eligible individuals at licensed, ambulatory SUD treatment agencies. DMHAS funded 7 agencies and a total of 10 sites.

Another highlight was the Opioid Reduction Options (ORO) initiative which provided funding to hospital Emergency Departments (EDs) to develop and implement programs to increase awareness and focus on non-opioid pain management strategies and decrease the use of opioids in EDs and the subsequent prescribing of opioids at ED discharge.

SOR 2 Grant SAMHSA released a second iteration of the State Opioid Response (SOR) grant for states and territories in March 2020. New Jersey was awarded funding in September 2020. The goals of the SOR are to address the opioid crisis by increasing access to medication-assisted treatment using the three FDA-approved medications for the treatment of opioid use disorder, decreasing unmet treatment need, and decreasing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder (OUD) (including illicit use of prescription opioids, heroin, and fentanyl and fentanyl analogs). This grant opportunity also supports evidence-based prevention, treatment and recovery support services to address stimulant misuse and use disorders, including for cocaine and methamphetamine.

Another initiative to promote low induction medication was through a mobile service and contracts with two programs to facilitate low induction medication, case management and other ancillary

services for individuals with an OUD in counties with low access to MAT as well as areas of the State with individuals who are homeless or at higher risk for homelessness. A third contract for this service is being planned with hopes to begin service in FFY 2024.

DMHAS will provide funding to increase paramedic OUD education, provide patients who have been reversed from an opioid overdose with a opioid overdose prevention package that includes emergency naloxone, develop protocols allowing paramedics to administer buprenorphine for opioid withdrawal symptoms, and provide next-day linkage to care. This program will be coordinated through Cooper Hospital at Rowan University who has already been able to implement a pilot program in the City of Camden. This funding will help expand this program to a few other locations throughout the State.

In April 2021, DMHAS launched an Expanded Hour Same Day Service initiative to increase access to MAT through expanding the hours at licensed Opioid Treatment Programs (OTPs). The intent of the program is to provide on-demand MAT, specifically methadone, followed by treatment or referral to ongoing care for individuals with an OUD. This program is operational at six (6) OTPs.

DMHAS partnered with both Rutgers University and Rowan University (the two State MAT Centers of Excellence) to ensure funding is available to support individuals at clinics who are indigent with an opioid use disorder, so they can be inducted and/or maintained on medications to treat opioid use disorder. Services for these individuals include other ancillary services such as care coordination, peer services and medications to assist individuals who have a co-occurring mental health or other SUD, for example tobacco use disorder.

In addition, DMHAS continues to assist all county correctional facilities establish MAT programs or enhance existing MAT services for incarcerated individuals with an OUD as well as provide care management services. Funding has been made available to promote clinical stability and effective recovery processes for individuals prior to release from incarceration. DMHAS also provides funding to the Northern and Southern Center of Excellence to provide technical assistance to all county jails participating in this program. Technical Assistance is specific to assist jails in the provision of MAT and proper medication protocols for individuals.

The Department of Human Services launched a statewide advertising campaign in 2020, through a contract with a marketing agency, centered around opioid use and bringing public awareness that medication can support recovery and encourages viewers of the advertisements to call ReachNJ, the 24/7 Addiction Hotline in New Jersey. Messaging is designed to reach multiple resident groups, such as student-athletes, pregnant women, older adults and prescribers. NJ saw a significant increase in call volume at ReachNJ, as the campaign has existed in both physical and digital platforms across the State.

Finally, DMHAS implemented a pilot program addressing the use of methamphetamine and cocaine use disorder utilizing contingency management at several licensed SUD programs. As of FFY 2024, DMHAS has ten contracted programs providing contingency management for stimulant use disorder.

SOR 3. A third iteration of SOR was released in May 2022. The State of New Jersey received \$66.7M as an annual award beginning September 2022 (expected to be a two-year grant) with an ongoing goal to address the opioid overdose crisis by continuing to increase access to FDA-approved medications for the treatment of opioid use disorder (MOUD), support the continuum of prevention, treatment, and recovery support services for opioid use disorder (OUD) and other concurrent substance use disorders. The SOR grant will also continue to support the continuum of care for stimulant misuse and use disorders. Most prevention, treatment, recovery support and training activities will continue that were commenced under earlier iterations of the same titled grant. Some noteworthy initiatives from the grant are listed below.

Programs continued to include the Expanded Hours/Same Day Service Opioid Treatment Programs (OTPs) that provide same-day access to on demand MOUD, the Mobile Van Pilot program that facilitates low induction medication in communities with low access to MOUD and high rates of homelessness.

Additionally, a program was funded to enhance overall recovery in stimulant use disorders utilizing contingency management. A public information campaign was funded to decrease discrimination and promote MOUD as the evidence-based practice for OUD. Also, training opportunities continued for OUD treatment professionals and recovery service workers. Prevention efforts included expanding groups that receive naloxone training and kits and expanded the availability of naloxone kits through a portal developed for entities including: county correctional facilities, EMS, law enforcement, shelters and treatment facilities. The Opioid Overdose Recovery Program and Public Education for Older Adults prevention programs also were continued. Recovery activities included the continuation of the Community Peer Recovery and Family Support Centers; and programs that provide case management and support services for individuals with an OUD such as the Support Team for Addiction Recovery and the Nurse Care Manager initiatives.

Anticipated outcomes of the grant include decreased/abstinence from drugs and alcohol, increases in employment, decreased criminal justice involvement, increased social connectedness, and increased percentage of individuals completing treatment at the recommended level of care. Additional outcomes include decreasing opioid overdoses, increasing retention in treatment, decreasing the length of time to relapse and prolonging recovery, and increasing number of individuals receiving medications to support their recovery.

SOR 4. A fourth iteration of the SOR grant was released by SAMHSA in May 2024 and DMHAS was awarded a grant in September 2024. SOR 4.0 is expected to be a three-year grant and will continue several of the above-mentioned prevention, treatment, recovery support and training initiatives that commenced under previous iterations of the grant. Newly planned activities in SOR 4.0 include the following: Fentanyl Awareness Campaign, Anti-Stigma Campaign, the Transportation Reimbursement and Invoicing Program (TRIP), which provides transportation for individuals to treatment, recovery support, services etc. when no other payor source exists, training for school staff in regard to prevention (specifically in regard to fentanyl awareness) and a program that would provide statewide overdose prevention training for behavioral health programs and include a distribution of related supplies.

Recovery Support Care Management (RSCM). RSCM was established and effective on March 7, 2023, and is a behavioral health service intended to support consumers who have a SUD with complex physical and/or psychosocial needs. RSCM provides direct and comprehensive assistance to consumers to ensure access to the necessary treatment, rehabilitative and recovery services with the intent of decreasing psychiatric and addiction symptoms, connect consumers with services, improve transitions between levels of care, implement strategies to address their unique needs, decrease opioid related deaths and sustain recovery in the community while supporting the consumers' continued stability and recovery throughout the continuum of care. This service is available as an enhancement in all levels of care. This service may be provided face-to-face or via a telehealth platform. Since Medicaid offers Care Management in outpatient, RSCM is excluded from reimbursement for consumers admitted into Ambulatory LOCs in Recovery Care Efficiency (RCE). RSCM is being funded with SUPTRS COVID-19 Supplemental and will continue with ARPA funding. As of March 31, 2025, there were 5,617 unduplicated clients who received this service.

Expanded Outpatient Hours. An RFP was issued in August 2022 to expand outpatient treatment services and enhance access to treatment by removing obstacles such as traditional service hours. Ten SUD outpatient treatment providers were awarded a contract to provide these services in October 2022. These expanded hours will provide increased access to outpatient treatment for individuals with an SUD. The purpose of this expansion for outpatient services is to support, enhance and encourage the emotional development and the development of consumer's life skills in order to maximize their individual functioning during alternate times from standard business hours (after hours and weekends). Providers are required to expand their hours at a minimum of six (6) days per week with the goal of extending hours into the evening and admitting new consumers for these services during these times. This program is funded with ARPA until the end of September 2025.

Compulsive 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.

In August 2021, DMHAS issued two gambling disorder RFPs funded by New Jersey State Gambling appropriations. One RFP is for gambling disorder clinician services. DMHAS made 10 awards to providers licensed as SUD providers to treat individuals with a gambling disorder. Awarded providers will hire, at minimum, 1 FTE equivalent Gambling Disorder Clinician and provide case management services provided by the clinician or additional staffing. The awards will be chosen regionally and based on need in order to offer statewide gambling disorder services.

The second RFP was for the development of a Provider Gambling Training and Technical Assistance Initiative. This RFP was for one award for \$1 million in one-time funding. Through this initiative, the successful bidder, Rutgers University School of Social Work Gambling Program provided robust training and consultation services with the goal of full implementation of gambling counseling practices within agencies across New Jersey that offer substance use disorder services. Clinicians who participate in the training do not have to be employed in a DMHAS contracted agency.

In January 2023, DMHAS issued a second Gambling Disorder RFP, funded by New Jersey State Gambling appropriations for 5 more providers including a Mental Health provider. A total of 15 provider sites now comprises the Gambling Disorder Treatment network.

In January 2025, DMHAS issued a third Gambling Disorder RFP, funded by New Jersey State Gambling appropriations for 6 more providers. A total of 21 provider sites now comprises the Gambling Disorder Treatment Network.

Recovery Support

Recovery support and recovery-oriented systems of care help people with mental illness and substance use disorders manage their conditions successfully. Peer support services include the coordination of personal, family, and community resources to achieve the best possible quality of life for every client entering the substance use early intervention and treatment system. The chronic nature of addiction requires recovery support to promote sustained periods of wellness to continuously decrease the need for additional acute care. Acute care substance use treatment without other recovery supports is often not sufficient in helping individuals to maintain long-term recovery. Recognizing that treatment for substance use disorders does not end upon discharge, a continuum of care recovery plan, including personal, family and community resources, is established. The plan ranges from low level contact such as quarterly telephone conversations to high level contact such as coaching, depending on support needed.

Citizen's Advisory Council. The Citizens Advisory Council (CAC) is composed of representatives from DMHAS-funded Community Peer Recovery Centers (CPRCs), which provide support and services for individuals facing substance use challenges. CAC members meet regularly with DMHAS leadership, including staff from the Office of Community Services and the Office of Advocacy and Peer Services.

These meetings foster communication, collaboration, and mutual support among persons who oversee the day-to-day operations of the CPRCs. They offer a platform for sharing updates on center activities, community needs, innovative practices, and both the successes and challenges experienced in delivering services.

The primary goals of the CAC meetings are to build a strong sense of community among those who oversee the day-to-day operations of the CPRCs, establish a professional support network, and maintain open lines of communication with DMHAS, particularly the Office of Advocacy and Peer Services. DMHAS staff provide updates on division-wide initiatives and receive direct feedback from persons who function as CPRC direct-care staff, while Advocacy and Peer Services

staff contribute valuable insights from their lived experience with recovery and navigating substance use disorder (SUD) services.

Moving forward, CAC will collaborate more closely with the Statewide Consumer Advisory Committee (SCAC), which represents Community Wellness Centers. This partnership aims to better coordinate services and support for individuals in the community with co-occurring mental health and substance use needs.

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. Providers have also included evidence-based approaches like SMART Recovery. Additionally, several providers in New Jersey have developed All-Recovery groups, which are open to anyone who is living with an addictive disorder: The meetings are attended by persons in recovery, and those seeking recovery, as well as their friends and loved ones.

Bringing Recovery Supports to Scale – Technical Assistance Center Strategy. In recent years, New Jersey has greatly expanded, particularly for substance abuse treatment consumers, opportunities to provide peer-delivered services. Accordingly, the number of peers providing these services has also increased. Most of the positions held by peers, however, are part-time or casual in nature. There is a widely acknowledged understanding, supported by scientific evidence, that peer-delivered services complement and enhance behavioral health care by creating the emotional, social and practical assistance necessary that enables the client/patient to manage their illness and stay healthy.

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

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

Peer Recovery Support Specialists. Peer-based recovery support is defined as a process of giving and receiving nonprofessional, nonclinical assistance to engage, educate, and support the client to make the necessary changes to live a self-directed life. In New Jersey, recovery support services are provided by certified peer recovery specialists with lived experience who have been successful in the recovery process in order to support others experiencing similar situations. DMHAS views peers as an integral and equal partner in our system of care as recovery support services expand the capacity of formal and informal treatment and recovery pathways. Peers are an essential component of programs, including residential, therapeutic community, outpatient, emergency department deployment, justice-involved programs, family, and community recovery centers. Through shared understanding, respect, and mutual empowerment, certified peer recovery specialists strengthen an individual's motivation to change by initiating the recovery process to decrease the likelihood of a return to substance use.

Recovery support services encompass SAMHSA's guiding principles of recovery and include four major dimensions that support a life in recovery: health, home, purpose, and community. Peer workers assist individuals with developing a recovery plan that enables them to identify goals for achieving wellness. Peer workers also help the clients they work with to facilitate resilience and manage setbacks or other stressful events that may precipitate a return to substance use. New Jersey's recovery support services are designed to span all stages of recovery – from initiation/stabilization through recovery maintenance and the enhancement of quality of life in long-term recovery.

Peer workers assist recoverees with accessing External and Internal Recovery Capital, and Family and/or Social Recovery Capital. External Recovery Capital includes, but is not limited to, financial assets, health insurance, safe and recovery-conducive shelter, clothing, food, and access to transportation. Internal Recovery Capital includes, but is not limited to, values, knowledge, educational/vocational skills and credentials, self-awareness, self-esteem, self-efficacy, hopefulness/optimism, perception of one's past/present/future, sense of wholeness and healing. Family and/or Social Recovery Capital includes, but is not limited to, intimate relationships, family and kinship relationships (defined here non-traditionally, i.e., family of choice), and social relationships that are supportive of recovery efforts. Recovery specialists encourage families (biological, nuclear or self-chosen) to become willing to participate in their loved one's treatment and recovery. The presence of others in recovery within the family and social network can help access sober outlets for sobriety-based fellowship/leisure and relational connections to conventional institutions (school, workplace, church, and other mainstream community organizations).

The Division supports the role of peers through several individual and family-based initiatives. These programs assist individuals with Opioid Use Disorders or those who are at risk of an opioid overdose through supportive services, case management, education, resources, and advocacy for families and individuals. For example, the Opioid Overdose Recovery Program (OORP), which operates in all 21 counties, provides support services to individuals reversed from opioid overdose treated at hospital emergency departments. Peers employed within the OORP program are instrumental in engaging recoverees by sharing stories of hope and recovery, meeting individuals where they are, and emphasizing that recovery occurs via many pathways.

Other DMHAS peer recovery-based programs include, the Support Team for Addiction Recovery (STAR) initiative, which operates in all 21 counties, and is comprised of 12 teams, each consisting of a program supervisor, two case managers, and two peer recovery specialists. STAR focuses on promoting self-determination and helps recoverees connect to housing, employment, health, and social services, etc. The STAR team maintains contact with individuals to support their recovery and lead a productive life.

The Maternal Wraparound Program (M-WRAP) is a statewide initiative that combines intensive case management, wraparound services, and recovery supports for pregnant/postpartum women who have a substance use disorder during pregnancy and up to one year after the birth event. Intensive case management focuses on developing a single, coordinated care plan for pregnant and parenting 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 women and their families. Plans of Safe Care (PoSC) are developed at the time of birth and addresses the needs of the mother, infant and family to ensure coordination of, access to, and engagement in services. The M-WRAP model is intended to promote maternal health, improve birth outcomes, and decrease the risks and adverse consequences of prenatal substance exposure.

Family Support Centers offered direct family support, education, resources, and advocacy in a safe and non-stigmatizing environment. Each regional center is staffed with Family Support Coordinators with lived experiences who are trained in the Community Reinforcement and Family Training (CRAFT) Model. This model teaches families self-protection and non-confrontational skills to help empower their loved one to seek treatment. It also helps each family member develop and work on their own Individualized Wellness Recovery Plan.

Community Peer Recovery Centers (CPRCs) are places where individuals can access peer support, information about substance use disorder treatment, recovery support services, and information about other community resources in a supportive substance free environment. All CPRC services and activities are led and driven by peers who have experienced addiction and recovery, either directly or indirectly as a family member or friend. The overall goal of the CPRC is to provide a safe place for recovering individuals to gather in support of one another and experience recovery-oriented living in a community setting.

In addition to the role of peer workers, NJ OORP and STAR programs employ patient navigators and case managers, respectively. By utilizing multiple methods to gather information from program staff across programs and roles, the Camden Coalition has assisted DMHAS in identifying core competencies and role functions for OORP patient navigators and STAR case managers. One of the goals of this project is to demonstrate and delineate the unique similarities and differences patient navigators and case managers have in ensuring sustained recovery. A second goal of the project is to provide program specific training, coaching, skill labs, refresher courses and regional resources mapping. Correspondingly, DMHAS is planning to formulate a professional credential for OORP patient navigators and STAR case managers and collaborate with Division of Medical Assistance and Health Services (DMAHS) to obtain Medicaid reimbursement for these services.

Over the last several years, DMHAS has made significant efforts to increase the SUD peer workforce. Peer support services have positively impacted and provided assistance to persons in recovery from serious mental illness, substance use, or co-occurring mental and substance use conditions before, during and after treatment. As a means to close the gap in the provision of peer services in residential settings, DMHAS issued an RFP in 2023 to expand the peer workforce to include peer services in inpatient withdrawal management, short-term and long-term residential and halfway house settings. The RFP resulted in DMHAS contracting with 9 providers to hire 50 peers who assist with issues that often occur concurrently with SUD, such as homelessness, legal issues, employment, childcare, etc. In addition to linking individuals with the appropriate community resources, peers also encourage individuals to remain in treatment as recommended in the treatment plan and modeling strategies on how to manage addiction successfully.

Recovery Data Platform. To assist recovery-oriented agencies and programs with tracking recoveree progress, a DMHAS peer recovery data collection system was implemented in 2020. The Recovery Data Platform (RDP) collects real-time data that helps track and organize participants' program interactions and progress. Programs can track individuals' growth and follow trends that assist in meeting recoverees' needs. The RDP allows recoverees to see the progress they are making in real time which facilitates motivation to sustain recovery. Significant data collection includes assessment of recovery capital, a relationship scale, and an engagement scale that measures cravings. Output data includes recovery coaching and telephone recovery support logs, referrals, education, employment, and resource information. The RDP has over 18,000 participants, surpassing the earmarked goal of 10,000, boasting one of the largest collections of recovery center data in the state of New Jersey.

Peer Roster. In order to accurately capture recovery program demographic data, DMHAS developed a Peer and Recovery Roster system. Staff working in DMHAS recovery programs are required to enter information into the Roster via an online Qualtrics survey link. Program staff input information on their position, agency, supervisor, educational level, certification, credentialing, and training record. DMHAS staff are able to use Roster data to accurately identify the number of peers working in DMHAS programs, follow trends, and assess program and workforce needs. The Peer Roster houses data on over 600 Peers and more than 1400 participants, including both current and former Peers involved in various DMHAS-funded initiatives.

Peer Medicaid Reimbursement. To ensure sustainability of recovery program services, DMHAS has been working closely with DMAHS to develop reimbursement for recovery and case management services. Since July 2019, DMAHS provides reimbursement for peers working in independent clinics providing outpatient substance use treatment services since. The New Jersey Medicaid 1115 Substance Use Disorder (SUD) Waiver included peer recovery support specialist (PRSS) services to be added to the State Plan. The purpose of a PRSS is to support NJ FamilyCare (NJFC) Medicaid beneficiaries throughout their continuum of care, improve transitions between levels of care, implement strategies to address opioid misuse related to an opioid use disorder, and decrease opioid related deaths. DMAHS also provides reimbursement for case management services for its supportive housing program.

DMHAS has worked with DMAHS to develop a bundled reimbursement rate for the Opioid Overdose Recovery Program (OORP). The New Jersey 1115 Substance Use Disorder (SUD) Demonstration included implementation of an OORP. The DMHAS initiated the program based on a recovery model to link individuals recovered from an opioid overdose and transported to an Emergency Department (ED) with appropriate addiction treatment and recovery support services. DMAHS began coverage of OORP services provided by DMHAS-contracted OORP providers effective January 2022.

Recovery Resource Directory. As an outcome of the SSA's State Opioid Response initiative, a need was identified to provide supportive training, coaching and resources for patient navigators and peer specialists employed in DMHAS recovery-based initiatives. In response to a repeated request by peers to have an informational directory which would allow users to quickly and conveniently identify resources when accessing services, the SSA funded a Recovery Resource Directory (RRD). The RRD is intended to assist peer workers to promote wellness and recovery for individuals managing a mental illness, substance use disorder, or co-occurring disorder. The web-based directory will quickly furnish peers and staff working in the Division's recovery-based initiatives with essential information and resources to facilitate and sustain individuals' recovery. Resources (e.g., organizations, support services, mutual aid meetings, housing, job placement, etc.) will be grouped by geographic location throughout New Jersey's 21 counties.

Peer Recovery Support Summit. Annually, the New Jersey Prevention Network (NJPN) a partner of DMHAS holds a Peer Recovery Support Summit. The last summit entitled, "Stronger Together: Shared Learning and Building a Unified Future" was held on May 12, 2025. This was NJPN's 9th summit. It equipped attendees with strategies in providing recovery support services across the continuum of care, best practices that are relevant to the addiction/recovery field, and opioid use disorders.

Opioid Overdose Recovery Program. DMHAS issued a Request for Proposals (RFP) in June 2015 to develop an Opioid Overdose Recovery Program (OORP) to respond to individuals reversed from opioid overdoses and treated at hospital emergency departments as a result of the reversal. This two-year initiative funded programs in Atlantic, Camden, Essex, Monmouth and Ocean Counties. Since then, using monies appropriated by the Governor, as well as STR and SOR funds, the program is now provided in all 21 NJ counties – and in 73 percent of hospital EDs throughout the state. The Opioid Overdose Recovery Program utilizes recovery specialists and patient navigators to engage individuals reversed from an opioid overdose to provide non-clinical assistance, recovery supports and appropriate referrals for assessment and substance use disorder treatment. The recovery specialists and patient navigators also maintain follow-up with these individuals. It is expected that, at minimum, recovery specialists will be accessible and on-call from Thursday evenings through Monday mornings. This initiative commenced in the fall of 2015. Additional OORP RFPs were released. As of June 30, 2025, 31,814 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.

Several peer-reviewed articles have been published about NJ's OORP program. Powell K, Treitler P, Peterson A, et al. *"Promoting opioid overdose prevention and recovery: An exploratory study of an innovative intervention model to address opioid abuse."* (International Journal of Drug

Policy, 64 (2019) 21-29) note that fatal opioid overdose is a national public health concern and a critical problem confronting New Jersey. New Jersey (DMHAS) developed an innovative program, the Opioid Overdose Recovery Program (OORP), to address the epidemic and the issue of low treatment admissions following a non-fatal overdose. The OORP utilizes an intervention model with peer recovery specialists (RSs) and patient navigators (PNs) to engage individuals within emergency departments (EDs) immediately following an opioid overdose reversal who have been transported by EMS. The purpose of this exploratory study was to examine the process through which the OORP was implemented in its first year and determine facilitators and obstacles to implementation. Data were collected in 2016-2017, through 17 telephone interviews and five focus groups totaling 39 participants. Participants were OORP staff and stakeholders selected through purposeful, non-random sampling. Standardized, open-ended interview guides were used. Thematic analysis was conducted to identify, analyze, and report overall patterns.

Findings revealed logistical obstacles to treatment including patients' lack of insurance and cell phones, lack of immediately available detox beds, and program ineligibility for some patients due to medical conditions. The model using peers as first responders had a positive impact as their experiences with addiction enabled them to more successfully engage patients. The PNs were critical in addressing high needs for case management and referral and external partners were also important for implementation. Results underscore the effort needed to integrate this important model within EDs as part of a multi-level approach to address opioid misuse. The identified challenges led to statewide strategic planning and areas for further development. OORP is a promising intervention to address the opioid epidemic in the US that might increase the number of individuals suffering with opioid disorders by linking to peer support, treatment and recovery.

A recent article by Treitler P, [Lloyd K](https://doi.org/10.1016/j.annemergmed.2025.06.616), Cantor J, et al. *“Treatment Initiation and Outcomes Associated With Receipt of Emergency Department-Based Peer Support Following Opioid Overdose”* (<https://doi.org/10.1016/j.annemergmed.2025.06.616>) examined whether participation in the New Jersey Opioid Overdose Recovery Program (OORP) was associated with drug treatment initiation and other post discharge outcomes. This retrospective cohort study used the 2015 to 2020 New Jersey Medicaid claims linked to OORP evaluation data. Outcomes during 180-day follow-up were compared between opioid overdoses among OORP participants and a propensity score-matched group of overdoses among nonparticipants. Outcomes included any medication for opioid use disorder initiation (primary), percentage of days covered with medication for opioid use disorder, psychosocial treatment initiation and engagement, repeat opioid and any drug overdose, and all-cause and opioid-related acute care utilization. A total of 7,109 overdose events among 5,475 patients were included. OORP participants (N=1,383 events) initiated medication for opioid use disorder at higher rates than nonparticipants. OORP participation was also associated with greater medication for opioid use disorder percentage of days covered, psychosocial treatment initiation, psychosocial treatment engagement, and lower risk of all-cause acute care utilization. Results suggest that peer recovery support service can support treatment linkages following ED-treated opioid overdose. Additional efforts are needed to retain patients in medication for opioid use disorder long-term to decrease their risk for repeat overdose.

A study by Lardier, D, Gillmore-Powell, K, Morton, C, et al. *“Peer Recovery Specialists and Referrals to Treatment: Clinical Correlates Among Patients of an Opioid Overdose Recovery*

Program in New Jersey” (Substance Use & Addiction Journal 1-13, 2024) examined demographic and clinical correlates with referral to substance use treatment services including prior engagement within an opioid overdose recovery program, mental health diagnosis, the number of naloxone administrations, prior overdoses, and hospital-level variability of Peer Recovery Specialists (PRS) time associated with treatment referrals. This study used data collected by providers among patients who engaged in an opioid overdose recovery program. Data were collected between January 2016 and September 2020. A total of 5,655 patients participated in the study. Significant associations were identified between demographic and clinical variables and referral to substance use treatment services. At the hospital level, recovery specialist time spent with the patient also showed a positive and significant association with referral to substance use treatment services. The cross-level interaction effect displayed that any period of time spent with PRS played an important role for those patients with a greater number of prior overdoses on referral to treatment. Results provide important information on the role of PRS in the cascade of care, as well as the time spent with those in this role for both individuals with varying number of prior overdoses.

An intention-to-treat retrospective cohort study by Treitler P, Crystal S, Cantor J, et al. *“Emergency department peer support program and patient outcomes after opioid overdose.”* (JAMANetwork Open. 2024, 7: e243614) used 2014 to 2020 New Jersey Medicaid data for Medicaid enrollees aged 18 to 64 years who were treated for nonfatal opioid overdose from January 2015 to June 2020 at 70 New Jersey acute care hospitals. The primary outcome was medication for opioid use disorder (MOUD) initiation within 60 days of discharge. Secondary outcomes included psychosocial treatment initiation, medically treated drug overdoses, and all-cause acute care visits after discharge. The study compared 180-day outcomes between patients treated in OORP hospitals and those treated in non-OORP hospitals. A total of 12,046 individuals were included in the study. Pre-implementation outcome trends were similar for patients treated in OORP and non-OORP hospitals. Implementation of the OORP was associated with an increase of 0.034 in the probability of 60-day MOUD initiation in the half-year after implementation, representing a 45% increase above the pre-implementation mean probability of 0.075. Program implementation was associated with fewer repeat medically treated overdoses 4 half-years and 5 half-years after implementation. OORP implementation was associated with an increase in MOUD initiation and a decrease in repeat medically treated overdoses.

A study by Lardier, D, Gillmore Powell, K, Peterson, A, et al. *“Polysubstance use latent class membership in New Jersey: Association with prior overdoses, prior emergency department peer recovery engagement, and mental health diagnosis among participants in an opioid overdose recovery program”* (Substance Abuse 2022, Vol. 43, No 1, 1011-1022) was conducted to understand subpopulations who demonstrated distinct patterns of polysubstance use among participants in an ED Opioid Overdose Recovery Program (OORP) in New Jersey. This study investigated patterns of polysubstance use among participants in a New Jersey OORP using latent class analysis. Multinomial logistic regression analyses examined latent class (LC) membership based on clinically relevant indicators. Five latent classes were identified. Multinomial logistic regression analyses showed that subgroups with the greatest odds of prior OORP engagement related to those in subgroups with heroin and polysubstance use. It is critical to examine the heterogeneity among people engaging in prescription opioid use and polysubstance use in the United States. This study represents an important contribution in identifying polysubstance use LC

membership groups and associations with clinically relevant indicators among those engaged in an opioid recovery program.

Support Team for Addiction Recovery. Support Teams for Addiction Recovery (STAR) provide case management and recovery support services for individuals with opioid use disorders (OUD). The STAR initiative is comprised teams, with each team consisting of a program supervisor, two case managers and two recovery specialists. The team maintains a caseload of 40 individuals. STAR case managers work with individuals to assist with issues that often occur concurrently with an OUD, such as homelessness, legal issues, employment, education, transportation, need for social services, health care, child welfare involvement, childcare, health insurance, etc. The STAR recovery specialists provide non-clinical assistance and recovery support services. The overall goal of STAR is to help individuals with an OUD achieve and maintain recovery, help decrease the risk of recurring episodes of opioid related problems and prevent future overdose. STAR programs in all 21 NJ counties are funded by the SOR grant. In early 2020, services were expanded in 10 counties to enable STAR to serve individuals newly released from county correctional facilities.

Maternal Wraparound Program. The Maternal Wraparound Program (M-WRAP) is a program that provides intensive case management and recovery support services to pregnant women with substance use disorder. Pregnant women are eligible for services through M-WRAP 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. Recovery Support Specialists provide non-clinical assistance, and recovery supports while maintaining follow-up with the women and their infants.

Block Grant funding supports seven MWRAP regions statewide. 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 of MWRAP is to alleviate obstacles to services for pregnant women who have a substance use disorder through comprehensive care coordination implemented within the five major timeframes when intervention in the life of the substance exposed infants (SEI) can decrease potential injury of prenatal substance exposure. The five timeframes are pre-pregnancy, prenatal, birth, neonatal and early childhood. Care coordination also addresses screening, early intervention, assessment, treatment and recovery supports.

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

MWRAP provided training in 2022 to ReachNJ, the central call-in line for New Jersey. MWRAP is offered as a resource to pregnant women who call ReachNJ and in response, Reach NJ will provide warm hand-off to MWRAP providers as needed. MWRAP services provides the support needed to help pregnant and parenting women maintain a healthy recovery, resulting in less overdoses, and improved birth outcomes and maternal child health.

Collegiate Recovery. Six public colleges and universities (Rutgers University at New Brunswick and Newark, The College of New Jersey, Ramapo College, Rowan University, Richard Stockton University, and Ocean County Community College) receive state funds to support students in recovery. Recovery supports include screening and intervention services for at risk students; dedicated recovery housing; self-help, mentoring, peer and academic support; crisis management and relapse prevention; community education; and alcohol-free/alternative programming and community service opportunities.

In State Fiscal Years 2019-20, capital agreements were established with The College of New Jersey and Ramapo College of New Jersey to develop and designate recovery housing for students and/or enhance existing recovery communities on campus. Capital improvements included: the re-purposing of a student recreation facility into a health and wellness center, creation of a recovery lounge, renovation of a single-family dwelling into recovery housing, and upgrade of an existing residential building with new kitchen and lounge areas for students in recovery.

Family Support Centers. Three regional Family Support Centers (FSC) continue to be funded through SOR funding to provide peer-to-peer family support services to families in each region whose loved ones mainly suffer from an opioid use and/or stimulant use disorder. FSCs were the first formal family support service in the New Jersey's Substance Use Disorder continuum of care that offered direct family support, education, resources and advocacy in a safe and non-stigmatizing environment. Each regional center is staffed with Family Support Coordinators with lived experiences who are trained in the Community Reinforcement and Family Training (CRAFT) Model which teaches families self-protection along with non-confrontational skills to help empower their loved one to seek treatment. The CRAFT Model which was developed and researched by Robert J. Meyers, PhD. is an evidence-based, non-confrontational intervention and skills-based program designed to impact families in multiple areas of their lives, including self-care, pleasurable activities, problem solving, and goal setting. CRAFT addresses their loved one's resistance to change, in addition to teaching families behavioral and motivational strategies for interacting with their loved one.

CRAFT training is provided by DMHAS to all FSC Coordinators. FSC Coordinators work with families on the three major goals of CRAFT:

- Decrease a loved one's harmful substance use;
- Influence a loved one to seek substance use treatment and recovery; and
- Improve the functioning of family members by making positive life changes.

Through brief CRAFT model supportive sessions, the FSC Coordinator assists family members in examining their interactions with the person who is using substance(s), improving their communication strategies, and decreasing emotional stress. Assistance is given to support parents, build hope and provide a sense of optimism, teach positive communication skills, be able to engage

in role-plays with parents to rehearse positive communication skills, conduct supportive or psycho-education groups, develop wellness plans, share stories of hope and recovery, connect family members to each other, and advocate for the addition of family members' health and safety.

The FSC Coordinator helps each family member develop and work on their own Individualized Wellness Recovery Plan. The overall goal of the FSC Coordinator is to provide compassionate support to empower family members to have a better quality of life, improve their psychological health, decrease levels of stress, feel less isolated, and gain skills needed to cope with their loved one's use. Families who receive FSC services also receive Naloxone Training and Kits to assist their loved ones at risk of opioid overdose.

In 2021, each regional FSC expanded due to the increased numbers of referrals coming from OORPs, STARs, ReachNJ, Connect4Recovery Call Center, Division of Children and Families, and Families, Drug Court, Probation, and Treatment Providers to assist family members of loved ones with an OUD/stimulant use disorder, and some families without. In 2024, each regional FSC expanded due to the increased need for staff to support each region. Each FSC Region now provides family support services for at least 150 families in their region.

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. Through June 2025, 2,387 individuals have been served by TRS. Additional information about TRS services is provided below.

- Total phone calls outgoing: 33,975
- Total phone calls incoming: 12,616 calls
- Average length outgoing: 5 minutes 53 seconds
- Average length incoming: 9 minutes 21 seconds

Prison Intensive Recovery Treatment Support. Since 2017, DMHAS has worked with the Department of Corrections to provide Intensive Recovery Treatment Supports (IRTS) post-release services to a cohort of eligible individuals (n=200) with Opioid Use Disorder that receive MAT prior to release from prison, and to another cohort of non-MAT eligible individuals (n=400) both pre- and post-release into the community.

In October 2020, NJ Governor Phil Murphy signed legislation for the decrease of sentences and early release of certain individuals incarcerated in NJ state prisons for non-violent offences. The law was effective in early November 2020. Through January 2021, almost 3,000 individuals were released from prison. Approximately 800 of these individuals had an OUD diagnosis and 364 enrolled in the IRTS program. Two additional IRTS teams were developed to serve them.

IRTS links eligible individuals with a conviction to recovery services necessary to support wellness and successful community re-integration. It helps individuals address issues such as: health/wellness, treatment adherence, employment, housing, and opportunities and skills to enhance the individual's ability to participate in meaningful life activities. There are five IRTS teams providing services for up to six months prior to release and up to 12 months post release.

In a subsample of IRTS (N = 334), the percentage who reported being housed increased from 74% in the first month after release to 84.7% in the fifth month, while the percentage who reported employment increased from 27% to 73%. The self-reported percentage using MOUD decreased modestly over this period but remained relatively high at 63.4% after five months. Self-reported alcohol and drug use increased over this time but remained below 30%. Among participants, on a monthly basis, 0.8% and 2.4% of active participants in the community experienced overdose or return to prison, respectively. Of 1,364 participants in the program, 4.4% were known to experience an overdose at any time while in the program.

The following table provides a description of IRTS participants as of 6/30/2024.

Characteristic	%
Sex	
Female	9.6
Male	90.3
Age	
18-24	6.6
25-34	35.9
35-44	31.7
45-54	17.6
55+	8.2

MAT use among participants with OUD, January 2020 – May 2024

Month	N with OUD	On MAT
Jan 2020	172	66.9%
Feb 2020	149	64.4%
Mar 2020	149	67.8%
Apr 2020	143	70.6%
May 2020	175	68.6%
Jun 2020	161	69.6%
Jul 2020	155	68.4%
Aug 2020	143	67.8%
Sep 2020	139	68.3%
Oct 2020	116	65.5%
Nov 2020	155	63.9%
Dec 2020	158	62.7%
Jan 2021	144	65.3%

Month	N with OUD	On MAT
Apr 2022	100	63.0%
May 2022	90	68.9%
Jun 2022	65	67.7%
Jul 2022	60	68.3%
Aug 2022	59	64.4%
Sep 2022	50	68.0%
Oct 2022	51	64.7%
Nov 2022	51	68.6%
Dec 2022	54	64.8%
Jan 2023	45	55.6%
Feb 2023	50	64.0%
Mar 2023	42	54.8%
Apr 2023	53	62.3%

Feb 2021	155	64.5%
Mar 2021	115	70.4%
Apr 2021	68	69.1%
May 2021	106	74.5%
Jun 2021	132	66.7%
Jul 2021	116	65.5%
Aug 2021	90	67.8%
Sep 2021	108	69.4%
Oct 2021	105	64.8%
Nov 2021	79	77.2%
Dec 2021	72	73.6%
Jan 2022	68	69.1%
Feb 2022	79	73.4%
Mar 2022	108	66.7%

May 2023	51	56.9%
Jun 2023	46	56.5%
Jul 2023	46	60.9%
Aug 2023	43	58.1%
Sep 2023	41	58.5%
Oct 2023	67	56.7%
Nov 2023	79	51.9%
Dec 2023	85	51.8%
Jan 2024	86	52.3%
Feb 2024	81	56.8%
Mar 2024	78	57.7%
Apr 2024	81	60.5%
May 2024	72	58.3%
Average	95	64.5%

Note: N represents the number of participants with documented OUD diagnosis who completed monthly reports for the month. Data entry may be incomplete for most recent months.

Recovery Centers. New Jersey has 23 community peer recovery centers for individuals in recovery from substance use disorders. Recovery centers are places that those in recovery can find help, fellowship, and a safe haven. Peer workers provide mentoring, coaching, care coordination, social and recreation activities, life skills, vocational training, support groups, wellness classes, workshops and assistance in housing, childcare, language and employment.

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

The SSA issued an RFP and subsequently awarded a contract to the Center for Family Services in Camden County in April 2012 to provide New Jersey's second Recovery Center. It opened in December 2012 at a suburban location in Camden County. Staff working seven days a week provide outreach to individuals in recovery as well as to provider treatment programs throughout the state. Like Eva's village before them, Living Proof Recovery Center has a peer advisory board and a full monthly calendar with weekly self-help meetings, anger management, resume-building and financial workshops. There are also sober social activities such as line dancing, wrap sessions and recovery movies on the weekends. Both recovery centers also provide Telephone Recovery

Support (TRS), an evidence-based and data driven method of successful recovery support (White, 209). Both centers have a strong core of volunteers who help with day-to-day operations and recruitment. At present, staff and volunteers at both centers have used CRSP and updated CDA certification for staff and volunteers.

Community Peer Recovery Centers (CPRC). DMHAS has expanded Recovery Centers through the SOR funding. Funding was issued in 2019 through a Request for Proposals (RFP) to develop three Community Peer Recovery Centers (CPRC) where individuals can access peer support, information about substance use disorder treatment, recovery support services, and information about other community resources in a supportive substance free environment. DMHAS initially awarded three providers in the amount of \$100,000 each for start-up small-scale Recovery Centers to provide peer-to-peer recovery support services to prevent recurrent of substance use and promote sustained recovery. DMHAS issued another RFP in 2020 with SOR funding to expand the CPRCs. DMHAS awarded seven additional providers for peer-to-peer recovery support services that are responsive to community needs. All activities and services through the CPRCs are led and driven by “peers”, individuals who have experienced addiction and recovery, either directly or indirectly as a family member or friend. The overall goal of the CPRC is to provide a safe place for recovering individuals to gather in support of one another and experience recovery-oriented living in a community setting. The CPRC is a place where those in recovery can have the opportunity to give back to their community thereby fostering senses of empowerment and independence. In March 2020, CPRCs have followed CDC and NJ DHS Guidelines due to the COVID Epidemic in providing virtual community support services (via phone and secure online services), and limited safe distancing in person recovery support services. All the CPRCs have now reopened their centers to in person as well as hybrid and virtual services. CPRCs found that one of the keys to building a recovery community is embracing the many pathways to recovery, as well as ensuring meeting individuals where they are at. CPRCs have been able to share information regarding recovery, treatment, and overdose prevention at their centers, including distributing Naloxone training and kits. DMHAS issued additional RFPs in SFY 2022-23 using SOR funds to expand to the 11 remaining New Jersey counties. By 2023, NJ achieved its goal of having a Recovery Center in all 21 counties. Each of the CPRCs received \$100,000 yearly to continue services.

In 2024, DMHAS issued an RFP to expand the CPRCs by utilizing \$100,000 SOR funding and \$275,000 Opioid Recovery and Remediation Funding for each CPRC. All of the awarded CPRCs now have an expansion of hours, staff and services in all 21 counties.

Recovery Management Check-Up. Recovery Management Check-up (RMC) is service for discharged clients to support independent living and success with recovery and provide more methods of outreaching to clients. This includes virtual face-to-face visits, text messaging and chat features, and also the opportunity for actual in person contacts. Monthly contact forms the core of the proposed RMC that aims to identify and alleviate client problems before they derail recovery. Problems are addressed using motivational interviewing techniques or connecting clients to appropriate community resources or treatment if needed, including medication assisted treatment (MAT). The conceptual framework of RMC is to treat addiction as a chronic disease, with long-term management to minimize the number of acute episodes of substance use disorder and with prompt treatment when episodes occur to prevent them from becoming more severe and

consequential. RMC is a statewide program designed to provide local recovery support services in the following three regions of the state.

- 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.

Key goals of the RMC are a) provide a regionalized, innovative recovery program to individuals recovering from SUD in all 21 counties of New Jersey; b) provide and coordinate integrated person-centered recovery support services to persons in recovery; c) identify, improve, and sustain the recovery capital for persons or individuals recovering from SUD. The overall purpose of RMC is to ensure optimal success for persons in recovery. To this end, the program employs four dimensions of recovery; health, home, purpose, and community. RMC seeks to meet participants wherever they are in their individual recovery journey by honoring their choice, voice, and agency.

Through concerted efforts, collaborations and team technical supports, the program was enhanced to gain buy-in and geared towards being institutionalized process in the recovery community in the state. To achieve this, the program launched the RMC Referral website and e-referral kiosk at <https://fvrhub.org/rmc-nj-cars/>, as an effective tool to facilitate referrals to the appropriate regions based on the participant's county of residence. Available indicators show that RMC had consolidated and registered progress across the three regions of the state. Data below will highlight the quantitative value of progress made in RMC from onset to present.

From program beginning to March 2025, for all three regions, a total of 14,032 outreach attempts were made by certified peer support specialists. 3,987 of those were successful contacts. On average, 584 attempts were made, with 166 succeeding, per month. The program's output was on an upwards trajectory, and the last 6 months of the program were its most productive. In that time, the program expanded to 1,030 outreach attempts per month, with 272 successes. The program was able to serve 1,503 unique participants. RMC was able to serve as a connective program, making 2,692 referrals to other both SUD and non-SUD-related programs.

Coalition for Addiction Recovery Support. The New Jersey Coalition for Addiction Recovery Support (NJ-CARS) is a statewide organization that provides a platform to celebrate the hope of recovery, promote the value of individuals with lived experience, and to incorporate and strengthen recovery support services across the continuum of care for substance use disorders throughout New Jersey. NJ-CARS, advocates for affordable, community-based services that support individuals and their families throughout the entire recovery process, ensuring accessibility no matter where they reside in New Jersey.

NJ-CARS Advisory committee is a broad group of experienced recovery support practitioners and providers from New Jersey comprised of 75% peers at minimum. NJ-CARS offers the opportunity for members to be part of a statewide voice for recovery. For organizations, it offers the opportunity to contribute to the development and expansion of recovery support services in New Jersey and an opportunity to coordinate the training and cultivation of the peer workforce. The organization is currently funded through SAMHSA's Building Communities of Recovery (BCOR) grant.

Grassroots Recovery Organizations and Centers. The Recovery Movement is well established in New Jersey. In terms of social media, there are numerous NJ Recovery Support pages on Facebook, Instagram, Bluesky – ranging from parent-to-parent support groups, to groups advocating for more treatment and recovery options for those suffering from a substance use disorder. At the community level, New Jersey has seen tremendous efforts in advocacy and recovery support. The New Jersey affiliate of the National Center for Advocacy and Recovery for Behavioral Health (NCAAR-BH – formerly NCADD-New Jersey) developed a “Recovery Advocates” program with graduates being divided into regional teams across the state. These Advocacy Leaders are trained on how to provide testimony to the New Jersey Assembly as well to develop regional events to educate the community about recovery and decrease stigma regarding addiction.

There are eight grassroots recovery organizations in NJ: Addictions Victorious (Gloucester County), A Change for Nick (Passaic County), CARES- Center for Addiction Recovery, Education and Success (Morris County), CARES (Warren County), City of Angels (Mercer County), CFC Loud and Clear (Monmouth County), Help Not Handcuffs (Monmouth County), Hope Sheds Light Foundation (Ocean County) and Recovery Advocates of America (Mercer County). Some of these organizations operate their own peer designed and run Recovery Centers independent of DMHAS funding: City of Angels, CARES- The Center for Addiction Recovery, Education and Success in Morris and Warren Counties, CFC Loud and Clear, Recovery Advocates of America and A Change for Nick. These organizations are community-based and help individuals access treatment, provide support throughout their treatment experience and provide aftercare/relapse prevention supports and services after discharge. These are peer-designed, non-12 step affiliated groups, although 12 step meetings are often held on site.

All of these centers train their peer recovery staff and volunteers using the Connecticut Community for Addiction Recovery (CCAR) curriculum. Once they meet the required education and service hours, peers can take the examination and earn the NJ-specific Certified Peer Recovery Specialist credential or the National Certified Peer Recovery Support Specialist credential offered by NAADAC.

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 which is located on the campus of Kean University in Union County. It is open to students all

across NJ. A Recovery High School is exclusively for young people that struggle with substance use disorders. Every member of the staff, faculty and administration in each school is required to attend numerous trainings regarding addiction and recovery. The school provides social, academic and counseling. The initial class enrolled approximately 20 students. The number of students enrolled is increasing annually. In 2018, two additional recovery high schools opened in New Jersey – one in Monmouth County, and the other in Cape May County. Planning is underway for another recovery high school in Ocean County. In 2023, the Ocean County Recovery High School Taskforce has been moving forward with their efforts by seeking to introduce peer recovery support services to adolescents trying to sustain long-term recovery. They have converted a separate section of its Ocean County Recovery Center into a youth-friendly environment that currently hosts academic support sessions, one-on-one meetings, and group sessions with a recovery specialist. By launching these services, the Ocean County Recovery High School Taskforce is taking the next step towards opening its recovery high school and will have the recovery services in place that will be directly integrated into the academic day once the school is open.

Group Homes for Persons in Recovery (Criterion 7). Funding is provided to Oxford Houses to provide administrative and programmatic oversight of the statewide network of peer-led group recovery homes in New Jersey. The Oxford House model offers recovery-oriented living as a choice in a person's continuum of care. Recovery is an individualized process for individuals with substance use disorders. As of February 2025, New Jersey has approximately 152 Oxford Houses (109 male houses, 32 women houses, and 11 women with children houses); total beds are 1,186 with 854 male and 332 female beds. The Revolving Loan Fund is administered by Oxford House annually to establish new homes, with additional funding from the Administrative Office of the Courts and DMHAS treatment contracts. This funding supports Oxford House, Inc.

Federal funding for the State Opioid Response (SOR) allowed for expansion of the Oxford House contract to support four (4) full-time outreach staff employed by Oxford House, Inc. to establish an additional ten (10) to fifteen (15) new homes per year or the moving of existing houses as needed. DMHAS expanded the Oxford House contract in State Fiscal Year 2022 with SUPTRS Block Grant Funds for two additional full-time outreach staff employed by Oxford House, Inc., and to support separate start-up funds to cover additional costs associated with the development and opening of houses for populations in need of services. The service populations include the following: women with children and men with children, individuals re-entering from incarceration and individuals with a history of opioid use who are at high risk for an overdose death.

State Fiscal Year 2024 utilized Opioid Settlement Expansion Funds to support five (5) full-time staff: one senior outreach coordinator, two outreach staff, one training and education coordinator and one resource coordinator. This funding with support from Oxford House Inc., will expand and/or stabilize the Oxford House network in New Jersey as needed with up to ten to twelve (10-12) new homes. Additional activities include training and education initiatives, offering regular training sessions on critical safety subjects, including opioid overdose prevention and medication-assisted recovery paths. The Resident Equal Expenses Shared (EES) assistance will be utilized for new members from populations, such as women with children or those re-entering from incarceration. These residents receiving support will work closely with the training and education and resource coordinators to ensure they receive additional support connections to community

providers. State Fiscal Year 2025 Oxford House Opioid Settlement Expansion Funds developed twelve (12) houses: six (6) men houses, three (3) women's houses, and three (3) women and children homes.

In response to the opioid overdose epidemic, and its effects related to Oxford House, DMHAS requires Oxford House outreach staff to conduct annual trainings (overdose specific) for the 14 Oxford House Chapters throughout the state. Trainings are provided at the Oxford House annual state workshop. Each home is required to maintain Naloxone kits on site. Oxford House has seen an increase in members applying for membership with Opioid Use Disorder (OUD). This increase supports the need for Naloxone training and information on access to Medical Assisted Recovery (MAR) options. The New Jersey outreach team continues to educate members on MAR and the importance of being an active member of their recovery community. Oxford House shall make every effort to accept individuals prescribed Medication Assisted Treatment (MAT) as well as other legitimately prescribed medications. Women and children Oxford Houses are responsible for providing lockboxes to each woman for medication storage, and residents in Oxford Houses are responsible for their individual medication lockboxes.

Oxford House reports that the housing market in New Jersey continues to be an obstacle in finding and acquiring affordable houses. The average cost to rent homes the size needed to be used as Oxford Houses has dramatically increased in the last year. These challenges have caused the team to struggle to find houses in some regions of the state where the rental amounts are much higher. New Jersey Oxford House also faces challenges in maintaining existing homes due to rising costs in the housing market. Many current landlords are incentivized to sell their properties or lease them at higher rates to other renters, making it difficult to secure affordable housing. The outreach team continues to be vigilant in exploring all possible ways of identifying new locations. As of June 2025 there are a total of 161 New Jersey Oxford Houses: 115 are men houses; 34 are women houses; and twelve (12) are women and children's homes.

Oxford House, Inc. is taking pro-active steps to address the needs of broad populations, particularly individuals with substance use disorder histories who are re-entering society from carceral settings. By providing presentations at local recovery community organizations and treatment centers, they ensure that individuals from various backgrounds, older adults and others are aware of the opportunity to join Oxford House. One notable aspect of Oxford House's approach is its acceptance criteria, which solely requires a history of SUD rather than imposing additional obstacles. This approach promotes access by providing an opportunity for individuals to access supportive housing and community resources. Oxford House implements interventions to help to promote access providing tailored supports to individuals who may face unique challenges in accessing treatment and support services.

Oxford House reports that outreach staff, alums, and Oxford House members visit each other in houses and hold face-to-face chapter and state meetings. These meetings have been a long-standing and stabilizing part of the Oxford House Model.

Supportive Housing. The SSA has two state-funded supportive housing programs incorporated into its MATI. These two contracts combined provide for a total of 63 housing units, 31 units in Camden and 32 units in Atlantic City. Services are provided to individuals with substance abuse

disorders who are homeless or at risk of becoming homeless, and are intravenous drug users. Women with children are given top priority. It includes rental subsidies and support services.

The SSA developed a Women's Intensive Supportive Housing (WISH) Program. This program provides permanent supportive housing for pregnant and/or parenting women with a co-existing substance abuse disorder and mental illness who are homeless or at risk of homelessness and being discharged from a licensed residential substance use disorder treatment and/or halfway house facility. An RFP was developed and released in January 2015. The goal of the WISH is to promote long-term recovery, personal growth, and the positive well-being of involved children. WISH combines the benefits of wrap around services and case management with those of supportive housing and is available to ten (10) women and their children. Services includes referrals and linkages to appropriate providers located nearby or that are readily accessible through public transportation, comprehensively addresses the family's physical and behavioral needs in the areas of primary medical health (such as regular care, maintaining appointments medication compliance, medication literacy, etc.) substance use disorder counseling and treatment, recovery supports, mental health (including Post Traumatic Stress Disorder), dental care, and HIV/STD prevention, treatment and support services. A contract was awarded in 2015 to a licensed substance use disorder treatment provider who specializes in women's gender specific treatment, offers a continuum of care, has a longstanding history of providing supportive housing and has demonstrated success in managing permanent supportive housing programs. The case management component of WISH is funded by SUPTRS.

Since 2014, DMHAS has a Memorandum of Understanding (MOU) with NJ DCF, DCP&P to fund ten (10) supportive housing subsidies annually for the "Keeping Families Together" (KFT) program for parents involved with the child welfare system who are homeless or at imminent risk and in which one or more adults in the family is diagnosed with a co-occurring mental illness and substance use disorder. DCP&P contracts with a provider for the KFT program in Essex County.

DMHAS awarded contracts in 2019 to provide individualized case management and supportive services to up to 200 individuals with an OUD, on average, up to 8 hours per month, billable in 15 units, based on individual needs. These services will assist individuals in seeking and connecting with behavioral health and or physical healthcare needs. DMHAS provides 175 rental subsidies, up to the fair market rate (FMR) as defined by the Department of Community Affairs (DCA) for lease-based housing. One-time funding will be available to consumers for security deposits, utility start-up costs and furnishings. Contracts were awarded four agencies to serve individuals in five counties: Atlantic, Burlington, Camden, Mercer and Monmouth. Since the awarding of the OUD contracts the number of referrals has reached approximately 250 referrals with a total of 114 subsidies currently occupied, and an additional 24 in housing search phase. The turnover of the OUD vouchers is approximately 10%, with consumers surrendering the subsidies. The onset of the COVID-19 Pandemic has resulted in the full payment of rent for some of the OUD consumers since they lost employment. As part of this process all DOH, Licensed Drug and Alcohol Independent Clinics, are eligible to bill for peer services following the criteria set forth in the Medicaid Newsletter, dated September 2021, Volume 31 No. 18, Peer Recovery Specialist. The requirement to bill is that all Peers are Certified Peer Recovery Specialists (CPRS).

In addition, the Medicaid Newsletter for Case Management (CM) Services, dated April 2021, Volume 31 No. 10, Care Management Services, allows DOH, Licensed Drug and Alcohol Clinics Outpatient to submit for FFS payments for Care Management Services. Requirements for the CM is listed in the Newsletter along with the role the CM can do.

Sober Housing. Contracts were awarded in 2019 for three pilot recovery-based housing residences (a minimum of five individuals in each residence), one in each region (North, Central and South), for individuals with an OUD who are homeless or at risk of homelessness. Individuals are in or recently discharged from treatment and are seeking a drug free, sober and supportive living environment, with access and linkage to sober community resources. Individualized case management and recovery-based housing services is provided for 15 individuals (a minimum of five individuals in each region) who have been identified as needing a safe, healthy, peer-lead, recovery-oriented environment. The housing provided must be licensed as a Class F, Cooperative Sober Living Residence (NJAC §5:27). Accordingly, individuals are responsible for providing their own food and taking care of their own laundry. Treatment nor counseling may be provided in the residence; however, non-clinical recovery support services may be provided at the site and the agency may require, at its discretion, drug or alcohol testing of residents. (NJAC §5:27-2.1). Although increased funded sober housing slots are needed, the pilots are thriving and continue to benefit those individuals seeking a stable sober environment.

Services to P Statutory Populations

Pregnant Women and Women with Dependent Children (Criterion 3).

In Depth Technical Assistance (IDTA) Neonatal Abstinence Syndrome and Substance Exposed Infants (NAS SEI). As a SAMHSA Prescription Drug Abuse Policy Academy State, NJ applied for a unique technical assistance opportunity through the SAMHSA supported NCSACW to address the multi-faceted problems of NAS and SEI. NJ DHS/DMHAS as the lead State agency, partnered with DCF and DOH, and submitted a successful application (no funding attached). The IDTA goal was to develop uniform policies/guidelines that address the entire spectrum of NAS and SEI from pre-pregnancy, prevention, early intervention, assessment and treatment, postpartum and early childhood. The IDTA provided technical assistance to NJ to strengthen collaboration and linkages across multiple systems such as addictions treatment, child welfare, and medical communities to improve services for pregnant women with opioid and other substance use disorders and outcomes for their babies. Three goals were established: (1) Increase perinatal SEI screening at multiple intervention points; (2) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women screening positive on the 4P's Plus get connected for a comprehensive assessment by establishing formal warm-handoffs and other safety net measures; and (3) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women delivering SEIs and their babies and any other eligible children, receive early support services for which they are eligible.

Workgroups were formed and comprised of representatives from the medical, addiction, child welfare community, and other stakeholders. The Labor, Delivery and Engagement (Infants) Workgroup developed a comprehensive survey with input from the medical community and perinatal cooperatives. The *Birthing Hospital Survey* was disseminated statewide March 2017 to

the labor and delivery hospitals. The survey sought to understand how pregnant women with SUD and SEI are identified, treated, and triaged with partners at discharge, and if treatment for NAS was explored. The results were intended to guide Departments in establishing statewide guidelines for best practice; aid in the development of cross system models to ensure families get access to services; establish education needs on issues of SEI/NAS and identify high risk areas. In an effort to increase access to SUD treatment and decrease unmet treatment needs of pregnant or parenting women with an Opioid Use Disorder (OUD), based from the *Birthing Hospital Survey* findings, the DMHAS engaged Rutgers/Robert Wood Johnson Medical School (Rutgers/RWJ) to provide technical assistance and training through the Extension for Community Healthcare Outcomes (ECHO) Program.

The Maternal Child Health, Pregnant and Parenting Women with Opioid Use Disorder (MCH PPW OUD) ECHO provides education and training to primary care practitioners, SUD treatment providers, behavioral health practitioners, and other stakeholders in multiple clinic settings and at home, utilizing a web-based video collaboration between a multi-disciplinary team of specialists and primary care practitioners on best practices for the assessment, case management, intervention, treatment and recovery support services for PPW with an OUD. The goal is to increase the capacity and competency of providers, community support organizations and clinical teams to support prevention, treatment and recovery of PPW with OUD. This ECHO positions communities to decrease the NAS birth rates, improve use of medication assisted treatment, family formation and early infant development; improve access to physical and mental health care by educating more providers, midwives, doulas, and other health care professionals on best practices during prenatal and perinatal periods; and to promote use of universal screening protocols and state reporting of pregnant women with OUD.

The ECHO series launched January 2020 through December 31, 2021. The MOA was extended several times to continue technical assistance, including education and training. The most recent extension is from October 2023 through September 2025. This ECHO series held evening sessions in an effort to reach out to practitioners and prescribers, with sessions focused on the latest FDA approved techniques for Medication Assisted Treatment (MAT), integrated care, and wraparound services, stigma of mental health and substance use, screening protocols, improving access to substance use treatment, Plans of Safe Care, and coordinated care for pregnant persons with OUD and their newborns. The new series which started January 2024 through August 2024 includes 18 sessions with five (5) community workshops and another 18 sessions with five (5) community education workshops through August 2025. The community education workshops focus on educating the audience on referral and linkages between providers, practitioners, and community services to support pregnant and parenting women and their family. These series focus on maternal opioid intervention and care coordination. Didactic topics with the 18 sessions range from integrative approach to care for pregnant persons; bridging the gap from patient to plan; implementation that is meaningful and impactful; prenatal care with an opioid/substance use disorder including alcohol misuse and effects on pregnancy; addressing stigma; perinatal depression; navigating the system to maximize successful family formation, etc.

New Jersey submitted a successful application and was awarded IDTA through the National Center on Substance Abuse and Child Welfare (NCSACW) 2023 Policy Academy: *Advancing Collaborative Practice and Policy: Promoting Healthy Development and Family Recovery for*

Infants, Children, Parents, and Caregivers Affected by Prenatal Substance Exposure. NJ State Policy Academy representatives include the Department of Health (DOH) DCF, DHS and the Governor's Office. The DMHAS Women's Treatment Coordinator represents DHS. Representatives from the medical, addictions and perinatal community also participate on this IDTA. The overall goal is to increase awareness of pregnant persons and SUD, through increased education and maximizing messaging through the perinatal work force, increase awareness and access to treatment, Plans of Safe Care, and improving screenings in hospitals and healthcare providers. Four goals have been established: *Goal 1:* Conduct a statewide landscape analysis of resources available to individuals with a SUD and understand how referrals are made to appropriate resources and levels of care. *Goal 2:* Address gaps in the SUD system of care to establish a comprehensive and fluid collaborative approach among state agencies, healthcare providers, and community-level and non-profit organizations to address substance use during and after pregnancy. *Goal 3:* By 2025, create and execute a state-wide prenatal Plans of Safe Care process that enables Community and Clinical Partners to formally support a birthing woman. *Goal 4:* Support birthing hospitals in updating their protocol related to screening and referring birthing people with SUD; and subsequently engaging in a comprehensive approach to implementing Plans of Safe Care in New Jersey.

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

DCF is the lead State agency on Plans of Safe Care for SEI, mothers and their families and has developed protocols for integrating Plans of Safe Care into child protection services and child welfare and child welfare assessments. DCF and DMHAS collaborate on multiple initiatives for pregnant and parenting women with SUD. 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 obstacles.

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

Persons Who Inject Drugs Services (Criterion 4). The SSA will continue to require all substance use disorder treatment agencies providing treatment to persons who inject drugs (PWID) to provide outreach activities to encourage PWID clients to seek and undergo treatment. The SSA will continue to incorporate a provision within the requirements section of each contract with the agencies providing treatment to PWID to ensure that these entities: 1) admit all individuals who request and are determined to be in need of treatment for intravenous drug use within 14 days of their request; or 2) make interim services available to the individuals within 48 hours of the request, and should the individual actively remain on the waiting list, admit the clients within 120 days. Each program will be notified that the following information about each client, who cannot be admitted to treatment within 14 days, shall be documented on the provider's standard waiting list: 1) date of placement on the waiting list; 2) unique client identifying number; 3) categorical priority status for admission; 4) record of provision of interim services by type and date; 5) record of weekly contact between client and entity; and 6) date and reason for removal from the waiting list. DMHAS will continue to utilize funding to support individuals requiring interim services through its Fee-for-Service (FFS) initiatives.

CY 2024 data indicated that the mean waiting time for the various levels of treatment ranged from 0 days (detox hospital inpatient) to 3.3 days (halfway house). Opioid maintenance programs had a wait time of .4 days.

Tuberculosis Services (Criterion 5). In New Jersey, all substance use disorder treatment facilities receiving contracts are required to conduct TB testing as part of the patients' admissions process. A provision of the guidelines requires that patients with TB, who were not admitted for treatment because the funded capacity at that facility had been exceeded, would be referred to another treatment provider for services. DMHAS will continue to have discussions with the NJ Department of Health, Division of HIV, STDs and Tuberculosis Services (DHSTS) to consider best practices in this regard. As of January 2023, the NJ Department of Health, Certificate of Need and Licensure Program, sent communication to all licensed SUD programs that any standards for TB testing that are promulgated by the Centers for Disease Control and Prevention (CDC) are to be followed by licensed SUD agencies and their patients, ensuring most up-to-date best practices are provided.

HIV Services (Criterion 6). New Jersey is no longer classified as a designated HIV Block Grant State. However, licensed substance use disorder treatment programs continue to be required by licensure standards to either provide HIV testing/screening on-site or refer out to a Division of HIV, STDs and Tuberculosis Services (DHSTS) funded site location. DMHAS continues its collaboration with DHSTS to ensure an integrated approach to SUD treatment and HIV care.

Mutual Agreement Program. The Department of Human Services (DHS), Division of Mental Health and Addiction Services (DMHAS) oversees the Mutual Agreement Program (MAP), a Parolee Substance Use Treatment Project implemented through Memoranda of Agreements between the DHS-DMHAS 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 Fee-For-Service (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.

Individuals Incarcerated in Prison. Since 2017, DMHAS has worked with the Department of Corrections to provide Intensive Recovery Treatment Supports (IRTS) post-release services to a cohort of eligible individuals (n=200) with Opioid Use Disorder that receive MAT prior to release from prison, and to another cohort of non-MAT eligible individuals (n=400) both pre- and post-release into the community.

In October 2020, NJ Governor Phil Murphy signed legislation for the decrease of sentences and early release of certain individuals incarcerated in NJ state prison for non-violent offences. The law was effective in early November 2020. Through January 2021, almost 3,000 individuals were released. Approximately 800 of these individuals had an OUD diagnosis and 364 enrolled in the IRTS program. Two additional IRTS teams were developed to serve them.

IRTS links eligible individuals with a conviction to recovery services necessary to support wellness and successful community re-integration. It helps individuals address issues such as: health/wellness, treatment adherence, employment, housing, and opportunities and skills to enhance the individual's ability to participate in meaningful life activities.

There are five IRTS teams providing services for up to six months prior to release and up to 12 months post release.

Jail Medication Assisted Treatment (JMAT). The New Jersey Department of Human Services' Division of Mental Health and Addiction Services (DMHAS), in collaboration with the Department of Corrections (DOC), Department of Health (DOH) and our community partners to coordinate and deliver medication-assisted treatment (MAT) for opioid addiction to individuals serving within county based correctional facilities. This partnership will help facilitate the connections individuals will need in order to sustain treatment services upon release.

This funding is being made available as part of Governor Murphy's initiative to combat the opioid epidemic in New Jersey and designed to encourage the use of or increase use of MAT in county correctional facilities for individuals with an opioid use disorder (OUD). Nationally, 75 percent of individuals incarcerated in prison with opioid use disorder are reported to have relapsed within three months of release and only 8 percent enter treatment after incarceration. (Fox et al., 2015) Few individuals receive MAT during incarceration despite MAT being the clinical standard for OUD treatment.

In New Jersey, a recent survey conducted by the DMHAS in collaboration with the County Jail Wardens' Association indicate that an average of 17 percent of jail detainees screen positive for a substance use disorder with a range of 10 percent - 69 percent among the jails reporting. (DMHAS/CJWA, 2018). Of particular concern are the rates of opioid overdose immediately following release from incarceration. In response to overdose deaths among its prison/jail population, the Rhode Island Department of Corrections initiated a model to screen and treat with MAT and sustain MAT post release through a community provider network. Results published in JAMA Psychiatry, researchers compared the pre- and post-intervention periods and found that "In

the 2016 period, 26 of 179 individuals (14.5%) who died of an overdose were recently incarcerated compared with 9 of 157 individuals (5.7%) in the 2017 period, representing a 60.5% decrease in mortality."(Green et al, JAMA Psychiatry, April 2018)

, Individuals may be released from incarceration prior to or while experiencing the onset of opioid withdrawal symptoms. This can put individuals at an increased risk for overdose. Nevertheless, MAT being introduced pre-release has been shown to improve the likelihood of recovery sustainability post-release and can alleviate the risk associated with shorter jail stays. This initiative seeks to support wardens in building the capacity to deliver and sustain MAT for the impacted population.

Co-Occurring Services. Beginning in SFY 2010, the SSA established a Co-Occurring Services Network (COSN) to provide treatment to clients with co-occurring disorders on a Fee for Service basis. Agencies eligible to join the SUD FFS Initiatives Network as a Co-Occurring Network must meet New Jersey Department of Health Certificate of Need Licensing Office (CN&L) requirements as a co-occurring provider. Currently, there are 135 agencies in the COSN. These agencies represent 247 individually licensed sites with COSN approval. Authorization to provide co-occurring services is predicated on agency's Co-occurring licensure approval.

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

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

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

Individuals with a Driving Under the Influence Offense. 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). Individuals convicted of DUI and 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 decrease the incidence of recidivism and ultimately creating safer roads and waterways. There are over 200 licensed sites in the Driving Under the Influence Initiative (DUII) fee-for-service network providing all levels of substance use disorder treatment services.

Older Adults. Based upon results from the New Jersey Older Adult Survey on Drug Use and Health, DMHAS identified unhealthy drinking patterns and prescription drug misuse among adults age sixty and older as an issue. Data from the Older Adult Survey indicated, that in terms of illicit drug use, respondents were more likely to use tranquilizers, sedatives, and opiates when compared with older adults who responded to the New Jersey Household Survey. Data also showed evidence of possible misuse of prescription drugs and alcohol, particularly among male respondents. New Jersey's 19 DMHAS-funded prevention coalitions are addressing issues regarding the misuse of alcohol or prescription drugs among older adults through the use of appropriate environmental programs and strategies.

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

In 2017, DMHAS utilized STR funds to develop the Alternative Approaches to Pain Management program for older adults. The programs provide information about managing acute and chronic pain with means other than opioid analgesics: NSAIDs, massage, yoga, nerve blocks, etc. The program is currently funded by SOR and is provided in 20 of 21 NJ counties.

Student Athletes. A major component of New Jersey's SPF Rx project focuses on young athletes. A toolkit called "Tackling Opioids through Prevention for Athletes" (TOP) was developed by the New Jersey Prevention Network for use by providers. Literature suggests that when young athletes are prescribed opioid pain relievers for sports-related injuries, there is a risk of addiction and medication misuse. The 19 county coalitions that were established by DMHAS use the TOP to provide education regarding this issue to coaches, parents, prescribers, and young athletes.

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

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

At-Risk Youth. The SSA provides prevention services to at-risk youth. The SSA awarded funding to the North Jersey Community Research Initiative (NJCRI) to expand their existing programs for high-risk youth by using a “Street Smart” prevention model developed by the Centers for Disease Control and Prevention, as well as early intervention services, social marketing, and structured recreational activities. NJCRI provides services covering the northern NJ counties. In the spring of 2023, DMHAS (by means of a competitive RFP process) identified two additional organizations to provide services to at-risk persons in their communities: Prevention Resources in Central NJ and the Robert Wood Johnson-Barnabas Health Institute for Prevention and Recovery, in the south.

Rural Population. For its CCBHC demonstration project, 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. New Jersey is the only state where all 21 counties are officially classified by the U.S. Census Bureau as “metropolitan,” though rural pockets exist throughout the northern, western and southern sections of the “Garden State.” Due to the fact that entire counties are designated as “metropolitan” when portions of several counties are rural in nature, the State used the Office of Rural Health Policy’s rural urban commuting area codes definition to identify nonurban census tracts within metropolitan areas for purposes of identifying its “rural” CCBHC. The selection of a “rural” CCBHC was important to the State due to the anticipated benefits the CCBHC offers our rural residents. Residents who live in rural areas of the State have unique treatment needs that align with the population and service delivery model under the CCBHCs. The New Jersey State Office of Rural Health, using Behavioral Risk Factor Surveillance System data, found that rural residents were at greater risk than their non-rural and/or the national population counterparts in risk correlated with overall health and SUDs, including:

- Percentage of people who had at least one alcoholic beverage within the past three months;
- Frequency of alcohol use for people who had at least one alcoholic beverage within the past three months;
- Percentage of people who have smoked at least 100 cigarettes in their lifetime;
- Percentage of people who are overweight;
- Percentage of people who have ever been told they have diabetes;
- Percentage of people who have ever had a heart attack; and
- Percentage of people who have ever been told they have angina or coronary heart disease.

Homeless Individuals. DMHAS has funded services in homeless shelters to increase access to buprenorphine and other ancillary services for individuals with SUD. Contractees provide these services regardless of whether people live in the shelter or drop in. The shelters have affiliations with primary care providers to address physical health needs, including pain management, and implement evidence-based overdose prevention or other interventions to promote consumers’ recovery and wellbeing. The prescriber is present at the shelter or available via telehealth when initiating the medication and maintains the person on medication at the shelter or transitions them to a community provider. Case managers and peer specialists support people on sustaining their

medication treatment and helping them to overcome obstacles common to people who are homeless or at risk of homelessness. Shelters offering buprenorphine are located in Paterson, Trenton, Camden, East Orange, and Newark.

DMHAS operates Projects for Assistance in Transition from Homelessness (PATH) program using a combination of federal and state funds. The population of service 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 State Mental Health Authority (SMHA) contracts with non-profit agencies to operate PATH programs within the state's 21 counties. A small number of PATH programs use PATH funding to directly provide psychiatric assessment and outpatient mental health services. Many PATH providers are Community Mental Health Centers and link their 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 2024, the PATH programs in New Jersey provided outreach to 2,559 individuals and served a total of 1,562 persons. There were 638 program participants that were linked to mental health services, 92 to substance use treatment services (an individual with a self-disclosed SUD is referred to SUD treatment resources and services), 166 to primary health/dental care, 368 to financial services, 299 to temporary housing/shelter, 250 to long term housing and 292 were linked to employment or vocational and educational services. In addition, the SMHA provides funding for At-Risk lease-based, supportive housing beds for individuals who are at risk for psychiatric hospitalization and/or homelessness due to mental illness. In addition, the SMHA provides funding for At-Risk supportive housing beds for individuals who are at risk for hospitalization and homelessness.

The Open Access to Medications for Opioid Use Disorder in Homeless Shelters is designed to increase access to buprenorphine and other ancillary services for individuals with a substance use disorder through current programming available at homeless shelters that are licensed by the NJ Department of Community Affairs. These providers have developed the capacity to provide medication and support services for individuals who reside or drop in at homeless shelters. The intent of the program is to provide low threshold medication services to individuals with SUD who present in these settings. The six participating shelters are located in Paterson, Trenton, Camden,

East Orange and Newark. The shelters were awarded a contract from a competitive RFP process; two were awarded in December 2022 and four were awarded in May 2024.

Opioid Settlement funds were used to fund an RFP for temporary housing for individuals being discharged from residential, inpatient, ambulatory SUD treatment and/or individuals with a history of SUD who may be or have become homeless. The funding through this RFP can serve as a bridge to permanent housing, allowing participants to receive the support and services they need around other challenges in their lives. DMHAS issued an RFP in October 2024 and made awards in February 2025 to six licensed 24-hour emergency shelters for a total of 150 beds. A companion RFP funded with opioid settlement funds was released for case management services for adult individuals placed in one of the 150 shelter beds. Case managers will help connect individuals with services/ resources in their area and entitlements and assist them in securing permanent housing as quickly as possible. It is anticipated that individuals will obtain permanent housing within four months of initial engagement. Individuals served in this program will have access to DMHAS funded housing subsidies. DMHAS issued an RFP in October 2024 and made awards in February 2025 to four agencies to provide these services in their region of the state.

Through an MOA with the Rutgers Northern Region MATx Center of Excellence (COE)'s, DMHAS funds a set of services and training designed to improve engagement in SUD and mental health services among unhoused individuals in Essex County. The COE's Outreach Partners program provides intensive case management to increase the success of individuals in achieving and maintaining their recovery goals through medications for addiction treatment (MAT). Shelter-based activities involve assisting residents with obtaining Medicaid and facilitating linkage/referral to community-based organizations that provide social services, mental health, substance use, and/or medical treatment for shelter residents with SUD. In addition, Rutgers team members lead a variety of thematic support groups for shelter residents on topics such as overdose prevention, relapse prevention, family/social network connection, mindfulness and stress mitigation. Shelter-based support includes assistance with cell phones to help people stay in communication with service providers and vouchers for transportation so individuals can attend treatment appointments. Shelter-based participants will also be offered a "Overdose Prevention Backpack."

This program also includes a statewide Learning Community and provides quarterly trainings on topics related to SUD, mental health, and housing philosophy, as well as providing "hands-on" support to housing stakeholders in Newark and Northern New Jersey in creating programming that is empathic and responsive to client needs.

Consumers < 350% Federal Poverty Level. The SSA has established a guideline of 350% Federal Poverty Level (FPL) for the receipt of state funded substance abuse treatment. Clients are means tested with a web-based tool, known as the DAS Income Eligibility (DASIE) prior to admission into substance abuse treatment to determine whether they qualify for public funding. Upon admission to a treatment provider, the provider is required to collect documentation to prove the financial eligibility.

Other SUPTRS 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 tools.

New Jersey is currently reviewing regulation, billing and IT systems to evaluate and plan to make the changes necessary to update our system to comply with ASAM 4th Edition. Currently we continue to utilize ASAM 3rd edition levels of care criteria. One notable step that NJ has taken is to use policy, funding and waivers to current regulation to allow and encourage providers to incorporate addictions medications in all levels of care.

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

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

Contractees must ensure that priority admission and interim services to their programs will be given to IV using, pregnant women and parenting women and publicize the fact. If a contractee is at full funded capacity and unable to admit the pregnant woman, they must refer such women to another facility or make interim services available within 48 hours. Interim services for pregnant and parenting women are designed to decrease the adverse health effects of substance use and promote individual health. At a minimum, interim services includes the following: counseling and education about HIV and Tuberculosis (TB), about the risks of needle-sharing, the risks of transmission to sexual partners and infants, and about steps that can be taken to ensure that HIV and TB transmission does not occur, as well as referral for HIV or TB treatment services. Other interim services offered to pregnant and parenting women includes individualized education, case management, referrals and MAT. if needed, while awaiting admission. If necessary, linkage to Recovery Centers and/or other recovery supports in the community, and referral and/or and referral and/or linkage to community naloxone education programs. For pregnant women, interim services also address alcohol use disorder and 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, childcare, 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 2024 Independent Peer Review (IPR) cycle. The treatment providers selected for review constitute at least five percent of those receiving FFY 2024 SUPTRS Block Grant funds and are representative of the population of such entities. A letter was sent informing the agencies that they had been selected for review. The letter also clearly defined the purpose of the IPR. The stated purpose of the IPR is to ensure continuity and quality of care delivered to individuals with substance use disorders, to improve the system of care and ensure that the IPR focus is on education and remediation rather than monitoring and enforcement. The letter indicated that participants could anticipate independent suggestions for service delivery improvement from the IPR Reviewer, and that the review would not be used by any agency for certification, licensing, compliance monitoring, funding related decisions, or for litigation purposes.

Each IPR that was conducted and completed during FFY 2024 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 2024 agency selection process, the focus was outpatient and intensive outpatient methadone maintenance programs. All three reports were completed for FFY 2024.

DMHAS has repeated the process of hiring three credentialed substance use disorder professionals to conduct three IPRs in the North, South and Central regions of the State by September 30, 2025. The chosen modality of the FFY 2025 IPR is long-term and short-term residential treatment programs.

Strengthening the Behavioral Health Workforce

Student Loan Repayment Program. The Home and Community-Based Services Provider Loan Redemption Program was launched 2024 in a partnership with the Department of Human Services (DHS), Department of Children and Families (DCF), and the Higher Education Student Assistance Authority (HESAA). The program aims to strengthen the healthcare, behavioral health, and social services workforce by offering up to \$50,000 in student loan relief for eligible professionals who commit to one year of service in approved home- and community-based settings or as self-directed employees. Funded through a \$100 million FY 2024 investment from DHS and the Centers for Medicare and Medicaid Services, the initiative allocates \$17 million to support workers across mental health, developmental disabilities, family services, and private duty nursing, with \$5 million dedicated to eligible employees serving in DMHAS contracted agencies. Eligible applicants include licensed healthcare providers, behavioral health specialists, social workers, nurses, and other certified professionals. Governor Murphy and state leaders emphasized that the program both relieves financial burdens on care workers and expands community-based care capacity.

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

To prepare clinical staff to obtain certification or licensure, and to comply with the New Jersey Board of Marriage and Family Therapy Examiners' Alcohol and Drug Counselor Committee continuing education requirements, the ATWD contract was renewed with the New Jersey Prevention Network (NJPN). The principal goal of this initiative was to provide accessible training opportunities statewide for those entering or presently working in the addiction field. The anticipated outcome was to increase the number of credentialed and licensed employees who provide treatment, prevention, and peer recovery support services. NJPN offered alcohol and drug counseling coursework leading to certification and licensure at geographically broad training sites across New Jersey. Training opportunities were available to individuals and in outpatient, residential, opioid use disorder, prevention, peer led recovery programs/centers, and behavioral

healthcare treatment programs. Since its inception in 2006 and through March of 2023, 1,193 students trained through ATWD have become credentialed as certified alcohol and drug counselors (CADC) or as Licensed Clinical Alcohol and Drug Counselors (LCADC).

NJPN also offered continuing education trainings for clinicians and peers that included Community Reinforcement Approach to Family Therapy (CRAFT), Mental Health First Aid, Medication for Opioid Use Disorder, Substance Use and Family Systems, HIV and Bloodborne Pathogens, Ethics Refresher, Law Enforcement and Peer Services, Stimulant Training, Peer Supervisor Practice, and Self-Care Strategies. In addition, NJPN offered course work leading to Clinical Supervisor and Prevention Specialist certifications.

NJPN was instrumental in assisting practitioners who, due to COVID-19, were able to apply for a temporary waiver to provide alcohol and drug counseling services through the Division of Consumer Affairs, Marriage and Family Therapy Examiners, Alcohol and Drug Counselor Committee. NJPN provided technical assistance to prospective candidates with posting requirements, answering questions, completing forms, and uploading documents. Instituted in June 2020, the temporary CADC license was awarded to individuals 192 to fill in a gap of services needed in response to COVID-19.

Peer Credentials. DMHAS recognizes and supports two primary pathways to peer certification:

- Certified Peer Recovery Specialist (CPRS) issued by the International Certification & Reciprocity Consortium (IC&RC) NJ affiliate, the Addiction Professionals Certification Board.
 - Current Certifications (CPRS) - 566
- National Certified Peer Recovery Support Specialist (NCPRSS) issued by NAADAC, the Association for Addiction Professionals.
 - Current Certifications (NCPRSS) – 110
- Dually Credentialed (CPRS and NCPRSS) – 14
- Completed all training requirements and in pursuit of certification, but have not achieved to date - 499

Peer Development. DMHAS supports the advancement of the peer workforce by offering comprehensive training and professional development opportunities designed to enhance recovery-based services. All peers are required to attend a three-day Ethics training, covering topics such as motivational interviewing, self-reflection, self-disclosure, and person-centered responsive practices, understanding medications for opioid use disorder (MOUD), and effective outreach and engagement strategies. Peers also attend the five-day Connecticut Community for Addiction Recovery (CCAR) Recovery Coach Academy, which fulfills the educational requirements for peer certification.

To ensure adequate staffing for DMHAS-funded recovery programs, DMHAS provides scholarships for peer training, certification, and testing fees.

Since peer training began in 2016:

- 1,335 students have completed the required three-day Ethics training.
- 1,028 students have completed the five-day CCAR Recovery Coach Academy.

- 875 students have completed both trainings, satisfying the educational requirements for the CPRS credential.
- Students have participated in 131 specialty and recertification trainings, totaling 2,379 participants.
- Across all offerings, NJPN has facilitated 260 trainings with 4,654 participants.

These efforts have contributed to a growing and well-trained peer workforce, strengthening recovery support services across New Jersey. 800 peers or 41% of all participants in the Peer Recovery Support Training Program have completed all training requirements for NJ state certification.

DMHAS held its 8th Annual Peer Summit in collaboration with NJPN on September 25, 2024 entitled, Stronger Together: Shared Learning and Building a Unified Future. This was an exciting 1-day in person event that featured keynote speakers, interactive workshops, and recovery-oriented activities. Attendees gained valuable insights, inspiration, connections and strategies for recovery with topics such as the latest in best practices.

The PAC Peer Recovery Support Services (PRSS) Committee developed *Guidelines for Best Practices: Peer Recovery Services* to help ensure that peer recovery support services are provided using best practices based in research and experiences in various settings. The PRSS Committee acknowledges that this report is the beginning of the development of necessary standards for peer recovery support services in New Jersey. The guidelines have been worked on for the past several years during the expansion of this evolving field. It is designed to bring practical processes, strategies and tools to peers, their supervisors, administrators, and others committed to initiating and sustaining best practices in the peer recovery support services field and the supporting work environments.

The SSA continued to build capacity among current credentialed clinical and peer professionals through its Memorandum of Agreement with The Rutgers University, Center for Alcohol Studies (CAS), Education and Training Division. During 2021-2022 CAS offered 66 highly specialized, one-day professional development seminars as well as the Emerging Addictions Conference, a daylong event addressing the triple threat of stimulants, opioids and COVID-19 in April of 2022. Both the seminars and conference offered training education hours that can be applied towards recertification or renewal for alcohol and drug counselors and behavioral healthcare professionals working within the addiction and co-occurring treatment fields. Scholarships were provided for 149 individuals to attend. The CAS was suspended for the 2025 fiscal year.

DMHAS and NJPN continued two innovative professional development opportunities for peer recovery specialists, addiction counselors, and behavioral healthcare staff. The first project which an immersive simulation training experience, called “SimMersion” provides an online flexible approach based on simulated conversations and role-plays that allow peer recovery specialists and others working in the addiction field to build skills and core competencies at their own pace while receiving on-demand feedback. By integrating an online platform which allows participants to engage in actual conversations and interventions with real individuals, the communication exchanges provide instant evaluation and coaching on Motivational Interviewing. These unique client interactive training modules focus on topic areas fundamental to peer interactions, including

treatment engagement and initiation, MOUD, recovery capital, boundaries, ethics, etc. to date, there are 672 participants registered and participating in this interactive training.

With the second project, DMHAS recognized how the impact of primary and secondary stressors placed on the helping profession can impact their personal and professional wellness. As a response, DMHAS and NJPN created safe spaces to discuss issues and strategies that can assist in the overall health and well-being of individuals working in the helping profession. Confab, as it is called, continues to provide supportive and professional counseling sessions to peers and clinical staff as needed through a virtual supportive environment.

Prevention Fellowship. The Prevention Fellowship Program was developed to expand New Jersey's prevention workforce to ensure that evidence-based quality services are being provided to the broad communities across the state. The program selected a cohort of young professionals with broad backgrounds and experience to become part of the Prevention Fellowship Program. Though NJ has worked hard to address the health gaps that exist in the state, to truly eliminate health gaps, the prevention workforce will need to help communities implement strategies that are responsive to the population of New Jersey. A competent workforce is essential to accomplish this goal. Yet the prevention field—like the public health field generally—has struggled to create and maintain a robust workforce. The NJ Prevention Fellowship Program will work to expand and strengthen the prevention workforce for the future.

The first cohort of five fellows began their fellowship in January 2023. The fellowship program was developed (in collaboration with DMHAS), and is delivered by, the New Jersey Prevention Network and includes both didactic and experiential components. The initial months of the program include participation in CADCA's Coalition Academy and coursework required for the Certified Prevention Specialist examination. The experiential component includes internships at DMHAS-funded prevention coalitions and agencies. Fellows who complete the entire program will be qualified to take the Certified Prevention Specialist examination. By the time the fellowship program ends on September 30, 2025, 35 fellows will have graduated from the program. A number of graduates found employment with DMHAS-funded prevention agencies and coalitions – which was the goal of this project.

Other Training. Project Echo® (Extension for Community Healthcare Outcomes) is a national guided practice model developed by the University of New Mexico that focuses on building provider capacity across a region by connecting specialists to local providers. The heart of the model is its hub-and-spoke knowledge-sharing networks which are led by expert teams who use videoconferencing to conduct virtual clinics with community providers. In this way, primary care doctors, nurses, and other clinicians learn to provide care to patients in their own communities. The Project ECHO program in New Jersey, funded through the federal Substance Abuse Prevention and Treatment Block Grant, has been training and educating Primary Care Providers (PCPs) on substance use disorders since January 2020. Topics focus on three critical areas of substance use disorders: specific substances, medications for opioid use disorder (MOUD) and implementation of best practices for screening, managing and treating patients in the primary care setting. In March of 2020, New Jersey's Project ECHO redirected its resources to providing ECHO sessions focused on COVID-19, Mental Health and SUD to meet the needs of those with a substance use disorder in this current environment. Although the SUD ECHO Hub

team has transitioned back to its original focus, virtual clinics continue to include discussions of the COVID-19 impact on patients with a substance use disorder in its curriculum.

DMHAS also has a Memorandum of Agreement (MOA) with Rutgers Robert Wood Johnson Medical School, Office of Community Health to provide ECHO technical assistance and training. The ECHO series *“Maternal Child Health Pregnant and Parenting Women with Opioid Use Disorder (MCH PPW-OD)”* started January 2020 through December 31, 2021. The MCH PPW-OD ECHO provides education and training to primary care practitioners, SUD treatment providers, behavioral health practitioners, and other stakeholders in clinic settings and at home, utilizing a web-based video collaboration between a multi-disciplinary team of specialists and primary care practitioners on best practices for the assessment, case management, intervention, treatment and recovery support services for PPW with an OUD. The ECHO goal is to increase the capacity and competency of behavioral health providers, community support organizations, medical community, and child welfare to support prevention, treatment, and recovery of pregnant and parenting women with OUD and other substances. ECHO positions communities to decrease the NAS birth rates, improve use of medication assisted treatment, family formation and early infant development; improve access to physical and mental health care by educating more providers, midwives, doulas, and other health care professionals on best practices during prenatal and perinatal periods.

The MOA was extended several times to continue technical assistance, including education and training. The most recent extension is from October 2023 through September 2025. This ECHO series held evening sessions in an effort to reach out to practitioners and prescribers, with sessions focused on the latest FDA approved techniques for Medication Assisted Treatment (MAT), integrated care, and wraparound services, stigma of mental health and substance use, screening protocols, improving access to substance use treatment, Plans of Safe Care, and coordinated care for pregnant persons with OUD and their newborns. The new series which started January 2024 through August 2024 includes 18 sessions with five (5) community workshops and another 18 sessions with five (5) community education workshops through August 2025. The community education workshops focus on educating the audience on referral and linkages between providers, practitioners, and community services to support pregnant and parenting women and their family. These series focus on maternal opioid intervention and care coordination. Didactic topics with the 18 sessions range from integrative approach to care for pregnant persons; bridging the gap from patient to plan; implementation that is meaningful and impactful; prenatal care with an opioid/substance use disorder; addressing stigma; perinatal depression; navigating the system to maximize successful family formation, etc.

DMHAS contracts with Rutgers University to implement a program called the Rutgers Interdisciplinary Opioid Trainers (RIOT). The RIOT has been designed as a train-the-trainer program by faculty who educate/train university students. The university students provide a free one-hour training (virtual since March 2020) to community members/groups to educate them about the opioid epidemic in NJ, how to manage an overdose, and increase education and decrease stigma and discrimination about Opioid Use Disorder (OUD) and the use of medications to treat the disease.

In 2019, DMHAS entered into a Memorandum of Agreement (MOA) with both Rutgers University and Rowan University/Cooper Hospital to coordinate statewide DATA 2000 Waiver trainings for practitioners to include physicians, Advance Practice Nurses (APNs) and Physician Assistants (PAs). The State held a total of 31 trainings statewide through both Rutgers University (northern region) and Rowan University (southern region) in CY 2019 and CY 2020. Over 1,000 prescribers were trained through this effort.

DHS has contracted with two Centers of Excellence (COE) to support and advance the use of Medication Assisted Treatment (MAT) in the State. Rutgers University covers Bergen, Essex, Hudson, Hunterdon, Middlesex, Monmouth, Morris, Passaic, Somerset, Sussex, Union, and Warren counties in the northern region. Rowan University in partnership with Cooper Health cover Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Ocean, and Salem counties in the southern region. Both COEs provide a 24-hour call line, website information, a listserv for prescribers, prescriber training and support opportunities, a Project Echo, navigator support and trainings, coffee clubs, MAT lunch hours, links to toolkits and best practice resources. In addition, both COE serve individuals seeking treatment and MAT for opioids, alcohol or other substances.

Opioid Summits. In September 2019, DMHAS held its first annual Opioid Summit to address the stigma and misinformation surrounding Opioid Use Disorder (OUD) and to enhance the understanding of treatment options, such as Medication-Assisted Treatment (MAT). The Summit was held in-person at the Atlantic City Convention Center in Atlantic City, NJ on Friday, September 20, 2019. The theme of the Summit was “*Saving Lives & Changing Perceptions: Medication-Assisted Treatment*”. The Summit keynote speaker was Sam Quinones, author of *Dreamland, The True Tale of America’s Opioid Epidemic*. In addition to the keynote, individuals attended three panels, one with State officials, one with medical professionals discussing MAT in NJ, and one panel discussing how we could change the perceptions of OUD in our communities. After those panels, individuals were able to choose two different workshops to attend in the afternoon. Topics included integrating MAT into opioid treatment, educating families on opioid treatment and OUD, opiate use guidelines in the justice system, public safety response to the opioid epidemic, MAT in emergency departments, MAT in jails and prisons, and innovative approaches to improve OUD treatment.

The Summit had over 500 attendees and the audience was comprised of medical professionals, family members, government officials, professional counselors, and other stakeholders. Continuing Medical Education Credits and Continuing Education Units were provided for medical and counseling professionals, respectively.

Unfortunately, due to the COVID-19 pandemic, DMHAS did not hold an Opioid Summit in 2020.

In 2021, DMHAS switched to a virtual conference. The summit was held over the course of two half-days on September 21st and September 22nd. The theme for the Summit was “*Medication for Opioid Use Disorder: Increasing Access and Saving Lives*”. The 2021 Opioid Summit showcased the initiatives New Jersey had developed that aim to increase access to medications for opioid use disorder (MOUD), increase awareness against stigma/discrimination, and support the efforts of integrative care across the spectrum of recovery. The purpose of the Opioid Summit was to present

relevant, research-based information to professional counselors, addiction professionals, medical professionals, nursing professionals, social workers, peers, family members, and other community stakeholders. Topics addressed at the Summit included the impact of COVID-19 on OUD, best practices for the use of MOUD as a tool in recovery, OUD and stigma, OUD and mental health, innovative, evidenced-based and best practices for OUD treatment, recovery support systems, and OUD treatment and support services populations such as the Deaf and Hard of Hearing community.

Due to this Summit being two days, we had two separate keynotes present. On the first day, Actress Marlee Matlin told her story of addiction and being a Deaf actress. The keynote speaker on the second day was Dr. Wilson Compton, the Deputy Director of the National Institute on Drug Abuse (NIDA). Dr. Compton spoke about NIDA and what they are doing to improve prevention and treatment of drug abuse and addiction. In addition to the keynotes, individuals attended one panel as well as a workshop session each day. The panel on day 1 discussed the collaboration of State Departments to alleviate the opioid overdose epidemic. The panel on day 2 discussed low-obstacle approaches to MOUD. Registrants were able to go back to the website and watch, or re-watch, the sessions on-demand after the summit was over.

Attendance for the 2021 summit was higher than 2019 due to the two half-day format. In total, there were about 1,400 registered for the two-day event. The audience was comprised of medical professionals, family members, government officials, professional counselors, and other stakeholders.

In 2022, DMHAS kept the summit virtual due to the success of the 2021 summit. The 2022 Opioid Summit was a one-day event on September 21, 2022. The theme for the 2022 Summit was “*The Evolving Opioid Crisis: A Collaborative Approach*”. The purpose of the summit was to highlight the collaboration between various providers in New Jersey to treat Opioid Use Disorder. The 2022 Opioid Summit focused on topics including OUD and stigma, and OUD treatment, supports for populations in need such as older adults, the impact of COVID-19, trends within drug abuse, contingency management, advocacy for health access, and integrating peers into the system of care. The keynote speaker was Dr. Daniel Schneider, a pharmacist from Louisiana who lost his son to a drug deal gone wrong. The Netflix Docuseries, *The Pharmacist*, tells his family’s story. In addition to the keynote, individuals attended two panels. The first panel was an update from State Department officials on their programs and efforts to alleviate the opioid crisis. The second panel showcased several recovery support programs and discussed their approaches to assist those suffering from an OUD. This panel included representatives from Telephone Recovery Support, Community Health Center of Asbury Park, STAR Program, Oxford House and NJ Association for the Treatment of Opioid Dependence (ATOD). Since this summit was virtual, registrants had the ability to go back and watch, or re-watch, any of the sessions for a six-month period.

Attendance for the 2022 Opioid Summit was just over 700 individuals. There were attendees from Virginia, Pennsylvania, Texas, Delaware, Maryland and New Jersey. The audience was comprised of medical professionals, family members, government officials, professional counselors, and other stakeholders.

In 2023, DMHAS held a virtual Opioid Summit on September 20th entitled “Revitalizing Communities: Healing Together from the Opioid Crisis”. Topics for the workshops and panels included, but were not limited to, fentanyl and xylazine, integrated health programs, NJ recovery services, grief supports, the chronic pain community and treatment, stigma surrounding OUD, and law enforcement and first responder addiction support programs. A major accomplishment for the 2023 Opioid Summit was having 942 individuals from ten different states register for the conference. The DMHAS Opioid Summit Planning Committee was able to organize the day to include a keynote speaker (Randy and Lydia Grimes), two panels discussing important state updates, and 10 unique workshops. The on-demand viewing of the event was available through June 30, 2024.

In 2024, DMHAS held a virtual Opioid Summit on September 18th entitled “Building Hope for the Future” and had over 1,000 people register from 15 different states to either attend the live-day or have access to the on-demand sessions. The live day session had 700 people in attendance. The Opioid Summit Planning Committee coordinated have Mitchell Ammons, a marathon runner who was invited to the 2024 Olympic Trials and who has lived experience, be the featured keynote speaker. The Summit also included an afternoon keynote, 11 unique workshops, a federal policy update, and two panels that discussed important State Department updates. The on-demand viewing is available through June 30, 2025.

DMHAS will hold its annual 2025 Opioid Summit on September 17, 2025. The Summit, entitled “New Jersey’s Resilience: Improving Lives and Making Strides” will present current research and evidence-based best practices to a broad group of professionals, including alcohol and drug counselors, social workers, criminal justice professionals, law enforcement, first responders, physicians, nurses, peer specialists, and other interested community members. Topics will include xylazine and wound care, data from Overdose Fatality Review Teams, nursing home addiction care, methadone initiation in the hospital settings, stimulant use disorder, as well as several more.

Promoting/Integrating Health and Behavioral Health

Medical Director’s Integration Office. DMHAS’ Medical Director’s Office has an Integration Unit with the goal of promoting integration between behavioral health agencies and primary health care providers. DMHAS works closely with the NJ DOH on a variety of initiatives to increase bi-directional integration. Please see “Roles of Other State Agencies with Respect to the Delivery of SUD Services/Interdivisional and Interdepartmental Collaboration” for details of the collaboration. DMHAS works with its partners at the Division of Medical Assistance and Health Services to address billing and eligibility requirements that effect integrated care. The main goal of the collaboration is to increase consumers with mental health and/or substance use disorders (SUDs) access to primary care and improve collaboration between behavioral health agencies and primary health care providers.

Integrated Rule. DMHAS is working with the Department of Health licensing office to comment on ambulatory regulations that act as obstacles to integrating services, with the goal of streamlining the regulations and increasing integration of services. The plan is to develop a single, unified ambulatory care regulation that will remove current obstacles and allow integrated services to

operate seamlessly. The draft rule was released for comment on April 21, 2025 and allows for a 60-day comment period.

An integrated rule will establish licensure and operational standards for the development of an integrated licensing system by which an outpatient facility that provides healthcare services, including primary care and reproductive health services; behavioral health services, including ambulatory mental health treatment, substance use disorder and/or other addiction treatment services; opioid treatment program services and/or any combination of these services. The proposed regulatory structure includes facility standards for healthcare and behavioral healthcare services including opioid treatment program services (draft issued by the NJ Department of Health) and program standards for behavioral healthcare, including opioid treatment program services (issued by the NJ Department of Human Services, Division of Mental Health and Addiction Services). The draft standards proposes regulatory and policy reform that streamlines the application process for greater standardization of regulations across service types, providers greater flexibility for best practice and innovation and will support funding reform that will support the provision of integrated services.

Certified Community Behavioral Health Clinics. DMHAS was selected to be one of the eight Certified Community Behavioral Health Clinic (CCBHC) demonstration states. The NJ CCBHC demonstration providers began services in July 2017. This project is a collaboration between the Department of Human Services' Division of Medical Assistance and Health Services (DMAHS) and DMHAS and the Department of Children and Families (DCF). 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. Participating clinics are paid a monthly bundled rate per client based on the provider's costs. 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 less serious or chronic conditions.

Many CCBHC provider outcomes continue to improve year after year and some of NJ's providers outperform the HEDIS measures. Many CCBHC provider outcomes continue to improve year after year and some of NJ's providers outperform the HEDIS measures. New Jersey's CCBHCs are proven to decrease client wait times; increase access to mental health and substance use services; expand the use of mental health and substance use peer supports; increase use of evidence-based practices such as Medications for Opioid Use Disorder (MOUDs); and provide screenings for medical needs. New Jersey's CCBHCs provide 24-hour crisis care for the clients they serve, treatment for co-occurring substance use disorder and mental illness, ambulatory withdrawal management, outpatient counseling, case management, and family support services.

CCBHC Case Load and Demographic Characteristics. In Demonstration Year 6, which ran July 1, 2022, to June 30, 2023, and which is the latest year of available data, CCBHCs collectively served 21,994 clients. The CCBHCs have reported an overall increase of 23% in client enrollment between the first year of the Demonstration (July 1, 2017 to June 30, 2018) and Demonstration Year 6 (DY6).

In Year 6 of the CCBHC Demonstration, NJ's CCBHCs served 14% children / adolescents; 78% adults 18 to 64; 8% seniors. Sixty-three percent of consumers had primary NJFamilyCare or dual Medicare/NJFamilyCare. Of the clients served in the CCBHC, 1.6% were homeless or living in a shelter.

Care Coordination and Identification of Co-Occurring Conditions. Care coordination through case management has been described as the “linchpin” of the person-centered CCBHC model. CCBHC case management includes a range of services provided to support CCBHC clients to develop skills to gain access to needed medical, behavioral health, housing, and employment resources as well as to other social, educational, and community services essential to meet basic needs of living. CCBHCs provide support during times of transitions between care facilities such as from an emergency department or psychiatric hospitalization to outpatient care. In Year 6, 17,274 (79%) CCBHC consumers received case management. Case management has been provided to more than three-quarters of CCBHC consumers since DY2. The reach of case management provided in Demonstration Year 6 varied by diagnostic subgroup. Nine tenths of primary SUD consumers received case management in DY6, eight tenths of General consumers received case management and three-quarters of primary SMI consumers received case management for the three groups that comprise 97% of all consumers.

CCBHC providers are required to provide screening and referral or follow-up for a variety of co-occurring conditions. In Year 6, 74% of the clients were screened for clinical depression. In addition, 82% of adults with Major Depressive Disorder were screened for suicide risk. Eighty-three percent of adults were screened for tobacco use and 84% of adults were screened for unhealthy alcohol use.

Through systematic screening practices, an increasing number of patients were identified as having a pattern of unhealthy drug use. In DY3 2,306 clients served were identified with unhealthy drug use. Of those, 60% had presented with a primary substance use disorder, 17% were categorized in the general category and 21% of those with unhealthy drug use presented with a primary serious mental illness. In Year 6, just three years later, 4,907 individuals served were identified with unhealthy drug use. Of those, 27% had presented with a primary SUD, 31% had presented with a general diagnosis and 42% of the clients who were seeking services for a primary serious mental illness were identified as having unhealthy drug use. As was the case with unhealthy drug use screening, of the 955 clients served during Demonstration Year 6 with Medications for Opioid Use Disorder (MOUD), nearly half (48%) did *not* have a primary Opioid Use Disorder diagnosis: 30% had a primary SMI diagnosis and 18% were from the General population. It's clear that the integrative treatment model embodied in the CCBHC appears to promote improved screening and greater access to care, as well as facilitates a greater *coordination* of care to address the multiple domains of health for each client.

Promoting Integration of Primary and Behavioral Health Care (PIPBHC). In March of 2020, NJ was awarded a SAMHSA Promoting Integration of Primary and Behavioral Health Care (PIPBHC) grant. The goal of this project was to provide integrated care that serves individuals with an opioid use disorder (OUD) and other health co-morbidities. The grant program ended in March 2025 and DMHAS is working with providers and partners to sustain the integrated services.

DMHAS was awarded the *Promoting Integration of Primary and Behavioral Health Care Collaborative Care Model* (PIPBHC CoCM) grant by the Substance Abuse and Mental Health Services Administration (SAMHSA), effective September 30, 2024. The grant provides \$900,000 annually, with a total anticipated award of \$5.2 million over five years, concluding on September 29, 2029, all contingent upon availability of funding.

This initiative aims to enhance the identification, assessment, and treatment of individuals with serious mental illness (SMI), serious emotional disturbance (SED), and co-occurring physical health and/or substance use disorders (SUDs) in primary care and pediatric settings. In partnership with Rutgers University Behavioral Health Care's (RUBHC) Center for Integrated Care (CIC), the Collaborative Care Model (CoCM) will be implemented at three clinical sites: Rutgers New Jersey Medical School Ambulatory Care Center – Internal Medicine, Newark, NJ, New Jersey Medical School Medicine-Pediatrics, Newark, NJ (serving children and adolescents) and Trinitas Regional Medical Center, Elizabeth, NJ. Over the five-year period, the initiative will serve approximately 1,100 unduplicated individuals.

Office Based Addictions Treatment. The Office Based Addictions Treatment (OBAT) initiative, rolled out in 2019 and was based on the “hub and spoke” approach. In this model, SUD clinics, such as the opioid treatment programs (OTPs) serve as the ‘hubs’ and treat patients with more complex needs; meanwhile, the ‘spokes’ are small office-based practices and primary care settings where patients with more routine treatment needs are treated. Office-based practitioners (e.g., family physicians, psychiatrists, medical specialists, advanced practice nurses and others) prescribe buprenorphine and naltrexone, and they would have to either make referral arrangements or directly provide counselling for the patients. As of August 2025, there are approximately 170 servicing providers.

To assist OBAT practitioners, Medicaid provides a bundled rate for this services which includes a cost for a patient navigator, whose role is to arrange social services and supports for patients and to help monitor their progress. The OBAT system of OUD services, also referred to as the MATRx, allows a two-way referral of patients with other Medicaid funded providers. Office-based providers can refer patients needing a higher level of medical and /or addiction services to providers (e.g., substance use treatment agencies, certified community behavioral health clinics, federally qualified Health Care centers, etc.) or to one of two Centers of Excellence (COEs). DMAHS contracted with Rutgers University and Cooper/Rowan Universities to serve as COEs for the OBAT initiative. In addition to providing MAT services, these Centers are available for treatment and consultation referrals of individuals with complex needs. Because many practitioners were without extensive experience with prescribing buprenorphine, and support was needed to maintain a MAT practice, the Centers also provided MAT training through CY 2020 to assist prescribers attain their Buprenorphine Waiver. The waiver requirement was permanently removed in December 2022, so any provider who is registered with the DEA to provide controlled substances can now provide buprenorphine.

Beginning in 2023, Federally Qualified Health Centers (FQHCs) were able to bill for the OBAT intake assessment and peer services outside of their current encounter payment system. This provides additional support to FQHCs who are providing peer services intended to connect members with community behavioral health supports offered outside of the FQHC.

Smoking Cessation. DMHAS has focused on a broad plan to decrease smoking rates in individuals with mental illness and / or substance use disorders (SUDs). DMHAS continues to contract with the Robert Wood Johnson RWJ) School of Medicine, for technical assistance from Dr. Jill Williams, who is an addiction psychiatrist and a nationally recognized leader in treating tobacco dependence in individuals with mental illness and addiction. Dr. Williams has revised the Learning About Healthy Living (LAHL) manualized training that her team had developed and has been utilized as a tobacco treatment program around the county. LAHL is being promoted by DMHAS as a treatment resource. The Division is also funding a consumer-driven program called CHOICES that has peer educators who educate individuals, many of whom have a co-occurring substance use, about the negative impact of smoking.

In 2017, DMHAS coordinated a State Strategy Session/Leadership Academy for Wellness and Tobacco-free Recovery, which allowed collaborative planning with the Department of Health (DOH), the Department of Children and Families (DCF), and other state and county agencies. Some of the initiatives that increased understanding and awareness about the impact of smoking on those with mental illness and /or SUDs; in addition, a variety of steps were taken to address smoking, which included an increase in Medicaid coverage for smoking cessation. While many elements of the plan were stalled, DMHAS held a follow-up of the State Strategy Session/Leadership Academy Recovery in late July 2019 that reinvigorated these activities and opened the discussion with the NJ Department of Health (DOH).

In the last few years, DMHAS has developed a collaboration with the Office of Tobacco Control in the NJ Department of Health (DOH), which has had a number of new smoking cessation projects funded by a 1% set aside from tobacco tax. This tax has funded 11 quit centers in the state, as well as prevention grants, a college campus NJ QUITs initiative, and mini grants for colleges to create some smoke-free policies. DMHAS has also partnered with the Quit centers and Smoke-Free NJ to provide webinars on the '2As and an R' (Ask, Advise, Refer) so that the behavioral health agency staff can work more effectively to get clients to make use of cessation services.

In 2023, NJ DOH provided DMHAS with funding to train behavioral health staff as Certified Tobacco Treatment Specialists (CTTSs). While no funding was made available in the last two years for further CTTS training, DMHAS plans to use state funding to support this in the coming year to continue this effort. DMHAS is working with provider agencies to see what obstacles continue to exist for providing more onsite tobacco cessation services, and it is developing a toolkit for behavioral health services to address tobacco use, which will focus on providing smoke-free environments and more on-site tobacco use treatment.

In addition, smoking cessation services continue to be incorporated into various DMHAS initiatives to address the opioid epidemic. The New Jersey Substance Abuse Monitoring System (NJSAMS) is a treatment database that collects data on client tobacco use and smoking cessation treatment. NJSAMS is providing valuable data about the efforts to address tobacco use in addiction programs, but no such data exists for the mental health programs. Some DMHAS initiatives and grant-funded programs continue to promote medications for smoking cessation in behavioral health and affiliated medical settings. These include the programs involved in the

Division's Promoting Integration in Primary and Behavioral Health Care grant and the Certified Community Behavioral Health Clinics (CCBHCs), among others.

Behavioral Health Innovation

Substance Use Disorder Promoting Interoperability Program (SUD PIP). Health Information Technology (HIT) and Electronic Health Records (EHR) are critical elements in New Jersey's strategy to address the substance use disorder (SUD) and opioid use disorder (OUD) crisis. Due to limitations in federal statute, SUD/OUD providers have generally not been able to participate in the federal Promoting Interoperability Program or meaningful use incentive programs. To promote interoperability between behavioral health and physical health providers caring for SUD/OUD individuals, the State of New Jersey made available a total of \$5.4 million in funding for a milestone-based SUD provider incentive program. Implementing EHR technology allows behavioral health providers to efficiently capture and store data in structured format that, with the proper privacy and security processes in place, can be easily retrieved, shared and transmitted to assist in patient care, monitoring and recovery. Among a host of benefits, the behavioral health provider adopting an EHR will have the ability to: (1) gather, analyze and report clinical and operational data; (2) prepare for and demonstrate interoperability to a Health Information Exchange (HIE) and associated use cases; (3) generate electronic prescription and connect to a Prescription Drug Monitoring Database (PDMP) and (4) collect and transmit information to the NJ Substance Abuse Monitoring System (NJSAMS). The SUD PIP was launched in 2019.

In order to make meaningful progress in connecting residents of New Jersey being treated for SUD/OUD, clinical information needs to be portable between SUD clinics, hospitals, and other providers. This will allow all types of providers caring for patients to be armed with the latest clinical information on a patient, enhancing care quality and appropriateness at all sites and avoiding inappropriate or duplication of care.

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

The Substance Use Disorder Promoting Interoperability Program (SUD PIP) is designed to incentivize SUD facilities to invest in information technology (IT) infrastructure. The program's goal is funding to enable SUD facilities to enhance efforts around care coordination and improve quality of care patients. Funding is most appropriately used when it helps connect "siloed systems of care" to decrease duplication of efforts and information blocking among healthcare providers, public health monitoring systems and registries.

This program was originally administered by the New Jersey Department of Health (DOH) in collaboration with the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) and the Division of Mental Health and Addiction Services (DMHAS). A new MOA was prepared with administrative oversight now managed by the Department of Human Services. Funding is available to participating SUD provider entities

on a first-come, first-serve basis through New Jersey Institute of Technology (NJIT) and its New Jersey Innovation Institute (NJII), formerly NJ-HITEC, the designated state entity that manages the New Jersey Health Information Network (NJHIN). As of June 2025, there is about \$2.6M in remaining funds for the SUD PIP. The program is intended to close out once the funds are fully exhausted.

1. The SUD provider must meet the following criteria to be eligible to participate in the program. A non-profit or for-profit entity or governmental entity.
2. A Medicaid provider and have adjudicated claims from Medicaid.
3. Licensed by the Department of Health's Certificate of Need and Licensing (CN&L) to provide SUD treatment prior to the start of services.
4. Have at least 1 SUD admission during the prior CY which is documented in NJSAMS.

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

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

As SAMHSA notes, grantees that provide clinical services are encouraged to demonstrate ongoing clinical use of an EHR. The SUD PIP program requires providers to implement an Office of the National Coordinator (ONC) certified EHR.

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

Milestone 1 – Participation Agreement / EHR Vendor Contract Agreement \$5,000

Milestone 2 – EHR Go-live / Upgrade \$20,000 / \$7,500

Milestone 3 – NJHIN/HIE Connectivity \$7,500

Milestone 4 – PMP Connectivity \$5,000

Milestone 5 – NJSAMS Connectivity \$5,000

Milestone 6 - Electronic Consent Services \$5,000

Milestone 7- Integrated Telehealth \$5,000

If all seven milestones are achieved, the total amount of incentive payment a Tier 1 participating SUD provider may potentially receive is \$52,500 while a Tier 2 participating SUD provider may potentially receive \$40,000. The goal is to have 120 providers participate. As of March 2025, there were 110 qualified agencies participating in this project. In terms of milestones, 102 have achieved Milestone 1, 80 achieved Milestone 2, 52 achieved Milestone 3, 55 achieved Milestone 4, and 6

achieved Milestone 7. The total number of participating clinicians, as outlined in the SUD PIP Participation Agreements, was 2,608 as of March 2025.

SUD PIP is a fixed budget program and planned to be sunset once the funds are fully exhausted. The State launched Behavioral Health PIP in July 2024 (inspired from the SUD PIP and expanding the participant groups) under the funding authority of 1115 Demonstration expansion waiver renewal, as a potential avenue for the qualified facilities to continue to participate in the milestone-based program and upgrade their technology. The New Jersey Association of Mental Health and Addiction Agencies (NJAMHAA) is providing technical assistance and developing learning collaboratives.

Some Testimonials that have been provided include:

“Without the alerts there are times when we would not be aware of hospitalization, or any follow-up needed. Clinical Care Managers receive alerts for clients admitted to medical inpatient or ER’s and registrations for tests or procedures at hospitals such as MRI’s, ultrasounds or PT. Alerts allow us to check in with the clients and make sure they complete any needed follow-up and show when clients are transferred from one facility to another.”

“The ADT (Admission, Discharge, and Transfer) alerts are a critical tool for our facility, enabling us to monitor patient movements across the healthcare system in real time. These alerts provide immediate updates whenever a patient is admitted, discharged, or transferred, allowing our care teams to respond swiftly to changes in a patient’s status, coordinate appropriate follow-up care, and facilitate seamless transitions between care settings.”

Behavioral Health Promoting Interoperability Program (BH PIP). The NJ Behavioral Health Promoting Interoperability Program (BH PIP) was established with the approved renewal of New Jersey's 1115 Demonstration Waiver by the Centers for Medicare and Medicaid Services (CMS) on March 30, 2023. The extension of the New Jersey FamilyCare Comprehensive Demonstration includes the introduction of a milestone-based payment program specifically designed for behavioral health facilities aimed at encouraging the adoption of electronic health record (EHR) technology. It presents an opportunity for behavioral health facilities to adopt EHR technology to efficiently capture and store data in a 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 facilities 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; and (3) generate electronic prescriptions and connect to New Jersey’s Prescription Monitoring Program Database (NJMPMP).

The primary objective of the Behavioral Health Promoting Interoperability Program (BH PIP) is to create an integrated behavioral health delivery system, enhancing the quality of care and coordination among providers. The program offers incentives to support behavioral health providers who have already invested in health information technology (HIT). The program focuses on facility-based participation. This meaningful investment in the IT infrastructure and

modernizing systems will enable behavioral health facilities to connect siloed systems of care to each other to enhance care coordination and quality. Modeled after the state's milestone-based Substance Use Disorder Promoting Interoperability Program (SUD PIP), this initiative also leverages and reuses several existing capabilities and experiences learned from years of HITECH program investments and implementation including but not limited to the State Level Repository (SLR), the New Jersey Health Information Network (NJHIN), the State's Health information Exchange (HIE). The incentives will also provide supplemental sustainability funds for the behavioral health providers that have already made substantial investments in Health Information Technology (HIT).

In order to make meaningful progress in connecting residents of New Jersey being treated for behavioral health, clinical information needs to be portable between clinics, hospitals, and other providers. This will allow all types of providers caring for patients to be armed with the latest clinical information on a patient, enhancing care quality and appropriateness at all sites and avoiding inappropriate or duplication of care.

This program is administered by 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). Funding is available to participating provider entities on a first-come, first-serve basis through New Jersey Institute of Technology (NJIT) and its New Jersey Innovation Institute (NJII), formerly NJ-HITEC, the designated state entity that manages the New Jersey Health Information Network (NJHIN). The program was first launched on July 1, 2024.

1. The BH facilities must meet the following criteria to be eligible to participate in the program. A non-profit or for-profit entity or governmental entity.
2. Have at least 20% Medicaid patient volume in the last 12 months (CHIP does not count towards patient volume and out of state patient percent shall not exceed the in-state patient percent).
3. Licensed by the Department of Health's Certificate of Need and Licensing (CN&L) to provide mental health services and/or SUD services treatment prior to the start of the program.

The program anticipated that there would be two categories or tiers of BH facilities that will be able to participate.

- Tier 1 is for the BH facilities who currently do not have an EHR and will be implementing a new EHR.
- Tier 2 is for BH facilities who currently have an EHR but will be upgrading to an Office of the National Coordinator for HIT (ONC) Certified EHR Technology (CEHRT).

The Substance Use Disorder (SUD) facilities that are currently participating or have participated in the SUD Promoting Interoperability Program (SUD PIP) will not be permitted to participate in the BH PIP.

As SAMHSA notes, grantees that provide clinical services are encouraged to demonstrate ongoing clinical use of an EHR. The BH PIP program reinforces this and requires participants to use a certified EHR that has been approved by the Office of the National Coordinator (ONC).

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 providers to register and submit attestation information. All milestones are expected to be achieved over a two-year funding period.

Milestone 1 – Participation Agreement / EHR Vendor Contract Agreement \$5,000

Milestone 2 (Tier 1 – Implement) – \$20,000

Milestone 2 (Tier 2 – Upgrade) - \$7,500

Milestone 3 – NJHIN/HIE Connectivity \$7,500

Milestone 4 – New Jersey Prescription Monitoring Program (NJMPMP) Connectivity \$5,000

Milestone 6- Electronic Consent Management Services (eCMS) \$5,000

Milestone 7- Telehealth \$5,000

If all six milestones are achieved, the total amount of incentive payment a Tier 1 participating facility may potentially receive is \$55,000, while a Tier 2 participating facility may potentially receive \$35,000. The goal is to have 100 BH facilities participate. There have been 26 applications sent, out of which 23 facilities have returned the signed applications indicating their interest to participate in this program. As of June 2025, there are 8 qualified agencies participating in this project and 206 clinicians. In terms of milestones, 7 have achieved Milestone 1, 2 achieved Milestone 2, 2 have completed Milestone 4, and 2 achieved Milestone 6.

Total program funding authorized by CMS is \$6 million over a period of five years. Core funding will be provided to NJII equally distributed in each of the four quarters annually over the span of five years to support overall BH Promoting Interoperability Program operations, including personnel and non-salary administrative costs. Direct funding for the incentive payments to the BH facilities incentive payments and other associated the NJII administrative cost will be provided.

Health Information Technology. In addition to its SUD PIP program described above, DMHAS implemented a *DMHAS SUPTRS COVID 19 Supplemental Reimbursement Program* (DSCOVERS) program to allow SUD providers to enhance their information technology infrastructure needs. The technology is to improve access to and coordination of SUD prevention, intervention, treatment and recovery support services consistent with the provisions of HIPAA and 42 CFR, Part 2. Providers are allowed to request up to \$20,000 for this purpose. One of the options we have promoted is the use of interactive communication technologies (ICT). Our partner NJAMHAA has hosted webinars for our providers to see various recovery support apps that are currently on the market.

Pay for Performance. Incentivizing provider performance or paying for performance (P4P) is an approach being explored to achieve better health and or behavioral health outcomes for clients. However, the literature suggests that few organizations use P4P to improve clinical outcomes directly. DMHAS has implemented a program, described below, to incentivize the provision of MAT in Long-term Residential facilities.

The Long-term Residential Performance Program pays treatment agencies an incentive for providing Medication Assisted Treatment (MAT) to clients. Effective June 1, 2020, the Long-term Residential (LTR) base reimbursement rate was increased as well as the ability to pay for MAT and MAT related services. On August 20, 2021, the Department of Health (DOH) issued Guidance 7-2021 that reported Long Term Residential (LTR) facilities do not need to seek approval from DOH to prescribe medication, other than Methadone, for the treatment of substance use disorders. As a result, effective October 15, 2021, the base rate for Long Term Residential [H0019HF] includes the MAT add-on of \$5.00 per unit and increased to \$152.60 per day including Room and Board.

Beginning July 1, 2020, additional incentive payments became available for the utilization of MAT and MAT capacity in LTR. The incentive rate creates the capacity to prescribe and administer MAT, which minimally includes Buprenorphine, but also may include Naltrexone and other FDA-approved products for Opioid Use Disorder (OUD) and for Alcohol Use Disorder (AUD). The rates and incentives are structured as follows.

- 1) The increased base LTR treatment rate with the MAT add-on plus Room and Board per diem.
- 2) When an LTR provider site has least 40% of eligible clients receiving an approved medication for treatment of an OUD or an AUD, the provider's rate will increase by \$10.00 per unit of service. This incentive threshold applies to medications arranged for using an external provider (e.g., Methadone from an OTP; Buprenorphine from OBAT) and medications provided by the LTR Provider.

To qualify for the incentive rates, Medicaid and DMHAS will determine a 40% MAT utilization rate through NJSAMS reporting at client discharge. This benchmark is measured as those individuals who are medication-eligible who receive qualifying medications as reported in the NJSAMS Discharge data. The measurement will include all discharges, including duplicated and unduplicated individuals.

	Base Rate	MAT Add-on	40 % threshold	Room & Board	Tier Total Including Room & Board
LTR Rate	x	x		x	152.60
LTR Incentive Payment	x	x	x	x	162.60

The medications that qualify are FDA-approved for the treatment for OUD and AUD and include Buprenorphine, Sublocade, Methadone, Naltrexone (for OUD), and Naltrexone for Disulfiram, Acamprosate (for AUD); note that, at a minimum, Buprenorphine must be provided to receive the incentive. The benchmark is measured by site based on the overall data, initially every three months starting July 1, 2020 for fiscal year 2021 and then every six months thereafter, which continues today. The applicable incentive rate applies to all billed LTR units for the prospective period when the provider site meets the 40% benchmark incentive criteria.

- 3) The LTR provider can bill for medications including of administration costs in addition to the new rates.

Secret Shopper Initiative. At a CSAT Core Technical Review in 2016, the reviewers conducted an “unannounced compliance check calls” exercise among SUD provider agencies. Based on this exercise and the information it yielded, the Assistant Commissioner directed the Office of Consumer Affairs to introduce the first DMHAS “Secret Shopper Program”. The purpose of this project is to generate feedback about how provider agencies respond to calls made by persons who pose as clients. The program provides the Division with valuable information to learn about some of the positive experiences, availability of appointments, and challenges that clients receiving services had. The initiative is currently under the direction of the Medical Director, Office of Advocacy and Peer Services.

- The Program currently has two community-based participants; one with a history of mental illness and the other with a history of co-occurring mental illness and substance use disorder. The participants split the phone calls to either MH agencies and SUD agencies. Each participant is issued a State allotted cell phone to use when making program calls.
- This is important because they can leave a message for a call back when they receive an answering service. Previous experience with this initiative left it up to the “shopper” if they were willing to use their private phone number for a return call.
- Each participant also receives an email account connected to the Division’s account. The Secret Shopper sends a synopsis of each call to the Project Supervisor by the middle of the following month. A total of 15 outreach calls per month is required per secret shopper. They are paid for their services.
- These Community based individuals, use their lived experience to provide valid scenarios to the agencies. They understand the services and are clear in what is expected when placing an initial call, and their responses are relevant in how they perceive the exchange with the agency representative answering the outreach inquiry.
- The feedback from agencies is tracked and monitored. There is a plan to outreach provider agencies of the results from each of these calls. The initiative is never meant to create blame of any provider for a below average call. Secret Shopper is used to enhance services and to make systemic awareness of a required expectation to respect and support an individual seeking services for any behavioral health related condition.
- Some issues identified by the Secret Shoppers have included:
 - Calls being answered by an answering machine rather than speaking to a live person.
 - Long wait times to get an appointment for emergent issues.
 - Having to call another number to make an appointment.
- An outcome of this project was that a pro-active group of providers met with DMHAS Executive Leadership to try to resolve some of the concerns expressed by the Secret Shopper callers. One of these concerns was the use of answering machines. The agencies didn’t like this practice either; however, the providers communicated that they could no longer afford the cost of having a receptionist available to take calls. Both groups brainstormed together and some resolutions were discussed and implemented. The agencies stated that using an answering machine was necessary due to staffing and funding constraints.
- Some more issues identified by the Secret Shoppers included:

- The majority of the calls made were being answered by an automated system.
- Answering systems were malfunctioning or went to random mailboxes.
- Agencies had gone out of business or merged and the directory numbers were no longer valid.
- DMHAS Executive Leadership addressed these issues with providers and solutions were reviewed and implemented. Some outcomes and adjustments that have occurred or have been made are:
 - The number of calls per month has decreased from 30 to 15 to relieve some of the pressure callers were experiencing.
 - The participants have received more training around completing the logs as our data showed inconsistent results concerning calls.
 - Some of the results showed the number of calls made per month varied.
 - The call logs were sent in with incomplete answers or were blank.
- Following these modifications and training DMHAS has found results to be more uniform.
- DMHAS Executive Leadership and Staff anticipate the Secret Shopper initiative to grow in the future, as the need for it has become apparent. At this time funds are available to maintain the Secret Shopper Initiative on an annual basis.

Financing Strategies. The SSA has explored financing strategies to ensure 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 decrease the treatment gap between met and unmet demand. 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.

SUPTRS COVID-19 Supplemental Grant Funded Initiatives

DMHAS' SUPTRS COVID-19 Supplemental Grant funding ended March 14, 2025. The following describes the programming DMHAS funded with this grant. *Programs with *continued with ARPA funding.*

Primary Prevention

Screening with EB tool (Universal ACE's). The Prevention Hubs utilized evidence-based tools for screening into their programs. Some of the tools involve Universal ACE's (Adverse Childhood Experiences). The Prevention Hubs also utilized a screening process to determine if an individual's behavior can be modified through SUD primary prevention education activities or services. During this reporting period, 3,656 distinct persons were screened. If, based upon the results of the screen, it was determined that services were warranted, referrals to an appropriate provider were made.

Preventure. PreVenture is an evidence-based prevention program that uses personality interventions to promote mental health and skill development and delay youth substance use. PreVenture is designed to help at-risk youth ages 12-17 learn useful coping skills, set long term goals, and channel their personality towards achieving them. It focuses on at-risk youth and introduces motivational pathways and coping skills based on the individual's personality. PreVenture can be implemented in school/non-school and online settings. PreVenture has been shown to decrease drug use, alcohol use and likelihood of binge drinking by 50%, delay initiation and frequency of cannabis use, decrease conduct problems and decrease risks for mental health struggles, such as anxiety and depression. During the reporting period, 123 young people participated in the program.

Strengthening Families for Criminal Justice. Prevention agencies provided the 7 or 14 week Strengthening Families Program (SFP) for families involved with the criminal justice system (Family Court, Drug Court, etc.). Strengthening Families greatly benefited communities within NJ. When families are engaged, they tend to stay connected to larger supports. The connection between families and the community increases the likelihood of positive experiences that can combat ACEs (Adverse Childhood Experiences). A total of 831 justice-involved families participated in SFP.

*Purchase of Technical Assistance. The New Jersey Prevention Network (NJPN) coordinated the development and operation of Prevention Hubs and the new programs and initiatives that were offered. Additionally, NJPN developed a website to provide information about Prevention Hub services as well as links to the county-based prevention coalitions that provide(d) the services. <https://www.njpreventionhub.org/> This contract continued with ARPA funding.

COVID-19 Awareness for persons with SUD. Agencies provided a broad range of support and made available public health trainings and outreach regarding vaccination to encourage people to get vaccinated and access local support.

Transportation to access prevention and vaccines. Prevention agencies made transportation to Covid-related services (vaccination clinics, etc.) and connected individuals and families to additional financial supports and health resources.

College Recovery. Block Grant Supplement funds were used to support three additional college recovery programs at: Rutgers University – Newark, Rowan University, and Ocean County Community College. Services included: recovery support, dedicated recovery housing, crisis and relapse prevention, and environmental prevention programs and services on campus. DMHAS was able to continue this program after March 14, 2025 with SOR grant funding.

Survey of 18-25 Year Olds. Few data on substance use/misuse within this population are available, especially individuals in this age group who are not in college. The Center for Research and Evaluation on Education and Human Services (CREEHS) at Montclair State University developed and fielded a survey to collect data about this population. The survey, administered to young adults living in NJ, assessed experiences and perceptions related to substance use, mental health, and social media. The purpose of this engagement was to design a survey instrument comparable to national surveys of substance use and demonstrate its utility for collecting data that could inform meaningful prevention programming for the young adult population. Survey recruitment yielded 1,074 respondents.

*Risk Messaging (adolescents/young adults and parents)/Social Media. The goal of risk communication through the Risk Messaging Regarding Alcohol, Marijuana & Illicit Substance Use and Misuse for Youth and Their Parents funding was to share information vital to saving life, protecting health and minimizing to self and others; to change beliefs; and/or to change behavior (SAMHSA, Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health, 2020) As such, NJPN worked to decrease substance use rates among youth (18 and under) as well as young adults (20 and under) by increasing the capacity and implementation of evidence-based risk messaging strategies. This program continued with ARPA funding.

*Warm Lines by Prevention Providers. There was a need for the public to have a better awareness of our prevention services. While NJ has helplines for accessing treatment (both mental health and substance use) and crisis, individuals are not adequately familiar with the array of prevention and recovery support services that are available. DMHAS developed and provided a prevention warm line service. These services continued with ARPA funding.

*Creation of Prevention Hub Infrastructure. Prevention Hubs were developed in each of NJ's 21 counties. NJ's system of prevention agencies became Prevention Hubs where individuals, local government entities, and community organizations youth, families and community members can obtain information and resources, get connected to outreach events, and do brief screenings and/or be connected to needed services. Funding of the prevention hubs continued with ARPA funding.

*Youth Peer Leadership and Education. The Governor's Council on Alcoholism and Drug Abuse created Youth Prevention Groups in each county and, at the state level, created a representative board (Youth Advisory Board). These Youth Groups train youth to educate their peers on effecting change within their schools and communities. Funding for this initiative continued with

ARPA funding.

*Over the Counter (OTC) Prevention. Coalitions used the Over-the-Counter Medicine Safety Guide developed by Community Anti-Drug Coalitions of America. Agencies and coalitions provided education and outreach to families, individuals, and merchants. Populations of focus were adolescents and older adults. This initiative continued with ARPA funding.

*Marijuana Prevention. NJ enhanced programs that serve underage marijuana use and marijuana abuse with these BG resources. These programs continued with ARPA funding.

*Military/Veteran Enhance services. The New Jersey Prevention Network (NJPN) developed evidence-based WISE (Wellness Initiative for Senior Education) curriculum was adapted to be sensitive to the needs of older veterans. NJPN field tested the new curriculum content at Veterans service and housing organizations. These services continued with ARPA funding.

Early Intervention

988 Implementation. On July 16th, 2022, as per a Federal Communications Commission mandate, 988 became the national three-digit dialing code for suicide prevention, mental health and substance use crisis. In response to the FCC's mandate, the New Jersey Legislature passed P.L. 2022, c.35 and the Commissioner of DHS identified DMHAS as the agency to develop the structure and programming for 988 in New Jersey. People experiencing suicidal, mental health and/or substance use crisis, or those worried about a loved one or friend, can call or text 988, or chat using the 988 Lifeline's online platform. There, trained crisis counselors will understand the primary concern, de-escalate the individual, provide support, and offer appropriate linkages to local mental health and/or substance use services. Funds were allocated for the implementation of 988.

*SBIRT (Screening, Brief Intervention and Referral to Treatment). Behavioral health services were integrated into primary care through the implementation of substance use Screening, Brief Intervention and Referral to Treatment services at general medicine, obstetric and gynecologic practices at Rowan - Virtua School of Osteopathic Medicine clinics. The SBIRT program through the primary care practices was continued with ARP funding.

*Media Campaign. DMHAS used funding for a multifaceted media campaign aimed at decreasing stigma surrounding SUD and informing the public about the importance of having access to naloxone to help with overdoses and save lives. This campaign ran in 2024. Other statewide campaigns to promote the use of medication to treat SUD, provide information about the pervasiveness of fentanyl, and encourage persons with SUD to seek recovery.

Naloxone Portal. DMHAS developed a web-based portal for community organizations to order naloxone kits. Community groups include county correctional facilities, EMS, law enforcement, libraries, shelters and contracted SUD and mental health programs. Naloxone or other FDA opioid antagonist kits will be made available through this portal. Services funded by

Naloxone and Training. Since 2016, staff from the Robert Wood Johnson (RWJ) Medical School

in New Brunswick, NJ have provided virtual and in-person training (known as the Opioid Overdose Prevention Network - OOPN) throughout NJ. Trainings focus on how to recognize an overdose and administer naloxone. In addition to these community trainings, RWJ developed a training of trainers model for recovery specialists who work in the Opioid Overdose Recovery Programs (OORP) and Support Teams for Addiction Recovery (STAR) whereby the recovery specialists train clients with whom they are working on how to recognize an overdose and administer naloxone. OOPN also provides naloxone to the OORPs and STARs, which the recovery specialists give to their clients. DMHAS provided additional funding to OOPN to enable its trainers to deliver the program and naloxone to additional populations, such as persons who work in the construction industry. Through July 31, 2025, OOPN has provided trainings to 29,767 persons and distributed 41,237 naloxone kits.

Treatment

*Crisis Receiving and Stabilization Centers (CRSC). This program will provide services to those in need of immediate in-person crisis intervention and stabilization for a behavioral health crisis. The centers will provide services to individual with a serious mental illness, substance use disorder, or in need of co-occurring services. This program will assess individuals 18 years of age or older. CRSC offers a no-wrong-door access to crisis stabilization, operating much like a hospital emergency department (ED) that accepts all walk-ins, law enforcement drop-offs, and fire department drop offs. The individuals served in the program will receive community-based treatment and supportive services 24 hours a day, 7 days a week, 365 days per year, with the goal of mitigating the need to use the ED to access community-based services and preventing unnecessary or inappropriate hospitalization. These facilities include access to trained staff who can provide assessment, crisis stabilization, intensive supports, engagement, psychoeducation, identification of strengths, collaborative problem solving, and individualized crisis planning. Services will be offered in a safe, clean, home-like environment conducive to the recovery process. Medication management, administration, and education will also be offered. Medication-Assisted Treatment will also be available at the CRSCs. Clinical staff in the program will strive to stabilize individuals and address mental health needs. The program will offer continuity of care promoting continued stability and ensuring linkages are arranged that meet the needs of the individual. The program will result in strong, positive individual outcomes and an improved individual experience while accessing services. The program will also result in cost savings through the decrease in avoidable ED visits, inpatient admissions, police engagement, and 911 calls. Funding for the Centers continued with the ARPA grant.

*Recovery Support Care Management (RSCM). RSCM has been developed to assist consumers as they transition throughout the SUD continuum of care. The intent is to identify available resources, and then assist them to access the care/services in order to meet their needs identified in their Multi-disciplinary Care Plans. The intent is to remove any obstacles to their recovery and achieve successful community living. Services are provided through DMHAS SUD treatment fee-for-service network and were continued with the ARPA grant.

*Peers in Residential Treatment Programs. Over the last several years, DMHAS has made significant efforts to increase the SUD peer workforce. Peer support services have positively impacted and provided assistance to persons in recovery from serious mental illness, substance use

or co-occurring mental and substance use conditions before, during and after treatment. As a means to close the gap in the provision of peer services in residential settings, DMHAS has issued an RFP in 2023 to expand the peer workforce to include peer services in inpatient withdrawal management, short-term and long-term residential and halfway house settings. The RFP resulted in DMHAS contracting with 8 provider agencies to hire 26 peers who will assist with issues that often occur concurrently with SUD, such as homelessness, legal issues, employment, childcare, etc. In addition to linking individuals with the appropriate community resources, peers will also encourage individuals to remain in treatment as recommended in the treatment plan and modeling strategies on how to manage addiction successfully. Funding for this program continued with the ARPA grant and further expanded when the RFP was reissued in 2024 to expand the program by contracting with 8 provider agencies to hire 19 peers.

Recovery Support

Resource Directory. As an outcome of the SSA's State Opioid Response initiative, a need was identified to provide supportive training, coaching and resources for patient navigators and peer specialists employed in DMHAS recovery-based initiatives. In response to a repeated request by peers to have an informational directory which would allow users to quickly and conveniently identify resources when accessing services, the SSA funded a Recovery Resource Directory (RRD). The RRD is intended to assist peer workers to promote wellness and recovery for individuals managing a mental illness, substance use disorder, or co-occurring disorder. The web-based directory will quickly furnish peers and staff working in the Division's recovery-based initiatives with essential information and resources to facilitate and sustain individuals' recovery. Resources (e.g., organizations, support services, mutual aid meetings, housing, job placement, etc.) will be grouped by geographic location throughout New Jersey's 21 counties.

Simulation Training. The Simulation Training initiative serves individuals working in the recovery support services and behavioral health workforce (e.g., peers, peer supervisors, LCADC, LPC, LCSW, etc.). Upon training completion, participants enhance their knowledge, skills, and attitudes on self-care, emotional wellbeing, and mindfulness-based recovery. The simulation trainings are specifically designed for NJ peer recovery specialists working in various community settings focus on MOUD, boundaries, commitment to change, and ethical scenarios. This initiative includes SIMmersion, an interactive training tool used to enhance evidence-based counseling skills. SIMmersion allows students to practice and develop core competency skills while gaining knowledge on motivational interviewing strategies that can improve effective communication. SIMmersion is based on simulated conversations and role-plays that allow participants to engage in real conversations and counseling interventions with life-like individuals. The exchanges provide instant evaluation and coaching on the student's motivational interviewing and engagement skills.

*Pregnant and New Moms (Other Substances). The Maternal Wraparound Program (M-WRAP) combines intensive case management, wraparound services, and recovery supports for pregnant/postpartum women who have a substance use disorder during pregnancy and up to one year after birth. The M-WRAP model is intended to promote maternal health, improve birth outcomes, and decrease the risks and adverse consequences of prenatal substance exposure. Intensive case management focuses on developing a single, coordinated care plan for

pregnant/postpartum women, their infants and families. Intensive Case Managers work as liaisons to all relevant entities involved with each woman. Recovery Support Specialists provide non-clinical assistance and recovery supports while maintaining follow-up with the women and their infants. Block Grant funding supports seven M-WRAP regions statewide.

The onset of the COVID-19 pandemic resulted in many significant safety precautions at the national and state level. The stay-at-home orders, such as closures of businesses, schools, restrictions in gatherings has had an impact on food, security, employment, income, access to medical care, etc.. Pregnant and parenting women with a history of substance use disorder (SUD) could be at risk for increase in substance use or experience relapse due to feelings of isolation, lack of family supports, or social support systems. Their mental health could be adversely affected exhibiting depression during pregnancy and postpartum. In July 2021, the M-WRAP statewide initiative eligibility criteria was expanded to include pregnant women with substance use disorder, not exclusive to opioid dependency. DMHAS used Supplemental and ARPA funding to expand the program. MWRAP capacity has been increased from fifty (50) pregnant individuals being served per region to sixty (60) pregnant individuals, for a statewide total of 420 unduplicated pregnant women.

*Peer Roster. A peer recovery roster was developed to collect information on peer staffing, employers, training, and certification, etc. The roster allows DMHAS to generate and analyze data to increase the depth of technical assistance and training that supports credentialing of the peer workforce. To date information has been collected on 401 Peer Recovery Specialists. With the information collected from the peer roster, reports for each funded DMHAS initiative are compiled that include summary data points to track certification progress, training completed and current employment information. The ARPA grant continued funding this service.

*Recovery Data Platform. Recovery Data Platform is one of the largest collections of Community Peer Recovery Center data for the state of NJ. RDP is being used by several initiatives to centralize information which allows a robust real-time analysis of recovery support services. Participating organizations entered data on peer recovery support services provided to over 12,000 participants which exceeded the earmarked 10,000 and is anticipating exceeding 15,000 in the current year. The ARPA grant continued funding this service.

Peer Recovery Specialist Training. A peer recovery roster was developed to collect information on peer staffing, employers, training, and certification, etc. The roster allows DMHAS to generate and analyze data to increase the depth of technical assistance and training that supports credentialing of the peer workforce. To date information has been collected on 401 Peer Recovery Specialists. With the information collected from the peer roster, NJPN has developed dashboard reports for each funded DMHAS initiative to represent summary data points to track certification progress, training completed and current employment information. Funding for the training continued with the ARPA grant.

Infrastructure

*Increased connectivity, Wi-Fi, equipment to improve service delivery. DMHAS recognizes the need to improve contracted provider agency connectivity and equipment to improve service

delivery in light of the current and continuing need for virtual services. Funding was allocated for DMHAS Substance Use COVID-19 Reimbursement (DSCOVERS) program to reimburse community-based, non-profit SUD providers under contract with DMHAS for eligible IT expenses up to a maximum of \$20,000 per provider. Eligible IT expenses include items such as: Improved Internet Bandwidth Services; Behavioral apps/digital approaches for SUD therapy, recovery, patient reminders, etc.; Expanded technology options for callers, e.g., texting; Enhanced broadband and cellular technology for provider use (not consumers); Video Conferencing; Wi-Fi Connectivity; Equipment such as laptops, headphones, webcams, smartphones, etc. for staff; Other technology to improve access to and coordination of SUD prevention, intervention, treatment and recovery support services consistent with the provisions of HIPAA and 42 CFR, Part 2; and Other software to improve service delivery, like evidence-based screening tools and treatment planning products. Eligible providers must submit completed DMHAS payment vouchers and documentation such as receipts and invoices in order to be reimbursed. Funding for this reimbursement program continued with the ARPA grant.

Personal Protective Equipment. Funding was allocated for DMHAS Substance Use COVID-19 Reimbursement (DSCOVERS) program to reimburse community-based, non-profit SUD providers under contract with the DMHAS for eligible personal protective equipment (PPE) expenses up to a maximum of \$20,000 per provider. Eligible PPE expenses included: face coverings; masks; face shields; gowns; gloves; and goggles. Eligible providers must submit completed DMHAS payment vouchers and documentation such as receipts and invoices in order to be reimbursed.

*Recovery Management Check-Up. Recovery Management Check-up (RMC) is service for discharged clients to support independent living and success with recovery and provide more methods of outreaching to clients. This will include virtual face-to-face visits, text messaging and chat features, and also the opportunity for actual in person contacts. This check-up service will help provide local recovery supports. RMC aims to identify and alleviate client problems before they derail recovery. Monthly contact forms the core of the proposed RMC. Problems will be addressed using motivational interviewing techniques or connecting clients to appropriate community resources or treatment if needed. The conceptual framework of RMC is to treat addiction as a chronic disease, with long-term management to minimize the number of acute episodes of substance abuse and with prompt treatment when episodes occur to prevent them from becoming more severe and consequential. Funding for this program continued with the ARPA grant.

Workforce Support

*Workforce Support. The Prevention Fellowship Program will expand New Jersey's prevention workforce to ensure that evidence-based quality services are being provided to the broad communities across the state. We will recruit and select a cohort of young professionals with broad backgrounds and experience to become part of the Prevention Fellowship Program. Though NJ has worked hard to address the health gaps that exist in the state, to truly eliminate health gaps, the prevention workforce will need to help communities implement strategies that are responsive to the population of the New Jersey. A competent prevention workforce is essential to accomplish this goal. Yet the prevention field—like the public health field generally—has struggled to create

and maintain a robust workforce. The NJ Prevention Fellowship Program will work to expand and strengthen the prevention workforce for the future. ARPA funding continued this program.

SUPTRS American Rescue Plan (ARPA) Funded Initiatives

DMHAS' SUPTRS ARPA Grant funding will end September 30, 2025. The following describes the programming DMHAS funded with this grant. Programs described in the previous section of SUPTRS COVID-19 Supplemental Grant Funded Initiatives with * were also funded by ARPA funding.

Primary Prevention

Vaping Prevention. Prevention agencies are funded to provide evidence based/informed prevention activities specific to vaping.

Strengthening Families for Women and Other Treatment Programs. Prevention agencies provided the seven (7) or fourteen (14) week Strengthening Families Program (SFP) for women in treatment and their families. When families are engaged they tend to stay connected to larger supports. The connection between families and the community increases the likelihood of positive experiences that can combat ACEs (Adverse Childhood Experiences).

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

Older Adult Conference. DMHAS will host a full-day statewide conference that will complement and expand on the information provided in the Alternative Approaches to Pain Management for Older Adults program (AAPMOA) program. The conference will offer presentations and information for older adults, their caregivers, and others who provide medical and social services to this population. DMHAS anticipates that over 1,200 persons will attend the conference. The title of the conference is "NJ Healthy Aging Summit: Opioid Safety and Alternatives."

Anti-Stigma Public Awareness Campaign. A multifaceted media campaign was launched July 2025 aimed at decreasing stigma surrounding SUD in New Jersey. Specifically, the campaign seeks to decrease stigma surrounding SUD diagnoses and treatment and increase the number of New Jersey residents who become connected to SUD treatment and recovery services and supports. DMHAS' contracted media vendor will promote anti-stigma messaging designed to reach the general population, individuals with SUDs and their families, general practitioners, emergency room physicians, pain management specialists, pharmacists, mental health and SUD providers. Also, the Vendor will assist with promoting public awareness to populations such as

older adults, high school and college athletes, and prescribers etc. New creatives will be launched shortly. The anti-stigma campaign will be tagged “There’s More to the Story”.

Early Intervention

Enhanced Naloxone Public Awareness Campaign. A multifaceted media campaign was launched July 2025 to inform the public about the importance of having access to naloxone to help with overdoses and save lives. Specifically, the campaign seeks to help prevent overdose deaths. Creatives will be developed promoting the importance of having access to Naloxone and how it can save a life to the general public. It will also serve individuals taking high-dose opioid medications, those using both opioids and benzodiazepines and people who use illicit opioids, e.g., heroin. New creatives will be launched shortly. The naloxone campaign is tagged “In Your Hands”, which emphasizes “you can save a life”.

Treatment

Expanded Hours. DMHAS released an RFP for the development of Expanded Hours for Substance Use Disorder (SUD) Outpatient Programs. These expanded services were developed to enhance access to treatment by removing obstacles such as traditional service hours. These expanded hours provided increased access to outpatient treatment for individuals with an SUD. The purpose of this expansion for outpatient services is to support, enhance and encourage the emotional development and the development of consumer’s life skills in order to maximize their individual functioning during alternate times from standard business hours (after hours and weekends).

Fee-for-Service SUD Treatment Services. The ARPA grant funded the New Jersey Statewide Initiative (NJSI) which provides behavioral health services to consumers with a SUD and complex physical and/or psychosocial needs. Eligible clients are New Jersey residents who have an income up to 350% of the FPL and have been determined to be in need of American Society of Addiction Medicine (ASAM) levels of care which include: Standard Outpatient (OP), Intensive Outpatient (IOP), Short Term Residential (STR), Halfway House (HWH); and Long Term Residential (LTR). Additional services include assessment; and enhancement services which are provided to individuals with complex needs to help support treatment.

The ARPA grant also funded the Substance Abuse Prevention and Treatment Initiative (SAPTI) that provides behavioral health services to consumers with a SUD and complex physical and/or psychosocial needs. Eligible clients are New Jersey residents who have an income up to 350% of the FPL and have been determined to be in need of ASAM levels of care which include: Methadone Outpatient (MOP); Intensive Outpatient (IOP); and Long Term Residential (LTR). Additional services include assessment and enhancement services which are provided to individuals with complex needs to help support treatment.

Recovery Support

Mobile Recovery Vans. The Recovery Mobile Van Program is a startup initiative funded by the ARPA that provides a recovery mobile van program for NJ’s seven counties that don’t have an existing program: Bergen, Camden, Cumberland, Gloucester, Hudson, Mercer and Union. Each

of the seven participating counties received \$200,000 in funding to purchase a mobile van.

SUPTRS COVID-19 Mitigation Grant Funded Initiatives

Funding was allocated for DMHAS Substance Use COVID-19 Reimbursement (DSCOVERS) program to reimburse community-based, non-profit SUD providers under contract with DMHAS for eligible testing kits and related items expenses up to a maximum of \$20,000 per provider. Eligible items include: test administration and supplies necessary for administration; activities/items to maintain healthy environments, and educational materials and printing costs of such materials to address consumer hesitancy regarding testing. Eligible providers must submit completed DMHAS payment vouchers and documentation such as receipts and invoices in order to be reimbursed. New Jersey's SUPTRS COVID-19 Mitigation grant will end September 30, 2025.

OPIOID Settlement Funds

New Jersey joined the nationwide settlement agreements with New Jersey-based Johnson & Johnson and the country's three largest pharmaceutical distributors – McKesson, Cardinal Health, and AmerisourceBergen – to resolve claims involving their roles in fueling the country's opioid crisis. The nationwide settlement agreements include lists of approved uses, which are incorporated into a Memorandum of Understanding (MOU) announced on March 11, 2022, entered between the State and its counties and municipalities. The MOU sets forth that almost all of the \$641 million New Jersey will receive will be divided evenly—with 50 percent going to the State and 50 percent going to counties and municipalities. Payments are scheduled for 18 years. Of the \$641 million coming to New Jersey, the agreement will distribute about \$326 million to the State and \$314 million to the counties and eligible municipalities. These funds will be spent on strategies to decrease the opioid epidemic's ongoing impact on residents and communities.

In 2021, New Jersey settled another \$13.287 million opioid related settlement with global consulting firm McKinsey & Company, resolving an investigation into the company's role in fueling the opioid epidemic by designing aggressive marketing strategies used by some of the nation's largest opioid manufacturers, including Purdue Pharma.

A bill introduced by the NJ State Legislature on June 3, 2021, established the Opioid Recovery and Remediation Fund and the Opioid Recovery and Remediation Fund Advisory Council. It provides for funds received from opioid settlements to support substance use disorder prevention and treatment programs.

A survey was developed that will be sent to all 21 counties and 241 municipalities that received opioid abatement funding. The recipients will provide information about the programs they are implementing. Reports are due September 1, 2025 and a final report is to be published October 1, 2025. Previous reports were sent in September 2023 and 2024.

The Opioid Recovery and Remediation Advisory Council recommended the following proposals

involving DMHAS for funding through the State's portion of Opioid Recovery and Remediation Funds. These proposals were subsequently approved by the Governor's Office. The link to all programs that were recommended across all State departments can be found at [Opioid Settlements](#). In addition a Strategic Plan was developed that can also be found at the referenced link.

Mobile Medication Unit for Substance Use Disorder. The Mobile Medication Unit for Substance User Disorder initiative will enable agencies to travel to communities on a regular basis to provide low-threshold medication services to people with a substance use disorder (SUD) who encounter obstacles to receiving services at traditional "brick-and-mortar" treatment agencies. It is designed to increase access to medications for SUD, i.e., methadone, buprenorphine, or naltrexone; medical referral services, case management; and recovery support services. DMHAS issued an RFP in July 2024 and awards were made in October 2024 to three licensed Opioid Treatment Programs for the provision of mobile medication services in Burlington, Middlesex and Monmouth/Ocean Counties.

Community Peer Recovery Centers. This initiative is focused on developing Community Peer Recovery Centers (CPRC). The CPRC is a place where individuals can access peer support, information about substance use disorder (SUD) treatment, recovery support services and information about other community resources in a supportive substance free environment. DMHAS issued an RFP in July 2024 and awards were made in November 2024 for all 21 NJ counties. This RFP was funded with braided funding from the SOR 4 grant and State Opioid Settlement dollars.

Housing: Temporary Shelter Housing Services for Adults Who Use Substances. Provides temporary housing for individuals being discharged from residential, inpatient, ambulatory SUD treatment and/or individuals with a history of SUD who may be or have become homeless. The funding through this RFP can serve as a bridge to permanent housing, allowing participants to receive the support and services they need around other challenges in their lives. DMHAS issued an RFP in October 2024 and made awards in February 2025 to six licensed 24-hour emergency shelters for a total of 150 beds.

Housing: Case Management Services for Adult Individuals with Substance Use Disorder in Temporary Shelter Bed Housing. Provides case management services for adult individuals with a substance use disorder (SUD) placed in temporary shelter housing and in need of long-term housing. Case managers will help connect individuals with services/ resources in their area and entitlements and assist them in securing permanent housing as quickly as possible. It is anticipated that individuals will obtain permanent housing within four months of initial engagement. Individuals served in this program will have access to DMHAS funded housing subsidies. DMHAS issued an RFP in October 2024 and made awards in February 2025 to four agencies to provide these services in their region of the state.

Legal Support: Legal and Navigation Services. This initiative is based on the medical / legal partnership model. It provides legal and navigation services for individuals with a substance use disorder (SUD) and enrolled in SUD treatment. Services will help address legal and social issues that present as obstacles to accessing needed services (medical, behavioral health, housing, insurance, entitlements, etc.) for individuals with a SUD and to decrease the burden of outstanding

legal issues that negatively impact an individual's recovery process and ability to successfully live in the community of their choosing. DMHAS issued an RFP in April 2025 and plans to make awards in August 2025 to seven licensed SUD treatment agencies.

Legal Support: Regional Legal Services. Provide legal and navigation services for individuals with a substance use disorder (SUD). Services will help address legal and social issues that present as obstacles to accessing needed services (medical, behavioral health, housing, insurance, entitlements, etc.) for individuals with a substance use disorder and to decrease the burden of outstanding legal issues that negatively impact an individual's recovery process and ability to successfully live in the community of their choosing. The Department of Human Services/Division of Mental Health and Addiction Services plans to fund four regional legal services providers that will cover regions of the state. It is anticipated that all 21 counties in the state will be served through this initiative. DMHAS issued an RFP in June 2025 and plans to make awards in Fall 2025.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system, including state plans for addressing identified needs and gaps with MHBG/SUPTRS BG award(s)

Narrative Question

This narrative should describe your state's needs assessment process to identify needs and service gaps for its population with mental or substance use disorders as well as gaps in the prevention system. A needs assessment is a systematic approach to identifying state needs and determining service capacity to address the needs of the population being served. A needs assessment can identify the strengths and the challenges faced in meeting the service needs of those served. A needs assessment should be objective and include input from people using the services, program staff, and other key community stakeholders. Needs assessment results should be integrated as a part of the state's ongoing commitment to quality services and outcomes. The findings can support the ongoing strategic planning and ensure that its program designs and services are well suited to the populations it serves. Several tools and approaches are available for gathering input and data for a needs assessment. These include use of demographic and publicly available data, interviews, and focus groups to collect stakeholder input, as well as targeted and focused data collection using surveys and other measurement tools.

Please describe how your state conducts needs assessments to identify behavioral health needs, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

Grantees must describe the unmet service needs and critical gaps in the state's current systems identified during the needs assessment described above. The unmet needs and critical gaps of required populations relevant to each Block Grant within the state's behavioral health system, including for other populations identified by the state as a priority should be discussed. Grantees should take a data-driven approach in identifying and describing these unmet needs and gaps.

Data driven approaches may include utilizing data that is available through a number of different sources such as the [National Survey on Drug Use and Health \(NSDUH\)](#), [Treatment Episode Data Set \(TEDS\)](#), [National Substance Use and Mental Health Services Survey \(N-SUMHSS\)](#), the [Behavioral Health Barometer](#), [Behavioral Risk Factor Surveillance System \(BRFSS\)](#), [Youth Risk Behavior Surveillance System \(YRBSS\)](#), the CDC mortality data, and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention, treatment, and recovery support services planning. States with current Strategic Prevention Framework - Partnerships for Success discretionary grants are required to have an active SEOW.

This step must also describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss their plan for implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations listed above, and any other populations, prioritized by the state as part of their Block Grant services and activities are addressed in these implementation plans.

1. Please describe how your state conducts statewide needs assessments to identify needs for mental and substance use disorders, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

I. A Data Driven Process for Identifying Unmet Needs and Critical Gaps

The Division of Mental Health and Addiction Services (DMHAS) uses a data driven process to identify unmet needs and critical gaps. (DMHAS) data sources include: Quarterly Contract Monitoring Reports (QCMR); Unified Services Transactions Form database (USTF+); Systems Review Committee (SRC) data; Hospital Census Database; and input from the Behavioral Health Planning Council. In addition, DMHAS obtained data from its contracted community mental health programs. Another primary resource used to identify gaps was the SMHA Consumer Perception of Care Survey, which provided critical data used to measure contracted agencies were performing and meeting each individuals' goals. DMHAS also relies on national data sets, including demographic data from the US Census Bureau, SAMHSA's NJ Behavioral Health Barometer, SAMHSA's Uniform Reporting System (URS) Data Tables, Annual Demographic Profiles generated by the NJ Department of Labor and Workforce Development, the NJ State Health Annual Assessment Date, Center for Health Statistics, NJ DOH, the NJ Violent Death Reporting System, the CDC-funded NJ Behavioral Risk Factor Survey, NJ DOH Uniform Billing data (evidencing hospital and emergency department use by demographic factors), and NJ DOH Licensing data (evidencing occupancy rates for psychiatric beds in general hospitals).

Persons with a SMI are the primary statutory population for SMHA funded services. However, DMHAS has identified service gaps and therefore prioritizes services to: persons with SMI in need of crisis intervention and stabilization services; individuals with

early serious mental illness (first episode psychosis); persons with SMI as well as Older Adults; Homeless Adults; individuals with SMI in rural areas; and children with a serious emotional disturbance and their families.

-Adults with SMI

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)¹. According to URS Table 2a, a total of 80,022 unduplicated persons ages 18 and over received services in programs provided or funded by the SMHA in FY 2024. The SMHA served 30,098 unduplicated adults with SMI (refer to URS data table 14a) in FY 2024. That was 7.48% of the total estimated adults with SMI in New Jersey (402,228). It is noteworthy that DMHAS has transitioned to the UTF+ data system as mentioned previously continue to provide monitor the data and provide technical assistance where needed. The QCMR provides duplicated data where an individual can be enrolled in a program, be discharged, and then be readmitted during the same year or an individual may be in one program and also in another program as long as they are not mutually exclusive. The QCMR data reveals that there were 270,263 individuals served in SFY 2024, of that total, 251,501 were 18 and older. In total, the data revealed the unmet needs and underutilization within the state by county and by level of care.

Various community providers reported extensive psychiatric wait times and continuing psychiatric staffing challenges. DMHAS is aware of psychiatric staffing shortages, and identified the need for additional licensed, professional psychiatric staff at various levels of care.

-Homeless Adults.

DMHAS conducts regularly scheduled monthly meetings with approximately forty-one contracted Community Support Services (CSS) provider agencies and the Supported Housing Connections (vendor). The state maintains and manages approximately three-thousand rental subsidies to support individuals with serious mental illness living in the community. DMHAS contracts with approximately forty-nine Residential Service providers.

New Jersey conducts a Point in Time (PIT) Count on an annual basis. PIT was conducted on January 24, 2024, and revealed there were 12,680 people experiencing homelessness in the State of New Jersey, up 24% from 2023. Thirty percent of those experiencing homelessness were homeless for over one year. 1,737 persons were unsheltered on the night of the count.

DMHAS monitors its bed enrollment data system, and both CSS and residential provider weekly report for vacancies in supervised and other residential beds. In doing so DMHAS is able to assess the levels care are in each geographic area.

-Older Adult Committee

DMHAS considered local survey data of waiting times by the Mental Health Association in New Jersey, along with regional considerations, and applications received to a competitive procurement opportunity to serve this population. The Request for Proposals solicited services needed for Burlington, Sussex and Union Counties. Services included medication management and psychotherapeutic counseling. DMHAS relied on an estimate from the American Association of Geriatric Psychiatry that 20% of people age 55 years or older experience some type of mental health concern. DMHAS also relied on the National Council on Aging which indicated that fewer than 50% of older adults with mental and/or substance use disorders receive treatment.

DMHAS and the Division of Behavioral Health Services (DBHS) are jointly conducting a performance improvement project for Older Adults looking at strategies to enhance, identify and provide training and discharge resources needed to facilitate the discharge of older adult patients at the state psychiatric hospitals.

-Coordinated Specialty Care (CSC), Coordinated Specialty Care, Community Integration (CSC CI). It was estimated at the incidence of FEP in adult populations 15-29 is 86 per 100,000¹. Three out of 100 people will experience psychosis at some time in their lives². It also was estimated that the lifetime prevalence of bipolar disorder 1 is .24% and major depressive disorder is .35%. In New Jersey, the CSC program was identified as an effective treatment, allowing individuals with FEP to live, work, learn, and socialize in the communities in which they live. Since inception, New Jersey's CSC program has received over 1,290 referrals and served 668 clients. The high demand for service prompted an expansion of services for each provider from a caseload of 35 clients to 70

clients with two of the centers currently operating in excess of the expected caseload. In addition, DMHAS meets with the CSC teams on a monthly basis and gathers information that provided an assessment of unmet needs and critical gaps regarding individuals served.

-Individuals in Need of Behavioral Health Crisis Services

Since the State's transition to 988 on July 16, 2022, New Jersey has identified an increased need for crisis services as demonstrated by a steady increase in call, text and chat demand to 988. Comparing data from the first year of transition (July 2022 – June 2023) to data for year two (July 2023 – June 2024), New Jersey has seen an approximately 35% increase in the average number of calls received per month. Between 2022 and 2023, the 988 Lifeline experienced a 65% increase in text demand from New Jersey-based phone numbers. In the first year of 988, in-state demand for chats rose by approximately 50%. Comparing 2022 and 2023 data, in-state chat demand has remained fairly consistent with a slight decrease of 8%. In the first two years of 988, New Jersey is averaging a 79% in-state call answer rate and is providing an in-state response to 58% of the chats and texts routed to New Jersey-based centers. NJ DMHAS continues to monitor 988 contact demand and answer rates to assess the statewide need for this crisis service.

National 988 quality improvement efforts are currently the responsibility of the 988 Lifeline Network Administrator, Vibrant Emotional Health (Vibrant). Lifeline centers have direct contracts with Vibrant to uphold quality standards. Centers that fall below established standards work directly with the Network Administrator to mitigate concerns in a timely manner. Vibrant and the centers are responsible for contacting NJ DMHAS if a center's performance falls outside of the acceptable range.

All Lifeline centers also have direct contracts with NJ DMHAS for the provision of in-state 988 services. Each Lifeline center is responsible for submitting monthly and ad hoc data reports to NJ DMHAS which include key performance indicators. DMHAS key performance metrics include primary presenting concern, demographics, disposition, and response data including emergency rescue or contacts resulting in a mobile crisis outreach response referral.

Calls, chats and texts come into the 988 Lifeline crisis center network from across the United States and its territories. They are routed to independently operated contact centers based on georouting at the national level or by the contact's area code (as indicated by the telephone number from which the contact originates). Once an individual reaches a Lifeline center, it is determined by a trained crisis counselor whether the individual needs urgent in-person assistance. If they do, the crisis counselor will request dispatch of emergency services which, for some time in New Jersey, included a Designated Screening Center (to assess for involuntary 988 Mobile Crisis Outreach Response Teams- 5 commitment), law enforcement, emergency medical services or other first responders. Nationally, only 1-2% of crisis contacts have required such an outreach. New Jersey therefore required a new, statewide, 24/7 Mobile Crisis Outreach Response system that would respond to non-life-threatening mental health, substance use or suicidal emergencies without emergency personnel when it is determined to be safe to do so.

For the 988 MCORT program, NJ DMHAS monitors outreach metrics through the state-required database to be used by all MCORT provider agencies. Through this database, NJ DMHAS is able to review key performance metrics and general outreach data such as response times, outcomes, referrals provided, dispatch arrival times, dispatches resolved or requiring further service involvement, number of contacts requiring follow-up, and average number of individuals served per shift.

DMHAS psychiatric emergency screening (PES) data reveals that less than 40% of the individuals who present to the Emergency Department (ED) in psychiatric crisis require inpatient treatment. In addition, SAMHSA concluded that too often, the treatment of psychiatric emergencies was delayed, or denied, which created "undue burdens" on individuals with SMI, first responders, emergency departments and justice systems. Finally, DMHAS conducted an assessment of need utilizing designated screening data, emergency room data, affiliated emergency services data, and state hospital data to determine the need for, a number of recliners for mental health and SUD in Crisis Receiving Stabilization Centers (CRSCs). CRSC were identified as the alternative to traditional crisis services by diverting individuals from going to EDs and inpatient treatment when community-based alternatives would better meet the needs of individuals experiencing a behavioral health crisis.

-Individuals with SMI or SED in Rural Areas

The SMHA defines a county as “rural” if, according to U.S. Census figures, 25% or more of its population live 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. A New Jersey community is considered rural if it has a population density of less than 500 people per square mile. According to USA.com, NJ population density rank, there are 60 cities out of 545, that have a population density less than 500/square mile. Ensuring access to services in rural or remote areas can be challenging. DMHAS provides many levels of care statewide. For services that are not offered in every county DMHAS has begun to look at the need for services in other counties. For example, there were 3 CSC programs providing services to 7 counties each. DMHAS evaluated the data submitted by the providers and identified an unmet need in surrounding counties, most notably the counties to the northwest (Sussex, Hunterdon, and Warren) and to the south (Atlantic, Cumberland, and Cape May). This illustrates another example of how data is used to identify and address unmet needs.

-Children with SED and families

The summary of the CSOC strengths as well as unmet service needs and gaps within the current system of care is based on data from the following sources of information:

Department of Children and Families Strategic Plan

DCF Commissioner’s Dashboard

CSOC Child and Youth Behavioral Electronic Record (CYBER) Data Collection and Reports

CSOC Internal Data Collection and Reports

DCF Internal Data Collection and Reports

CSOC Youth Services Survey for Families

Monthly statewide system partner meetings (CMO, FSO, JJC)

County-based Children’s Inter-Agency Coordinating Council (CIACC) meetings

Bi-Annual Needs Assessments submitted by the HSACs

CIACC Dashboard

Traumatic Loss Coalition for Youth Program Reports

New Jersey Kids Count – The State of Our Children, Advocates for Children of New Jersey

New Jersey Student Health Survey

Robert Wood Johnson Foundation County Health Rankings and Roadmaps

SAMHSA National Study on Drug Use and Health

CSC Youth Risk Behavioral Surveillance System

To operationalize the DCF vision of ensuring New Jersey children and families are safe, healthy, and connected, the Department of Children and Families has established a Strategic Plan to best align the priorities of CSOC with the DCF vision and values. The Strategic Plan identifies the following CSOC priorities:

Promote integrated health and behavioral health.

Build capacity to deliver evidence-based interventions and services.

Enhance CSOC capacity to ensure access to all

-Data Sources - The SMHA has steadily improved its capacity to organize mental health promotion initiatives utilizing prevalence estimates and epidemiological analyses at the state and county levels. The data sources SMHA will continue to utilize in driving the planning for the prevention and mental health promotion initiatives include:

DMHAS internal data systems such as Quarterly Contract Monitoring Report (QCMR), Beds Enrollment Database (BEDS), Unified Services Transaction Form (USTF) database, Systems Review Committee (SRC) Data, and the State Hospital Database.

Data obtained from different mental health community programs funded by DMHAS.

SMHA Consumer Perception of Care Survey

Other State and National Data Sets

Demographic Data from the US Census Bureau.

SAMHSA's New Jersey Behavioral Health Barometer.

SAMHSA's Uniform Reporting System (URS) Data Tables.

Annual Demographic Profiles summarized by New Jersey Department of Labor and Workforce Development based upon Census 2020, Intercensal Population Estimates, and Population projection estimates by the U.S. Census Bureau.

New Jersey State Health Annual Assessment Data, Center for Health Statistics, New Jersey Department of Health (DOH).

The New Jersey Violent Death Reporting System (NJVDRS), a CDC-funded surveillance system, which records suicide (with known circumstances).

CDC-funded New Jersey Behavioral Risk Factor Survey, in which mental health modules were implemented (Depression and Anxiety Module, 2010 and 2011; and Mental Illness and Stigma Module, 2012, 2013, 2014 and 2017). The SMHA funded the collection of Mental Illness and Stigma Module in NJBRFS in 2014.

New Jersey DOH Uniform Billing data which show hospital and emergency room use by demographic factors.

New Jersey DOH Healthcare Facility Licensing data, with which occupancy rates for psychiatric beds in general hospitals are calculated.

New Jersey State Health Assessment Data (NJSHAD) which provides access to health status data of individuals in NJ, including emergency department and inpatient admissions by diagnosis code and age.

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 approximately 100 separate agencies on 24 different program elements for roughly 630 separate sub-program elements (e.g., a specific program element, run by specific agency and specific site) on a quarterly basis.

Of these 24 programs elements, 23 are included in the web-based QCMR portal. These 23 programs consist of Acute Intensive Family Support Services, Community Advocates / POST, Designated Screening Centers, Early Intervention Support Services, Affiliated Emergency Services, Integrated Case Management, Intensive Family Support Services, Intensive Outpatient Treatment & Support Services, Legal Services, Outpatient, Services of the homeless, Partial Care, Residential Services, Consumer Operated Wellness Centers/Self Help Centers, Career Services/Supported Employment, Community Support Services, Supported Education, Involuntary Outpatient Commitment Services, Coordinated Specialty Care Community Integration - CSC/CI, Mobile Crisis Outreach Response Teams, Crisis Diversion Homes and Crisis Receiving Stabilization Centers

The one program not currently captured by the web-based portal is, Projects for Assistance in Transition from Homelessness which is collected by New Jersey Housing and Mortgage Finance Agency (HMFA) in the Homeless Management Information System (HMIS) and shared with DMHAS. Data for this program is collected separately and updated by DMHAS. As new program elements are added, new QCMRs are developed. DMHAS collaborates with program coordinators and database programmers to add each of these program elements into the QCMR portal, allowing for standardized and automated data collection and reporting of all DMHAS-funded programs.

The QCMR historically emphasized program-level data, but as the QCMR data field layouts change over time, increasing numbers of data points related to aggregate consumer outcomes have been included. The QCMR does not collect client level data. The QCMR provides essential data for many routine reports generated by the SMHA including: DMHAS Evaluation data table for URS reporting of numbers served by program, annual Budget Briefing reports, and planning resources for the annual Consumer Perception of Care Survey. In addition, the QCMR provides reliable information for the majority of ad-hoc reports created by the Division, specifically around the topics of utilization management, provider performance and the geographic distribution of available services.

-Unified Services Transaction Form (USTF) Legacy Database

The USTF database was an electronic client level registry originally developed in 1978 (revised in SFY 1990 and last upgraded in 2000). It was an Access desktop application which was used by all MH providers who submit their files to DMHAS each quarter. In SFY 2022, there were over 500,000 records—with each record containing the potential for over 50 separate data fields. USTF was last utilized for reporting SFY 2022 data and the data for the 2022 URS data tables.

-USTF+ Client Level Web-based Application.

In the Spring of 2020, the SMHA renewed construction of its updated USTF system. Meanwhile, DMHAS started to design and implement a secure, web-based comprehensive client registry and client-level data (CLD) system. Phase 1 of the USTF+ was rolled out in FY 2022, and was the “staging environment” (e.g., the trial/practice version of the application where functionality and user interface were tested and evaluated) in iterative stages – initially to a small number of pilot agencies and later, to the group of the 60+ providers whom the SMHA works with. That version of the USTF+ consisted of updated versions of current fields as well as new data elements that will satisfy federal CLD guidelines and evolving needs for data-driven understanding of populations served by the SMHA. Upon satisfactory testing of the system on a pilot basis in the Summer/Fall of 2022, the SMHA launched a series of nine statewide videoconferences in late 2022 to demonstrate its entire provider community on the use of the new system. Over 400 representatives/staff members from community-based provider agencies participated in these video conferences.

USTF+ system was completed and released to production on July 5, 2023. DMHAS provided the opportunity for providers to do a one-time upload of their current active caseload or to enter their information manually. DMHAS issued a correspondence to each provider in mid-July informing them that DMHAS would provide them with one time funding to help them with entering the data into the new application. At the same time, DMHAS issued credentials to each provider for an Administrator at their site who would in turn create and maintain the credentials for their agency.

The development of USTF+ was essential due to four key imperatives: 1. to streamline reporting from DMHAS providers eliminating duplication of reporting, 2. to manage the transition of DMHAS to outcomes reporting, 3. to provide the public with more “forward facing” online performance data, and 4. to satisfy federal mandates of SAMHSA—including reporting of data required by the Community Mental Health Services Block Grant (CMHBG), Mental Health National Outcome Measures (NOMS), and Client-Level Data.

The USTF+ data system is already helping to facilitate the reporting of URS Data tables and Client Level NOMS, as well as significantly improve the quality of ad hoc reporting and production of data dashboards. In addition to the reporting mentioned

above, the SMHA will be including evidence-based assessment tools in the CLD such as the WHODAS. T1/T2 client level outcomes (e.g., changes in educational achievement, employment and involvement with recidivism) have been built into the system. Program level outcomes (including outcomes from SAMHSA's evidence-based toolkits) are planned for future phases of the USTF+. The CLD will enable the SMHA to provide data dashboards for provider agencies as well as the SMHA senior leadership to drive planning and evaluate programs. It will allow the SMHA to collect detailed data to help determine unmet needs. The goal is for the USTF+ 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) Legacy data system, the Quarterly Contract Monitoring Report (QCMR), and the Systems Review Committee (SRC) data system), thus decreasing duplication of data entry, 2. provide fine-grained utilization management data that allows the Division to drill down to service use at the program level, the agency level, the county level and the client level, 3. document consumer outcome measures to evaluate program (and provider) effectiveness, and 4. provide users with reliable and meaningful data to drive and inform decision-making. With the ability to utilize encounter data from Medicaid and NJMHAPP combined, along with the data from the USTF+ CLD (client level of functioning, quality of life measures, etc.), the SMHA will be able to gauge the impact of services, Medicaid penetration rates, etc. The SMHA will be able to significantly enhance its planning efforts and capacity for data informed decision making once the system has been fully programmed. DMHAS rolled out the first phase and has been updating the data system at least twice a year to improve functioning and user experience. The USTF+ data will be critical data when preparing a comprehensive need assessment including county-based needs, barriers, critical gaps, and reporting on statutory populations.

Since the launch of USTF+, DMHAS has expanded the USTF+ to include additional programs, including Designated Screening Centers (DSC), Short Term Care Facilities (STCFs), Mobile Crisis Outreach Response Teams (MCORT), Coordinated Specialty Care Community Integration (CSC-CI), Peer Crisis Respite (PCR), Crisis Receiving Stabilization Centers (CRSC) and Crisis Homes (CH) bringing the total number of program elements included in the system to twenty-six.

Other system improvements include the addition of client outcomes reporting ("T1/T2") and specialized reporting for individuals in CSC-CI, CRSC, improved Help Ticket processing functionality, updated program compatibility, and improved client search functions to enhance coordination of care among system users.

Accompanying the development, testing and roll-out of the USTF+ and its subsequent updates have been provider outreach and support, which take myriad forms.

Educational Materials for the User Community have been created and remain in regular production, including the following:

A 62-page "Provider User Guide Document". The comprehensive user manual complete with screenshots, and step-by-step instructions on performing all required functions in the USTF+ system (produced by DMHAS OIS). This is available through the USTF+ website itself and is frequently sent directly to providers by the Office of Planning Research Evaluation Prevention and Olmstead (OPREPO) staff.

Quarterly "On the + Side" USTF+ newsletters produced by OPREPO and distributed to all registered users of the USTF+ system to announce system upgrades, user support and helpful reminders.

Three how-to/system demonstration YouTube videos – over 100 minutes of content on how to use the USTF+ system (produced by DMHAS OIS).

Help Ticket Resolution: In FY 2025, USTF+ users have created 2,634 USTF+ help tickets, of those 94.6%, 2,492 Help Tickets have been successfully resolved by a joint effort of OPREPO and OIS staff. The remainder of the Help tickets are new and/or are in process of being resolved.

Direct Assistance to Providers: To support the agency users of the USTF+ system, OPREPO's USTF+ Team and OIS staff have engaged in thousands of emails and phone calls with agency staff. Such communications are conducted to resolve technical issues that were not submitted via the Help Ticket system, respond to ad-hoc user questions, and provide access support. DMHAS makes a commitment to providing all users with positive, friendly and collegial provider support from OPREPO staff members,

whose mantra in working with providers is “we want to set you up for success”.

Two Listserv accounts have been created, one for all USTF+ users and one for USTF+ provider admins, to ensure quick communication to all users.

Live training sessions have been conducted by OPREPO staff in over 20 separate, live, USTF+ training events for the provider community. Including: Large scale videoconferences with multiple provider agencies as well as small group sessions. More will be conducted in the future—conducted by request and often at the suggestion/invitation of OPREPO staff.

Over 600 staff members from over 100 agencies have participated in / received training in the large-group, live trainings.

Provider Admin Monthly Meetings: Starting in fall of 2024, monthly meetings have been occurring with provider administrators of the USTF+ system. These meetings serve as a way to engage system administrators, have them take ownership of their data, and encourage questions and comments about utilizing the system. These meetings are typically attended by 40+ providers with 50-100 participants.

-Systems Review Committee (SRC) Datasets. SRC are a series of linked MS-Excel documents submitted monthly from 24 Short Term Care Facilities (STCFs) and 23 Designated Screening Centers (DSCs). By regulation, SRC data is collected and reviewed monthly by localized county specific committees comprised of acute care providers and governmental staff. These SRC processes include review of trends related to volume, capacity, referral patterns, system flow, length of stay and disposition. The SRC dataset provides program/agency-specific data that is the aggregate of each program’s consumers served within a given month. The conversion of the SRC data submission files (from STCF and DSC provider agencies) into single ‘flat files’ has improved the ability of DMHAS staff to efficiently and accurately query SRC data. DMHAS is planning to incorporate the SRC into the USTF+ web-based application, eliminating duplication of data submission from SRC providers and enhancing the completeness of the SRC data.

-State Hospital Database. The State Hospital database is the central information system for storing client-specific records on consumers admitted into New Jersey’s three regional inpatient adult psychiatric state hospitals and one forensic state psychiatric hospital. To keep up with the flow of consumers entering, and exiting the state hospitals, this data is updated on a daily basis by hospital personnel. The scalable nature of the database provided the opportunity to add additional data items such as the “Individual Needs for Discharge Assessment” which is designed to identify discharge barriers as early as possible during the course of hospitalization. The INDA is first administered within seven days of admission and subsequently updated every 30 days, so that successful community integration can be addressed in advance of discharge readiness. Although the state hospital data 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. The state hospital data provides admission, discharge and census data, as well as demographic data, civil commitment status, length of stay data, readmission data, etc.

In addition to canned reports that are available in the system, DMHAS has the ability to access the data and can prepare reports. DMHAS has developed several reports and data dashboards that have been shared with the Division of Behavioral Health Services and reviewed with DBHS on a regular basis. The state hospital data allows for hospital and central office users to summarize and examine hospital census data in an aggregated and/or snapshot view of individuals served each year. The database is used by DMHAS for utilization management; Olmstead monitoring, planning and evaluation; and reporting of data for the URS data tables. DMHAS and DBHS have been meeting to discuss report queries, data definitions, and cadence of reports to ensure that the reports that are generated by each Division in the course of business operations and that these reports closely align and utilize the same parameters and same data definitions. DMHAS and DBHS utilize these reports for collaborative performance improvement projects.

-New Jersey Mental Health Application for Payment Processing (NJMHAPP). New Jersey Mental Health Application for Payment Processing (NJMHAPP) allows agencies contracted with DMHAS for mental health services to submit eligible encounters/billing for all fee for service (FFS) programs for payment processing. It does not replace other contractually obligated data requirements by DMHAS such as QCMR and USTF. NJMHAPP will only be accessed for services that are NOT covered by Medicaid or other insurance since the state is the payer of last resort

-Beds Enrollment Database (BEDS). Since 2015 the SMHA has been utilizing a secure, reliable web-based system (BEDS) to provide real-time access to vacancy information, which helps to facilitate assignments, in a more streamlined manner, and facilitate better

communication with state psychiatric hospitals. This system was created to facilitate the assignment of consumers from state psychiatric hospitals into safe and appropriate community-based residential settings, in accordance with [1],[2],[3]. Analysis of the utilization of independent (e.g., Community Support Services) and supervised settings (e.g., group homes and supervised apartments) allows for assessment of the Division's progress toward community integration. The system also enables planning at both the individual consumer level for placement purposes and system-wide for purposes of enhancements in community resources. In recent years BEDS has been enhanced to include short-term care facility (STCF), enhanced reporting functionality, and streamlined search features, to give the SMHA a better view of both community-based residential resources and the acute care system. As of early August 2025, BEDS contains detailed data for over 5,100 residential beds, CSS slots and STCF beds.

-Provider Weekly Reports (PWRs). DMHAS Olmstead and Diversion Office facilitated a performance improvement initiative in 2019 designed to facilitate hospital discharges and diversions from admissions; decrease the current length of time to place state hospital clients into residential beds; identify complex issues impacting discharges from a state hospital; and provide a mechanism to gather information on agency capacity, census, vacancy, and specific information on pending assignments, including barriers to discharge. The performance improvement initiative was a collaborative effort with the State Psychiatric Hospitals, DMHAS Office of Community Services, DMHAS of Housing, and DMHAS funded providers. The Provider Weekly Report was developed as a result of this performance improvement initiative. The report contains information that is not included in the current BEDS system and assists with tracking and following up of referrals as weekly updates from agencies are provided which assists the Olmstead/Diversion office with following up on those referrals that require assistance. A significant number of providers submit the PWRs on a weekly basis. The compliance from January 2025 through July 2025 averaged 97.6% and the median was 98.1% in terms of submission of the PWRs. Reports are due on Thursdays of each week and if a report is not submitted, the DMHAS Olmstead staff will contact the provider with a reminder and obtain the missing PWR.

-Web-based Electronic Referral System - Crisis Management Module

DMHAS is looking to replace its current BEDS database with a new comprehensive online, statewide, database and referral tool for a broad continuum of services that go beyond beds or residential placements and include DMHAS services slots including acute care, outpatient services, recovery supports, and other community-based services and supports along the DMHAS continuum of care for individuals with behavioral health needs in NJ. The DMHAS anticipates starting with acute care services, as the implementation of 988 necessitates having a system in place to make referrals, including referrals from the crisis call centers and Mobile Crisis Outreach Teams (MCORTS). The web-based enabled system will be rolled out in phases. As other care components are added, the solution will be designed to expand to accommodate additional services, resources and functionality. In addition to being used for the 988 system, subsequent phases will incorporate the full array of contracted and licensed behavioral health services. Effective 3/3/2025, the Crisis Module went live and included a real-time connection between crisis call center professionals, the Caredon Managing Entity, and mobile crisis response teams. Prospectively, functionality will include crisis stabilization services and community treatment providers.

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

The web-based application will have the ability to search for services using various criteria, real-time facility availability, and two-way digital communication. The system will provide the ability to create and send a digital referral to a facility based on service need, payment type, particular needs, geographic location, and other criteria. The system will provide for the ability to close the loop on referrals and obtain feedback regarding treatment engagement and outcomes using secure messaging. The data system will maintain information and communications on community and hospital referrals and provides the information needed to monitor referrals and intervene to facilitate placement and linkages to services. The ability to manage behavioral health bed vacancies and ongoing referral communications in one system allows for timely response and efficiently managing diversionary efforts. The electronic registry will assist in diverting admissions from emergency rooms and inpatient settings including state

hospitals. The electronic registry is necessary to enhance movement along the continuum. The data system will foster a continuum of community-based care that meets the needs of the individual where they live. The solution will include the ability to track various metrics.

-Consumer Perception of Care Survey. Since 2011, the SMHA Consumer Perception of Care Surveys have been distributed in the summer/fall of each year to a representative sample of adult consumers of all community-based, non-acute programs [4]. The survey results are reported in the annual CMHBG Implementation Report. An unmodified version of the Mental Health Statistics Improvement Program (MHSIP) Adult Survey (Draft Version 1.2, February 17, 2006)[5] is used as the survey instrument, with the addition of ten questions related to primary health, from the Behavioral Risk Factor Surveillance System (BRFSS) survey [6]. Each non-acute mental health program contracted by the SMHA, has served as sampling stratum. Agency program coordinators are instructed by the SMHA on techniques of random sampling and systematic error mitigation. 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 2024 the average General Satisfaction score was 97.8%.

The 2020 Consumer Perception of Care Survey was not expedited due to reasons directly related to the Covid-19 global pandemic/State emergency (e.g., clients receiving services via telehealth and not onsite at the provider agency where the surveys are usually distributed, and workflow disruptions at the SMHA).

Following the pandemic, the SFY 2021 Survey of Adult Mental Health Perception of Care was undertaken (for the first time) using an electronic platform (e.g., SurveyMonkey), rather than the more cumbersome (and expensive) paper format. Consumer engagement in that SFY2021 survey was high (over 750 questionnaires were received) of which 92% (+/-5.4%) respondents reported positively about general satisfaction with services (URS Data Table 11). The subsequent survey in SFY22 was again conducted via the same electronic platform and yielded an increased satisfaction rate (97% +/-6%). In SFY 2023 the general satisfaction rate was 98.3%, with a response rate of 19.6%. In SFY 2024 the general satisfaction rate was 98.4%, with a response rate of 24.9%.

-Coordinated Specialty Care Client Level Data System. DMHAS has a data collection tool to capture demographic and outcome data elements. This manual data collection system for CSC CI will no longer be utilized once all of the program outcomes specific to CLD are added to the new USTF+. Currently the data is collected every three months and analyzed to track the progress of CSC clients who have received services. Client measures include client referral source; age; male/female;; psychiatric and medical hospitalizations; psychotropic medication adherence; co-occurring substance use disorder; discharge and re-admission; insurance status; language, and global functioning using the MIRECC GAF scale. In addition to the CSC data spreadsheet, CSC programs submit a quarterly progress report to DMHAS. The quarterly progress report outlines community outreach progress and any questions regarding the client service model, recommendations, and client referral demographic data. The new web-based USTF+ CLD system includes a program-specific module for CSC CI CLD which provides assessment scale/scores including MIRECC, CGI (optional), BPRS, ACES, PHQ-9, MDQ, as well as psychotropic medication adherence, inpatient hospitalization and designated screening visit history while enrolled in the program. These new features are anticipated to be functional in the Fall of 2025. Trainings on these features will commence shortly after. DMHAS anticipates having a full year of data for SFY 2027.

The QCMR collects data which provides information specific to the CSC program as well as the step down or Community Integration (CI) program). Additionally, the QCMR provides information for individuals admitted to, discharged from and caseloads for First Episode Psychosis (FEP) and Affective Psychosis. Individuals served and units of service are also monitored, as well as payer mix and staffing ratios.

-Crisis Receiving Stabilization Centers (CRSCs)

The new web-based USTF+ CLD system includes a program-specific module for CRSC CLD which provides admission time of the day, arrival type (first responder drop offs and walk-ins, length of time for drop off) diagnoses for primary assessment mental health and SUD, one-on-one supervision, follow-up visit to outpatient programs after completion of CRSC (within next business

day, within 7 days and post 7 days). These new features are anticipated to functional in the Fall of 2025. Trainings on these features will commence shortly after. DMHAS anticipates having a full year of data for SFY 2027.

The QCMR collects data which provides information specific to CRSC, including referrals, post-discharge contacts, referral source, follow up appointments, length of stay, medication-assisted treatment and contracted staffing. DMHAS follows the SAMHSA guidance to develop data capture tools to measure outcomes.

-Other Statewide and Nationwide Data Sets

The SMHA uses several independent datasets, alongside national and statewide datasets to shed light on goals, priorities and success. Specifically, this constellation of datasets is most commonly used to identify counties that are most appropriate (in terms of need and access to mental health services) for new community services and Requests for Proposals (RFPs). Additional statewide and county-specific data is obtained from the US Census Bureau (e.g.<https://www.census.gov/acs/www/data/data-tables-and-tools/data-profiles/>) to inform comparisons of population density, residential characteristics, unemployment rate, age distribution, household income, poverty levels and other factors helpful in determining need. The NJ Jersey Department of Labor and Workforce Development also generates important economic and employment data (https://www.nj.gov/labor/lpa/employ/uirate/lfest_index.html) which is often used by the SMHA in making inter-county comparisons of economic need. Data on crime statistics in New Jersey is compiled by the NJ State Police, and its reports (<https://www.njsp.org/ucr/crime-reports.shtml>) are utilized by the SMHA in obtaining a clear picture of county stressors and crime rates. In addition, the SMHA utilizes publicly available state population health information from the NJ State Health Assessment Data (NJ-SHAD) <https://www-doh.nj.gov/doh-shad/> which provides community profiles and dataset queries.

National data is often examined by the SMHA to shed light on New Jersey mental health efforts, relative to similar states. SAMSHA, through its compilation of Behavioral Health Barometer (Behavioral Health Barometer: New Jersey, Volume 6 (samhsa.gov)) and URS data tables, and state level detail reports provide useful information in this regard 2024 Uniform Reporting System (URS) Table For New Jersey | CBHSQ Data). 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/>).

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SSA

The SSA has a long history of conducting needs assessments to determine overall treatment need for substance abuse treatment, demand and gaps, and treatment need and gaps for populations in need in New Jersey. Obtaining reliable substance abuse treatment need estimates is critical to the state's ability to promote a rational planning and resource allocation process. The Division of Mental Health and Addiction Services (DMHAS) employs a variety of scientifically valid methods for estimating substance abuse treatment needs. Primary among these are: 1) surveys, 2) social indicator analysis, and 3) "synthetic" statistical estimation techniques, called modeling.

Our methodologies also allow us to determine need at the county level. This information is important for the planning and development of new substance abuse prevention and treatment services. Needs assessment data are incorporated into our Request for Proposals (RFPs) for developing new substance abuse and treatment services, are incorporated into funding formulas for distribution to our counties per Alcoholism, Education, Rehabilitation and Enforcement Fund1 (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 and the CDC High School YRBS); specific surveys such as Older Adults, Veterans; Young Adults; relative needs assessment; synthetic estimation techniques such as capture-recapture; and social indicator analysis. in order to develop needs assessment strategies. For over 25 years, New Jersey has used a household survey to estimate: 1) the prevalence of both legal and illegal substance use, 2) alcohol treatment need and 3) unmet treatment demand. The SSA also utilizes Geographic Information Systems (GIS) for the spatial visualization of social service needs and advanced analytic techniques such as multiple

Please see attached file for further information for the SSA's statewide needs assessments to identify needs for substance use disorder, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

2. Please describe the unmet service needs and critical gaps in the state's current mental and substance use systems identified in the needs assessment described above. The description should include the unmet needs and critical gaps for the required populations specified under the MHBG and SUPTRS BG "Populations Served" above. The state may also include the unmet needs and gaps for other populations identified by the state as a priority.

II. Unmet Needs and Critical Gaps and How to Meet the Identified Unmet Service Needs and Gaps

-Adults with SMI

The SMHA continues to maintain and expand its network of community providers. In addition, DMHAS reviews and reassesses mental health contracts to ensure provider agencies have appropriate funding ceilings and service commitments so the SMI population in each of the state's counties has access to various levels of services. Unmet needs were identified as psychiatric staffing and wait times, due in significant part by psychiatric staffing shortages. Specifically, agencies reported difficulty filling staff positions and increased salary demands.

-Homeless Adults

The most critical gaps and unmet needs identified by PATH providers are lack of a sufficient number to satisfy increased need for: 1) shelters and shelter beds, rooming and boarding homes, safe transitional/emergency housing; 2) affordable, safe, permanent housing; 3) supportive housing resources and group homes; and 4) housing subsidies. The utilization of community support services with subsidies has been beneficial in providing rehabilitative services to individuals coming out of state and county hospitals and being integrated into the community.

Additional unmet needs include: tenancy start-up costs (such as security deposits and utilities); financial resources for individuals who have reached their maximum allowable time on General Assistance or who do not otherwise meet the criteria for General Assistance, such as those with SSI/SSDI benefits; delays in approval for benefits from the Board of Social Services; and obtaining medications for those persons without health insurance.

-Older Adults

The American Association of Geriatric Psychiatry states, "It is estimated that 20% of people age 55 years or older experience some type of mental health concern". However, the National Council on Aging indicated that fewer than 50% of older adults with mental and/or substance use disorders receive treatment. Based on local survey data by the Mental Health Association in New Jersey on wait times, regional considerations, and applications received, DMHAS determined there were unmet needs of older adults aged 55 years of age and older, in three New Jersey counties (Burlington, Sussex and Union) for outpatient services.

-ESMI Coordinated Specialty Care

From meeting with CSC providers over the years, providers indicated that they were in need of the ability to serve individuals who presented with affective psychosis as well as individuals in need of step-down from the CSC. At that time, affective psychosis was not part of the admission criteria for our early psychosis programs, nor did DMHAS have a step-down program.

-Individuals in Need of Behavioral Health Crisis Services

988 Lifeline center answer rate data revealed the need to increase capacity at our 988 contact centers to meet the in-state demand. Per the above needs assessment, NJ 988 has seen a consistent increase in call, chat and text demand since its launch in July of 2022. Standards set forth by SAMHSA and the 988 Network Administrator outline that each state is expected to achieve and maintain a 90% in-state answer rate for calls, chats and texts. While NJ 988 has continued to increase the number of contacts answered, the state continues to fall short of the 90% expectation. As a result, contacts that are not answered in-state are routed to the national backup network where localized care cannot be achieved.

NJ 988 MCORT utilization data to date reveals a need to expand awareness and community trust related to this service.

The evaluation of screening center and hospital data revealed unmet needs for a full continuum of crisis stabilization services in the community. In keeping with SAMHSA's National Guidelines for Behavioral Crisis Care, DMHAS identified the need to implement the third pillar of the toolkit, A Place to Go. Therefore, the assessment identified the need for community-based crisis receiving stabilization centers to further enhance DMHAS' diversionary efforts in its existing crisis continuum.

-Individuals with SMI or SED in Rural Areas

DMHAS identified gaps in services for individuals in rural areas from the data that was reviewed. One of the gaps identified was a need to increase access to services for individuals in Atlantic, Cumberland, Cape May, Sussex, Hunterdon and Warren Counties.

-Children with SED and Families/Youth with SED in Rural Communities/Youth with SED Experiencing Homelessness

CSOC acknowledges gaps and unmet service needs within the current system of care and has identified activities to address them. The system infrastructure includes a full continuum of services and supports embedded in every region of the state, aligned with court vicinages, that allows for the development of robust local cross system partnerships (e.g., schools, faith-based organizations) to ensure access and engagement in needed services. For youth with SED, each region includes a Care Management Organization (CMO) designed to provide intensive care management services to youth with moderate to high level behavioral health needs. There are Care Management Organizations that provide services in all 21 New Jersey's counties including designated rural counties (Salem, Sussex, Warren, Cumberland, Atlantic and Cape May).

-Unmet Needs and Critical 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 contexts – as specified within a recognized diagnostic classification system (e.g., most recent editions of DSM, ICD, etc.), and (2) display functional impairment, as determined by a standardized measure that impedes progress towards recovery and substantially interferes with or limits the person's role or functioning in family, school, employment, relationships, or community activities.

Prevalence: According to the Federal methodology proposed for estimating the prevalence of SMI, the proportion of adults within the state with SMI is 5.4% (Federal Register, Volume 64, No. 121, p. 33890)7.

According to figures released by the United States Census Bureau, the 2024 adult population of New Jersey was 7,448,667. The size of the New Jersey child population was 2,052,184. 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 2024 was 402,228. Using the upper SMI limit of 7.1%, the estimated number of adults with SMI in New Jersey in 2024 was 528,855. Accordingly, using the lower SMI limit of 3.7%, the estimated number of SMI adults in New Jersey in 2024 was 275,600. (Table is uploaded as a separate document).

According to URS Table 2a, a total of 80,022 unduplicated persons ages 18 and over received services in programs provided or funded by the SMHA in FY 2024. The SMHA served 30,098 unduplicated adults with SMI (refer to URS data table 14a) in FY 2024. That was 7.48% of the total estimated adults with SMI in New Jersey (402,228). It is noteworthy that DMHAS has transitioned to the USTF+ data system as mentioned previously continue to provide monitor the data and provide technical assistance where needed. The QCMR provides duplicated data where an individual can be enrolled in a program, be discharged, and then be readmitted during the same year or an individual may be in one program and also in another program as long as they are not mutually exclusive. The QCMR data reveals that there were 270,263 individuals served in SFY 2024, of that total, 251,501 were 18 and older. Additionally, according to the DMHAS NJMHAPP data for SFY 2024, there were 13,130 individuals served in the Division's FFS programs, and of those individuals served, there were 6,810 SMI unduplicated individuals served, and 7,310 Duplicated individuals served.

Also shown in URS data table 14a, out of the total 30,098 unduplicated adults with SMI served by the SMHA in FY 2024, 14,693 (48.8%) were ethnic minorities (and those who did not report a racial affiliation). The SMHA will be re-evaluating the data once there is sufficient data in the new USTF+ application.

Persons who are SMI are the statutory population for SMHA funded services. The SMHA also prioritizes services to individuals with SMI who meet the criteria for first episode psychosis, as well as individuals with SMI in need of crisis intervention and stabilization services. However, the SMHA also prioritizes services to with access needs, including older adults, individuals with co-occurring mental health and substance use disorders, hearing impairment, and developmental disabilities. 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. The Planning Council identified several broad areas of interest for improvement: access to care (which may be impeded by licensing requirements and staffing issues), housing (which is chronically in short supply in the state), increasing peer support services, re-entry of formerly incarcerated individuals with SMI challenges, integration within and to the children's behavioral health system, and the ability of older adults to navigate the community mental health system.

-Homeless Adults

The SMHA is the recipient of the federally funded PATH program, which is matched with state funding. The SMHA contracts with 25 non-profit agencies to operate PATH programs within the state's 21 counties. The statutory population is homeless adults or those at risk of homelessness who have a serious mental illness, including those with co-occurring substance use disorders who are not currently engaged in and are resistant to mental health and other community support services. Programs for homeless adults are described in Planning Step 1 under Criterion 4.

The most critical gaps and unmet needs identified by PATH providers are: 1) lack of shelters and shelter beds, rooming and boarding homes, safe transitional/emergency housing. 2) lack of available affordable, safe, permanent housing; 3) limited supportive housing resources and group homes accepting referrals from the community. 4) lack of housing subsidies and housing programs, especially for persons who are not chronically homeless, or who have criminal backgrounds for distribution or Meghan's Law.

PATH funds cannot be used to support emergency shelters. The SMHA has created some housing for the population at risk for homelessness, but sustained efforts are needed to combat the housing problem. In 2019 and 2020, the Governor expanded housing for individuals with a substance use disorder and mental illness through the provision of state dollars under the Governor's Opioid Funding Initiative.

Unmet needs include subsidies do not cover utilities; lack of financial/emergency assistance for persons who have reached their maximum allowable time on General Assistance or who do not otherwise meet the criteria for General Assistance, such as those with SSI/SSDI benefits; delays in approval for benefits from the Board of Social Services; long wait time to see a psychiatrist; obtaining medications for those persons without health insurance; availability of inpatient integrated treatment for persons with co-occurring mental illness and substance use disorder; public transportation.

-ESMI Coordinated Specialty Care Client Level Data System.

DMHAS has a data collection tool to capture demographic and outcome data elements. This manual data collection system for CSC CI will no longer be utilized once all of the program outcomes specific to CLD are added to the new USTF+. Currently the data is collected every three months and analyzed to track the progress of CSC clients who have received services. Client measures include client referral source; age; male/female; psychiatric and medical hospitalizations; psychotropic medication adherence; co-occurring substance use disorder; discharge and re-admission; insurance status; and global functioning using the MIRECC GAF scale. In addition to the CSC data spreadsheet, CSC programs submit a quarterly progress report to DMHAS. The quarterly progress report outlines community outreach progress and any questions regarding the client service model, recommendations, and client referral demographic data. The new web-based USTF+ CLD system includes a program-specific module for CSC CI CLD which provides assessment scale/scores including MIRECC, CGI (optional), BPRS, ACES, PHQ-9, MDQ, as well as psychotropic medication adherence, inpatient hospitalization and designated screening visit history while enrolled in the program. These new features are anticipated to functional in the Fall of 2025. Trainings on these features will commence shortly after. DMHAS anticipates having a full year of data for SFY 2027.

The QCMR collects data which provides information specific to the CSC program as well as the step down or Community Integration (CI program). Additionally, the QCMR provides information for individuals admitted to, discharged from and caseloads for First Episode Psychosis (FEP) and Affective Psychosis. Individuals served and units of service are also monitored, as well as payer mix and staffing ratios.

-Peer Recovery Warm Line.

The Peer Recovery Warmline has been an integral part of NJ peer services since 2009. The warmline is fully staffed and supervised by experienced peer staff who provide support, education, advocacy and “personal peer to peer support” to the most isolated person in recovery. Utilizing WRAP (Wellness Recovery Action Planning) and IPS (Intentional Peer Support) models, the team operates 7 days a week, and volunteers to work all the holiday. Each year over 40,000 calls are answered each year. The PRW offers an optional text/chat component that provides daily text messages of support throughout the day and week. This provides another level of support and connection. PRW operates as part of the MHANJ Call Center that has multiple behavioral health lines – that provides easy access warm transfers to information and referral- through NJ Mental Health Cares- that also provides the PRW with a vast data base community recovery support services to share with peer warmline callers. In 2022 MHANJ became an anchor of the NJ 998 network- leading and advocating for peers to play a major role in crisis response. As a result, peers have been hired on 988 and facilitate easy warm transfers to PRW for 988 crisis callers. MHANJ continues to expand the role of peers in the operation of the call center – with many peers integrated across all our lines in partnerships with strong support, supervision, and clinical backup- proving their value to NJ’s crisis response network.

-Gaps Observed by the New Jersey Behavioral Health Planning Council

The partnership of community stakeholders with the SMHA is critical to the success of the Division. The New Jersey Behavioral Health Planning Council (NJBHPC, a.k.a., “The Planning Council”) is the primary (but by no means sole) voice of the community. Through the participation of the Planning Council, and its Advocacy subcommittee, the Division has obtained the following guidance on service needs and gaps within the current system of care. The Council has been concerned with the continuity and provision of behavioral health services. As mentioned in detail in other parts of this application, DMHAS provides the Planning Council with regular updates on the CMHSBG /SUPTRS.

The observed gaps reported here by the Planning Council are based on the findings and recommendations of the Chair of the Planning Council, as was informed by the Chair of the Planning Council's Block Grant Committee. That committee was comprised of Council members who are: consumers, family members, advocates, providers, representatives from other parts of state government, and facilitated by the Chairwoman of the Council and State Mental Health Planner. To gather feedback from the entire, general membership of the Council, the Block Grant Committee solicited the thoughts of the general membership of the Council via a survey with open-ended responses. The results obtained from that survey, and other inputs from Council members were reviewed, synthesized, and summarized here. The eight general areas identified by the Council are presented here.

Issues related to Access to Care:

Administrative complications posed by dual, separate licensing requirements (physical health, and behavioral health) pose challenges to truly integrated services.

Anecdotally, members report that individuals seeking various community-based mental health services continue to experience long wait times

BH staffing shortages have been reported on by community members; absences in unfilled positions may and contribute to disruptions in treatments.

Issues related to Housing:

Affordable and accessible housing remains a foundational need for individuals with behavioral health conditions in the state of New Jersey.

Some community members advocate for an expansion of recovery residences, (i.e., Class F sober homes) to decrease recidivism, homelessness, and/or re-institutionalization.

Issues related to Peer Support & Navigation Services:

Peer-run crisis alternatives may be lacking across some counties

When leaving any acute and/or long-term mental health or substance use facility, there is a gap in navigation and peer follow-up services for peer integration.

Issues related to Youth and Families:

Lack integration and differentiation within the Children's behavioral health system. The patchwork of services and authorities (school-based services, services provided by the Children's System of Care, hospitals/clinics, and private providers) makes it difficult for families to navigate and access services for children. Youth may be swiftly routed to emergency departments, which inadvertently often leads to delays in getting the most appropriate services at the right time.

Statewide shortage of mental health professionals (in both clinical, acute and school settings) with experience and expertise in children's issues.

Disruptions/delays in services due to Medicaid reimbursement policies and outdated treatment models that do not reflect the current realities of adolescent SUD.

Siloed data collection practices leading to difficulty in better understanding (and improving) the system of youth/adolescent behavioral health services.

Issues related to Aging & Dementia Services

Older adults are particularly vulnerable to gaps in transportation services and community health navigation.

Crisis and respite services tailored to individuals with dementia are important, to assist in the screening process.

Issues related to Program Oversight & Accountability

Heightened evaluation of funded providers by the SMHA is recommended by the Council.

Greater state oversight in the stability of staffing at contracted agencies is suggested, to better ensure continuity & access to care.

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Data Gaps

Older Adult Survey

During its strategic planning processes, DMHAS determined that one of the top data gaps in New Jersey was the lack of information on the older adult population and the prevalence of substance use, misuse, and mental health issues within this group. Among the reasons cited for the gap were lack of data, difficulty accessing existing data, inadequate technology for data tracking, and inadequate capacity to aggregate data in more meaningful and useful configurations. The New Jersey Department of Human Services, Division of Mental Health and Addiction Services (DMHAS) was awarded a State Prevention Enhancement (SPE) grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2012 and one of the key deliverables was to conduct a survey of older adults in New Jersey, which was conducted in 2012 with a total of 800 individuals living in New Jersey who were age 60 and older responding.

The goal of the New Jersey Older Adult Survey on Drug Use and Health (OASDUH) was to obtain data on the prevalence of substance abuse among older adults in New Jersey. The OASDUH is one of few to have focused on older adult health and drug use which gathered information about a broad range of health indicators. Older individuals experience more chronic ailments than younger people and are prescribed more drugs, including powerful painkillers that carry a high risk of misuse or addiction. They experience changes in their metabolism that intensify the effects of alcohol and drugs, making them susceptible to falls, injuries, cognitive impairment, depression, overdose, and even death.

The survey instrument contained 44 items, comprised of several validated subscales and demographic items, and was conducted via telephone in 2012 and taking about 19 minutes. The sample was comprised of 801 people living in New Jersey who were aged 60 and older. Another measure contained in OASDUH included items assessing the participant's social network and potential for social isolation. Social isolation has been found to be a risk factor for heavy drinking and binge drinking. People who have high social support have been found to have less excessive alcohol use. It appears that social support can also alleviate excessive drinking as a response to loss.

Some key findings of the OASDUH were:

64.8% of the participants reported having smoked a cigarette during their lifetime and of those, 15.3% reported smoking cigarettes within the last 30 days

A total of 92.4% of the participants reported drinking alcohol during their lifetime and of that group, a total of 57.3% reported drinking alcohol within the last 30 days;

Of the 13.8% of participants who reported using marijuana during their lifetime, 7.8% used it within the past 30 days

Of the 12.9% of participants who reported using pain killers or other opiates recreationally or not as prescribed during in their lifetime, 22.0% reported this use within the

The majority (81.4%) of respondents rated their physical health as good to excellent, as well as their mental health (92.8%).

Using data from the New Jersey Older Adult Survey on Drug Use and Health discussed above, an article by Farmer, A., Wang, Y, Peterson, A., et al, "Social Isolation Profiles and Older Adult Substance Use: A Latent Profile Analysis"(Journals of Gerontology: Social Sciences, 2022, Vol.77, No. 5, 919-929, doi:10.1093/geronb/gbab078) aimed to determine substance use among older adults based upon their social isolation and loneliness profiles. Latent profile analysis (LPA) was used to determine the profiles of older adults (N = 801) based on 5 dimensions of social isolation and loneliness. The "connected and active" group had the lowest odds of cigarette use. The "alone but not lonely" group had the highest odds of cigarette use, alcohol use, and high-risk drinking. The "alone and lonely" group had the highest odds of nonmedical drug use. In working with older adults who are using substances, it is important to inquire about their social isolation and loneliness. Cognitive behavioral therapy for the "alone and lonely" group may be beneficial, as it has been deemed effective in decreasing loneliness and enhancing social networks.

DMHAS was then awarded the Partnerships for Success grant by SAMHSA in 2013 and allocated funding to address the need for further research on this population relating to substance use and mental health issues. The overall goals of the New Jersey Older Adult Survey (NJOAS) were three-fold: (1) to assess the prevalence, risk, and protective factors of substance misuse and mental health issues among New Jersey older adults; (2) to obtain enough data to create small-area estimates of the prevalence of substance abuse and mental health for the 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.

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 (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. The goal this time was to produce county-level data. 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, a 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.

Key findings of the survey were:

Data showed that 63.2% of older adults smoked a cigarette at some point in their lives with most trying their first tobacco product before the age of 18 (64%).

Of the older adults who currently smoke, 89% stated that they have smoked all 30 days of the past month (n= 312).

On average, respondents had at least one drink for eight days of the month.

Among older adults who responded that they used substances over 5 times in their lives, pain killers such as codeine, Demerol, or other opiates were the most frequently used substance (32%), with only 1% having used them without a prescription from a doctor.

The highest proportion of older adults have received drug prescriptions from just one doctor (55.8%), followed by those who received drug prescriptions from more than one doctor (28.3%).

Physical and mental health data indicate that the older adults felt that they were in very good physical health (33%), and that they had excellent mental health (43%).

A study by Gold, S., Gilmore Powell, K, Eversman, et al. (High-Risk Obtainment of Prescription Drugs by Older Adults in New Jersey: The Role of Prescription Opioids. (Journal of American Geriatric Society, 64:e67–e71, 2016) used data from this survey to explore the high-risk ways in which older adults obtain prescription opioids and to identify predictors of obtaining prescription opioids from high risk sources, such as obtaining the same drug from multiple doctors, sharing drugs, and stealing prescription pads. Items such as obtaining prescriptions for the same drug from more than one doctor and stealing prescription drugs were measured to determine high-risk obtainment of prescription opioids. Almost 15% of the sample used high-risk methods of

obtaining prescription opioids.

To summarize, our efforts to fill in data gaps concerning older adults has helped guide us in better understanding the risk and protective factors surrounding this population and eventually led us to develop our Alternative Approaches to Pain Management for Older Adults (AAPMOR) program which is implemented in 20 of NJ's 21 counties.

Veteran's Survey

New Jersey continues to focus on returning Veterans as a priority population. This is another population for which there were limited data. DMHAS had reached out to the New Jersey Department of Military and Veteran's Affairs as well as the New Jersey National Guard to solicit their active participation on the SEOW and Advisory Council in light of this priority.

DMHAS commissioned Rutgers University School of Social Work (SSW) and to conduct a needs-based survey among the New Jersey veteran population which was funded under our PFS grant. Avalon Health Economics was contracted by the SSW in February 2014 to conduct the survey. The goals of the New Jersey Veteran Survey (NJVS) were two-fold: (1) to assess the issues of mental health and substance abuse in New Jersey veterans and (2) 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 veterans. The questionnaire asks veterans to report information regarding their service (when and where they served), types of substance abuse (alcohol, tobacco, prescription drugs), mental health (signs of depression, behavioral health, associations with substance abuse), and other signs of abuse such as gambling, as well as basic demographic information (ethnicity, education, current job status, etc.). Survey questions were adapted from several past surveys that were aimed at the general population. The sample pertained to all living New Jersey veterans. A total of 1,185 questionnaires were completed by New Jersey veterans. Data collection began on September 14, 2015 and ended on October 9, 2015. Data collection was multi-modal, with data collected via both the telephone and online. The average survey length was 20 minutes per respondent. Key findings were:

A large majority of veterans had their first drink of an alcoholic beverage between the ages of 12 and 21 (91.9%),

64.2% of veterans had a drink of an alcoholic beverage within the last 30 days.

A large majority of veterans feel that they do not have a problem with alcohol (82.9%).

Among veterans who regularly use tobacco products, 39.7% have used a tobacco product 365 days a year.

65.9% of veterans have used a prescription drug within the past 30 days.

An overwhelming majority feel that they have not had a problem with gambling within the last 12 months (93%)

A majority of veterans responded to their mental health as being excellent (42%), compared to those who responded as very good (24%).

Results from the NJVS provided useful information into the alcohol, substance, and gambling use, as well as physical and emotional issues among the New Jersey veteran population. Our findings suggest higher rates of health risk behaviors but lower perceived needs and lower problem recognition reported by veterans. The need for outreach to increase perceived need is especially important given the demographic make-up of veteran populations – predominantly older adults who have been shown to be especially unlikely to seek mental health or substance use disorder services. Further attention should be paid to pain medication use among veterans, including chronic opioid use. There is a need and opportunity for provider training related to the military, which is especially important as more Veterans are now seeking treatment outside of VHA.

Young Adult Survey

adults living in NJ, assessed experiences and perceptions related to substance use, mental health, and social media. The purpose was to design a survey instrument comparable to national surveys of substance use and demonstrate its utility for collecting data that could inform meaningful prevention programming for the young adult population for a hard-to-reach and under-reported population.

In partnership with DMHAS, the survey was developed and piloted by the Center for Research and Evaluation on Education and Human Services (CREEHS) at Montclair State University. Eligible survey participants were young adults between the ages of 18 and 25 years who lived in NJ for six or more months during the prior year. Participants were recruited using non-probability sampling methods, specifically convenience sampling. There were two main recruitment strategies: crowdsourcing platforms and email listservs. Survey information was posted to two crowdsourcing platforms (e.g., Prolific and Amazon Mechanical Turk via Cloud Research) and distributed by prevention partners, colleges and universities, young alumni associations, and trade schools to eligible participants through their existing listservs. The survey was made available via Qualtrics from September to December 2023.

More than 11,000 responses were received; however, more than 90% of these responses were flagged as ineligible and/or fraudulent. Extensive data cleaning was performed to determine which responses were eligible and valid, yielding 1,074 responses in the final analytic sample.

Key findings were:

The most frequently reported substances used (lifetime or past 30 days) were alcohol, followed by tobacco (including cigarettes), marijuana, vapes (also known as e-cigarettes), and ecstasy.

The majority of respondents reported first using alcohol (65%), tobacco (59%), and vapes (52%) before age 18. For all other substances listed, respondents most frequently reported first using between the ages of 18 and 20.

More than a quarter (28%) of YAS-NJ Survey respondents reported that they have had a problem with their own drug or alcohol use in their lifetime.

77% of respondents reported daily binge drinking to be at least a moderate risk, while 39% reported monthly marijuana use to be at least a moderate risk.

Almost half (46%) of all respondents reported having ever had a mental health problem.

About four in 10 respondents felt nervous (45%), that everything was an effort (40%), and/or restless or fidgety (39%) most of the time or always within the past 30 days.

Three-quarters of respondents (75%) reported using social media apps or sites several times per day or almost constantly.

Only 2% of respondents said they have not seen content on their social media related to alcohol, marijuana, or other drugs.

Overall, the information gleaned from this survey can be used to inform future research as well as funding and programming for NJ prevention efforts that aim to decrease substance use amongst this age group. Future efforts to survey this young adult population should consider lessons learned from this survey related to effective recruitment, sufficient planning and coordination time, and open online data collection.

Municipal Level Data

A critical challenge for the 19 county prevention coalitions, as well as County Drug and Alcohol Directors, and Municipal Alliance Coordinators in New Jersey, has been the lack of available data at very specific and detailed geographic units of analysis (e.g., municipal, census tract, neighborhood, etc.). A social indicator database project was completed under the SPE grant which used a variety of methods to acquire new data and merge information from existing systems to provide a foundation for an integrated data infrastructure. Purposes of this database are: to help identify high need communities; promote data-driven planning;

support funding allocation methods based on need; enhance capacity in local communities and strengthen their ability to identify meaningful local indicators; and to help produce community-level epidemiological profiles. Presently, the County Chartbooks contain a wealth of municipal level data.

Service Gaps in the Substance Use Disorder Continuum of Care

In order for clients who have or are at risk for a substance use disorder it is critical that there are recovery supports in place so clients can realize their full potential and clients have access to evidence-based treatment. The following areas have been identified by the SSA as areas that need enhancement.

Relapse Prevention

Drug and alcohol rehab statistics show that the percentage of people who will relapse ranges from 50% to 90%. Data from NJSAMS for CY 2024 indicated that of 43,415 individuals, 8,708 (20%) individuals experienced two admissions during the year and 8,516 (20%) had 3 or more admissions. Of these, 4,204 (11.7%) returned to care between 31 and 90 days, and 1,527 (8.9%) had a readmission 91 or more days later (within CY 2024). We define a new episode of care when admission to treatment exceeds 30 days, i.e., not within the existing episode where there may be movement to other LOCs within the continuum of care for that episode. Our goal is to provide recovery supports to help these individuals move to and remain in recovery for longer periods of time. Currently the Opioid Overdose Recovery Program, the Support Team for Addiction Recovery, Telephone Recovery Support and Peer Recovery Centers are helping to fill the gap. A new initiative was implemented in SFY 2023 to further support this effort: Recovery Management Check-Up (RMC).

Housing

Studies cited by the Corporation for Supportive Housing (CSH) indicate that supportive housing has positive impacts on decreasing or ending substance use.⁷ Once people with histories of substance use achieve sobriety, their living situation is often a factor in their ability to maintain their recovery.⁷ According to the Kentucky Interagency Council on Homelessness (KICH), a one-year follow-up study of 201 graduates of the Eden Programs chemical dependency treatment programs in Minneapolis found that 56.6% of those living independently remained sober, 56.5% of those living in a halfway house remained sober, while 90% of those living in supportive housing remained sober.

There are also studies that documented positive impacts on health with decreases of more than 50% in tenants' emergency room visits and hospital inpatient days; decreases in tenants' use of emergency detoxification services by more than 80%; and increases in the use of preventive health care services. Positive impacts on employment have also been found, with increases of 50% in earned income and 40% in the rate of participant employment when employment services are provided in supportive housing.

Stable, affordable housing is a crucial component of recovery for individuals with substance use disorders. Supportive housing combines affordable housing with services that help people who face the most complex challenges to live with stability, autonomy and dignity. Supportive housing has been proven as an effective solution to ending homelessness for active substance users; housing provides a necessary platform to access a variety of services, participate in long-term recovery and give individuals the opportunity to engage in important community roles.

DMHAS only has 273 supported housing slots for individuals with a substance use disorder: two programs in Camden (31 beds) and Atlantic (32 beds) counties, a 10-bed program for women in Somerset County, and 200 supportive housing subsidies for those with an OUD. Supportive housing is a successful, cost-effective, combination of affordable housing with services that help people live more stable, productive lives. It offers permanent housing with services that work for individuals and families who face complex challenges such as homelessness and/or have serious and persistent issues that may include substance use, mental

illness, and HIV/AIDS.

DMHAS awarded contracts in 2019 to provide individualized case management and supportive services to up to 200 individuals with an OUD, on average, up to 8 hours per month, billable in 15 units, based on individual needs. These services will assist individuals in seeking and connecting with behavioral health and or physical healthcare needs. DMHAS provides 200 rental subsidies, up to the fair market rate (FMR) as defined by the Department of Community Affairs (DCA) for lease-based housing. One-time funding will be available to consumers for security deposits, utility start-up costs and furnishings. Contracts were awarded four agencies to serve individuals in five counties: Atlantic, Burlington, Camden, Mercer and Monmouth. Since the awarding of the OUD contracts the number of referrals have reached approximately 225 referrals with a total of 95 subsidies currently occupied, and an additional 24 in housing search phase. The turnover of the OUD vouchers is approximately 10%, with consumers surrendering the subsidies. The onset of the COVID-19 Pandemic has resulted in the full payment of rent for some of the OUD consumers since they lost employment.

Contracts were awarded in 2019 for three pilot recovery-based housing residences (a minimum of five individuals in each residence), one in each region (North, Central and South), for individuals with an OUD who are homeless or at risk of homelessness. Individuals are in or recently discharged from treatment and are seeking a drug free, sober and supportive living environment, with access and linkage to recovery community resources. Individualized case management and recovery-based housing services is provided for 15 individuals (a minimum of five individuals in each region) who have been identified as needing a safe, healthy, peer-lead, recovery-oriented environment. The housing provided must be licensed as a Class F, Cooperative Sober Living Residence (NJAC § 5:27). Accordingly, individuals are responsible for providing their own food and taking care of their own laundry. Treatment and counseling may not be provided in the residence; however, non-clinical recovery support services may be provided at the site and the agency may require, at its discretion, drug or alcohol testing of residents. (NJAC § 5:27-2.1). Although increased funded sober housing slots are needed, the pilots are thriving and continue to benefit those individuals seeking a stable recovery environment.

With the award of ARPA funding, DMHAS issued an RFP for an Interim Housing Program for individuals experiencing SUD challenges. The program would have allowed individuals an opportunity to have temporary stable housing for up to two months while the provider tried to arrange for more stable permanent housing. Unfortunately, the RFP issued in October 2022 had to be withdrawn for technical issues.

Opioid Settlement funds were used to fund an RFP for temporary housing for individuals being discharged from residential, inpatient, ambulatory SUD treatment and/or individuals with a history of SUD who may be or have become homeless. The funding through this RFP can serve as a bridge to permanent housing, allowing participants to receive the support and services they need around other challenges in their lives. DMHAS issued an RFP in October 2024 and made awards in February 2025 to six licensed 24-hour emergency shelters for a total of 150 beds. A companion RFP funded with opioid settlement funds was released for case management services for adult individuals placed in one of the 150 shelter beds. Case managers will help connect individuals with services/ resources in their area and entitlements and assist them in securing permanent housing as quickly as possible. It is anticipated that individuals will obtain permanent housing within four months of initial engagement. Individuals served in this program will have access to DMHAS funded housing subsidies. DMHAS issued an RFP in October 2024 and made awards in February 2025 to four agencies to provide these services in their region of the state.

It is an urgent issue to create housing opportunities for individuals with SUD. One of the negative outcomes is that homeless individuals who have overdosed and are in our OORP program are then discharged to costly inpatient care due to the lack of suitable community housing options.

DMHAS continues to explore potential residential opportunities for SUD clients. A possibility is implementing ASAM Level 3:1: Clinically Managed Low-Intensity Residential Services. Examples of this level is a halfway house, group home or other Supportive Living Environment (SLE) with 24-hour staff and close integration with clinical services. It only requires 5 hours of treatment per week. This level is suited for homeless individuals while their issue of homelessness is addressed. It is an appropriate setting for individuals who need time and structure to practice and integrate their recovery and coping skills in a residential, supportive environment.

Transportation

One of the obstacles to accessing services frequently reported across all healthcare domains, including behavioral health, is transportation (Locatelli et al., 2017; Syed et al., 2013). According to Bellamy et al. (2016), unreliable access to transportation was the most frequently documented and reported non-medical obstacle to clients seeking substance abuse and mental health outpatient services. Transportation obstacles manifest themselves in several ways: a lack of independent car ownership, high cost of public transportation, travel distance, travel time, parking fees, a lack of public transportation, distance from agency to a bus stop, and cost of ride-sharing services (Locatelli et al., 2017). Without adequate and affordable transportation options, clients are unable to begin vital treatment nor consistently attend and complete treatment, resulting in suboptimal outcomes. NJ's 2018 Household Survey of Drug Use and Health indicated that of the clients surveyed who indicated they wanted treatment, transportation was an obstacle for 39% of the participants.

Transportation is a key recovery support. A reliable means of transportation is needed so clients can get to prevention, recovery and treatment support programs. As a result of this gap, DMHAS has developed a new program called the Transportation Reimbursement and Invoicing Program (TRIP). This will enable transportation to treatment for individuals who do not have Medicaid, as well as enable transportation to and from non-healthcare facilities such as Community Peer Recovery Centers or prevention programs. TRIP is intended and designed to eliminate transportation obstacles and facilitate access to substance use disorder Treatment, Prevention and Recovery Support Services (RSS). SUPTRS Block Grant COVID-19 Supplemental funded this initiative. ARPA funds are currently being utilized. DMHAS plans to fund TRIP with SOR funding after the ARPA grant ends.

Recovery Centers

There is a need for DMHAS to continue to support recovery support services at Recovery Centers. There were only two state funded centers prior to 2019, one in the northern region of the state, Eva's Village in Paterson, and one location in the southern region of the state, Living Proof in Voorhees. From 2019 to 2024 DMHAS was able expanded Recovery Centers to every county in New Jersey through the SOR funding. Funding was issued through Request for Proposals (RFP) to develop small scale Community Peer Recovery Centers (CPRC) in every county with \$100,000 startup funding. Recovery support is an essential part of the continuum of care since addiction is a chronic biologically based disease of the brain and as such requires a system of care designed to treat a chronic condition rather than an acute illness. With other chronic conditions, e.g., diabetes, hypertension, heart disease, that are characterized by periods of wellness and acute episodes of care, the care system and intervention are designed to manage the illness in order to promote sustained periods of wellness and eliminate or minimize the need for acute care. Similarly, the addiction treatment system must adapt so as to support the process of sustained recovery. The New Jersey Recovery Centers has been effective with many individuals seeking recovery.

DMHAS intends to continue to support 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 2024, there were 78,797 discharges from substance abuse treatment in New Jersey. Of these, 20,949 or 27%, dropped out of treatment. While all clients can benefit from recovery support services, those clients who did not complete treatment may find recovery support beneficial and a gateway back into treatment and/or sustained recovery. It is clear that there are significant numbers of people who could benefit from ongoing recovery programs. While these figures are drawn from those who enter the formal treatment system, there is a group of people of unknown size who have never accessed formal treatment who could also benefit from recovery services. This will also be an opportunity for those for whom access to treatment is not possible or delayed. The DMHAS Recovery Centers offer training, social, educational and recreational opportunities. There are classes focused on wellness, nutrition and illness management, including classes on self-care, stress management, financial management, literacy education, job, and parenting skills. Housing assistance (e.g., finding apartments and roommates) is provided, and telephone support is available to Recovery Center participants. It is expected that this peer-delivered service will result in improved social functioning, decreased substance abuse and an improved quality of life, including more social connectedness.

DMHAS has expanded Recovery Centers through the SOR funding and Opioid Settlement funding for Community Peer Recovery Centers (CPRC) to provide peer-to-peer recovery support services to prevent recurrent of substance use and promote sustained recovery.?? All activities and services through the CPRCs are led and driven by "peers", individuals who have experienced addiction and recovery or co-occurring behavioral health issues, either directly or indirectly as a family member or friend. The overall goal of the CPRC is to provide a safe place for recovering individuals to gather in support of one another and experience recovery-oriented living in a community setting.? The CPRC is a place where those in recovery can have the opportunity to give back to their community thereby fostering senses of empowerment and independence.?

Since March 2020, CPRCs have found creative new ways to keep individuals engaged with their centers. They keep track and report quarterly of Traditional In-Person Groups and Individual Recovery Support Service as well as Virtual and Hybrid Services. Some centers also offer Community Activities In-Person, Virtual or Hybrid. Prior to 2024, the goal was for 50% of the centers use the Recovery Data Platform (RDP) to document individuals served. The goal for 2025 is for 100% of the Recovery Centers to use the RDP. The biggest obstacles reported by CPRCs is limited funding for Transportation, Recovery Support Housing, Overdose Prevention Supplies, and Recruiting and Retention of workforce.

Recovery Case Management

There were no formal case management services in the NJ addiction service system. Research indicates that substance-dependent individuals who have prompt access to a full continuum of services that address individual client needs and co-morbidities experience improved recovery outcomes. Kirk (2007) describes a client-centered service delivery model that promotes access to a broad array of services, decreases 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 decreases 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 incorporation of recovery case management within our current system of care to decrease service fragmentation, promote service continuity, and increase clients' capacity to manage their chronic health condition.

With STR funding, DMHAS was able to initially create 10 Support Teams for Addiction Recovery (STAR). Additional SOR funding allowed the development of 11 more STAR programs. This resulted in statewide coverage.

DMHAS was able to create two new recovery support services, described below, with the award of SABG Supplemental and ARPA funding.

Recovery Management Check-Up (RMC). RMC is a service for discharged clients to support their independent living and success with recovery. This program provides more methods of outreach to clients that include virtual face-to-face visits, text messaging and chat features, and the opportunity for in-person contacts. This check-up service will help provide local recovery supports, including information about local resources such as self-help meetings, food pantries, and sober houses, if needed. RMC aims to identify and alleviate client problems before they undermine recovery. Monthly contact forms the core of RMC. During these contacts, staff will assess clients using a brief assessment tool to evaluate the individual's progress, current needs and check on recovery status. Problems will be addressed using motivational interviewing techniques, connecting clients to appropriate community resources and/or treatment, if needed. The conceptual framework of RMC is to treat addiction as a chronic disease,

with long-term management to minimize the number of acute episodes of substance abuse and with prompt treatment when episodes occur to prevent them from becoming more severe and consequential.

Recovery Support Care Management (RSCM). RSCM provides direct and comprehensive assistance to consumers to ensure access to the necessary treatment, rehabilitative and recovery services with the intent of decreasing psychiatric and addiction symptoms, connect consumers with services, improve transitions between levels of care, implement strategies to address their unique needs, decrease opioid related deaths and sustain recovery in the community while supporting the consumers' continued stability and recovery throughout the continuum of care. This service is available as an enhancement in all levels of care and has been incorporated into the SUD fee-for-service system. This service may be provided face-to-face or via a telehealth platform. One unit of service is 15 minutes. The rate is \$24.97 per unit. The limits of this service are 4 units per diem and 16 units per month, with no annual limit per consumer.

Medication Assisted Treatment

NJSAMS data indicated while heroin plus other opiates were the primary drugs accounting for 36%, or 29,354, of New Jersey's treatment admissions during 2024, the use of either methadone (15%) or buprenorphine (10%), a total of just 25%, was in the treatment plan for these admissions, a difference of 11%. The number of people who entered either opioid maintenance - outpatient or -intensive outpatient was only 12% (9,393). This difference of 24% 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 decrease the demand for Inpatient Withdrawal Management (IWM) as well as other residential treatment services.

Ambulatory Withdrawal Management

Currently there are 18 licensed providers in NJ that provide Ambulatory Withdrawal Management (AWM). This is a service that has been a great benefit to individuals with an opioid use disorder (OUD) and has been used as an option to the costlier, and not always clinically indicated, Inpatient Withdrawal Management (IWM). A requirement for AWM agencies is that they minimally have to offer outpatient programming at their agencies.

Public Awareness Campaigns

In order to help decrease stigma surrounding addiction and increasing awareness of the dangers of new drugs as well as awareness of overdose life-saving products, there needs to be active public awareness campaigns throughout the state. To decrease this gap, DMHAS has made great strides in implementing new campaigns. DMHAS, with the support of the Department Human Services (DHS) Central Office, Office of Public Relations, secured a vendor that has been delivering a public awareness campaign to help decrease stigma around the use of MAT. The campaign was initially launched in the Spring of 2020 and continually refreshes its campaign. Most messaging continues around opioid use with the goal to bring public awareness that medication can support recovery and encourages viewers of the advertisements to call ReachNJ, the 24/7 Addiction Hotline in New Jersey. Messaging has continued to multiple resident groups, such as student-athletes, pregnant women, older adults and prescribers. Various forms of messaging include TV ads, radio commercials, social media and billboards in the community. In addition to this initial campaign, DMHAS has launched several new campaigns (described in Step 1) funded through ARPA and SOR.

Three regional Family Support Centers (FSC) continue to be funded through SOR Funding to provide peer to peer family support services to families in each region whose loved ones suffer from an opioid use and/or stimulant use disorder. FSCs were the first formal family support service in the New Jersey's Substance Use Disorder continuum of care that offered direct family support, education, resources and advocacy in a safe and non-stigmatizing environment. Each regional center is staffed with Family Support Coordinators with lived experiences who are trained in the Community Reinforcement and Family Training (CRAFT) Model which teaches families self-protection along with non-confrontational skills to help empower their loved one to seek treatment; as well as helping each family member develop and work on their own Individualized Wellness Recovery Plan. The overall goal of the FSC Coordinator is to provide compassionate support to empower family members to have a better quality of life, improve their psychological health, decrease levels of stress, feel less isolated, and gain skills needed to cope with their loved one's use. Families who receive FSC services also receive Naloxone Training and Kits to assist their loved ones at risk of opioid overdose.

In 2021 each regional FSC expanded due to the increased numbers of referrals coming from OORPs, STARs, Connect4Recovery Call Center, Division of Children and Families, Probation, and Treatment Providers to assist family members of loved ones with or without an opioid use and/or stimulant use disorder. While the FSCs saw an increase in referrals, one the main obstacle continues to be difficulty recruiting family support peers who can connect and engage family members in accordance with NCLAS.

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 10,3446 Narcan administrations in New Jersey from January 1, 2024 to December 31, 2024, NJSAMS data indicated that during that same period, there were only 731 admissions who reported a Narcan administration "in the past 30 days." This difference of 9,615 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 decrease this gap. Using STR funding, brochures were printed which were given to individuals who refuse transport to the hospitals by EMS that provides a list of resources for follow-up help. The brochures are tailored by county. Using SOR funding, additional brochures were printed. DMHAS is also working with the Department of Health (DOH) to better connect our OORP teams with local EMS providers; a meeting was held between these two groups in February 2021. Also, several of our OORP staff attended the "Five Minutes to Help" training that was developed by the DOH for EMS providers.

Narcan Reversals Who Refuse Hospital Transport

Standard protocol specifies that, after reversing a person from overdose, the person should be transported to the emergency room for medical evaluation and observation. The Opioid Overdose Recovery Programs (OORP) in all 21 NJ counties provide supportive services for these individuals, with a goal of helping them find their way to recovery from their OUD. At times, however, someone who's been reversed by Emergency Medical Services (EMS) or law enforcement refuses transport to the emergency room. In early 2024, DMHAS offered funds to OORP providers to engage these individuals and provide supportive services with, again, the goal of helping the person find their way to recovery.

EMS are key partners in reaching these persons. As such, OORPs use these funds to establish or enhance the relationship with EMS or law enforcement to identify and communicate with these persons in the communities they serve. Some examples of activities developed by OORPs for this initiative include:

Providing educational opportunities for EMS to learn about recovery support services, overdose prevention and the stigma associated with problematic substance use.

Providing Naloxone Rescue Kits to EMS/law enforcement for distribution to the survivor that includes information on how to contact the OORP for navigation to treatment, linkage to services, and information about community resources.

Providing the survivor with literature that includes a QR code, in addition to the traditional contact information. Scanning the code brings the individual to the OORP website and a dedicated space where the individual may complete a short online form that will generate a call from a peer recovery specialist.

Providing education to staff at motels that are utilized for temporary housing, as well as naloxone rescue kits including literature mentioned above.

Offering transportation to individuals to recovery centers and to other services including treatment.

Since it began, this initiative has engaged more than 300 persons and connected them with some type of recovery services.

Linkage from Withdrawal Management to Other Levels of Care

One of DMHAS' concerns is the movement of clients from withdrawal management (WM) to the next appropriate level of care. Data for CY 2024 indicated that of 15,500 residential WM discharges, only 8,729 (56%) were linked to another level of care. The Single State Authority on Substance Abuse (SSA) is considering different strategies to improve the connection to treatment, such as the incorporation of peers in these programs, incentives for agencies and motivational interviewing to help decrease client refusal for continuing treatment.

Peers in Treatment Services

While the SSA has expanded the role of peers in prevention and recovery services, work was needed to incorporate peers in treatment settings. To address this gap, the DMHAS issued an RFP in March 2023 for residential providers to expand the peer workforce to include peer services in inpatient withdrawal management, short-term and long-term residential and halfway house settings. The successful bidders will hire peers who will assist with issues that often occur concurrently with SUD, such as homelessness, legal issues, employment, childcare, etc. In addition to linking individuals with the appropriate community resources, peers will also encourage individuals to remain in treatment as recommended in the treatment plan and modeling strategies on how to manage addiction successfully. Awards were made in June 2023 for 26 Peer Recovery Staff in residential treatment settings with COVID-19 Supplemental funding. Funding for this program continued with the ARPA grant and the program was further expanded when the RFP was reissued in 2024 to contract with an additional 8 provider agencies to hire 19 peers.

Buprenorphine Bridge Clinics

The Bridge model is a clinical model in which ED practitioners screen patients for opioid use disorder (OUD), provide short-term prescriptions for buprenorphine and then provide patients with warm handoff directly to a co-located, outpatient bridge clinic that provides medications for opioid use disorder. The Bridge model may be modified to establish a virtual bridge clinic utilizing telehealth.

School-Based Educational Prevention

Utilizing certified recovery specialists, individuals would share personal stories of their struggles and identify when they began using substances and how their substance use disorder escalated.

Screening for Substance Use Disorders and Adverse Childhood Experiences (ACEs) in Pediatric and Primary Care

Programs that provide interventions that are person-centered and resilience-focused to children impacted by addiction and that have ACEs are a key strategy in disrupting intergenerational SUDs and providing services to arguably one of the most at-risk populations of children. Preventing ACEs can lead to a significant decrease in chronic health conditions and socioeconomic challenges, including obesity, depressive disorder, substance use, medically uninsured people and unemployment.

Gaps Observed by the New Jersey Behavioral Health Planning Council.

The partnership of community stakeholders with the SMHA is critical to the success of the Division. The New Jersey Behavioral Health Planning Council (NJBHPC, a.k.a., "The Planning Council") is the primary (but by no means sole) voice of the community. Through the participation of the Planning Council, and its Advocacy subcommittee, the Division has obtained the following guidance on service needs and gaps within the current system of care. The Council has been concerned with the continuity and provision of behavioral health services. As mentioned in detail in other parts of this application, DMHAS provides the Planning Council with regular updates on the CMHSBG /SUPTRS.

The New Jersey Behavioral Health Planning Council (BHPC) previously developed a white paper expressing concerns with the wait to admission into residential withdrawal management. The SSA invested a significant amount of funding into residential withdrawal management in FY 17. Funds were added to the SAPTI fee-for-service initiative for this level of care and a new STORI treatment initiative was developed using STR funds which included residential withdrawal management. In addition, ambulatory withdrawal management was added to this initiative once the rates were finalized. While STR has ended, several of the SUD FFS initiatives now fund this level of care, which has made it very accessible. Four initiatives reimburse (DUII, SJI and MAP-SPB) both AWM and IWM. AWM is also available in NJSI; MATI and SAPT both fund IWM.

At the June 2019 BHPC meeting, gaps identified were: 1) a key obstacle to MAT for opioid SUD is transportation and homelessness and 2) services for older adults with opioid addictions. With regards to older adults, DMHAS has made 20 awards for programs to educate older adults on alternate strategies for opioid prescriptions.

At the July 2021 meeting, gaps were once again addressed. The issue of transportation came up and we are exploring whether our FFS programs can provide transportation. The issue of homelessness and services was raised. We are currently in the process of developing programs in homeless shelters to deliver MAT in the shelters. A final issue was that housing is a number one priority. We will be expanding our Oxford House program to help address this issue.

At the July 2022 meeting, gaps were again addressed. One focused on the issue of older adults and the need to increase services to this population. DMHAS has been making progress in this area. We have a prevention-focused Adult Education program in 20 of 21 counties. We recently issued an RFP for treatment services to populations in need and one provider is focusing on serving older adults. Another concern is addressing feelings of isolation among our consumers and the negative impact this can have.

The latest observed gaps reported for 2025 by the Planning Council are based on the findings and recommendations of the Chair of the Planning Council, as was informed by the Chair of the Planning Council's Block Grant Committee. That committee was comprised of Council members who are: consumers, family members, advocates, providers, representatives from other parts of state government, and facilitated by the Chairwoman of the Council and State Mental Health Planner. To gather feedback from the entire, general membership of the Council, the Block Grant Committee solicited the thoughts of the general membership of the Council via a survey with open-ended responses. The results obtained from that survey, and other inputs from Council members were reviewed, synthesized, and summarized here. The eight general areas identified by the Council are presented here.

Issues related to Access to Care:

Administrative complications posed by dual, separate licensing requirements (physical health, and behavioral health) pose challenges to truly integrated services.

Anecdotally, members report that individuals seeking various community-based mental health services continue to experience long wait times

BH staffing shortages have been reported on by community members; absences in unfilled positions may and contribute to disruptions in treatments.

Issues related to Housing:

Affordable and accessible housing remains a foundational need for individuals with behavioral health conditions in the state of New Jersey.

Some community members advocate for an expansion of recovery residences, (i.e., Class F sober living homes) to decrease recidivism, homelessness, and/or re-institutionalization.

Issues related to Peer Support & Navigation Services:

Peer-run crisis alternatives may be lacking across some counties.

When leaving any acute and/or long-term mental health or substance use facility, there is a gap in navigation and peer follow-up services for peer integration.

Issues related to Access

The current public transportation system is seen by many as an obstacle to access to primary, behavioral health and other services needed for self-sufficiency.

Lack of non-English speaking services among some service providers may be an obstacle to access & engagement in care.

Gaps in services for populations in need (i.e., deaf/hard of hearing, older adults, veterans, etc.)

Issues related to Criminal Justice & Reentry

Continuity of care, access to treatment access, and stigma for recently incarcerated populations is seen as being essential in decreasing recidivism.

Transitional planning for recently incarcerated populations with behavioral health issues (to prepare them for employment and reintegration into community life) which are supported by mental health services and SUD recovery supports are seen as important.

Issues related to Youth and Families:

Lack integration and differentiation within the Children's behavioral health system. The patchwork of services and authorities (school-based services, services provided by the Children's System of Care, hospitals/clinics, and private providers) makes it difficult

for families to navigate and access services for children. Youth may be swiftly routed to emergency departments, which inadvertently often leads to delays in getting the most appropriate services at the right time.

Statewide shortage of mental health professionals (in both clinical, acute and school settings) with experience and expertise in children's issues.

Disruptions/delays in services due to Medicaid reimbursement policies and outdated treatment models that do not reflect the current realities of adolescent SUD.

Siloed data collection practices leading to difficulty in better understanding (and improving) the system of youth/adolescent behavioral health services.

Issues related to Aging & Dementia Services

Older adults are particularly vulnerable to gaps in transportation services and community health navigation.

Crisis and respite services tailored to individuals with dementia are important, to assist in the screening process.

Issues related to Program Oversight & Accountability

Heightened evaluation of funded providers by the SMHA is recommended by the Council.

Greater state oversight in the stability of staffing at contracted agencies is suggested, to better ensure continuity & access to care.

Please see attached file for further information for the SSA regarding unmet service needs and critical gaps in the state's current substance use systems identified in the needs assessment described above.

3. Please describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss plans for the implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations and any other populations prioritized by the state as part of the Block Grant services and activities are addressed in the implementation plan.

III. How to Meet the Identified Unmet Service Needs and Gaps

-Adults with SMI

In order to address the staff shortages/wait times for psychiatry, DMHAS issued RLI's to fund community psychiatry residencies. Two separate RLI's resulted in awards for twelve (12) child and adolescent residencies/fellowships, and one hundred and one (101) adult residencies/fellowships.

In addition, in order to meet the assessed needs of the SMI population, DMHAS provides a broad range of programs and levels of care to the SMI population. The SMHA offers the following crisis, early intervention initiatives and community levels of care to address the needs of the SMI population.

Crisis Stabilization Services: 988 Lifeline Centers (a nationwide 3-digit number for suicide prevention as well as mental health and/or substance use crisis); Mobile Crisis Outreach Response Teams (MCORTS) (statewide crisis response, in the community, to non-life-threatening mental health, substance use or suicidal crises).

Crisis Stabilization and Diversionary Services: Crisis Diversion Homes (hospital diversion; serves individuals who have recently experienced a crisis and are in need of further crisis stabilization); Crisis House (short term (21-30 days) residential program

offering continuous 24/7 supervision and support for adults (18+) diagnosed with a mental illness; direct alternative to psychiatric hospitalization; stabilization services for individuals recently discharged from inpatient psychiatric care); Peer Respite (alternative to inpatient psychiatric hospitalization. Peer respite staff provide 24/7 peer to peer support to help work through a behavioral health crisis); Diversionary Beds (inpatient mental health treatment beds for individuals who are uninsured and/or under insured to go into a community hospital; alternative to state hospital).

Acute Care Services: Designated Screening Centers (ambulatory care service which provides mental health services including assessment, emergency and referral services to mentally ill to ascertain whether the individual meets involuntary commitment standards); Affiliated Emergency Services (assessment and crisis intervention available 24-hours a day for mental health and psychiatric emergencies); Early Intervention Support Services (short term, mental health and co-occurring mental and substance use disorder services for adults who are experiencing significant emotional or psychiatric distress and are in need of immediate intervention; alternative to hospital-based emergency room treatment. Outreach (non-office based) services are available); Involuntary Outpatient Commitment (community based mental health services for individuals, who are court ordered into mental health treatment); Short Term Care Facilities (acute care adult psychiatric units in a general hospital for the short-term admission of individuals who meet the legal standards for involuntary commitment and require intensive treatment).

Peer Recovery Support: Peer Wellness Centers (community-based centers providing activities designed to encourage consumers to develop support networks to assist in decreasing isolation, support recovery and community tenure).

Family Support: Intensive Family Support Services (IFSS) (a range of supportive interventions designed to improve the overall functioning and quality of life of families with a relative with serious mental illness; may include psychoeducation groups, single family consultation, respite services, family support groups, systems advocacy and referral/service linkage); Acute Family Support Programs (AFS) (located within a Screening Center; assists families with navigation, education, provides resources and referrals for their family member in crisis).

Systems Advocacy: Legal assistance provided to mental health consumers; includes advice, case coordination, and court representation regarding government entitlements, housing, evictions, employment, etc.).

Treatment and Rehabilitative Supports: Intensive Outpatient Treatment Support Services (IOTSS) (community based ambulatory treatment alternatives for adults with SMI; includes comprehensive assessments, Wellness and Recovery Action Plans (WRAPS), medication and medication education, individual therapy, structured group therapy, illness management and relapse prevention groups, family psycho-education, referral to physical health care and direct linkage to ongoing clinical and support services); Programs for Assertive Community Treatment (PACT) (comprehensive, integrated rehabilitation, treatment and support services to individuals with SMI experiencing repeated hospitalizations; offers highly individualized services with a majority of contacts in natural community settings; available for psychiatric crises 24/7); Projects for Assistance in Transition for Homelessness (PATH) (serves individuals with SMI and with or without co-occurring substance use disorder who are homeless or at imminent risk of becoming homeless); Community Support Services (CSS) (designed to provide SMI with a choice of permanent, safe, affordable housing in the community and offers individualized rehabilitative supports to maintain community tenure); Residential Services (supervised residences that provide supports and encouragement in the development of life skills required to sustain successful living in the community); Supported Employment (SE) (assists SMI consumers find and maintain meaningful, competitive jobs in the community based on the person's preference and abilities); Supported Education (Sed) (includes the provisions of supported educational coaching services; includes enrollment and registration assistance, teaching study skills, illness management and recovery skills related to school, assistance and advocacy in obtaining "reasonable accommodations" from the school); Illness Management individuals with and Recovery (IMR) (a standardized psychosocial intervention designed to help individuals with SMI manage their illness and achieve personal recovery goals); Integrated Case Management Services (ICMS) (outreach and case management services with linkages provided predominantly in the consumer's natural environment to facilitate access to needed mental health, medical, social, educational, vocational, housing and other services and resources); Outpatient Services (OP) (provided to individuals with MI and SMI s; includes therapy, counseling and supportive services for relatively brief sessions (between 30 minutes and 2 hours) and medication services when appropriate; Partial Care (PC) (individualized services provided in a group day program setting to maximize client's, with SMI, independence and community living skills); Statewide Clinical Outreach Program for the Elderly (S-COPE) (innovative statewide response and technical assistance resource for Long Term Care facilities, screening centers, psychiatric inpatient units, and for community-based mental health residents; a multi-disciplinary team providing clinical consultation to professionals regarding adult's age 55+ residing in long term care facilities); Certified Community Behavioral Health Clinic (CCBHC) (program designed to provide a comprehensive array of services needed to create greater access, and provide the necessary treatment for those with mental illnesses and substance use disorders).

-Homeless Adults

help individuals with serious mental illness live in the community. The various housing options include supervised community residences (such as group homes), supervised apartments (with varying levels of supports, including case management, medication management, counseling, tenancy sustaining supports, etc.) and rental subsidies for individuals with serious mental illness who can live more independently in the community (again, with varying levels of support). Other resources include transitional housing programs that provide short-term support following a psychiatric hospitalization or relapse to help individuals transition back into the community.

DMHAS partners with other state and community-based entities to maximize the utilization of housing subsidies and support services for integration into the community. In addition, DMHAS RFP'd housing for SMI individuals being discharged from state or county psychiatric hospital and SMI individuals who are homeless. DMHAS issued a total of eight awards in four counties and regions, in order to serve twenty-four unduplicated SMI consumers who were homeless. DMHAS also RFP'd and issued four regional awards in order to serve twenty unduplicated consumers. DMHAS utilizes Community Support Services, a rehabilitative service, for individuals transitioning out of state hospitals into the community. DMHAS served 5,894 individuals and increase from 2024 where 5,624 were served. DMHAS acknowledges that it cannot use PATH funds to support emergency shelters, so the SMHA is seeking to identify alternate resources to further address housing needs.

In order to address the unmet needs of SMI individuals without public benefit, staff assist with applications for GoodRx, which is a free discount card to assist in lowering medication costs. Staff will also reach out to the specific drug manufacturers to identify any prescription assistance programs associated with the specific medication. In addition to the above efforts, staff research drug prices among large chain pharmacies, mail pharmacies, and small local pharmacies to identify the lowest cost to the individuals.

DMHAS also uses "wrap" funding to assist SMI individuals with medications, and with tenancy start-up costs, such as rent security and utility deposits. Wrap funds also are available for limited household expenses, such as food and other essentials, to help transition consumers into the community.

DMHAS notes that the State has seen an increase of individuals in need of emergency housing due to the current housing market. DMHAS currently supports short term residential programs via its respite and peer respite homes. In addition, DMHAS will be opening at least two Crisis Diversion Homes, to provide short-term residential services as an alternative to an inpatient psychiatric hospitalization. In addition to DMHAS funded programs, staff will assist with linkages to community alternatives such as emergency housing assistance with the Board of Social Services in each county, which can fund short term stays at motels, hotels, rooming houses, etc. The goal is for individuals to have safe place to stay until something more permanent is identified. Our individuals also use shelters if no other options are available to them.

-Older Adults

In order to address the needs of older adults, who have a serious mental illness, the state mental health authority issued a Request for Proposal (RFP) for outpatient services in the fall of 2023 using American Rescue Plan Act funding. For this RFP, "older adults" were defined as 55 years old or older. DMHAS made three (3) funding awards in each of the three (3) identified counties (Burlington, Sussex and Union) to serve three hundred thirty (330) unduplicated individuals. Data indicates that the awarded programs exceeded goals and served a total of four hundred six individuals. Services included medication management and psychotherapeutic counseling.

-ESMI Coordinated Specialty Care – Community Integration

In order to meet the needs of the increasing number of individuals with early psychosis, including affective psychosis as well as transitional support program post-CSC intensive treatment, DMHAS developed an RFP for Coordinated Specialty Care Community Integration (CSC-CI) which would provide Coordinated Specialty Care services and step-down in six regions covering twenty-one counties of the state. CSC-CI would provide ESMI services for individuals with first-episode psychosis (FEP) and affective psychosis (AP) as well as Community Integration (CI, a tiered step-down model). The CSC programs follow the Recovery After an Initial Schizophrenia Episode (RAISE) model. From the RFP there were five (5) awards. Currently there is one region, that includes three counties, that does not have an awarded provider. (DMHAS posted the RFP twice but did not have a successful bidder. This remains, at this point in time, an unmet need that DMHAS will seek to fill).

-Individuals in Need of Behavioral Health Crisis Services

To increase capacity to respond to a minimum of 90% of in-state contacts to 988, NJ DMHAS has established state and federal funding streams to support the existing 988 centers. Since 2022, NJ DMHAS has utilized federal funding streams, including MHBG and SUPTRS funding to support centers in hiring staff to increase their ability to respond to 988 contacts. Most recently, NJ DMHAS has been able to award ongoing state funding to all current in-state 988 Lifeline centers to further expand their services. With this state funding, centers have been able to hire additional staff members and expand the 988 services they offer.

Ongoing assessments have shown that demand to 988 is continuing to increase and additional efforts must be made to continue to meet the needs of our population. Additional sustainable funding streams are being explored and will be subject to the State's procurement processes.

To increase awareness and trust in the MCORT system, NJ DMHAS is promoting MCORT throughout the state. To further address utilization rates, NJ DMHAS is exploring the possibility of expanding access to MCORT beyond referral from the NJ 988 Suicide and Crisis Lifeline.

An RFP for Crisis Receiving Stabilization Centers (CRSC) was posted in January of 2024 to address a need for the creation of five new CRSCs in the following counties: Morris, Essex, Monmouth, Camden, and Bergen. Each center will have 22 recliners and serve a crisis population of individuals 18 years of age and older with a primary SMI or SUD diagnosis who are experiencing acute psychiatric and/or substance use disorder symptoms that could interfere with community tenure. The centers will be using a "no wrong door approach" and will be open for referrals, walk-ins, and first responder drop-offs, 24 hours per day, 7 days per week, every day of the year. The goal of the CRSCs is to develop an appropriate alternative to the use of local hospital emergency services and in-patient psychiatric hospitalization by providing crisis stabilization services. Additionally, the goal of the CRSCs offer continuity of care through linkages for services and placement support for individuals in need of permanent housing.

-Individuals with SMI or SED in rural areas and Youth with SED and Families

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 (8) 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 area of Atlantic County. The CCBHCs offer services within an integrated physical and behavior 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 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. Since the start of the CCBHC Demonstration Project in 2017, AtlantiCare's CCBHC has increased the number of clients it has served. AtlantiCare more than doubled the number of clients served in Year 7, providing care to 1,194 individuals between July 1, 2023 to June 30, 2024, compared with 575 served between July 1, 2017 to June 30, 2018.

AtlantiCare has also consistently demonstrated success in the very important performance metric of time to care. AtlantiCare has outperformed the CCBHC average in terms of the number of days from first contact to evaluation in all seven years of the Demonstration and has provided an evaluation to CCBHC clients in less than eight (8) days from time of first contact. AtlantiCare also provides significant amounts of case management services. More than nine-tenths of AtlantiCare CCBHC clients have received case management during the last five (5) years of the Demonstration, including in the most recent Demonstration Year 7. The CCBHC Demonstration Program ended September 30, 2025. The state is currently pursuing plans to sustain the program through Medicaid.

DMHAS also posted an RFP that would expand the scope of the Coordinated Specialty Care program as well as the number of programs. Programs would be awarded to cover the counties that had insufficient service coverage by existing programs. One of awards will cover Morris, Sussex, Hunterdon and Warren counties. Sussex, Hunterdon, and Warren counties had insufficient service coverage in the north. An award was made in the south to Atlantic, Cumberland and Cape May counties which had insufficient service coverage.

In order to address access to services during the pandemic, DMHAS providers were able to transition to telehealth services.

Telehealth services were instrumental in reaching individuals with early psychosis as well as individuals in other levels of care by offering a hybrid approach to treatment for flexibility and can be useful when transportation from rural locations is an unmet need. Telehealth increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across behavioral health and primary care settings. Telehealth is useful for rural areas to access out of state providers to increase capacity thus extending networks.

The Children's System of Care has Mobile Response and Stabilization Services (MRSS), Care Management Organizations (CMOs) and Family Supports Organizations (FSO) support youth under 21 years of age with moderate to high mental health needs in all of New Jersey's 21 counties, including Salem, Sussex, Warren, Cumberland, Atlantic and Cape May counties, which are considered rural counties.

CMOs provide care coordination of services through a wraparound approach to ensure all youth engaged with their organization receive the necessary services regardless of their location minimally ensuring engagement with community-based services and supports and out of home treatment.

-Individuals SED experiencing homelessness

The Adolescent Housing Hub (AHH or the Hub) is a real-time database designed to assist youth with placement in a transitional or permanent housing program. The AHH program is managed by the Office of Adolescent Services under the Department of Children and Families. AHH services are available to eligible homeless youth, youth at risk for homelessness, and youth aging out of the child welfare system, ages 18 – 21 years. Youth may contact PerformCare at 1-877-652-7624 24 hours a day to find out about housing and supports available to help. These supervised and supported transitional housing programs address the complex needs of homeless youth and those transitioning out of the system of care. The programs provide safe and stable housing as well as life skills coaching, case management services, and assistance with meeting educational and employment plans. The goal of supportive housing is to help youth achieve independent living skills and successfully transition to adulthood.

-SED Individuals in need of behavioral crisis services

Mobile Response and Stabilization Services are provided in every region of the state for youth and families experiencing a self-defined crisis and designed to delivery assessment and stabilization services as needed.

-SED Program Workforce Challenges

In recognition of unprecedented workforce challenges for behavioral health systems, DCF has engaged in efforts to inform strategies of workforce recruitment and retention to ensure continued quality service delivery, including:

A contracted labor market analysis including diagnostics and recommended strategies and solutions

Holding conversations with partner/provider groups and stakeholders

Adjustment of practice elements that provide efficiencies for providers and maintain youth safety and quality service delivery.

-SED Individual's Access to integrated physical healthcare and behavioral healthcare.

Planned activities:

Infuse integrated care and wellness activities across the CSOC continuum by identifying and expanding opportunities for integration within the CSOC service array and supporting the development of other primary health-behavioral health integration models.

-SED Individual's Access to evidence-based practices (EBP), services, and supports across the CSOC service continuum.

Planned activities:

Support evidence-based practices in the continuum by increasing EBP capacity in both community-based and out-of-home

services.

-Improved SED outcomes through increased collaboration among system, family, and other partners.

Planned activities:

Encourage collaboration among all partners through strategic statewide and local partnerships.

Continue collaboration through external advisory group.

Strengthen CSOC's quality improvement strategy, including development and implementation of outcome measures aligned with the CSOC logic model goals, objectives, and activities.

-Strengthen and expand youth and family peer support.

Planned activities:

Promote the importance of youth and family support.

Explore opportunities to increase access to peer support services.

-Increase public awareness of availability and accessibility of the Children's System of Care. Planned Activities:

Promote usage of the CSOC Social Media Tool Kit and Public Service Announcement by all partners.

Presentations provided to community stakeholders upon request.

Design and implement training and support to increase access to services for unhoused youth and their families.

-Ensure access for all.

Planned Activities:

Promote data collection and entry across the service array.

Participate in DCF learning activities.

-Expand Service Array to include supports and services for infant mental health/youth under five years old.

Planned Activities: Continuation of "Zero to Five: Helping Families Thrive" infant and early childhood mental health workforce training and technical assistance activities.

-Older Adult Committee

The SMHA has convened an Older Adult Committee to be a resource for DHS, DOH/DBHS (Division of Behavioral Health Services) regional state psychiatric hospitals, and DMHAS-funded community agencies that serve the older adult population. Through the

review of existing programmatic data, case reviews, literature reviews and presentation by experts and professionals in the field, the committee strives to better serve the needs of the older adult which is a growing demographic in New Jersey. The committee will also strive to assure that programs and services offered at the regional state psychiatric hospitals and through our contracted agencies are age relevant, cost effective, beneficial, and dignified. In order to incorporate a wider range of perspectives and expertise, the committee membership was expanded from DMHAS Olmstead/Diversion, DOH/DBHS state psychiatric hospitals and Centralized Admission Unit, and Statewide Clinical Outreach Program representatives to also include representation from the Area Agency on Aging, New Jersey Advocates for Aging Well, New Jersey Hospital Association, Office of Long-term Care Resiliency, and the Office of Community Choices Options.

-Coordinated Specialty Care (CSC), Coordinated Specialty Care – Community Integration (CSC-CI)

With the issuance of Block Grant Supplemental funds in 2023, DMHAS awarded five contracts to serve 18 of 21 counties of the state and expanded the ESMI population of it's Coordinated Specialty Care (CSC) program for First Episode Psychosis to include Affective Psychosis. Coordinated Specialty Care, Community Integration (CI), a stepped-care approach, has been added to CSC services to provide the opportunity for individuals in CSC to remain engaged with their current CSC team while receiving transitional support post-CSC intensive treatment. Research has shown that many clients struggle to maintain superior outcomes after CSC 8. Evidence also has shown that shortening the duration of untreated psychosis by limiting gaps in service can have a positive impact on long-term outcomes for the FEP population 9. The CSC CI programs continue to serve consumers that need less intensive services and will be able to move to the transitional program and titrate services according to their need. Treatment and supports will be geared toward reintegration of the individual into the community, return to school/work, symptom stabilization, diversion from inpatient services and a decrease of screening center utilization. These programs will provide a supportive environment where the client can access an array of services and remain connected in the community, thus decreasing hospital recidivism, integration of health and behavioral health via continuity of care between the CSC APN and the client's primary care practitioner, decrease in duration of untreated illness, increase in medication adherence, and increase in level of functioning. Clients will be able to transition to step down or transition up to CSC seamlessly based upon clinical need without changing providers or their clinical team. An additional CSC CI team is needed to cover the remaining 3 counties in New Jersey, Mercer, Monmouth, and Ocean.

-Peer Recovery Warm Line

Funding to expand Peer Outreach Support Teams within the mental health system either by direct positions or allow Medicaid reimbursement is the major barrier. MHANJ has established a strong program model that can work within the traditional treatment system and also work effectively with the large number individuals with mental health and substance use disorders who are not receiving services. MHANJ is using the POST model with other funding sources to engage individuals with emotional issues and is currently involved with a pilot project with Horizon BlueCross/Shield to offer Peer Support services to its commercial clients. Once Medicaid funding to peer support flows MHANJ is in the position to significantly expand these peer support services.

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SSA

Addressing Needs and Gaps of Services of Statutory Populations and Populations in Need

Pregnant Women and Women with Dependent Children.

In 2014, as a SAMHSA Prescription Drug Abuse Policy Academy State, New Jersey submitted a successful application for In-Depth Technical Assistance (IDTA) 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 was the lead State agency and partnered with the Departments of Children and Families and Health Department of Health (DOH). 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

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 identify low utilization areas to increase the prevalence of prenatal screening.

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

The IDTA commenced in 2017. DMHAS as the IDTA lead state agency, requested modified technical assistance from the NCSACW to support New Jersey to interpret the key findings from the Birthing Hospital Survey, and apply these findings to the Project ECHO (Extension for Community Outcomes) program design. DMHAS Office of Treatment and Recovery Supports has a Memorandum of Agreement (MOA) with Rutgers Robert Wood Johnson Medical School, Office of Community Health to provide ECHO technical assistance and training. The ECHO series "Maternal Child Health Pregnant and Parenting Women with Opioid Use Disorder (MCH PPW-OD)" started January 2020 through December 31, 2021. The MCH PPW-OD ECHO provides education and training to primary care practitioners, SUD treatment providers, behavioral health practitioners, and other stakeholders in clinic settings and at home, utilizing a web-based video collaboration between a multi-disciplinary team of staff and primary care practitioners on best practices for the assessment, case management, intervention, treatment and recovery support services for PPW with an OUD. The ECHO goal is to increase the capacity and competency of behavioral health providers, community support organizations, medical community, and child welfare to support prevention, treatment, and recovery of pregnant and parenting women with OUD and other substances. ECHO positions communities to decrease the NAS birth rates, improve use of medication assisted treatment, family formation and early infant development; improve access to physical and mental health care by educating more providers, midwives, doulas, and other health care professionals on best practices during prenatal and perinatal periods. The MOA was extended several times to continue technical assistance, including education and training. The most recent extension is from October 2023 through September 2025. This ECHO series held evening sessions in an effort to reach out to practitioners and prescribers, with sessions focused on the latest FDA approved techniques for Medication Assisted Treatment (MAT), integrated care, and wraparound services, stigma of mental health and substance use, screening protocols, improving access to substance use treatment, Plans of Safe Care, and coordinated care for pregnant women with OUD and their newborns. The new series which started January 2024 through August 2024 includes 18 sessions with five (5) community workshops and another 18 sessions with five (5) community education workshops through August 2025. The community education workshops focus on educating the audience on referral and linkages between providers, practitioners, and community services to support pregnant and parenting persons and their family. These series focus on maternal opioid intervention and care coordination. Didactic topics with the 18 sessions range from integrative approach to care for pregnant women; bridging the gap from patient to plan; implementation

that is meaningful and impactful; prenatal care with an opioid/substance use disorder; addressing stigma; perinatal depression; navigating the system to maximize successful family formation, etc.

New Jersey submitted a successful application and was awarded IDTA through the National Center on Substance Abuse and Child Welfare (NCSACW) 2023 Policy Academy: Advancing Collaborative Practice and Policy: Promoting Healthy Development and Family Recovery for Infants, Children, Parents, and Caregivers Affected by Prenatal Substance Exposure. NJ State Policy Academy representatives include the Department of Health (DOH) DCF, DHS and the Governor's Office. The DMHAS Women's Treatment Coordinator represents DHS. Representatives from the medical, addictions and perinatal community also participate on this IDTA. The overall goal was to increase awareness of pregnant women with SUD, through increased education and maximizing messaging through the perinatal work force, increase awareness and access to treatment, Plans of Safe Care, and improving screenings in hospitals and healthcare providers. Four goals have been established: Goal 1: Conduct a statewide landscape analysis of resources available to individuals with a SUD and understand how referrals are made to appropriate resources and levels of care. Goal 2: Address gaps in the SUD system of care to establish a comprehensive and fluid collaborative approach among state agencies, healthcare providers, and community-level and non-profit organizations to address substance use during and after pregnancy. Goal 3: By 2025, create and execute a state-wide prenatal Plans of Safe Care process that enables Community and Clinical Partners to formally support a birthing woman. Goal 4: Support birthing hospitals in updating their protocol related to screening and referring birthing women with SUD; and subsequently engaging in a comprehensive approach to implementing Plans of Safe Care in New Jersey.

In November 2021, a Memorandum of Agreement with the Rowan University, School of Osteopathic Medicine (SOM) was developed for Screening, Brief Intervention and Referral to Treatment (SBIRT) for persons receiving services at their internal medicine, family care, OB/GYN clinics, and the Rowan University Student Health Center. Utilizing national best-practice standards for substance use screening, Rowan SOM has developed and implemented a fully sustainable, integrated SBIRT model as part of routine medical care. Additionally, Rowan SOM will implement annual, universal screening protocol, and office-based risk interventions, as part of patient intake services in all OB/GYN clinical settings.

Child Welfare/Parents with Dependent Children Programs.

On July 1, 2015, the treatment contracts for parents with substance use disorders via a Memorandum of Understanding between the SSA and DCF Division of Child Protection & Permanency (DCP&P) transitioned over to DCF.

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

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 decrease the gaps in service delivery and improve coordination of services. The Consortia allow for cross systems collaboration with local treatment programs and other community partners who can provide the expertise needed to better serve families in the child welfare system.

Women's Intensive Supportive Housing Program.

The SSA developed a Women's Intensive Supportive Housing (WISH) Program. This program provides permanent supportive housing for pregnant and/or parenting women with a co-existing substance abuse disorder and mental illness who are homeless or at risk of homelessness and being discharged from a licensed long-term residential substance abuse treatment and/or halfway house facility. An RFP was developed and released in January 2015. The RFP was for the development of a WISH team to provide case management and supportive housing services for 10 women and their children. A contract was awarded in 2015 to a licensed treatment provider who specializes in women's treatment, offers a continuum of care, and has a longstanding history of providing supportive housing and has demonstrated success in managing permanent supportive housing programs.

Since 2014, DMHAS has a Memorandum of Understanding (MOU) with NJ DCF, DCP&P to fund ten (10) supportive housing subsidies annually for the "Keeping Families Together" (KFT) program for parents involved with the child welfare system who are homeless or at imminent risk and in which one or more adults in the family is diagnosed with a co-occurring mental health illness and substance use disorder. DCP&P contracts with a provider for the KFT program in Essex County.

Maternal Wraparound Program

The Maternal Wraparound Program (M-WRAP) is a program that provides intensive case management and recovery support services for pregnant and postpartum women with substance use disorder. 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 Staff provide non-clinical assistance and recovery supports while maintaining follow-up with the women and their infants.

Block Grant funding supports seven M-WRAP regions statewide. 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 obstacles to services for pregnant women with substance use disorder through comprehensive care coordination implemented within the five major timeframes when intervention in the life of the substance exposed infants (SEI) can decrease potential injury of prenatal substance exposure: pre-pregnancy, prenatal, birth, neonatal and early childhood. Care coordination also addresses screening, early intervention, assessment, treatment and recovery supports.

To ensure that the needs of the mother, infant and family receive coordination, access to and engagement in services, providers are required to develop Plans of Safe Care. Plans of Safe Care are developed prior to the birth event, whenever possible and in collaboration with treatment providers, health care providers, early childhood service providers and other members of the multidisciplinary team as appropriate. The M-WRAP model is intended to promote maternal health, improve birth outcomes for women, their infants and families, and decrease the risks and adverse consequences of prenatal substance exposure. Each MWRAP region is required to provide services to sixty (60) unduplicated women, a total of 420 unduplicated women.

In late fall, 2022 ReachNJ, the central call-in line for New Jersey residents seeking help with a SUD, dedicated their public service announcement campaign to reach pregnant women. MWRAP provided training to ReachNJ to offer MWRAP as a resource and to provide warm hand-offs. MWRAP services provides the support needed to help pregnant and parenting women maintain a healthy recovery, resulting in less overdoses, and improved birth outcomes and maternal child health.

Integrated Opioid Treatment Services and Substance Exposed Infants (IOT-SEI)

Five providers across the State submitted successful applications through a Referral for Proposals (RFP). The IOT-SEI Initiative is funded with Governor's State Opioid funds. This Initiative provides an array of integrated services for opioid dependent pregnant women, their infants and family. Providers are required to ensure a full continuum of services and to establish mechanisms to develop a coordinated and cohesive approach for working together across systems that include, SUD treatment, medical community, maternal child health, and child welfare. Initiative focuses on alleviating obstacles to services. Services range from: mother's medical/prenatal and obstetrical care, SUD treatment for OUD including MAT, new born/infant medical care, child welfare services as identified, intensive case management, recovery supports, assistance with housing, case management and other wraparound services. Providers must ensure that there is comprehensive care coordination from prenatal through the birth event, postpartum, and early childhood.

Mental Health First Aid and Perinatal Mental Health (MHFA)

Recognizing that some contributing factors among pregnancy associated, but not related cases for mental health and SUD can be lack of provider knowledge, DMHAS increased efforts to educate the perinatal workforce, medical community, and the behavioral health providers on services, resources and best practices that can have a positive impact on maternal health. SFY 2024, DHS through DMHAS provided funding to the New Jersey Quality Health Care Institute to partner with a provider to conduct statewide trainings to MWRAP staff and the perinatal workforce on MHFA to raise awareness around the impact of perinatal mental health. The perinatal workforce is uniquely positioned to identify mental health symptoms early and intervene when needed on MHFA. The trainings focused on maternity-specific scenarios to teach participants how to assist pregnant and parenting persons experiencing mental health symptoms in crisis and non-crisis situations and intervene when needed.

Maternal and Child Health Policy Innovation Program (MCH PIP)

DMHAS Women's Services Coordinator participated on the Maternal and Child Health Policy Innovation Program (MCH PIP) Alumni Policy Academy from August 2023 through April 2024 convened by the National Academy for State Health Policy (NASHP) with support from the Health Resources and Services Administration, Maternal and Child Health Bureau (HRSA-MCH). State partners include DHS with Medicaid as the lead agency, DMHAS and representatives from the DOH and DCF. The overall goal is to improve maternal health outcomes by addressing SDOH related obstacles (e.g., transportation, child care, language/low literacy) to accessing maternity care; effective referral processes for health-related needs of pregnant and parenting persons. DMHAS maternal child health initiatives (IOT-SEI and MWRAP) provide intensive case management, recovery supports, and services to assist pregnant and parenting persons with SUD and co-occurring to access care, address barriers to help improve maternal health outcomes.

Maternal Mental Health Learning Collaborative (LC)

January, 2024 SAMHSA's Center for Mental Health Services (CMHS) invited all states and territories to apply for the Maternal Mental Health LC, a competitive process where only eight (8) states/territories would be selected. The New Jersey Division of Mental Health and Addiction Services (DMHAS) submitted a successful application. Areas of focus included: building the existing integrated behavioral healthcare collaborations to address mental health issues and SUD for pregnant and parenting persons; strengthen coordinated care; improve continuity of care and linkages; identify obstacles to care; expand state capacity to address needs that impact perinatal and postpartum populations (e.g. housing, employment, legal, food security, etc.); address stigma, improve access to services; and build on the existing practices and current initiatives. The DMHAS LC goal was to improve collaboration and care coordination around mental health and SUD prenatally through postpartum, up to one year after the birth event.

Tuberculosis (TB) Services

Unlike some other communicable diseases, TB is not easily transmitted. It takes close and prolonged exposure for TB transmission to occur. Early detection and treatment of TB are essential to control the spread of the disease and to prevent outbreaks. The rate

of TB in NJ for 2024 was 3.6 per 100,000 population with a count of 342 cases.

In line with this information, in New Jersey, all substance use disorder treatment facilities receiving contracts are required to conduct TB testing as part of the patients' admissions process. A provision of the guidelines requires that patients with TB, who were not admitted for treatment because the funded capacity at that facility had been exceeded, be referred to another treatment provider for services. DMHAS continues to have discussions with the NJ Department of Health, Division of HIV/AIDS, STDs and Tuberculosis Services (DHSTS) to consider the latest best practices for this effort. DMHAS sent a letter to all SUPTRS Block Grant funded SUD treatment agencies regarding the tuberculosis evaluation requirement.

A need is to increase the compliance rate of DMHAS' SUPTRS Block Grant contracted agencies offering every client a tuberculosis evaluation. According to SFY 2025 Annual Site Monitoring Reports of DMHAS' SUPTRS Block Grant contracted agencies, 94% of the agencies that were monitored (34 of 36 agencies) were in compliance with offering every client a tuberculosis evaluation.

DMHAS will track compliance via quarterly surveys. Monitors will review compliance during quarterly surveys and at 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.

Persons Who Inject Drugs (PWID)

In CY 2024, 13,169 (16%) of 81,217 admissions used drugs intravenously. This particular group is at high risk for other infectious diseases such as HIV and hepatitis, indicating the need for linkage to primary care. One attempt to address this need was applying for, and being awarded, a Promoting Integration of Primary and Behavioral Health (PIPBHC) grant. The two awardees provided models of integration to serve individuals with opioid use disorder (OUD) and other health co-morbidities.

Another activity to address the need of PWID has been our partnership with Department of Health, the National Alliance of State and Territorial AIDS Directors (NASTAD) and the JSI Research & Training Institute, Inc. (JSI). One-time funds were provided to support activities related to the Strengthening Systems of Care for People with HIV and Opioid Use Disorder (SSC) project. These funds were designated to support concrete, time-based activities focused on enhancing systems of care for people with HIV and OUD and in alignment with state technical assistance plans developed for the project. Stigma and its effects contribute to the syndemics of HIV and opioid use disorder (OUD), acting as an obstacle to care for people seeking services. An area that has been explored is data sharing among the two Departments to determine the number of individuals in substance use disorder (SUD) treatment who have HIV and the number of individuals who have HIV that are in SUD treatment. If a plan can be executed for the data sharing, information could be utilized by both Departments to help improve health outcomes for this population by better engaging individuals to seek either HIV or SUD treatment.

The SSA requires all substance use disorder treatment agencies providing treatment to persons who inject drugs (PWID) to provide outreach activities to encourage PWID clients to seek and undergo treatment. The SSA incorporates a provision within the requirements section of each contract with the agencies providing treatment to PWID to ensure that these entities: 1) admit all individuals who request and are determined to be in need of treatment for intravenous drug use within 14 days of their request; or 2) make interim services available to the individuals within 48 hours of the request, and should the individual actively remain on the waiting list, admit the clients within 120 days. To address the need for interim services for PWID, DMHAS utilizes funding to support individuals requiring interim services through its Fee-for-Service (FFS) initiatives.

An initiative to promote low induction medication is through mobile medication programming. Currently, DMHAS contracts with seven agencies to facilitate low induction medication, case management and other ancillary services for individuals with an OUD, which includes PWID, in counties with low access to MAT, as well as areas of the State with individuals who are homeless or at higher risk for homelessness.

2024 indicated that 15% methadone and 10% buprenorphine was planned for use in treatment, despite the fact that heroin and other opiates accounted for 36% of primary drug admissions. DMHAS is committed to decreasing the gap between the use of MAT for people with OUD, particularly PWID. DMHAS, in partnership with the Department Human Services (DHS), Office of Public Relations, secured a vendor that has been delivering a public awareness campaign to help address stigma around the use of MAT for OUD. The campaign was initially launched in the Spring of 2020 and continues to refresh with new ads. Various forms of messaging including TV ads, radio commercials, social media and billboards have been utilized.

In addition, DMHAS offers extensive training on the use of MAT in efforts to make this the standard of care. In CY 2023, DMHAS contracted with Cooper Medical School of Rowan University (CMSRU), the State's Southern Center of Excellence (COE), to provide tailored training and technical assistance on Addiction Medicine, specifically buprenorphine induction, throughout New Jersey. This includes various training topics, formats, office hour sessions, and "elbow to elbow" on-site consultation services. The training is aimed at increasing the use of buprenorphine to treat opioid use disorders, specifically at Emergency Departments, Federally Qualified Healthcare Centers and Primary Care offices.

At-Risk Youth

The SSA provides prevention services to At-risk youth. The SSA awarded funding to the North Jersey Community Research Initiative (NJCRI) to expand their existing programs for high-risk youth by using a "Street Smart" prevention model developed by the Centers for Disease Control and Prevention, as well as early intervention services, social marketing, and structured recreational activities. NJCRI provides services covering the northern NJ counties. In the spring of 2023, DMHAS (by means of a competitive RFP process) identified two additional organizations to provide services to at-risk persons in their communities: Prevention Resources in Central NJ and the Robert Wood Johnson-Barnabas Health Institute for Prevention and Recovery, in the south.

Homeless

DMHAS has developed numerous programs to address the needs of homeless populations. DMHAS has funded services in homeless shelters to increase access to buprenorphine and other ancillary services for individuals with SUD. Contractees provide these services regardless of whether people live in the shelter or drop in. The shelters have affiliations with primary care providers to address physical health needs, including pain management, and implement evidence-based overdose prevention or other interventions to promote consumers' recovery and wellbeing. The prescriber is present at the shelter or available via telehealth when initiating the medication and maintains the person on medication at the shelter or transitions them to a community provider. Case managers and peer specialists support people on sustaining their medication treatment and helping them to overcome obstacles common to people who are homeless or at risk of homelessness. Shelters offering buprenorphine are located in Paterson, Trenton, Camden, East Orange, and Newark.

DMHAS operates Projects for Assistance in Transition from Homelessness (PATH) program using a combination of federal and state funds. The service 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 State Mental Health Authority (SMHA) contracts with non-profit agencies to operate PATH programs within the state's 21 counties. In SFY 2024, the PATH programs in New Jersey provided outreach to 2,559 individuals and served a total of 1,562 persons. There were 638 program participants that were linked to mental health services, 92 to substance use treatment services (an individual with a self-disclosed SUD is referred to SUD treatment resources and services), 166 to primary health/dental care, 368 to financial services, 299 to temporary housing/shelter, 250 to long term housing and 292 were linked to employment or vocational and educational services.

The Open Access to Medications for Opioid Use Disorder in Homeless Shelters is designed to increase access to buprenorphine and other ancillary services for individuals with a substance use disorder through current programming available at homeless shelters that are licensed by the NJ Department of Community Affairs. These providers have developed the capacity to provide medication and support services for individuals who reside or drop in at homeless shelters. The intent of the program is to provide low threshold medication services to individuals with SUD who present in these settings. The six participating shelters are located in Paterson, Trenton, Camden, East Orange and Newark. The shelters were awarded a contract from a competitive RFP process; two were awarded in December 2022 and four were awarded in May 2024.

Opioid Settlement funds were used to fund an RFP for temporary housing for individuals being discharged from residential, inpatient, ambulatory SUD treatment and/or individuals with a history of SUD who may be or have become homeless. The funding through this RFP can serve as a bridge to permanent housing, allowing participants to receive the support and services they need around other challenges in their lives. DMHAS issued an RFP in October 2024 and made awards in February 2025 to six licensed 24-hour emergency shelters for a total of 150 beds. A companion RFP funded with opioid settlement funds was released for case management services for adult individuals placed in one of the 150 shelter beds. Case managers will help connect individuals with services/ resources in their area and entitlements and assist them in securing permanent housing as quickly as possible. It is anticipated that individuals will obtain permanent housing within four months of initial engagement. Individuals served in this program will have access to DMHAS funded housing subsidies. DMHAS issued an RFP in October 2024 and made awards in February 2025 to four agencies to provide these services in their region of the state.

Through an MOA with the Rutgers Northern Region MATx Center of Excellence (COE)'s, DMHAS funds a set of services and training designed to improve engagement in SUD and mental health services among unhoused individuals in Essex County. The COE's Outreach Partners program provides intensive case management to increase the success of individuals in achieving and maintaining their recovery goals through medications for addiction treatment (MAT). Shelter-based activities involve assisting residents with obtaining Medicaid and facilitating linkage/referral to community-based organizations that provide social services, mental health, substance use, and/or medical treatment for shelter residents with SUD. In addition, Rutgers team members lead a variety of thematic support groups for shelter residents on topics such as overdose prevention, relapse prevention, family/social network connection, mindfulness and stress mitigation. Shelter-based support includes assistance with cell phones to help people stay in communication with service providers and vouchers for transportation so individuals can attend treatment appointments. Shelter-based participants will also be offered a "Overdose Prevention Backpack."

This program also includes a statewide Learning Community and provides quarterly trainings on topics related to SUD and mental health, as well as providing "hands-on" support to housing stakeholders in Newark and Northern New Jersey in creating programming that is empathic and responsive to client needs.

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Footnotes:

Revision Request updates on 11/3/25:

1. <https://www.nimh.nih.gov/health/topics/schizophrenia/raise/fact-sheet-first-episode-psychosis>

2. <https://jamanetwork.com/journals/jamapsychiatry/fullarticle/209973#:~:text=The%20LTP%20was%203.06%25%20for,%2C%20and%200.62%25%2C%20respectively>

Original Submission - 9/1/25

[1] <https://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4509>

[2] http://www.nj.gov/humanservices/dmhas/initiatives/olmstead/olmstead_settlement_agreement.pdf

[3] http://www.state.nj.us/humanservices/dmhas/regulations/bulletins/Mental%20Health/5_11.pdf

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

[8] Jones, N. (2016). What comes after early intervention? Step-down, discharge and continuity of care in early intervention in psychosis programs for first episode psychosis. Retrieved from https://www.nasmhpd.org/sites/default/files/Issue%20Brief%20-%20What%20Comes%20After%20Early%20Intervention_0.pdf.

[9] Jones, N. (2016). What comes after early intervention? Step-down, discharge and continuity of care in early intervention in psychosis programs for first episode psychosis. Retrieved from https://www.nasmhpd.org/sites/default/files/Issue%20Brief%20-%20What%20Comes%20After%20Early%20Intervention_0.pdf.

Estimates of SMI, SED, and General Population of New Jersey, 2010, 2011, 2016, 2018, 2020, 2022, and 2024

Year	Total Adult Population	Total Adult SMI (5.4%)	Adult SMI Lower Limit of Estimate (3.70%)	Adult SMI Upper Limit of Estimate (7.10%)	Total Children	Total Children SED (8%)	Total New Jersey Population
2010	6,726,680	363,241	248,887	477,594	2,065,214	165,217	8,791,894
2011	6,778,345	366,031	250,799	481,263	2,042,810	163,425	8,821,155
2016	6,959,717	375,825	257,510	494,140	1,984,752	158,780	8,944,469
2018	6,948,646	375,227	257,100	493,354	1,528,702	122,296	8,477,348
2020	6,947,836	375,183	257,070	493,296	1,934,535	154,763	8,882,371
2022	7,275,144	392,858	269,180	516,535	1,992,555	159,404	9,261,699
2024	7,448,667	402,228	275,600	528,855	2,052,184	164,175	9,500,851

Planning Step 2: Identify the unmet service needs and critical gaps within the current system, including state plans for addressing identified needs and gaps with MHBG BG award

#1 Please describe how your state conducts statewide needs assessments to identify needs for mental and substance use disorders, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

I. A Data Driven Process for Identifying Unmet Needs and Critical Gaps

The Division of Mental Health and Addiction Services (DMHAS) uses a data driven process to identify unmet needs and critical gaps. (DMHAS) data sources include: Quarterly Contract Monitoring Reports (QCMR); Unified Services Transactions Form database (USTF+); Systems Review Committee (SRC) data; Hospital Census Database; and input from the Behavioral Health Planning Council. In addition, DMHAS obtained data from its contracted community mental health programs. Another primary resource used to identify gaps was the SMHA Consumer Perception of Care Survey, which provided critical data used to measure contracted agencies were performing and meeting each individuals' goals. DMHAS also relies on national data sets, including demographic data from the US Census Bureau, SAMHSA's NJ Behavioral Health Barometer, SAMHSA's Uniform Reporting System (URS) Data Tables, Annual Demographic Profiles generated by the NJ Department of Labor and Workforce Development, the NJ State Health Annual Assessment Data, Center for Health Statistics, NJ DOH, the NJ Violent Death Reporting System, the CDC-funded NJ Behavioral Risk Factor Survey, NJ DOH Uniform Billing data (evidencing hospital and emergency department use by demographic factors), and NJ DOH Licensing data (evidencing occupancy rates for psychiatric beds in general hospitals).

Persons with a SMI are the primary statutory population for SMHA funded services. However, DMHAS has identified service gaps and therefore prioritizes services to: persons with SMI in need of crisis intervention and stabilization services; individuals with early serious mental illness (first episode psychosis); persons with SMI as well as Older Adults; Homeless Adults; individuals with SMI in rural areas; and children with a serious emotional disturbance and their families.

-Adults with SMI

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)¹. According to URS Table 2a, a total of 80,022 unduplicated persons ages 18 and over received services in programs provided or funded by the SMHA in FY 2024. The SMHA served 30,098 unduplicated adults with SMI (refer to URS data table 14a) in FY 2024. That was 7.48% of the total estimated adults with SMI in New Jersey (402,228). It is noteworthy that DMHAS has transitioned to the USTF+ data system as mentioned previously continue to provide monitor the data and provide technical assistance where needed. The QCMR provides duplicated data where an individual can be enrolled in a program, be discharged, and then be readmitted during the same year or an individual may be in one program and also in another program as long as they are not mutually exclusive. The QCMR data reveals that there were 270,263 individuals

served in SFY 2024, of that total, 251,501 were 18 and older. In total, the data revealed the unmet needs and underutilization within the state by county and by level of care.

Various community providers reported extensive psychiatric wait times and continuing psychiatric staffing challenges. DMHAS is aware of psychiatric staffing shortages, and identified the need for additional licensed, professional psychiatric staff at various levels of care.

-Homeless Adults.

DMHAS conducts regularly scheduled monthly meetings with approximately forty-one contracted Community Support Services (CSS) provider agencies and the Supported Housing Connections (vendor). The state maintains and manages approximately three-thousand rental subsidies to support individuals with serious mental illness living in the community. DMHAS contracts with approximately forty-nine Residential Service providers.

New Jersey conducts a Point in Time (PIT) Count on an annual basis. PIT was conducted on January 24, 2024, and revealed there were 12,680 people experiencing homelessness in the State of New Jersey, up 24% from 2023. Thirty percent of those experiencing homelessness were homeless for over one year. 1,737 persons were unsheltered on the night of the count.

DMHAS monitors its bed enrollment data system, and both CSS and residential provider weekly report for vacancies in supervised and other residential beds. In doing so DMHAS is able to assess the levels care are in each geographic area.

-Older Adult Committee

DMHAS considered local survey data of waiting times by the Mental Health Association in New Jersey, along with regional considerations, and applications received to a competitive procurement opportunity to serve this population. The Request for Proposals solicited services needed for Burlington, Sussex and Union Counties. Services included medication management and psychotherapeutic counseling. DMHAS relied on an estimate from the American Association of Geriatric Psychiatry that 20% of people age 55 years or older experience some type of mental health concern. DMHAS also relied on the National Council on Aging which indicated that fewer than 50% of older adults with mental and/or substance use disorders receive treatment.

DMHAS and the Division of Behavioral Health Services (DBHS) are jointly conducting a performance improvement project for Older Adults looking at strategies to enhance, identify and provide training and discharge resources needed to facilitate the discharge of older adult patients at the state psychiatric hospitals.

-Coordinated Specialty Care (CSC), Coordinated Specialty Care, Community Integration (CSC CI). It was estimated at the incidence of FEP in adult populations 15-29 is 86 per 100,000¹. Three out of 100 people will experience psychosis at some time in their lives². It also was estimated that the lifetime prevalence of bipolar disorder 1 is .24% and major depressive disorder is .35%. In New Jersey, the CSC program was identified as an effective treatment, allowing individuals with FEP to live, work, learn, and socialize in the communities in which they live. Since inception, New Jersey's CSC program has received over 1,290 referrals and served 668 clients. The high

demand for service prompted an expansion of services for each provider from a caseload of 35 clients to 70 clients with two of the centers currently operating in excess of the expected caseload. In addition, DMHAS meets with the CSC teams on a monthly basis and gathers information that provided an assessment of unmet needs and critical gaps regarding individuals served.

-Individuals in Need of Behavioral Health Crisis Services

Since the State's transition to 988 on July 16, 2022, New Jersey has identified an increased need for crisis services as demonstrated by a steady increase in call, text and chat demand to 988. Comparing data from the first year of transition (July 2022 – June 2023) to data for year two (July 2023 – June 2024), New Jersey has seen an approximately 35% increase in the average number of calls received per month. Between 2022 and 2023, the 988 Lifeline experienced a 65% increase in text demand from New Jersey-based phone numbers. In the first year of 988, in-state demand for chats rose by approximately 50%. Comparing 2022 and 2023 data, in-state chat demand has remained fairly consistent with a slight decrease of 8%. In the first two years of 988, New Jersey is averaging a 79% in-state call answer rate and is providing an in-state response to 58% of the chats and texts routed to New Jersey-based centers. NJ DMHAS continues to monitor 988 contact demand and answer rates to assess the statewide need for this crisis service.

National 988 quality improvement efforts are currently the responsibility of the 988 Lifeline Network Administrator, Vibrant Emotional Health (Vibrant). Lifeline centers have direct contracts with Vibrant to uphold quality standards. Centers that fall below established standards work directly with the Network Administrator to mitigate concerns in a timely manner. Vibrant and the centers are responsible for contacting NJ DMHAS if a center's performance falls outside of the acceptable range.

All Lifeline centers also have direct contracts with NJ DMHAS for the provision of in-state 988 services. Each Lifeline center is responsible for submitting monthly and ad hoc data reports to NJ DMHAS which include key performance indicators. DMHAS key performance metrics include primary presenting concern, demographics, disposition, and response data including emergency rescue or contacts resulting in a mobile crisis outreach response referral.

Calls, chats and texts come into the 988 Lifeline crisis center network from across the United States and its territories. They are routed to independently operated contact centers based on georouting at the national level or by the contact's area code (as indicated by the telephone number from which the contact originates). Once an individual reaches a Lifeline center, it is determined by a trained crisis counselor whether the individual needs urgent in-person assistance. If they do, the crisis counselor will request dispatch of emergency services which, for some time in New Jersey, included a Designated Screening Center (to assess for involuntary 988 Mobile Crisis Outreach Response Teams- 5 commitment), law enforcement, emergency medical services or other first responders. Nationally, only 1-2% of crisis contacts have required such an outreach. New Jersey therefore required a new, statewide, 24/7 Mobile Crisis Outreach Response system that would respond to non-life-threatening mental health, substance use or suicidal emergencies without emergency personnel when it is determined to be safe to do so.

For the 988 MCORT program, NJ DMHAS monitors outreach metrics through the state-required database to be used by all MCORT provider agencies. Through this database, NJ DMHAS is able to review key performance metrics and general outreach data such as response times, outcomes, referrals provided, dispatch arrival times, dispatches resolved or requiring further service involvement, number of contacts requiring follow-up, and average number of individuals served per shift.

DMHAS psychiatric emergency screening (PES) data reveals that less than 40% of the individuals who present to the Emergency Department (ED) in psychiatric crisis require inpatient treatment. In addition, SAMHSA concluded that too often, the treatment of psychiatric emergencies was delayed, or denied, which created "undue burdens" on individuals with SMI, first responders, emergency departments and justice systems. Finally, DMHAS conducted an assessment of need utilizing designated screening data, emergency room data, affiliated emergency services data, and state hospital data to determine the need for, a number of recliners for mental health and SUD in Crisis Receiving Stabilization Centers (CRSCs). CRSC were identified as the alternative to traditional crisis services by diverting individuals from going to EDs and inpatient treatment when community-based alternatives would better meet the needs of individuals experiencing a behavioral health crisis.

-Individuals with SMI or SED in Rural Areas

The SMHA defines a county as “rural” if, according to U.S. Census figures, 25% or more of its population live 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. A New Jersey community is considered rural if it has a population density of less than 500 people per square mile. According to USA.com, NJ population density rank, there are 60 cities out of 545, that have a population density less than 500/square mile. Ensuring access to services in rural or remote areas can be challenging. DMHAS provides many levels of care statewide. For services that are not offered in every county DMHAS has begun to look at the need for services in other counties. For example, there were 3 CSC programs providing services to 7 counties each. DMHAS evaluated the data submitted by the providers and identified an unmet need in surrounding counties, most notably the counties to the northwest (Sussex, Hunterdon, and Warren) and to the south (Atlantic, Cumberland, and Cape May). This illustrates another example of how data is used to identify and address unmet needs.

-Children with SED and families

The summary of the CSOC strengths as well as unmet service needs and gaps within the current system of care is based on data from the following sources of information:

- Department of Children and Families Strategic Plan
- DCF Commissioner’s Dashboard
- CSOC Child and Youth Behavioral Electronic Record (CYBER) Data Collection and Reports

- CSOC Internal Data Collection and Reports
- DCF Internal Data Collection and Reports
- CSOC Youth Services Survey for Families
- Monthly statewide system partner meetings (CMO, FSO, JJC)
- County-based Children's Inter-Agency Coordinating Council (CIACC) meetings
- Bi-Annual Needs Assessments submitted by the HSACs
- CIACC Dashboard
- Traumatic Loss Coalition for Youth Program Reports
- New Jersey Kids Count – The State of Our Children, Advocates for Children of New Jersey
- New Jersey Student Health Survey
- Robert Wood Johnson Foundation County Health Rankings and Roadmaps
- SAMHSA National Study on Drug Use and Health
- CSC Youth Risk Behavioral Surveillance System

To operationalize the DCF vision of ensuring New Jersey children and families are safe, healthy, and connected, the Department of Children and Families has established a Strategic Plan to best align the priorities of CSOC with the DCF vision and values. The Strategic Plan identifies the following CSOC priorities:

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

-Data Sources - The SMHA has steadily improved its capacity to organize mental health promotion initiatives utilizing prevalence estimates and epidemiological analyses at the state and county levels. The data sources SMHA will continue to utilize in driving the planning for the prevention and mental health promotion initiatives include:

- DMHAS internal data systems such as Quarterly Contract Monitoring Report (QCMR), Beds Enrollment Database (BEDS), Unified Services Transaction Form (USTF) database, Systems Review Committee (SRC) Data, and the State Hospital Database.
- Data obtained from different mental health community programs funded by DMHAS.
- SMHA Consumer Perception of Care Survey
- Other State and National Data Sets
 - Demographic Data from the US Census Bureau.
 - SAMHSA's New Jersey Behavioral Health Barometer.
 - SAMHSA's Uniform Reporting System (URS) Data Tables.
 - Annual Demographic Profiles summarized by New Jersey Department of Labor and Workforce Development based upon Census 2020, Intercensal Population Estimates, and Population projection estimates by the U.S. Census Bureau.
 - New Jersey State Health Annual Assessment Data, Center for Health Statistics, New Jersey Department of Health (DOH).

- The New Jersey Violent Death Reporting System (NJVDRS), a CDC-funded surveillance system, which records suicide (with known circumstances).
- CDC-funded New Jersey Behavioral Risk Factor Survey, in which mental health modules were implemented (Depression and Anxiety Module, 2010 and 2011; and Mental Illness and Stigma Module, 2012, 2013, 2014 and 2017). The SMHA funded the collection of Mental Illness and Stigma Module in NJBRFS in 2014.
- New Jersey DOH Uniform Billing data which show hospital and emergency room use by demographic factors.
- New Jersey DOH Healthcare Facility Licensing data, with which occupancy rates for psychiatric beds in general hospitals are calculated.
- New Jersey State Health Assessment Data (NJSHAD) which provides access to health status data of individuals in NJ, including emergency department and inpatient admissions by diagnosis code and age.

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 approximately 100 separate agencies on 24 different program elements for roughly 630 separate sub-program elements (e.g., a specific program element, run by specific agency and specific site) on a quarterly basis.

Of these 24 programs elements, 23 are included in the web-based QCMR portal. These 23 programs consist of Acute Intensive Family Support Services, Community Advocates / POST, Designated Screening Centers, Early Intervention Support Services, Affiliated Emergency Services, Integrated Case Management, Intensive Family Support Services, Intensive Outpatient Treatment & Support Services, Legal Services, Outpatient, Services of the homeless, Partial Care, Residential Services, Consumer Operated Wellness Centers/Self Help Centers, Career Services/Supported Employment, Community Support Services, Supported Education, Involuntary Outpatient Commitment Services, Coordinated Specialty Care Community Integration - CSC/CI, Mobile Crisis Outreach Response Teams, Crisis Diversion Homes and Crisis Receiving Stabilization Centers

The one program not currently captured by the web-based portal is, Projects for Assistance in Transition from Homelessness which is collected by New Jersey Housing and Mortgage Finance Agency (HMFA) in the Homeless Management Information System (HMIS) and shared with DMHAS. Data for this program is collected separately and updated by DMHAS. As new program elements are added, new QCMRs are developed. DMHAS collaborates with program coordinators and database programmers to add each of these program elements into the QCMR portal, allowing for standardized and automated data collection and reporting of all DMHAS-funded programs.

The QCMR historically emphasized program-level data, but as the QCMR data field layouts change over time, increasing numbers of data points related to aggregate consumer outcomes have been included. The QCMR does not collect client level data. The QCMR provides essential data

for many routine reports generated by the SMHA including: DMHAS Evaluation data table for URS reporting of numbers served by program, annual Budget Briefing reports, and planning resources for the annual Consumer Perception of Care Survey. In addition, the QCMR provides reliable information for the majority of ad-hoc reports created by the Division, specifically around the topics of utilization management, provider performance and the geographic distribution of available services.

-Unified Services Transaction Form (USTF) Legacy Database

The USTF database was an electronic client level registry originally developed in 1978 (revised in SFY 1990 and last upgraded in 2000). It was an Access desktop application which was used by all MH providers who submit their files to DMHAS each quarter. In SFY 2022, there were over 500,000 records—with each record containing the potential for over 50 separate data fields. USTF was last utilized for reporting SFY 2022 data and the data for the 2022 URS data tables.

-USTF+ Client Level Web-based Application.

In the Spring of 2020, the SMHA renewed construction of its updated USTF system. Meanwhile, DMHAS started to design and implement a secure, web-based comprehensive client registry and client-level data (CLD) system. Phase 1 of the USTF+ was rolled out in FY 2022, and was the “staging environment” (e.g., the trial/practice version of the application where functionality and user interface were tested and evaluated) in iterative stages – initially to a small number of pilot agencies and later, to the group of the 60+ providers whom the SMHA works with. That version of the USTF+ consisted of updated versions of current fields as well as new data elements that will satisfy federal CLD guidelines and evolving needs for data-driven understanding of populations served by the SMHA. Upon satisfactory testing of the system on a pilot basis in the Summer/Fall of 2022, the SMHA launched a series of nine statewide videoconferences in late 2022 to demonstrate its entire provider community on the use of the new system. Over 400 representatives/staff members from community-based provider agencies participated in these video conferences.

USTF+ system was completed and released to production on July 5, 2023. DMHAS provided the opportunity for providers to do a one-time upload of their current active caseload or to enter their information manually. DMHAS issued a correspondence to each provider in mid-July informing them that DMHAS would provide them with one time funding to help them with entering the data into the new application. At the same time, DMHAS issued credentials to each provider for an Administrator at their site who would in turn create and maintain the credentials for their agency.

The development of USTF+ was essential due to four key imperatives: 1. to streamline reporting from DMHAS providers eliminating duplication of reporting, 2. to manage the transition of DMHAS to outcomes reporting, 3. to provide the public with more “forward facing” online performance data, and 4. to satisfy federal mandates of SAMHSA—including reporting of data required by the Community Mental Health Services Block Grant (CMHBG), Mental Health National Outcome Measures (NOMS), and Client-Level Data.

The USTF+ data system is already helping to facilitate the reporting of URS Data tables and Client Level NOMS, as well as significantly improve the quality of ad hoc reporting and production of data dashboards. In addition to the reporting mentioned above, the SMHA will be including evidence-based assessment tools in the CLD such as the WHODAS. T1/T2 client level outcomes (e.g., changes in educational achievement, employment and involvement with recidivism) have been built into the system. Program level outcomes (including outcomes from SAMHSA's evidence-based toolkits) are planned for future phases of the USTF+. The CLD will enable the SMHA to provide data dashboards for provider agencies as well as the SMHA senior leadership to drive planning and evaluate programs. It will allow the SMHA to collect detailed data to help determine unmet needs. The goal is for the USTF+ 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) Legacy data system, the Quarterly Contract Monitoring Report (QCMR), and the Systems Review Committee (SRC) data system), thus decreasing duplication of data entry, 2. provide fine-grained utilization management data that allows the Division to drill down to service use at the program level, the agency level, the county level and the client level, 3. document consumer outcome measures to evaluate program (and provider) effectiveness, and 4. provide users with reliable and meaningful data to drive and inform decision-making. With the ability to utilize encounter data from Medicaid and NJMHAPP combined, along with the data from the USTF+ CLD (client level of functioning, quality of life measures, etc.), the SMHA will be able to gauge the impact of services, Medicaid penetration rates, etc. The SMHA will be able to significantly enhance its planning efforts and capacity for data informed decision making once the system has been fully programmed. DMHAS rolled out the first phase and has been updating the data system at least twice a year to improve functioning and user experience. The USTF+ data will be critical data when preparing a comprehensive need assessment including county-based needs, barriers, critical gaps, and reporting on statutory populations.

Since the launch of USTF+, DMHAS has expanded the USTF+ to include additional programs, including Designated Screening Centers (DSC), Short Term Care Facilities (STCFs), Mobile Crisis Outreach Response Teams (MCORT), Coordinated Specialty Care Community Integration (CSC-CI), Peer Crisis Respite (PCR), Crisis Receiving Stabilization Centers (CRSC) and Crisis Homes (CH) bringing the total number of program elements included in the system to twenty-six.

Other system improvements include the addition of client outcomes reporting (“T1/T2”) and specialized reporting for individuals in CSC-CI, CRSC, improved Help Ticket processing functionality, updated program compatibility, and improved client search functions to enhance coordination of care among system users.

Accompanying the development, testing and roll-out of the USTF+ and its subsequent updates have been provider outreach and support, which take myriad forms.

Educational Materials for the User Community have been created and remain in regular production, including the following:

- A 62-page “Provider User Guide Document”. The comprehensive user manual complete with screenshots, and step-by-step instructions on performing all required functions in the USTF+ system (produced by DMHAS OIS). This is available through the USTF+ website itself and is frequently sent directly to providers by the Office of Planning Research Evaluation Prevention and Olmstead (OPREPO) staff.
- Quarterly “On the + Side” USTF+ newsletters produced by OPREPO and distributed to all registered users of the USTF+ system to announce system upgrades, user support and helpful reminders.
- Three how-to/system demonstration YouTube videos – over 100 minutes of content on how to use the USTF+ system (produced by DMHAS OIS).

Help Ticket Resolution: In FY 2025, USTF+ users have created 2,634 USTF+ help tickets, of those 94.6%, 2,492 Help Tickets have been successfully resolved by a joint effort of OPREPO and OIS staff. The remainder of the Help tickets are new and/or are in process of being resolved.

Direct Assistance to Providers: To support the agency users of the USTF+ system, OPREPO’s USTF+ Team and OIS staff have engaged in thousands of emails and phone calls with agency staff. Such communications are conducted to resolve technical issues that were not submitted via the Help Ticket system, respond to ad-hoc user questions, and provide access support. DMHAS makes a commitment to providing all users with positive, friendly and collegial provider support from OPEPO staff members, whose mantra in working with providers is “we want to set you up for success”.

Two Listserv accounts have been created, one for all USTF+ users and one for USTF+ provider admins, to ensure quick communication to all users.

Live training sessions have been conducted by OPREPO staff in over 20 separate, live, USTF+ training events for the provider community. Including: Large scale videoconferences with multiple provider agencies as well as small group sessions. More will be conducted in the future—conducted by request and often at the suggestion/invitation of OPREPO staff.

Over 600 staff members from over 100 agencies have participated in / received training in the large-group, live trainings.

Provider Admin Monthly Meetings: Starting in fall of 2024, monthly meetings have been occurring with provider administrators of the USTF+ system. These meetings serve as a way to engage system administrators, have them take ownership of their data, and encourage questions and comments about utilizing the system. These meetings are typically attended by 40+ providers with 50-100 participants.

-Systems Review Committee (SRC) Datasets. SRC are a series of linked MS-Excel documents submitted monthly from 24 Short Term Care Facilities (STCFs) and 23 Designated Screening Centers (DSCs). By regulation, SRC data is collected and reviewed monthly by localized county specific committees comprised of acute care providers and governmental staff. These SRC

processes include review of trends related to volume, capacity, referral patterns, system flow, length of stay and disposition. The SRC dataset provides program/agency-specific data that is the aggregate of each program's consumers served within a given month. The conversion of the SRC data submission files (from STCF and DSC provider agencies) into single 'flat files' has improved the ability of DMHAS staff to efficiently and accurately query SRC data. DMHAS is planning to incorporate the SRC into the USTF+ web-based application, eliminating duplication of data submission from SRC providers and enhancing the completeness of the SRC data.

-State Hospital Database. The State Hospital database is the central information system for storing client-specific records on consumers admitted into New Jersey's three regional inpatient adult psychiatric state hospitals and one forensic state psychiatric hospital. To keep up with the flow of consumers entering, and exiting the state hospitals, this data is updated on a daily basis by hospital personnel. The scalable nature of the database provided the opportunity to add additional data items such as the "Individual Needs for Discharge Assessment" which is designed to identify discharge barriers as early as possible during the course of hospitalization. The INDA is first administered within seven days of admission and subsequently updated every 30 days, so that successful community integration can be addressed in advance of discharge readiness. Although the state hospital data 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. The state hospital data provides admission, discharge and census data, as well as demographic data, civil commitment status, length of stay data, readmission data, etc.

In addition to canned reports that are available in the system, DMHAS has the ability to access the data and can prepare reports. DMHAS has developed several reports and data dashboards that have been shared with the Division of Behavioral Health Services and reviewed with DBHS on a regular basis. The state hospital data allows for hospital and central office users to summarize and examine hospital census data in an aggregated and/or snapshot view of individuals served each year. The database is used by DMHAS for utilization management; Olmstead monitoring, planning and evaluation; and reporting of data for the URS data tables. DMHAS and DBHS have been meeting to discuss report queries, data definitions, and cadence of reports to ensure that the reports that are generated by each Division in the course of business operations and that these reports closely align and utilize the same parameters and same data definitions. DMHAS and DBHS utilize these reports for collaborative performance improvement projects.

-New Jersey Mental Health Application for Payment Processing (NJMHAPP). New Jersey Mental Health Application for Payment Processing (NJMHAPP) allows agencies contracted with DMHAS for mental health services to submit eligible encounters/billing for all fee for service (FFS) programs for payment processing. It does not replace other contractually obligated data requirements by DMHAS such as QCMR and USTF. NJMHAPP will only be accessed for services that are NOT covered by Medicaid or other insurance since the state is the payer of last resort

-Beds Enrollment Database (BEDS). Since 2015 the SMHA has been utilizing a secure, reliable web-based system (BEDS) to provide real-time access to vacancy information, which helps to facilitate assignments, in a more streamlined manner, and facilitate better communication with state psychiatric hospitals. This system was created to facilitate the assignment of consumers from state psychiatric hospitals into safe and appropriate community-based residential settings,

in accordance with¹~~OBJ~~²~~OBJ~~³~~OBJ~~. Analysis of the utilization of independent (e.g., Community Support Services) and supervised settings (e.g., group homes and supervised apartments) allows for assessment of the Division's progress toward community integration. The system also enables planning at both the individual consumer level for placement purposes and system-wide for purposes of enhancements in community resources. In recent years BEDS has been enhanced to include short-term care facility (STCF), enhanced reporting functionality, and streamlined search features, to give the SMHA a better view of both community-based residential resources and the acute care system. As of early August 2025, BEDS contains detailed data for over 5,100 residential beds, CSS slots and STCF beds.

-Provider Weekly Reports (PWRs). DMHAS Olmstead and Diversion Office facilitated a performance improvement initiative in 2019 designed to facilitate hospital discharges and diversions from admissions; decrease the current length of time to place state hospital clients into residential beds; identify complex issues impacting discharges from a state hospital; and provide a mechanism to gather information on agency capacity, census, vacancy, and specific information on pending assignments, including barriers to discharge. The performance improvement initiative was a collaborative effort with the State Psychiatric Hospitals, DMHAS Office of Community Services, DMHAS of Housing, and DMHAS funded providers. The Provider Weekly Report was developed as a result of this performance improvement initiative. The report contains information that is not included in the current BEDS system and assists with tracking and following up of referrals as weekly updates from agencies are provided which assists the Olmstead/Diversion office with following up on those referrals that require assistance. A significant number of providers submit the PWRs on a weekly basis. The compliance from January 2025 through July 2025 averaged 97.6% and the median was 98.1% in terms of submission of the PWRs. Reports are due on Thursdays of each week and if a report is not submitted, the DMHAS Olmstead staff will contact the provider with a reminder and obtain the missing PWR.

-Web-based Electronic Referral System - Crisis Management Module

DMHAS is looking to replace its current BEDS database with a new comprehensive online, statewide, database and referral tool for a broad continuum of services that go beyond beds or residential placements and include DMHAS services slots including acute care, outpatient services, recovery supports, and other community-based services and supports along the DMHAS continuum of care for individuals with behavioral health needs in NJ. The DMHAS anticipates starting with acute care services, as the implementation of 988 necessitates having a system in place to make referrals, including referrals from the crisis call centers and Mobile Crisis Outreach Teams (MCORTS). The web-based enabled system will be rolled out in phases. As other care components are added, the solution will be designed to expand to accommodate additional services, resources and functionality. In addition to being used for the 988 system, subsequent phases will incorporate the full array of contracted and licensed behavioral health services.

¹ <https://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4509>

² http://www.nj.gov/humanservices/dmhas/initiatives/olmstead/olmstead_settlement_agreement.pdf

³ http://www.state.nj.us/humanservices/dmhas/regulations/bulletins/Mental%20Health/5_11.pdf

Effective 3/3/2025, the Crisis Module went live and included a real-time connection between crisis call center professionals, the Carelon Managing Entity, and mobile crisis response teams. Prospectively, functionality will include crisis stabilization services and community treatment providers.

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

The web-based application will have the ability to search for services using various criteria, real-time facility availability, and two-way digital communication. The system will provide the ability to create and send a digital referral to a facility based on service need, payment type, particular needs, geographic location, and other criteria. The system will provide for the ability to close the loop on referrals and obtain feedback regarding treatment engagement and outcomes using secure messaging. The data system will maintain information and communications on community and hospital referrals and provides the information needed to monitor referrals and intervene to facilitate placement and linkages to services. The ability to manage behavioral health bed vacancies and ongoing referral communications in one system allows for timely response and efficiently managing diversionary efforts. The electronic registry will assist in diverting admissions from emergency rooms and inpatient settings including state hospitals. The electronic registry is necessary to enhance movement along the continuum. The data system will foster a continuum of community-based care that meets the needs of the individual where they live. The solution will include the ability track various metrics.

-Consumer Perception of Care Survey. Since 2011, the SMHA Consumer Perception of Care Surveys have been distributed in the summer/fall of each year to a representative sample of adult

consumers of all community-based, non-acute programs.⁴ The survey results are reported in the annual CMHBG Implementation Report. An unmodified version of the Mental Health Statistics Improvement Program (MHSIP) Adult Survey (Draft Version 1.2, February 17, 2006)⁵ is used as the survey instrument, with the addition of ten questions related to primary health, from the Behavioral Risk Factor Surveillance System (BRFSS) survey.⁶ Each non-acute mental health program contracted by the SMHA, has served as sampling stratum. Agency program coordinators are instructed by the SMHA on techniques of random sampling and systematic error mitigation. 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 2024 the average General Satisfaction score was 97.8%.

The 2020 Consumer Perception of Care Survey was not expedited due to reasons directly related to the Covid-19 global pandemic/State emergency (e.g., clients receiving services via telehealth and not onsite at the provider agency where the surveys are usually distributed, and workflow disruptions at the SMHA).

Following the pandemic, the SFY 2021 Survey of Adult Mental Health Perception of Care was undertaken (for the first time) using an electronic platform (e.g., SurveyMonkey), rather than the more cumbersome (and expensive) paper format. Consumer engagement in that SFY2021 survey was high (over 750 questionnaires were received) of which 92% (+/-5.4%) respondents reported positively about general satisfaction with services (URS Data Table 11). The subsequent survey in SFY22 was again conducted via the same electronic platform and yielded an increased satisfaction rate (97% +/-6%). In SFY 2023 the general satisfaction rate was 98.3%, with a response rate of 19.6%. In SFY 2024 the general satisfaction rate was 98.4%, with a response rate of 24.9%.

-Coordinated Specialty Care Client Level Data System. DMHAS has a data collection tool to capture demographic and outcome data elements. This manual data collection system for CSC CI will no longer be utilized once all of the program outcomes specific to CLD are added to the new USTF+. Currently the data is collected every three months and analyzed to track the progress of CSC clients who have received services. Client measures include client referral source; age; male/female;; psychiatric and medical hospitalizations; psychotropic medication adherence; co-occurring substance use disorder; discharge and re-admission; insurance status; language, and global functioning using the MIRECC GAF scale. In addition to the CSC data spreadsheet, CSC

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>

programs submit a quarterly progress report to DMHAS. The quarterly progress report outlines community outreach progress and any questions regarding the client service model, recommendations, and client referral demographic data. The new web-based USTF+ CLD system includes a program-specific module for CSC CI CLD which provides assessment scale/scores including MIRECC, CGI (optional), BPRS, ACES, PHQ-9, MDQ, as well as psychotropic medication adherence, inpatient hospitalization and designated screening visit history while enrolled in the program. These new features are anticipated to functional in the Fall of 2025. Trainings on these features will commence shortly after. DMHAS anticipates having a full year of data for SFY 2027.

The QCMR collects data which provides information specific to the CSC program as well as the step down or Community Integration (CI program). Additionally, the QCMR provides information for individuals admitted to, discharged from and caseloads for First Episode Psychosis (FEP) and Affective Psychosis. Individuals served and units of service are also monitored, as well as payer mix and staffing ratios.

-Crisis Receiving Stabilization Centers (CRSCs)

The new web-based USTF+ CLD system includes a program-specific module for CRSC CLD which provides admission time of the day, arrival type (first responder drop offs and walk-ins, length of time for drop off) diagnoses for primary assessment mental health and SUD, one-on-one supervision, follow-up visit to outpatient programs after completion of CRSC (within next business day, within 7 days and post 7 days). These new features are anticipated to functional in the Fall of 2025. Trainings on these features will commence shortly after. DMHAS anticipates having a full year of data for SFY 2027.

The QCMR collects data which provides information specific to CRSC, including referrals, post-discharge contacts, referral source, follow up appointments, length of stay, medication-assisted treatment and contracted staffing. DMHAS follows the SAMHSA guidance to develop data capture tools to measure outcomes.

-Other Statewide and Nationwide Data Sets

The SMHA uses several independent datasets, alongside national and statewide datasets to shed light on goals, priorities and success. Specifically, this constellation of datasets is most commonly used to identify counties that are most appropriate (in terms of need and access to mental health services) for new community services and Requests for Proposals (RFPs). Additional statewide and county-specific data is obtained from the US Census Bureau (e.g. <https://www.census.gov/acs/www/data/data-tables-and-tools/data-profiles/>) to inform comparisons of population density, residential characteristics, unemployment rate, age

distribution, household income, poverty levels and other factors helpful in determining need. The NJ Jersey Department of Labor and Workforce Development also generates important economic and employment data (https://www.nj.gov/labor/lpa/employ/uirate/lfest_index.html) which is often used by the SMHA in making inter-county comparisons of economic need. Data on crime statistics in New Jersey is compiled by the NJ State Police, and its reports (<https://www.njsp.org/ucr/crime-reports.shtml>) are utilized by the SMHA in obtaining a clear picture of county stressors and crime rates. In addition, the SMHA utilizes publicly available state population health information from the NJ State Health Assessment Data (NJ-SHAD) <https://www-doh.nj.gov/doh-shad/> which provides community profiles and dataset queries.

National data is often examined by the SMHA to shed light on New Jersey mental health efforts, relative to similar states. SAMSHA, through its compilation of Behavioral Health Barometer ([Behavioral Health Barometer: New Jersey, Volume 6 \(samhsa.gov\)](https://www.samhsa.gov/behavioral-health-barometer)) and URS data tables, and state level detail reports provide useful information in this regard [2024 Uniform Reporting System \(URS\) Table For New Jersey | CBHSQ Data](#)). 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/>).

SSA

Please see attached file for further information for the SSA.

II. Unmet Needs and Critical Gaps and How to Meet the Identified Unmet Service Needs and Gaps

-Adults with SMI

The SMHA continues to maintain and expand its network of community providers. In addition, DMHAS reviews and reassesses mental health contracts to ensure provider agencies have appropriate funding ceilings and service commitments so the SMI population in each of the state's counties has access to various levels of services. Unmet needs were identified as psychiatric staffing and wait times, due in significant part by psychiatric staffing shortages. Specifically, agencies reported difficulty filling staff positions and increased salary demands.

-Homeless Adults

The most critical gaps and unmet needs identified by PATH providers are lack of a sufficient number to satisfy increased need for: 1) shelters and shelter beds, rooming and boarding homes, safe transitional/emergency housing; 2) affordable, safe, permanent housing; 3) supportive housing resources and group homes; and 4) housing subsidies. The utilization of community support services with subsidies has been beneficial in providing rehabilitative services to individuals coming out of state and county hospitals and being integrated into the community.

Additional unmet needs include: tenancy start-up costs (such as security deposits and utilities); financial resources for individuals who have reached their maximum allowable time on General

Assistance or who do not otherwise meet the criteria for General Assistance, such as those with SSI/SSDI benefits; delays in approval for benefits from the Board of Social Services; and obtaining medications for those persons without health insurance.

-Older Adults

The American Association of Geriatric Psychiatry states, “It is estimated that 20% of people age 55 years or older experience some type of mental health concern”. However, the National Council on Aging indicated that fewer than 50% of older adults with mental and/or substance use disorders receive treatment. Based on local survey data by the Mental Health Association in New Jersey on wait times, regional considerations, and applications received, DMHAS determined there were unmet needs of older adults aged 55 years of age and older, in three New Jersey counties (Burlington, Sussex and Union) for outpatient services.

-ESMI Coordinated Specialty Care

From meeting with CSC providers over the years, providers indicated that they were in need of the ability to serve individuals who presented with affective psychosis as well as individuals in need of step-down from the CSC. At that time, affective psychosis was not part of the admission criteria for our early psychosis programs, nor did DMHAS have a step-down program.

-Individuals in Need of Behavioral Health Crisis Services

988 Lifeline center answer rate data revealed the need to increase capacity at our 988 contact centers to meet the in-state demand. Per the above needs assessment, NJ 988 has seen a consistent increase in call, chat and text demand since its launch in July of 2022. Standards set forth by SAMHSA and the 988 Network Administrator outline that each state is expected to achieve and maintain a 90% in-state answer rate for calls, chats and texts. While NJ 988 has continued to increase the number of contacts answered, the state continues to fall short of the 90% expectation. As a result, contacts that are not answered in-state are routed to the national backup network where localized care cannot be achieved.

NJ 988 MCORT utilization data to date reveals a need to expand awareness and community trust related to this service.

The evaluation of screening center and hospital data revealed unmet needs for a full continuum of crisis stabilization services in the community. In keeping with SAMHSA’s National Guidelines for Behavioral Crisis Care, DMHAS identified the need to implement the third pillar of the toolkit, A Place to Go. Therefore, the assessment identified the need for community-based crisis receiving stabilization centers to further enhance DMHAS’ diversionary efforts in its existing crisis continuum.

-Individuals with SMI or SED in Rural Areas

DMHAS identified gaps in services for individuals in rural areas from the data that was reviewed. One of the gaps identified was a need to increase access to services for individuals in Atlantic, Cumberland, Cape May, Sussex, Hunterdon and Warren Counties.

-Children with SED and Families/Youth with SED in Rural Communities/Youth with SED Experiencing Homelessness

CSOC acknowledges gaps and unmet service needs within the current system of care and has identified activities to address them. The system infrastructure includes a full continuum of services and supports embedded in every region of the state, aligned with court vicinages, that allows for the development of robust local cross system partnerships (e.g., schools, faith-based organizations) to ensure access and engagement in needed services. For youth with SED, each region includes a Care Management Organization (CMO) designed to provide intensive care management services to youth with moderate to high level behavioral health needs. There are Care Management Organizations that provide services in all 21 New Jersey's counties including designated rural counties (Salem, Sussex, Warren, Cumberland, Atlantic and Cape May).

-Unmet Needs and Critical 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 contexts – as specified within a recognized diagnostic classification system (e.g., most recent editions of DSM, ICD, etc.), and (2) display functional impairment, as determined by a standardized measure that impedes progress towards recovery and substantially interferes with or limits the person's role or functioning in family, school, employment, relationships, or community activities.

Prevalence: According to the Federal methodology proposed for estimating the prevalence of SMI, the proportion of adults within the state with SMI is 5.4% (Federal Register, Volume 64, No. 121, p. 33890)⁷.

According to figures released by the United States Census Bureau, the 2024 adult population of New Jersey was 7,448,667. The size of the New Jersey child population was 2,052,184. 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 2024 was 402,228. Using the upper SMI limit of 7.1%, the estimated number of adults with SMI in New Jersey in 2024 was 528,855. Accordingly, using the lower SMI limit of 3.7%, the estimated number of SMI adults in New Jersey in 2024 was 275,600. (Table is uploaded as a separate document).

Estimates of SMI, SED, and General Population of New Jersey, 2010, 2011, 2016, 2018, 2020, 2022, and 2024

Year	Total Adult Population	Total Adult SMI (5.4%)	Adult SMI Lower Limit of Estimate (3.70%)	Adult SMI Upper Limit of Estimate (7.10%)	Total Children	Total Children SED (8%)	Total New Jersey Population

⁷ <https://www.gpo.gov/fdsys/pkg/FR-1999-06-24/html/99-15377.htm>

2010	6,726,680	363,241	248,887	477,594	2,065,214	165,217	8,791,894
2011	6,778,345	366,031	250,799	481,263	2,042,810	163,425	8,821,155
2016	6,959,717	375,825	257,510	494,140	1,984,752	158,780	8,944,469
2018	6,948,646	375,227	257,100	493,354	1,528,702	122,296	8,477,348
2020	6,947,836	375,183	257,070	493,296	1,934,535	154,763	8,882,371
2022	7,275,144	392,858	269,180	516,535	1,992,555	159,404	9,261,699
2024	7,448,667	402,228	275,600	528,855	2,052,184	164,175	9,500,851

According to URS Table 2a, a total of 80,022 unduplicated persons ages 18 and over received services in programs provided or funded by the SMHA in FY 2024. The SMHA served 30,098 unduplicated adults with SMI (refer to URS data table 14a) in FY 2024. That was 7.48% of the total estimated adults with SMI in New Jersey (402,228). It is noteworthy that DMHAS has transitioned to the USTF+ data system as mentioned previously continue to provide monitor the data and provide technical assistance where needed. The QCMR provides duplicated data where an individual can be enrolled in a program, be discharged, and then be readmitted during the same year or an individual may be in one program and also in another program as long as they are not mutually exclusive. The QCMR data reveals that there were 270,263 individuals served in SFY 2024, of that total, 251,501 were 18 and older. Additionally, according to the DMHAS NJMHAPP data for SFY 2024, there were 13,130 individuals served in the Division's FFS programs, and of those individuals served, there were 6,810 SMI unduplicated individuals served, and 7,310 Duplicated individuals served.

Also shown in URS data table 14a, out of the total 30,098 unduplicated adults with SMI served by the SMHA in FY 2024, 14,693 (48.8%) were ethnic minorities (and those who did not report a racial affiliation). The SMHA will be re-evaluating the data once there is sufficient data in the new USTF+ application.

Persons who are SMI are the statutory population for SMHA funded services. The SMHA also prioritizes services to individuals with SMI who meet the criteria for first episode psychosis, as well as individuals with SMI in need of crisis intervention and stabilization services. However, the SMHA also prioritizes services to with access needs, including older adults, individuals with co-occurring mental health and substance use disorders, hearing impairment, and developmental disabilities. 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. The Planning Council identified several broad areas of interest for improvement: access to care (which may be impeded by licensing requirements and staffing issues), housing (which is chronically in short supply in the state), increasing peer support services, re-entry of formerly incarcerated

individuals with SMI challenges, integration within and to the children's behavioral health system, and the ability of older adults to navigate the community mental health system.

-Homeless Adults

The SMHA is the recipient of the federally funded PATH program, which is matched with state funding. The SMHA contracts with 25 non-profit agencies to operate PATH programs within the state's 21 counties. The statutory population is homeless adults or those at risk of homelessness who have a serious mental illness, including those with co-occurring substance use disorders who are not currently engaged in and are resistant to mental health and other community support services. Programs for homeless adults are described in Planning Step 1 under Criterion 4.

The most critical gaps and unmet needs identified by PATH providers are: 1) lack of shelters and shelter beds, rooming and boarding homes, safe transitional/emergency housing. 2) lack of available affordable, safe, permanent housing; 3) limited supportive housing resources and group homes accepting referrals from the community. 4) lack of housing subsidies and housing programs, especially for persons who are not chronically homeless, or who have criminal backgrounds for distribution or Meghan's Law.

PATH funds cannot be used to support emergency shelters. The SMHA has created some housing for the population at risk for homelessness, but sustained efforts are needed to combat the housing problem. In 2019 and 2020, the Governor expanded housing for individuals with a substance use disorder and mental illness through the provision of state dollars under the Governor's Opioid Funding Initiative.

Unmet needs include subsidies do not cover utilities; lack of financial/emergency assistance for persons who have reached their maximum allowable time on General Assistance or who do not otherwise meet the criteria for General Assistance, such as those with SSI/SSDI benefits; delays in approval for benefits from the Board of Social Services; long wait time to see a psychiatrist; obtaining medications for those persons without health insurance; availability of inpatient integrated treatment for persons with co-occurring mental illness and substance use disorder; public transportation.

-ESMI Coordinated Specialty Care Client Level Data System.

DMHAS has a data collection tool to capture demographic and outcome data elements. This manual data collection system for CSC CI will no longer be utilized once all of the program outcomes specific to CLD are added to the new USTF+. Currently the data is collected every three months and analyzed to track the progress of CSC clients who have received services. Client measures include client referral source; age; male/female; psychiatric and medical hospitalizations; psychotropic medication adherence; co-occurring substance use disorder; discharge and re-admission; insurance status; and global functioning using the MIRECC GAF scale. In addition to the CSC data spreadsheet, CSC programs submit a quarterly progress report to DMHAS. The quarterly progress report outlines community outreach progress and any questions regarding the client service model, recommendations, and client referral demographic data. The new web-based USTF+ CLD system includes a program-specific module for CSC CI

CLD which provides assessment scale/scores including MIRECC, CGI (optional), BPRS, ACES, PHQ-9, MDQ, as well as psychotropic medication adherence, inpatient hospitalization and designated screening visit history while enrolled in the program. These new features are anticipated to be functional in the Fall of 2025. Trainings on these features will commence shortly after. DMHAS anticipates having a full year of data for SFY 2027.

The QCMR collects data which provides information specific to the CSC program as well as the step down or Community Integration (CI program). Additionally, the QCMR provides information for individuals admitted to, discharged from and caseloads for First Episode Psychosis (FEP) and Affective Psychosis. Individuals served and units of service are also monitored, as well as payer mix and staffing ratios.

-Peer Recovery Warm Line.

The Peer Recovery Warmline has been an integral part of NJ peer services since 2009. The warmline is fully staffed and supervised by experienced peer staff who provide support, education, advocacy and “personal peer to peer support” to the most isolated person in recovery. Utilizing WRAP (Wellness Recovery Action Planning) and IPS (Intentional Peer Support) models, the team operates 7 days a week, and volunteers to work all the holiday. Each year over 40,000 calls are answered each year. The PRW offers an optional text/chat component that provides daily text messages of support throughout the day and week. This provides another level of support and connection. PRW operates as part of the MHANJ Call Center that has multiple behavioral health lines – that provides easy access warm transfers to information and referral- through NJ Mental Health Cares- that also provides the PRW with a vast data base community recovery support services to share with peer warmline callers. In 2022 MHANJ became an anchor of the NJ 998 network- leading and advocating for peers to play a major role in crisis response. As a result, peers have been hired on 988 and facilitate easy warm transfers to PRW for 988 crisis callers. MHANJ continues to expand the role of peers in the operation of the call center – with many peers integrated across all our lines in partnerships with strong support, supervision, and clinical backup- proving their value to NJ’s crisis response network.

-Gaps Observed by the New Jersey Behavioral Health Planning Council

The partnership of community stakeholders with the SMHA is critical to the success of the Division. The New Jersey Behavioral Health Planning Council (NJBHPC, a.k.a., “The Planning Council”) is the primary (but by no means sole) voice of the community. Through the participation of the Planning Council, and its Advocacy subcommittee, the Division has obtained the following guidance on service needs and gaps within the current system of care. The Council has been concerned with the continuity and provision of behavioral health services. As mentioned in detail in other parts of this application, DMHAS provides the Planning Council with regular updates on the CMHSBG /SUPTRS.

The observed gaps reported here by the Planning Council are based on the findings and recommendations of the Chair of the Planning Council, as was informed by the Chair of the Planning Council's Block Grant Committee. That committee was comprised of Council members who are: consumers, family members, advocates, providers, representatives from other parts of state government, and facilitated by the Chairwoman of the Council and State Mental Health Planner. To gather feedback from the entire, general membership of the Council, the Block Grant Committee solicited the thoughts of the general membership of the Council via a survey with open-ended responses. The results obtained from that survey, and other inputs from Council members were reviewed, synthesized, and summarized here. The eight general areas identified by the Council are presented here.

Issues related to **Access to Care:**

- Administrative complications posed by dual, separate licensing requirements (physical health, and behavioral health) pose challenges to truly integrated services.
- Anecdotally, members report that individuals seeking various community-based mental health services continue to experience long wait times
- BH staffing shortages have been reported on by community members; absences in unfilled positions may and contribute to disruptions in treatments.

Issues related to **Housing:**

- Affordable and accessible housing remains a foundational need for individuals with behavioral health conditions in the state of New Jersey.
- Some community members advocate for an expansion of recovery residences, (i.e., Class F sober homes) to decrease recidivism, homelessness, and/or re-institutionalization.

Issues related to **Peer Support & Navigation Services:**

- Peer-run crisis alternatives may be lacking across some counties
- When leaving any acute and/or long-term mental health or substance use facility, there is a gap in navigation and peer follow-up services for peer integration.

Issues related to **Youth and Families:**

- Lack integration and differentiation within the Children's behavioral health system. The patchwork of services and authorities (school-based services, services provided by the Children's System of Care, hospitals/clinics, and private providers) makes it difficult for families to navigate and access services for children. Youth may be swiftly routed to emergency departments, which inadvertently often leads to delays in getting the most appropriate services at the right time.
- Statewide shortage of mental health professionals (in both clinical, acute and school settings) with experience and expertise in children's issues.
- Disruptions/delays in services due to Medicaid reimbursement policies and outdated treatment models that do not reflect the current realities of adolescent SUD.

- Siloed data collection practices leading to difficulty in better understanding (and improving) the system of youth/adolescent behavioral health services.

Issues related to **Aging & Dementia Services**

- Older adults are particularly vulnerable to gaps in transportation services and community health navigation.
- Crisis and respite services tailored to individuals with dementia are important, to assist in the screening process.

Issues related to **Program Oversight & Accountability**

- Heightened evaluation of funded providers by the SMHA is recommended by the Council.
- Greater state oversight in the stability of staffing at contracted agencies is suggested, to better ensure continuity & access to care.

SSA

Please see attached file for further information for the SSA.

III. How to Meet the Identified Unmet Service Needs and Gaps

-Adults with SMI

In order to address the staff shortages/wait times for psychiatry, DMHAS issued RLI's to fund community psychiatry residencies. Two separate RLI's resulted in awards for twelve (12) child and adolescent residencies/fellowships, and one hundred and one (101) adult residencies/fellowships.

In addition, in order to meet the assessed needs of the SMI population, DMHAS provides a broad range of programs and levels of care to the SMI population. The SMHA offers the following crisis, early intervention initiatives and community levels of care to address the needs of the SMI population.

Crisis Stabilization Services: **988 Lifeline Centers** (a nationwide 3-digit number for suicide prevention as well as mental health and/or substance use crisis); **Mobile Crisis Outreach Response Teams (MCORTS)** (statewide crisis response, in the community, to non-life-threatening mental health, substance use or suicidal crises).

Crisis Stabilization and Diversionary Services: **Crisis Diversion Homes** (hospital diversion; serves individuals who have recently experienced a crisis and are in need of further crisis stabilization); **Crisis House** (short term (21-30 days) residential program offering continuous 24/7 supervision and support for adults (18+) diagnosed with a mental illness; direct alternative to

psychiatric hospitalization; stabilization services for individuals recently discharged from inpatient psychiatric care); **Peer Respite** (alternative to inpatient psychiatric hospitalization. Peer respite staff provide 24/7 peer to peer support to help work through a behavioral health crisis); **Diversionary Beds** (inpatient mental health treatment beds for individuals who are uninsured and/or under insured to go into a community hospital; alternative to state hospital).

Acute Care Services: **Designated Screening Centers** (ambulatory care service which provides mental health services including assessment, emergency and referral services to mentally ill to ascertain whether the individual meets involuntary commitment standards); **Affiliated Emergency Services** (assessment and crisis intervention available 24-hours a day for mental health and psychiatric emergencies); **Early Intervention Support Services** (short term, mental health and co-occurring mental and substance use disorder services for adults who are experiencing significant emotional or psychiatric distress and are in need of immediate intervention; alternative to hospital-based emergency room treatment. Outreach (non-office based) services are available); **Involuntary Outpatient Commitment** (community based mental health services for individuals, who are court ordered into mental health treatment); **Short Term Care Facilities** (acute care adult psychiatric units in a general hospital for the short-term admission of individuals who meet the legal standards for involuntary commitment and require intensive treatment).

Peer Recovery Support: **Peer Wellness Centers** (community-based centers providing activities designed to encourage consumers to develop support networks to assist in decreasing isolation, support recovery and community tenure).

Family Support: **Intensive Family Support Services (IFSS)** (a range of supportive interventions designed to improve the overall functioning and quality of life of families with a relative with serious mental illness; may include psychoeducation groups, single family consultation, respite services, family support groups, systems advocacy and referral/service linkage); **Acute Family Support Programs (AFS)** (located within a Screening Center; assists families with navigation, education, provides resources and referrals for their family member in crisis).

Systems Advocacy: **Legal assistance** provided to mental health consumers; includes advice, case coordination, and court representation regarding government entitlements, housing, evictions, employment, etc.).

Treatment and Rehabilitative Supports: **Intensive Outpatient Treatment Support Services (IOTSS)** (community based ambulatory treatment alternatives for adults with SMI; includes comprehensive assessments, Wellness and Recovery Action Plans (WRAPS), medication and medication education, individual therapy, structured group therapy, illness management and relapse prevention groups, family psycho-education, referral to physical health care and direct linkage to ongoing clinical and support services); **Programs for Assertive Community Treatment (PACT)** (comprehensive, integrated rehabilitation, treatment and support services to individuals with SMI experiencing repeated hospitalizations; offers highly individualized services with a majority of contacts in natural community settings; available for psychiatric crises 24/7); **Projects for Assistance in Transition for Homelessness (PATH)** (serves individuals with SMI and with or without co-occurring substance use disorder who are homeless or at imminent risk of becoming homeless); **Community Support Services (CSS)** (designed to provide SMI with a

choice of permanent, safe, affordable housing in the community and offers individualized rehabilitative supports to maintain community tenure); **Residential Services** (supervised residences that provide supports and encouragement in the development of life skills required to sustain successful living in the community); **Supported Employment (SE)** (assists SMI consumers find and maintain meaningful, competitive jobs in the community based on the person's preference and abilities); **Supported Education (Sed)** (includes the provisions of supported educational coaching services; includes enrollment and registration assistance, teaching study skills, illness management and recovery skills related to school, assistance and advocacy in obtaining "reasonable accommodations" from the school); **Illness Management and Recovery (IMR)** (a standardized psychosocial intervention designed to help individuals with SMI manage their illness and achieve personal recovery goals); **Integrated Case Management Services (ICMS)** (outreach and case management services with linkages provided predominantly in the consumer's natural environment to facilitate access to needed mental health, medical, social, educational, vocational, housing and other services and resources); **Outpatient Services (OP)** (provided to individuals with MI and SMI s; includes therapy, counseling and supportive services for relatively brief sessions (between 30 minutes and 2 hours) and medication services when appropriate; **Partial Care (PC)** (individualized services provided in a group day program setting to maximize client's, with SMI, independence and community living skills); **Statewide Clinical Outreach Program for the Elderly (S-COPE)** (innovative statewide response and technical assistance resource for Long Term Care facilities, screening centers, psychiatric inpatient units, and for community-based mental health residents; a multi-disciplinary team providing clinical consultation to professionals regarding adult's age 55+ residing in long term care facilities); **Certified Community Behavioral Health Clinic (CCBHC)** (program designed to provide a comprehensive array of services needed to create greater access, and provide the necessary treatment for those with mental illnesses and substance use disorders).

-Homeless Adults

The DMHAS housing model provides permanent, safe, and affordable housing that may be integrated with support services to help individuals with serious mental illness live in the community. The various housing options include supervised community residences (such as group homes), supervised apartments (with varying levels of supports, including case management, medication management, counseling, tenancy sustaining supports, etc.) and rental subsidies for individuals with serious mental illness who can live more independently in the community (again, with varying levels of support). Other resources include transitional housing programs that provide short-term support following a psychiatric hospitalization or relapse to help individuals transition back into the community.

DMHAS partners with other state and community-based entities to maximize the utilization of housing subsidies and support services for integration into the community. In addition, DMHAS RFP'd housing for SMI individuals being discharged from state or county psychiatric hospital and SMI individuals who homeless. DMHAS issued a total of eight awards in four counties and regions, in order to serve twenty-four unduplicated SMI consumers who were homeless. DMHAS

also RFP'd and issued four regional awards in order to serve twenty unduplicated consumers. DMHAS utilizes Community Support Services, a rehabilitative service, for individuals transitioning out of state hospitals into the community. DMHAS served 5,894 individuals and increase from 2024 where 5,624 were served. DMHAS acknowledges that it cannot use PATH funds to support emergency shelters, so the SMHA is seeking to identify alternate resources to further address housing needs.

In order to address the unmet needs of SMI individuals without public benefit, staff assist with applications for GoodRx, which is a free discount card to assist in lowering medication costs. Staff will also reach out to the specific drug manufacturers to identify any prescription assistance programs associated with the specific medication. In addition to the above efforts, staff research drug prices among large chain pharmacies, mail pharmacies, and small local pharmacies to identify the lowest cost to the individuals.

DMHAS also uses "wrap" funding to assist SMI individuals with medications, and with tenancy start-up costs, such as rent security and utility deposits. Wrap funds also are available for limited household expenses, such as food and other essentials, to help transition consumers into the community.

DMHAS notes that the State has seen an increase of individuals in need of emergency housing due to the current housing market. DMHAS currently supports short term residential programs via its respite and peer respite homes. In addition, DMHAS will be opening at least two Crisis Diversion Homes, to provide short-term residential services as an alternative to an inpatient psychiatric hospitalization. In addition to DMHAS funded programs, staff will assist with linkages to community alternatives such as emergency housing assistance with the Board of Social Services in each county, which can fund short term stays at motels, hotels, rooming houses, etc. The goal is for individuals to have safe place to stay until something more permeant is identified. Our individuals also use shelters if no other options are available to them.

-Older Adults

In order to address the needs of older adults, who have a serious mental illness, the state mental health authority issued a Request for Proposal (RFP) for outpatient services in the fall of 2023 using American Rescue Plan Act funding. For this RFP, "older adults" were defined as 55 years old or older. DMHAS made three (3) funding awards in each of the three (3) identified counties (Burlington, Sussex and Union) to serve three hundred thirty (330) unduplicated individuals. Data indicates that the awarded programs exceeded goals and served a total of four hundred six individuals. Services included medication management and psychotherapeutic counseling.

-ESMI Coordinated Specialty Care – Community Integration

In order to meet the needs of the increasing number of individuals with early psychosis, including affective psychosis as well as transitional support program post-CSC intensive treatment, DMHAS developed an RFP for Coordinated Specialty Care Community Integration (CSC-CI) which would

provide Coordinated Specialty Care services and step-down in six regions covering twenty-one counties of the state. CSC-CI would provide ESMI services for individuals with first-episode psychosis (FEP) and affective psychosis (AP) as well as Community Integration (CI, a tiered step-down model). The CSC programs follow the Recovery After an Initial Schizophrenia Episode (RAISE) model. From the RFP there were five (5) awards. Currently there is one region, that includes three counties, that does not have an awarded provider. (DMHAS posted the RFP twice but did not have a successful bidder. This remains, at this point in time, an unmet need that DMHAS will seek to fill).

-Individuals in Need of Behavioral Health Crisis Services

To increase capacity to respond to a minimum of 90% of in-state contacts to 988, NJ DMHAS has established state and federal funding streams to support the existing 988 centers. Since 2022, NJ DMHAS has utilized federal funding streams, including MHBG and SUPTRS funding to support centers in hiring staff to increase their ability to respond to 988 contacts. Most recently, NJ DMHAS has been able to award ongoing state funding to all current in-state 988 Lifeline centers to further expand their services. With this state funding, centers have been able to hire additional staff members and expand the 988 services they offer.

Ongoing assessments have shown that demand to 988 is continuing to increase and additional efforts must be made to continue to meet the needs of our population. Additional sustainable funding streams are being explored and will be subject to the State's procurement processes.

To increase awareness and trust in the MCORT system, NJ DMHAS is promoting MCORT throughout the state. To further address utilization rates, NJ DMHAS is exploring the possibility of expanding access to MCORT beyond referral from the NJ 988 Suicide and Crisis Lifeline.

An RFP for Crisis Receiving Stabilization Centers (CRSC) was posted in January of 2024 to address a need for the creation of five new CRSCs in the following counties: Morris, Essex, Monmouth, Camden, and Bergen. Each center will have 22 recliners and serve a crisis population of individuals 18 years of age and older with a primary SMI or SUD diagnosis who are experiencing acute psychiatric and/or substance use disorder symptoms that could interfere with community tenure. The centers will be using a "no wrong door approach" and will be open for referrals, walk-ins, and first responder drop-offs, 24 hours per day, 7 days per week, every day of the year. The goal of the CRSCs is to develop an appropriate alternative to the use of local hospital emergency services and in-patient psychiatric hospitalization by providing crisis stabilization services. Additionally, the goal of the CRSCs offer continuity of care through linkages for services and placement support for individuals in need of permanent housing.

-Individuals with SMI or SED in rural areas and Youth with SED and Families

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 (8) 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 area of Atlantic County. The CCBHCs offer services within an integrated physical and behavior 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 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. Since the start of the CCBHC Demonstration Project in 2017, AtlantiCare's CCBHC has increased the number of clients it has served. AtlantiCare more than doubled the number of clients served in Year 7, providing care to 1,194 individuals between July 1, 2023 to June 30, 2024, compared with 575 served between July 1, 2017 to June 30, 2018.

AtlantiCare has also consistently demonstrated success in the very important performance metric of time to care. AtlantiCare has outperformed the CCBHC average in terms of the number of days from first contact to evaluation in all seven years of the Demonstration and has provided an evaluation to CCBHC clients in less than eight (8) days from time of first contact. AtlantiCare also provides significant amounts of case management services. More than nine-tenths of AtlantiCare CCBHC clients have received case management during the last five (5) years of the Demonstration, including in the most recent Demonstration Year 7. The CCBHC Demonstration Program ended September 30, 2025. The state is currently pursuing plans to sustain the program through Medicaid.

DMHAS also posted an RFP that would expand the scope of the Coordinated Specialty Care program as well as the number of programs. Programs would be awarded to cover the counties that had insufficient service coverage by existing programs. One of awards will cover Morris, Sussex, Hunterdon and Warren counties. Sussex, Hunterdon, and Warren counties had insufficient service coverage in the north. An award was made in the south to Atlantic, Cumberland and Cape May counties which had insufficient service coverage.

In order to address access to services during the pandemic, DMHAS providers were able to transition to telehealth services. Telehealth services were instrumental in reaching individuals with early psychosis as well as individuals in other levels of care by offering a hybrid approach to treatment for flexibility and can be useful when transportation from rural locations is an unmet need. Telehealth increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across behavioral health and primary care settings. Telehealth is useful for rural areas to access out of state providers to increase capacity thus extending networks.

The Children's System of Care has Mobile Response and Stabilization Services (MRSS), Care Management Organizations (CMOs) and Family Supports Organizations (FSO) support youth

under 21 years of age with moderate to high mental health needs in all of New Jersey's 21 counties, including Salem, Sussex, Warren, Cumberland, Atlantic and Cape May counties, which are considered rural counties.

CMOs provide care coordination of services through a wraparound approach to ensure all youth engaged with their organization receive the necessary services regardless of their location minimally ensuring engagement with community-based services and supports and out of home treatment.

-Individuals SED experiencing homelessness

The Adolescent Housing Hub (AHH or the Hub) is a real-time database designed to assist youth with placement in a transitional or permanent housing program. The AHH program is managed by the Office of Adolescent Services under the Department of Children and Families. AHH services are available to eligible homeless youth, youth at risk for homelessness, and youth aging out of the child welfare system, ages 18 – 21 years. Youth may contact PerformCare at 1-877-652-7624 24 hours a day to find out about housing and supports available to help. These supervised and supported transitional housing programs address the complex needs of homeless youth and those transitioning out of the system of care. The programs provide safe and stable housing as well as life skills coaching, case management services, and assistance with meeting educational and employment plans. The goal of supportive housing is to help youth achieve independent living skills and successfully transition to adulthood.

-SED Individuals in need of behavioral crisis services

Mobile Response and Stabilization Services are provided in every region of the state for youth and families experiencing a self-defined crisis and designed to delivery assessment and stabilization services as needed.

-SED Program Workforce Challenges

In recognition of unprecedented workforce challenges for behavioral health systems, DCF has engaged in efforts to inform strategies of workforce recruitment and retention to ensure continued quality service delivery, including:

- A contracted labor market analysis including diagnostics and recommended strategies and solutions
- Holding conversations with partner/provider groups and stakeholders
- Adjustment of practice elements that provide efficiencies for providers and maintain youth safety and quality service delivery.

-SED Individual's Access to integrated physical healthcare and behavioral healthcare.

Planned activities:

- Infuse integrated care and wellness activities across the CSOC continuum by identifying and expanding opportunities for integration within the CSOC service array and supporting the development of other primary health-behavioral health integration models.

-SED Individual's Access to evidence-based practices (EBP), services, and supports across the CSOC service continuum.

Planned activities:

- Support evidence-based practices in the continuum by increasing EBP capacity in both community-based and out-of-home services.

-Improved SED outcomes through increased collaboration among system, family, and other partners.

Planned activities:

- Encourage collaboration among all partners through strategic statewide and local partnerships.
- Continue collaboration through external advisory group.
- Strengthen CSOC's quality improvement strategy, including development and implementation of outcome measures aligned with the CSOC logic model goals, objectives, and activities.

-Strengthen and expand youth and family peer support.

Planned activities:

- Promote the importance of youth and family support.
- Explore opportunities to increase access to peer support services.

-Increase public awareness of availability and accessibility of the Children's System of Care.

Planned Activities:

- Promote usage of the CSOC Social Media Tool Kit and Public Service Announcement by all partners.
- Presentations provided to community stakeholders upon request.
- Design and implement training and support to increase access to services for unhoused youth and their families.

-Ensure access for all.

Planned Activities:

- Promote data collection and entry across the service array.
- Participate in DCF learning activities.

-Expand Service Array to include supports and services for infant mental health/youth under five years old.

Planned Activities: Continuation of "Zero to Five: Helping Families Thrive" infant and early childhood mental health workforce training and technical assistance activities.

-Older Adult Committee

The SMHA has convened an Older Adult Committee to be a resource for DHS, DOH/DBHS (Division of Behavioral Health Services) regional state psychiatric hospitals, and DMHAS-funded community agencies that serve the older adult population. Through the review of existing programmatic data, case reviews, literature reviews and presentation by experts and professionals in the field, the committee strives to better serve the needs of the older adult which is a growing

demographic in New Jersey. The committee will also strive to assure that programs and services offered at the regional state psychiatric hospitals and through our contracted agencies are age relevant, cost effective, beneficial, and dignified. In order to incorporate a wider range of perspectives and expertise, the committee membership was expanded from DMHAS Olmstead/Diversion, DOH/DBHS state psychiatric hospitals and Centralized Admission Unit, and Statewide Clinical Outreach Program representatives to also include representation from the Area Agency on Aging, New Jersey Advocates for Aging Well, New Jersey Hospital Association, Office of Long-term Care Resiliency, and the Office of Community Choices Options.

-Coordinated Specialty Care (CSC), Coordinated Specialty Care – Community Integration (CSC-CI)

With the issuance of Block Grant Supplemental funds in 2023, DMHAS awarded five contracts to serve 18 of 21 counties of the state and expanded the ESMI population of its Coordinated Specialty Care (CSC) program for First Episode Psychosis to include Affective Psychosis. Coordinated Specialty Care, Community Integration (CI), a stepped-care approach, has been added to CSC services to provide the opportunity for individuals in CSC to remain engaged with their current CSC team while receiving transitional support post-CSC intensive treatment. Research has shown that many clients struggle to maintain superior outcomes after CSC⁸. 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 population⁹. The CSC CI programs continue to serve consumers that need less intensive services and will be able to move to the transitional program and titrate services according to their need. Treatment and supports will be geared toward reintegration of the individual into the community, return to school/work, symptom stabilization, diversion from inpatient services and a decrease of screening center utilization. These programs will provide a supportive environment where the client can access an array of services and remain connected in the community, thus decreasing hospital recidivism, integration of health and behavioral health via continuity of care between the CSC APN and the client's primary care practitioner, decrease in duration of untreated illness, increase in medication adherence, and increase in level of functioning. Clients will be able to transition to step down or transition up to CSC seamlessly based upon clinical need without changing providers or their clinical team. An additional CSC CI team is needed to cover the remaining 3 counties in New Jersey, Mercer, Monmouth, and Ocean.

-Peer Recovery Warm Line

⁸ Jones, N. (2016). What comes after early intervention? Step-down, discharge and continuity of care in early intervention in psychosis programs for first episode psychosis. Retrieved from https://www.nasmhpd.org/sites/default/files/Issue%20Brief%20-%20What%20Comes%20After%20Early%20Intervention_0.pdf.

⁹ Jones, N. (2016). What comes after early intervention? Step-down, discharge and continuity of care in early intervention in psychosis programs for first episode psychosis. Retrieved from https://www.nasmhpd.org/sites/default/files/Issue%20Brief%20-%20What%20Comes%20After%20Early%20Intervention_0.pdf.

Funding to expand Peer Outreach Support Teams within the mental health system either by direct positions or allow Medicaid reimbursement is the major barrier. MHANJ has established a strong program model that can work within the traditional treatment system and also work effectively with the large number individuals with mental health and substance use disorders who are not receiving services. MHANJ is using the POST model with other funding sources to engage individuals with emotional issues and is currently involved with a pilot project with Horizon BlueCross/Shield to offer Peer Support services to its commercial clients. Once Medicaid funding to peer support flows MHANJ is in the position to significantly expand these peer support services.

The Single State Authority on Substance Abuse (SSA)

Planning Step 2: Identify the unmet service needs and critical gaps within the current system, including state plans for addressing identified needs and gaps with SUPTRS BG award.

The SSA has a long history of conducting needs assessments to determine overall treatment need for substance abuse treatment, demand and gaps, and treatment need and gaps for populations in need in New Jersey. Obtaining reliable substance abuse treatment need estimates is critical to the state's ability to promote a rational planning and resource allocation process. The Division of Mental Health and Addiction Services (DMHAS) employs a variety of scientifically valid methods for estimating substance abuse treatment needs. Primary among these are: 1) surveys, 2) social indicator analysis, and 3) "synthetic" statistical estimation techniques, called modeling.

Our methodologies also allow us to determine need at the county level. This information is important for the planning and development of new substance abuse prevention and treatment services. Needs assessment data are incorporated into our Request for Proposals (RFPs) for developing new substance abuse and treatment services, are incorporated into funding formulas for distribution to our counties per Alcoholism, Education, Rehabilitation and Enforcement Fund¹ (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 and the CDC High School YRBS); specific surveys such as Older Adults, Veterans; Young Adults; relative needs assessment; synthetic estimation techniques such as capture-recapture; and social indicator analysis. in order to develop needs assessment strategies. For over 25 years, New Jersey has used a household survey to estimate: 1) the prevalence of both legal and illegal substance use, 2) alcohol treatment need and 3) unmet treatment demand. The SSA also utilizes Geographic Information Systems (GIS) for the spatial visualization of social service needs and advanced analytic techniques such as multiple regression, logistic regression, survival analysis and structural equation modeling.

Data Driven Planning Process

The SSA is committed to providing timely and high-quality data to inform our various stakeholders and the public to help them understand substance use trends. It believes in a data-driven approach to inform our policies and assess the impact of our programs. The SSA has numerous Memorandum of Agreements with a variety of university partners to assist us in the evaluation of key programs and managing our large-scale population surveys.

¹ The AEREF legislation refers to P.L.1983, c.531, amended by Chapter 51 of P.L.1989.

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

- New Jersey Substance Abuse Monitoring System (NJSAMS)
- Prevention Outcomes Management System (POMS)
- Contract Information Management System (CIMS)
- Gainwell Fiscal Agent Billing System

SSA Surveys

- NJ Household Survey on Drug Use and Health
- NJ Middle School Risk & Protective Factor Survey
- Survey of Older Adults
- Returning Veterans Survey
- Young Adults Survey
- NJ High School Student Health Survey

Other SSA Data Sources

- NJ Epidemiological Profile for Substance Abuse County and Municipal Social Indicator Chartbooks
- NJ Substance Abuse Provider Performance Reports (bi-annual)
- NJ Substance Abuse Overviews (annual)
- Treatment Provider Performance Reports (annual)

Other State Data Sources

- NJ DOH Uniform Billing (UB-04)
- Uniform Crime Reports
- NJ Department of Education Student Health Survey
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- Behavioral Risk Factor Surveillance System (BRFSS)
- New Jersey State Health Assessment Data (NJSHAD)
- Prescription Drug Monitoring Program
- Overdose Data (Medical Examiner)
- Narcan Reversals Dashboard (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)
- National Substance Use and Mental Health Services Survey (N-SUMHSS)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Fatality Analysis Reporting System (FARS)
- National Vital Statistics System (NVSS): Multiple Causes of Death (Mortality)
- Uniform Crime Reports (UCR): Police Reported Crimes
- CDC Youth Risk Behavior Surveillance System (YRBSS)
- CDC State Unintentional Drug Overdose Reporting System (SUDORS)
- National Vital Statistics System (NVSS)
- Web-based Injury Statistics Query and Reporting System (WISQARS)
- Substance Abuse and Mental Health Data Archive (SAMHDA)
- 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 SUBG and TEDS reporting, needs assessment, evaluation and planning processes. Other new systems allow for the collection of outcome data.

New Jersey Substance Abuse Monitoring System. The client level data system, known as the New Jersey Substance Abuse Monitoring System (NJSAMS) was developed and implemented in 2005 by the SSA to be a real-time, web-based substance use treatment data collection and reporting system. The system is required to be used by all licensed substance use clinic-based treatment providers in New Jersey, regardless of whether or not contracted with the SSA. It collects basic demographic, substance use, financial, clinical and service information on all clients enrolled and served in New Jersey's substance abuse treatment system. Admission data are collected and reported for services that have different payers. In 2024 there were 81,217 admissions to treatment. The system consists of numerous modules and contains all the clinical assessments providers are required to complete. There are 255 licensed providers reporting on NJSAMS, representing 418 sites with 3002 active users. There are also 185 Intoxicated Driver Resource Center (IDRC) affiliated providers representing 291 sites and 1,786 active users.

NJSAMS was developed over time under the initial auspices of the Center for Substance Abuse Treatment (CSAT). The purpose was to develop the state's capacity to use web-based information technology for the collection and reporting of data necessary to meet Federal Performance Partnership Grant (PPG) and Government Performance and Reporting Act (GPRA) reporting requirements. NJSAMS was developed in response to the need for: timelier reporting on substance abuse treatment episodes, better monitoring of client outcomes, quality improvement,

better client placement into appropriate level of care based on assessed need and tracking of treatment through the continuum of care. The NJSAMS website is hosted by the Rutgers University Computer Center under a Memorandum of Agreement with the SSA. It is a secure web-based system designed to collect confidential health information and is HIPAA and 42CFR compliant.

A major IT accomplishment was the complete re-architecture of NJSAMS, which was originally written in classic ASP and included numerous webpages making data entry slow. Work began on this project in September 2011 and the new system was successfully launched mid-November 2013. The NJSAMS includes the latest Addiction Severity Index V.5, the Level of Care Index (LOCI-3), DSM-5, as well as additional modules that can collect further information on client care and needs. The system is capable of producing the CSAT National Outcome Measures (NOMs) and generates the data needed for Provider Performance Reports. Data from NJSAMS are used to fulfill Block Grant reporting requirements and are also submitted quarterly to the Treatment Episode Data System (TEDS). The system contains nearly 1000 data elements and over 1 million records, dating back to 2006.

Contract Information Management System. (CIMS). The Contract Information Management System is a web-based, paperless contract processing system that providers use to submit their contract actions. CIMS went live July 1, 2010 for renewal contracts which included the electronic submission of the Annex B (budget). On January 1, 2011, the system went live for the Annex A and Programmatic Requirements.

The four main areas CIMS was designed to address are:

- ensure compliance with Department of Human Services (DHS) contracting policies
- provide more accountability for the utilization of state funds
- improve transparency and tracking of SSA contracting
- develop a more efficient process for submitting, reviewing and approving contract documents

DMHAS has secured a new vendor for contract management to provide enhanced reporting capability known as SAGE and is actively working with the vendor to configure the application.

Prevention Outcomes Management System. The web-based Prevention Outcomes Management System (POMS) collects process data on evidence-based substance abuse prevention services that are delivered in New Jersey. This system went live in August 2009 and has been enhanced since that time. All New Jersey substance abuse prevention providers and coalitions that receive SSA funding are required to use the system for data reporting. POMS includes two modules that collect county-based prevention coalition and education data. The system supports download of 1-6 reports per module and has 131 password-registered agency users (representing 25 agencies and 95 grants), 6 administrators, and 4 system administrators.

Contracted agency users report data into POMS via an Environmental Module and 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) Decrease Underage Drinking, (b) Decrease use of Illegal Substances, (c) Decrease Prescription Misuse Across the Lifespan, and (d) Decrease use of New and Emerging Drugs of Abuse. 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) audience, (3) priority, (4) curriculum/program name, (5) county of service, (6) date of service, (7) # of individuals/families in attendance, and (8) applicable CSAP strategy. Curriculum-based reports include participant demographic data by county, priority, strategy, and curriculum. These reports are used for program monitoring.

Plans are underway to update the POMS system to more accurately address the changes in prevention services and new strategies that were developed to address the opioid epidemic. The update will also allow DMHAS to collect data according to new demographic categories required by SAMHSA. A survey of prevention agencies was conducted by the Center for Prevention Services at the Rutgers School of Social Work to collect feedback. While feedback on using the system is generally positive, several design and technical issues were identified. These issues will be addressed in the update.

Maternal Wrap Around System (MWRAPS) and Integrated Opioid Treatment and Substance Exposed Infants (IOT-SEI) Initiative Systems. The MWRAP and IOT & SEI collect program data consistent with federal and state maternal health strategies.^{2,3} Using MS Office software, the initiatives ensure quality data collection and dissemination in order to measure program impact and outcomes as well as to inform program and policy decisions. Some providers use electronic medical record (EMR) systems alongside the program required reporting tools. Data sourced from 10 contracted providers are documented using three approved surveys developed through MS Word documents: 1) Intake Survey, 2) Birth and Postpartum Survey, and 3) Discharged Survey. Information gathered through these surveys are recorded and reported through an approved custom-designed MS Excel reporting template on the 15th of each month. The reporting requirements also include regular data monitoring, quarterly data quality check, and a quarterly meeting with the contracted providers and state partners.

Data collected through the MWRAP and the IOT-SEI initiatives covers eight data categories: 1. Biographical data, 2. Enrollment and admission data, 3. Contact data, 4. Maternal health data, 5. SUD and OUD data, 6. Other care and support data, 7. Legal data, and 8. Exit data. These eight

² The White House. “*White House Blue Print for Addressing the Maternal Health Crisis*”. <https://www.whitehouse.gov/wp-content/uploads/2022/06/Maternal-Health-Blueprint.pdf>. June 2022

³ New Jersey. “*Nurture New Jersey 2021 Strategic Plan*”. nurturenj.nj.gov/wp-content/uploads/2021/01/20210120-Nurture-NJ-Strategic-Plan.pdf. 2021

categories also comprise additional data sets to fully capture a wide range of information across various levels of care:

1. Biographical data
 - Consumer's name
 - Date of birth
 - Ethnicity
 - Residence
 - Marital Status
 - # of children in home
 - # of children out of home
 - Individual's housing status
 - Education status
 - Source of income and employment status
2. Enrolment and admission data
 - Admission data
 - Admission status
 - Referral source
3. Contact data
 - Total number of attempted contacts
 - Total number of successful contacts
 - Date of last contact
 - Mode of communication
4. Maternal health data
 - Health Insurance
 - Health rating
 - # of lifetime pregnancies
 - # of live births and birth details
 - Week of gestation at intake
 - Prenatal care
5. SUD and OUD data
 - Co-occurring mental health diagnosis
 - Has client even been in SUD treatment and # of times
 - # of times withdrawal/detox
 - Current SUD treatment and type of treatment center
 - Referral to SUD treatment
 - Current MAT
 - Substance use in past 30 day and type of substance
 - Substance use in past 12 months and type of substance
 - Current use of tobacco or cigarettes
 - Current use of e-cigarettes or vape
 - Overdose in past 30 days
 - Overdose in past year
 - Current frequency of use of any substance

- Past year total time abstinent from identified substance
- 6. Other care and Support data
 - COVID-19 and most urgent reported challenges
 - Plan of safe care
 - Hep C
 - Treatment care status
 - NAS
- 7. Legal data
 - Arrested in the past 30 days
 - Arrested, if yes, how many times?
 - Awaiting charges
 - Currently on probation or parole
 - Currently in Intensive Supervision Program (ISP)
- 8. Exit data
 - Care or service discharge
 - Care or service exit categories
 - Care or service exit concerns

Support Team for Addiction Recovery (STAR) Data Collection. In addition to GPRA, STAR clients also receive the Support Team for Addiction Recovery Survey which is captured in a HIPAA-compliant web-based RedCap database developed by RU-CPS. STAR collects data on individuals' demographics including age, ethnicity, and male/female. The STAR key outcomes are assessed as follows: past 30-day substance use; individuals receiving MAT (Buprenorphine, Methadone, Vivitrol); engagement in education/training; employment; housing stability; Medicaid enrollment; and provider outreach and engagement efforts. STAR providers collect baseline and follow-up surveys (every three months until discharge a year later) regarding substance use, recovery, and quality of life.

Family Support Centers (FSC) Data Collection. Data collected measures the family members' loved one's recovery/treatment status and is captured in Qualtrics. Self-care measures such as communication, understanding recovery and resources, effects on interpersonal relationships, effects of the Center on the participants' financial, family and vocational responsibilities as well as their own emotional wellbeing and welfare are also measured. FSC providers collect baseline, and six-month follow-up surveys which contains items on demographics, service needs, loved one's substance use as well as above self-care measures

Telephone Recovery Support (TRS) System. Data collected from TRS is recorded in the provider's Salesforce system. TRS staff capture demographic information, as well as information on referral source, engagement, and other outcomes such as housing, employment, education, criminal justice involvement and overdose in past 3 months. The Salesforce system also tracks the number of calls, the length of the call, and allows for TRS staff to enter specific call-related notes for record keeping and continued relationship building.

Opioid Overdose Recovery Program (OORP) Database. A data collection system has been designed to collect detailed information on clients who are brought to the emergency department after being reversed with naloxone. Information is collected on patients' mental health and

substance use disorder history, referrals, linkages to treatment and other services provided by the Recovery Specialists and Patient Navigators, patient outreach and follow-up, and the client's participation in recovery.

The OORP Database website is developed in PHP 7 using Drupal 7 for the framework and content management system. The tables are created through an automated process initiated by Drupal using MySQL 5.7. All data pertaining to the OORP application is stored in databases on a single server and retrieved only through the Drupal web interface. The OORP Database contains field validation to ensure responses are in the appropriate format and to decrease invalid responses.

Contingency Management. Contingency management utilizes multiple data gathering tools. First, surveys are administered at admission to and at conclusion of the program. Intake and discharge surveys are conducted via MS Forms with data downloaded as an Excel worksheet. The intake survey, measures patient demographics as well as treatment goals. The discharge survey measures patient outcomes in the treatment program, number of treatment sessions taken as well as total amount of incentives given throughout their course of treatment. The data gathered here is linked to the providers' entry of client information into the New Jersey Substance Abuse Monitoring System (NJSAMS) as part of the intake process. Finally, since this program is funded by SOR, data is also obtained through administration of the GPRA on intake, at discharge and the 6-month follow-up GPRA.

Expanded Hours for Outpatient Treatment. The Expanded Hours for SUD Outpatient Programs is intended to provide increased access to outpatient treatment for individuals with an SUD. MS Forms data collection system was designed in late 2022 and implemented in January 2023. Each awarded provider site has its own real-time data input website link to input its data each time client used the expanded hour services. As of March 2025, the 10 providers have provided 10,939 times of service to a total of 2,814 unique individuals.

Data collected through the Expanded Hours data collection system covers three data categories: 1. Biographical data, 2. Enrollment and admission data, 3. Service data. These three categories also comprise additional data sets to fully capture a wide range of information of how Expanded Hours Outpatient program services consumers:

1. Biographical data:
 - Date of Birth
2. Enrollment and admission data:
 - Consumer's ID in New Jersey Substance Abuse Monitoring System (NJSAMS)
 - Consumer's treatment admission date in NJSAMS
3. Service data:
 - Date of the service
 - Time of the service
 - Type of service provided
 - If this is the first time the consumer uses this service.

Peers in Residential Services. The Peer Recovery Specialists for SUD Residential Treatment Program is intended to expand and increase SUD peer workforce and to provide peer recovery support services in residential settings. A MS Forms data collection system for Peer Program was

designed and implemented in August 2023 to capture program progress. All awarded provider sites utilize their own real-time data input website link to update their program data. Each quarter, all providers are required to input detailed information of each of their peer's work progress. As of March 2025, 9 providers with a total of 65 peer recovery specialists are awarded this program, total 29,695 times of services are provided to 10,495 unique clients.

Data collected through the Peer Residential data collection system covers three data categories: 1. Peer Biographical data, 2. Peer qualification data, 3. Peer Service data. These three categories also comprise additional data sets to fully capture a wide range of information of how peer recovery specialists service consumers:

1. Peer Biographical data:
 - Name
 - Date of Birth
 - Male/Female
 - Ethnicity
2. Peer Qualification:
 - Qualification or certification of the peer
 - If Peer completes DMHAS ethics training
 - If Peer receives adequate supervision
3. Peer Service:
 - Level of Care Peer works on
 - Type of service provided
 - Number of consumer contacts, visits, meetings serviced

Recovery Data Platform. The Recovery Data Platform (RDP) is a cloud-based software solution developed in part by Faces & Voices of Recovery and Recovery Trek. The platform aids Peer Service Providers with the tools and assessments needed to effectively implement peer recovery coaching programs. Through the use of robust reporting and scheduling tools, RDP provides an organization with outcomes data and service management tools. It is designed to capture peer services offered by organizations to individuals impacted by substance use disorders (SUDs). Recovery Data Platform (RDP) is one of the largest collections of data for participants in SUD peer services for the state of NJ. RDP is being used by several initiatives to centralize information which allows a robust real-time analysis of recovery support services.

The data used to conduct outcome analyses is gathered in RDP using scientifically validated tools. The three outcome measures predominately used by the RDP pilot program are: Assessment of Recovery Capital, Cravings Rating Scale, and Outcome Rating Scale. These scores are based off of participant answers to questionnaires that are administered at regularly scheduled intervals. The outcome analysis focuses on establishing a baseline at the initiation of services and then re-evaluating.

Currently 13 programs are participating in the RDP Pilot. By August 2025, there were 31,098 patient charts in the RDP. Participating organizations provided peer recovery support services to 11,076 participants during FFY 2025. The RDP is currently in a pilot phase and there are plans to eventually expand this to all SUD peer-based programs. In 2025, all 21 CPRC programs will be added to RDP.

Community Peer Recovery Centers (CPRC) Data Collection. Individuals participating in multiple CPRC activities or receiving more individualized services will be administered an intake survey and a follow-up survey 3 months later built into the RDP. These surveys measure demographics, substances used, MAT usage, housing status, employment status and criminal justice involvement will be measured. Furthermore, these surveys include measures of recovery capital such as the Brief Assessment of Recovery Capital (BARC-10) and the Outcome Rating Scale.

Summary. As a result of our IT and data collection systems, the SSA can report any of its data at the client level (demographic, clinical, financial, encounter, etc.). Currently it reports on all Treatment Episode Data System (TEDS) items, which includes the System Data Set (SDS), the Minimum Data Set (MDS) and the Supplemental Data Set (SuDS). The SSA has been reporting TEDS data through NJSAMS for many years. The Fiscal Agent system allows the SSA to determine costs for episodes of care and by specific services. The specialized systems allow for reporting outcomes on seven programs: M-WRAP, SEI/NAS, STAR, FSC, OORP, Contingency Management, and Expanded Hours at multiple points in time, rather than only at admission and discharge. Additionally, RDP reports outcomes for peer delivered services. A new report is being implemented for Peers in Residential Programs.

Quality Reporting

As a data driven planning organization, the SSA develops numerous reports that are posted on the DMHAS website so all stakeholders can review the information to inform their planning and needs assessment processes. Several of our major reports are described below.

Substance Use Overview

The statewide Substance Use Overview provides statistics on substance use disorder treatment in New Jersey for each calendar year. These data are submitted through the web-based New Jersey Substance Abuse Monitoring System (NJSAMS). A research analyst extracts data from the database to produce this report.

The Statewide Overview includes:

- State Totals for Substance Use Treatment Admissions
- Substance Use Treatment Trend Charts for Admission, Primary Drug, Level of Care and Age Group
- Substance Use Admissions by County and Primary Drug
- Substance Use Admissions by Primary Drug within County
- Substance Use Admission Rates by County and Primary Drug
- Map for Number of Substance Use Admissions by County of Residence
- First Time Clients by County of Residence and Primary Drug
- Admissions by Age Group, Male/Female, and Primary Drug
- State Totals for Substance Use Treatment Discharges
- Length of Stay by Level of Care
- Waiting Time to Treatment Admission
- Reasons for Waiting Time over 3 Days to Treatment Admission

- Time to First Readmission
- Detox Continuing Care Status at Discharge
- Detox Continuing Care within 90 days by Level of Care
- Substance Use Treatment Demand Estimate

In addition, detailed County reports are prepared for all 21 individual counties.

Substance Use Disorder Treatment State Performance Report

The Substance Use Disorder Treatment State Performance Report is produced every calendar and fiscal year. The Substance Use Disorder Treatment State Performance Report is one strategy that DMHAS has adopted in its continuous quality improvement efforts focused on helping to improve services to the clients we serve. The outcome measures are one way to monitor client outcomes, help direct system improvements and achieve better accountability.

The reports are based on client data that providers enter in DMHAS' client administrative data system. Data is aggregated across all providers but the outcomes are provided for each level of care. Outcomes are computed as the difference in percentage between discharge and admission. The outcome measures include:

- Decreased Morbidity
 - Abstinence from Alcohol
 - Abstinence from Other Drugs
- Employment
- Education (School or Job Training)
- Crime and Criminal Justice
 - Arrests
- Homelessness
- Access/Capacity
- Unduplicated number of clients discharged
- Retention
- Length of Stay
- Treatment Completion

Substance Use Treatment Provider Performance Report

The Senate and General Assembly of the State of New Jersey enacted an Act concerning substance use treatment facility performance (N.J.S.A. 26: 2G-38.) requiring the annual preparation of a "Substance Use Treatment Provider Performance Report". The performance report shows and compares the overall performance of each substance use treatment provider in the State with the Statewide average performance based on national outcome measures for each level of care. The division uses the national outcome measures (NOMs) identified below and, as appropriate, any other national outcome measures identified by the Substance Abuse and Mental Health Services Administration. The performance report shall include the following national outcome measures: (1) percentage of clients abstinent from alcohol on admission and discharge; (2) percentage of clients abstinent from drugs on admission and discharge; (3) percentage of clients employed on

admission and discharge; (4) percentage of clients enrolled in school or a job training program at admission and discharge; (5) percentage of clients who are homeless on admission and discharge; and (6) average length of client treatment.

The performance report includes data on number of admissions and discharges, length of stay in treatment and performance on the national outcome measures for each provider as well as statewide performance. The domains of focus are: abstinence, employment, education/training, stability in housing and retention in treatment. The report is broken out by the level of care provided. Outcomes are only reported if the agency had at least 20 discharges. The outcomes are based on data for the same client. That is, all discharges were selected for the reporting year and then the admission information for that discharge was linked in order to compute the outcome measures. By publicly reporting these outcomes, the DMHAS hopes to provide consumers with information on the outcomes achieved so they can make informed decisions about choosing a provider and helps providers see how they are doing compared to their New Jersey peers and to the state so that they can identify areas that might need improvement. These performance reports are one strategy that DMHAS has adopted in its continuous quality improvement efforts focused on helping to improve services to the clients we serve. The NOMs are one way to monitor client outcomes, help direct system improvements and achieve better accountability.

State Outcome Measures

The State Outcome Measures (SOMs) is a system created that provides a single, sortable file for counties to evaluate the performance of contracted providers. The SOMs scores were created to provide county directors with a tool to help them review providers for their programs in the AEREF. The county directors use the scoring to evaluate the performance of their current contracted providers. In addition, they also to help them choose which providers they would like to purchase for new programming in their planning. On occasion, counties have discontinued contracts with providers, influenced by poor performances seen in their SOMs scoring over a span of a couple years.

The SOMs scores range from 1-4, worst to best. The system uses the percentiles of five categories which are the following.

- Alcohol Abuse: Absolute Percentage change of clients abstinent from alcohol at admission vs. discharge
- Drug Abuse: Absolute Percentage change of clients abstinent from other drugs at admission vs. discharge
- Employed: Absolute Percentage change of clients employed at admission vs. discharge
- Job Training: Absolute Percentage change of clients enrolled in school or job training at admission vs. discharge
- Arrested: Absolute Percentage change of clients arrested in prior 30 days at admission vs discharge
- Homeless: Absolute Percentage change of clients homeless at admission vs. discharge

The formula to calculate the SOMs scores requires taking the average of the five categories for each provider, which is called the Agency average. Then, the average and standard deviation of the Agency averages of those providers are taken together within their respective level of care

(LOC) to create the LOC average and LOC standard deviation. The LOC average is subtracted from the Agency average to yield a difference (Agency Average – LOC Average). The differences are put against the LOC standard deviation to determine the rank the score of each provider. A set of determinants, (TRUE or FALSE functions) are used to place the scores from 1-4. Essentially, the lower the difference against the LOC standard deviation, the lower the SOM score. The higher the difference against the LOC standard deviation, the higher the SOM score. Each provider is only scored in competition with other providers within their LOC.

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 sub-populations surveys combined with treatment utilization data from the New Jersey Substance Abuse Monitoring System (NJSAMS), as well as the application of Geographic Information Systems (GIS) methodology using Arcview for visual data presentations, provides the SSA with data to assess both service needs and delivery capacities which drive its SUPTRS Block Grant Application, its statewide strategic planning, and its multi-year county comprehensive planning. In addition, it prepares numerous reports which are publicly posted to help stakeholders identify system issues.

At both the state and local levels, the New Jersey substance abuse planning process is designed to employ both quantitative and qualitative data to assess the relative need for alcohol and drug abuse prevention, early intervention, treatment, and recovery support services. It uses both administrative databases prepared by federal, state, and local governments, as well as general and targeted population and service provider surveys conducted by DMHAS to engage in “gap” analysis of unmet treatment demand by age, ethnicity 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. Analysis of treatment admissions and delivery at the municipal level provides the SSA with the capacity for spatial analysis of unmet treatment demand and access to care. Thus, analysis of both primary and secondary data sources drives New Jersey’s state planning and policy development for substance use services.

Needs Assessment: Treatment

NJ Household Survey

In 1993, 1998 and 2003, the SSA was awarded a State Treatment Needs Assessment Program (STNAP) grant from SAMHSA’s Center for Substance Abuse Treatment (CSAT) to conduct a “family of studies” centered around a statewide household survey supplemented by surveys of sub-populations not expected to be included in the telephone sampling frame. After the STNAP ended in 2003, the SSA conducted its 2009 needs assessment “family of studies” using SUPTRS Block Grant funding.

For 27 years, New Jersey has surveyed its adult population 18 years of age or older to estimate: 1) the prevalence of both legal and illegal substance use, 2) alcohol treatment need and 3) unmet treatment demand. The SSA conducts the New Jersey Household Survey on Drug Use and Health

(NJHSDUH) at approximately 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). The questionnaire employs a core set of questions originally provided 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. Beyond these core elements, the SSA's questionnaire regularly includes sections on tobacco use and gambling behavior. Typically, the NJHSDUH includes one or more 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 NJHSDUH, which was the first NJHSDUH 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 topic of substance use among pregnant women.

The population for this survey are New Jersey adult residents (18 years old or above) residing in private households. Excluded are populations living in institutional residences (such as college dormitories, residential treatment settings, jails and prisons, etc.) as well as individuals who were homeless. 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.

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. 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.

The 2018-20 survey differed from prior surveys in that it was administered across three rolling statewide surveys designed to be administered each year between 2018 and 2020. The 2018 Household Survey is the largest of the three surveys, sampling a total of 3,100 New Jersey adults. Sample sizes were meant to decrease in each subsequent survey year, with the 2019 Household Survey sampling 2,423 residents and the 2020 Household Survey, 1,622 residents. At the end of the three-year survey period, the data were aggregated across surveys to produce an overall statewide sample. Also, the 2018-20 sample was large enough to generate county-level estimates of substance abuse treatment need. The sample size aggregated across the three survey years totaled 7,145, which will include approximately 340 residents per county.

The Department of Psychiatry, Rutgers-Robert Wood Johnson Medical School was commissioned by DMHAS to conduct the 2023 New Jersey Household Survey on Drug Use and Health. Data were collected from a stratified, random sample of 22,200 respondents online and by telephone from October 2022 to August 2023. It collected detailed information on substance use/abuse, mental health and treatment as well as on medical and recreational cannabis use, nicotine use, and gambling.

For the first time in the history of the NJSDUH, the majority of data collection was conducted online. As a result, the sample size of 22,200 significantly exceeded the sample sizes of previous New Jersey surveys. Also of note is the fact that the National Survey of Drug Use and Health only samples 1,500 individuals from NJ and cannot support our county planning process. Our NJ sample was nearly 15 times larger than the national sample.

Previous implementations of the NJSDUH involved telephone-based interviewer-administered surveys conducted via both landlines and cell phones. While telephone surveys have proven cost-effective for social science research in the past, studies show that the proliferation of cell phones and cell phone-only households have resulted in increased survey costs and lower participation rates. Studies also suggest that sampling methodologies used in telephone surveys which select households through random digit dialing, may produce samples that are less likely to use illicit drugs than address-based samples drawn to include households with no telephones.

Online surveys also have the advantage of being self-administered, an administration mode found to increase the reporting of sensitive behaviors, like substance use and other sensitive behaviors measured in this survey. The present survey capitalized on recent changes in survey research methodologies by employing a multimodal survey approach that utilized both telephone and internet-based survey methods. Data for the 2023 New Jersey Statewide Household Survey was collected via internet-based, landline- and cell phone-based questionnaires.

The 2023 New Jersey Household Survey of Drug Use and Health (NJSDUH) contains findings that have important implications for public policy, including notable trends in substance abuse and mental health, specific sub-populations of need.

Some key findings from the 2023 survey were:

Drug Use

- 56% of adults drank alcohol in the past 30 days, increasing from 54% in 2020; 3% drank heavily and 10% binge drank.
- 26% of residents used one or more illicit drugs other than cannabis in their lifetime, 6% used illicit drugs in the last 12 months, and 3%, in the last 30 days.
- 19.5% of New Jersey adults used cannabis in the past year, increasing from 17.3% in 2020.

Substance Abuse/Dependence

- 5.1% of NJ adults met DSM-IV diagnostic criteria for abuse or dependence on drugs and/or alcohol, continuing a decline from 7.5% in 2019 and 6.5% in 2020.

Nicotine Use

- 8% of adults smoked cigarettes in the last month, continuing a long downward trend since 1998, when 20% smoked.
- The largest decrease in current smoking was in young adults 18-25 (from 32% in 2003 to 4% in 2023).
- Since 2016, rates of past-year e-cigarette use rose dramatically in 18-25 year olds (from 13.8% to 21.8%).

Mental Health and Co-Occurring Disorders

- More than 23% of residents reported at least one psychiatric diagnosis in their lifetime, including 15% who were diagnosed with depression, 13% with anxiety and 4% with PTSD.
- With respect to current mental health problems, 11% screened positive for anxiety, 9% for depression, and 9% for moderate/severe psychological distress on the brief version of the Patient Health Questionnaire (PHQ-4).

Gambling

- Among all NJ residents, 63% engaged in some form of gambling in the last 12 months, including 55% of residents who played the lottery, 21% who gambled in a casino, 13% who played betting games not online (bingo, cards, horse racing, sports), and 11% who gambled on the internet.
- Frequent and heavy gambling were associated with substance use. Thus 10% of frequent gamblers and 12% of heavy gamblers smoked cigarettes daily compared to 3% of non-gamblers.
- Similarly, frequent and heavy gamblers were more likely than non-gamblers to drink heavily (6% and 14%, respectively, vs. 2%), engage in illicit drug use (10% and 15%, respectively, vs. 5%) and to have used cannabis in the last 12 months (23% and 33%, respectively, vs. 15%).

Regarding treatment access, most individuals screening positive for substance abuse/dependence and/or mental health symptoms did not receive formal treatment in the last 12 months. Overall, however, mental health treatment was substantially more accessible to those with mental health symptoms than addiction treatment was to those with substance abuse problems. Thus, 44% of those with mental health symptoms had been treated in the past year, compared to only 9% of those with symptoms of substance abuse or dependence. Moreover, lack of access to addiction treatment by those in need varied by demographic characteristics, geographic location and type of disorder. Among those with symptoms of disorder or dependence, young adults aged 18-25 had substantially lower access to addiction treatment than their counterparts.

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 use disorder treatment. Together with the alcohol treatment need estimates obtained from the NJ household survey, DMHAS produces an annual estimate of total treatment need that is used in the distribution of alcohol and drug abuse treatment funds.

Planning is beginning for the 2028 survey.

NJSAMS

A keystone source of information for needs assessment and gap analysis for addiction services is the NJSAMS. The SSA is able to establish the number of persons receiving substance use disorder treatment from licensed treatment providers through its mandated reporting of essential client health data to this combined public health disease surveillance and provider-oriented, management information system.

Stakeholder Input

The SSA utilizes local input such as this to help guide its overall statewide program development. As some specific examples, the Medication Assisted Treatment Initiative (MATI) has helped improve “access on demand” to medically assisted treatment for opiate injecting 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 adoption of Level .5 (Early Intervention) into NJSAMS reporting. Interim Services is now a funded (October 2019) fee-for-service initiative.

In-Depth Technical Assistance (IDTA)

As noted in Step 1, the SSA in 2014 was awarded technical assistance through the SAMHSA supported National Center on Substance Abuse and Child Welfare (NCSACW) to address the multi-faceted problems of Substance Exposed Infants (SEI) and Neonatal Abstinence Syndrome (NAS). The goal was to develop uniform policies/guidelines that address the entire spectrum of NAS and SEI from pre-pregnancy, prevention, early intervention, assessment and treatment, postpartum and early childhood.

In SFY 2023 New Jersey Department of Health successfully applied for 2023 In-Depth Technical Assistance (IDTA) through SAMHSA’s National Center on Substance Abuse and Child Welfare: – *Advancing Collaborative Practice and Policy: Promoting Healthy Development and Family Recovery for Infants, Children, Parents, and Caregivers Affected by Prenatal Substance Exposure*. The overall goal is to increase awareness of pregnant women and SUD, through increased education and maximizing messaging through the perinatal work force; increase awareness and access to treatment, Plans of Safe Care, and improving screenings in hospitals and healthcare providers. Four goals have been established:

- Conduct a statewide landscape analysis of resources available to individuals with a SUD and understand how referrals are made to appropriate resources and levels of care;

- Address gaps in the SUD system of care to establish comprehensive and fluid collaborative approach among state agencies, healthcare providers, and community-level and non-profit organizations to address substance use during and after pregnancy;
- By 2025, create and execute a state-wide prenatal Plans of Safe Care process that enables community and clinical partners to formally support a birthing woman;
- Support birthing hospitals in updating their protocol related to screening and referring pregnant women with SUD; and subsequently engaging in a comprehensive approach to implementing Plans of Safe Care in New Jersey.

Estimation of the Population in Need of Treatment

The estimated size of New Jersey's 2024 resident adult population in need of treatment for *alcohol* abuse or dependence is 263,350 persons. It is found by applying the proportion in need identified by the 2023 NJ-HSDUH to the U.S. Census Bureau's estimate of New Jersey's resident adult population for 2024. The size of the 2024 adult population needing treatment for *drug* abuse or dependence in New Jersey is 110,177 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 2023 and 2025 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 2024 New Jersey total substance abuse treatment need or 373,527 (See Table 1).

Table 1					
Estimate of Treatment Need for Alcohol and Drug Addiction, New Jersey 2024					
County	Adult Population 2024	Need for Alcohol Treatment	Need for Drug Treatment	Total Need for Alcohol and Drug	Total Need as % of the Adult County Population
	[1]	[2]	[3]	[4]	[5]
Atlantic	221,617	5,097	9,442	14,539	6.6
Bergen	776,062	23,282	3,614	26,896	3.5
Burlington	378,510	15,140	6,280	21,420	5.7
Camden	413,307	15,292	10,401	25,693	6.2
Cape May	78,010	4,369	2,457	6,826	8.7
Cumberland	117,693	3,884	4,275	8,159	6.9
Essex	675,250	13,505	14,367	27,872	4.1
Gloucester	245,997	13,284	5,101	18,385	7.5
Hudson	593,365	20,768	5,322	26,089	4.4
Hunterdon	106,683	5,654	959	6,613	6.2
Mercer	306,260	13,475	6,038	19,513	6.4
Middlesex	701,414	17,535	7,437	24,972	3.6
Monmouth	513,483	23,620	6,996	30,616	6.0
Morris	415,827	18,712	1,939	20,651	5.0
Ocean	499,826	19,493	8,208	27,701	5.5
Passaic	402,847	19,337	6,489	25,826	6.4
Salem	51,382	1,439	1,697	3,135	6.1
Somerset	282,756	7,917	1,906	9,823	3.5
Sussex	118,692	3,798	937	4,735	4.0
Union	455,721	14,127	5,079	19,206	4.2
Warren	90,521	3,621	1,256	4,877	5.4
Total	7,445,222	263,350	110,177	373,527	5.0
[1] Source: U.S. Census Bureau, Population Division: 2024 American Community Survey 5-Year Estimates. [2] Alcohol treatment need derived from the 2023 New Jersey Household Survey on Drug Use and health. [3] Drug treatment need is estimated by applying a two-sample Capture-Recapture statistical model using the 2020 and 2022 NJSAMS data. [4] Percent of Drug treatment need was derived by dividing the population in need of treatment in each county (column 4) by the adult population in that county, times 100.					

Met and Unmet Treatment Demand

Table 2 presents the met and unmet demand for substance abuse treatment as well as the ratio of unmet to met treatment demand, or “gap” in New Jersey by county. It can be seen that of 155,093 individuals who wanted substance abuse treatment, 43,415 received it. This resulted in an unmet demand of 111,678 or a gap of 72.0%.

The 2023 NJHSDUH asked people who either had been treated or felt they needed treatment in the past year, what prevented their access to care, the most prevalent response was individuals reported reasons affecting access to care felt they could manage problem on their own (72%), not being ready to stop using substances (57%), couldn't afford cost (53%), time constraints (49%), afraid others would find out (47%), couldn't find the right treatment (40%), thought treatment wouldn't help (39%), didn't believe they had a problem (38%), inconvenient program hours (34%), feared treatment information was not confidential (34%), lengthy waits for admission (30%). and 18.2% worried about legal consequences (14%).

Table 2					
2024 Estimates of Met and Unmet Demand for Substance Use Treatment of the Adult Population in New Jersey					
County	2024 Adult Population (1)	Met Demand (2)	Unmet Demand (3)	Total Demand (2)+(3)	Gap: Unmet Demand as Percent of Total Demand
Atlantic	221,617	3263	1,995	5,258	37.9
Bergen	776,062	1878	6,208	8,086	76.8
Burlington	378,510	2374	7,192	9,566	75.2
Camden	413,307	3750	7,853	11,603	67.7
Cape May	78,010	1010	1,170	2,180	53.7
Cumberland	117,693	1757	2,001	3,758	53.2
Essex	675,250	4730	12,830	17,560	73.1
Gloucester	245,997	1923	2,952	4,875	60.6
Hudson	593,365	2162	4,747	6,909	68.7
Hunterdon	106,683	400	2,027	2,427	83.5
Mercer	306,260	2092	7,044	9,136	77.1
Middlesex	701,414	3259	4,910	8,169	60.1
Monmouth	513,483	3247	7,189	10,436	68.9
Morris	415,827	1079	4,990	6,069	82.2
Ocean	499,826	3618	12,995	16,613	78.2
Passaic	402,847	2480	9,668	12,148	79.6
Salem	51,382	561	668	1229	54.4
Somerset	282,756	1028	1,697	2,725	62.3
Sussex	118,692	592	2,255	2,847	79.2
Union	455,721	2016	7,292	9,308	78.3
Warren	90,521	531	1,358	1,889	71.9
Total	7,445,223	43,415	111,678	155,093	72.0
[1] 2024 Estimates of the Resident Population for Counties in New Jersey. U.S. Census Bureau, Population Division. [2] Met demand: The number of unduplicated counts of adults admitted for alcohol and drug treatment in 2024. Source: NJSAMS data – 2024 Substance Abuse Overview. [3] Unmet demand: Proportion of the 2023 NJ Household Survey estimated adult population who did not receive treatment in the 12 months prior to the interview but who felt they needed and wanted treatment, times the 2024 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 identify prevention and treatment resources by location and socio-economic characteristics of at-risk populations. The scale calculates an index of risk for each county for which the indicators can be obtained. Because the scale is an interval level of measurement that sums to one, scores are comparable and easily interpreted across jurisdictions. In FFY 2014, the SSA provided RNAS indexes down to the municipal level for use in the county comprehensive planning process. In the past county comprehensive planning process for 2016 to 2019, the RNAS model, updated to include data from the 2019 U.S. Census, was used to identify areas within counties with potentially high concentrations of people with substance abuse prevention, treatment and recovery support service needs.

Geographic Information Systems

The SSA maps the spatial distribution of treatment services across all counties and modalities of care and uses this information in its county comprehensive planning. It routinely uses Geographic Information Systems (GIS) to map its treatment services in order to guide its planning of services in areas of need. 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 inspections to produce walking maps for the inspectors to follow.

Treatment Initiatives Based on Need

Medications for Opioid Use Disorder

Data from NJSAMS for Calendar Year 2024 indicates that 15% of methadone and 10% of buprenorphine is planned in treatment for clients admitted to treatment, yet heroin and other opiates are the primary drugs of 36% of admissions in New Jersey's addiction treatment system. The development of the Medication Assisted Treatment Initiative (MATI) has been an attempt to help decrease this gap by providing increased access to Medications for Opioid Use Disorder (MOUD) by offering methadone, as well as buprenorphine, to individuals with an opioid use disorder through five mobile medication units licensed as Opioid Treatment Programs (OTPs). One mobile medication unit currently provides methadone to inmates at Atlantic County Jail as part of their business plan and connects them to continued care when released. Another attempt to increase access to MOUD, specifically buprenorphine, has been the development of statewide

buprenorphine training courses utilized as an educational component for physicians, Advanced Practical Nurses (APNs) and Physician Assistants (PAs) to attain their Buprenorphine Waiver. The State held a total of 31 trainings statewide through both Rutgers University (northern region) and Rowan University (southern region) in CY 2019 and CY 2020. Over 1,000 prescribers were trained through this effort. In December 2022, the buprenorphine waiver requirement was permanently removed in, so any provider who is registered with the DEA to provide controlled substances can now provide buprenorphine in the State of New Jersey.

Other initiatives implemented to expand the use of MOUD in New Jersey have been the Expanded Hour Access OTP Program and the Mobile Medication Unit Program. In early CY 2021, DMHAS initiated contracts with four OTPs that provide over 35 additional hours of service per week and began in July 2021, with most providing evening hours, in efforts to assist individuals access services during times intakes at OTPs are not typically available. The intent of the program has been to provide low barrier, on-demand MOUD followed by treatment or referral to ongoing care for individuals with an OUD. DMHAS secured funding to start-up two additional Expanded Hour OTPs and contracts began with those entities in by the end of CY 2021. Services commenced with the two additional providers in CY 2022. The other initiative which was developed provides funding for programs to facilitate low induction medication, case management and other ancillary services through use of a mobile van for individuals with an OUD in counties with low access to MOUD as well as areas of the State with individuals who are homeless or at higher risk for homelessness. In CY 2022, two agencies were awarded contracts. In CY 2023, both contracted programs procured Mobile Medication Units (MMUs) from Mission Mobile, a vendor recommended by the National Association of Addiction Treatment Providers. Both have been prescribing buprenorphine from the vans since May 2023. Both are currently working with the NJ Department of Health, Certificate of Need & Licensing (CN&L), to attain an OTP license, which will enable them to dispense both methadone and buprenorphine from the vehicles. DMHAS solicited a Request for Proposal (RFP) in late 2023 for a third MMU and awarded and initiated a contract with a provider in CY 2024. The provider attained a van in the same year and began prescribing buprenorphine. This provider is also currently working with CN&L to obtain OTP licensure and is expected to receive that later in 2025.

The SSA's goal is to continue to develop a system of care that offers high risk clients the means to enter and sustain recovery. In this effort, the SSA implemented a pilot program in September 2011 for the DUI offender with an alcohol or opioid use disorder that included medication assisted treatment using the FDA approved medication Vivitrol (an injectable form of naltrexone). A comprehensive research protocol was developed, and numerous client outcomes were assessed. The pilot was launched in September 2011; clients received the medication for up to six months. There was a follow-up survey six months after the client's last injection. The pilot ended in September 2013 once 100 clients had received the medication. Since results were promising, Vivitrol has since been incorporated as an enhancement in most of its current SUD Fee for Service Initiatives, New Jersey Statewide Initiative (NJSI), South Jersey Initiative (SJI), Mutual Agreement Program-State Parole Board (SPB), Medication Assisted Treatment Initiative (MATI); Substance Abuse Prevention and Treatment Initiative; State Hospital Access to Rehabilitation and Education (SHARE), and the Driving Under the Influence Initiative (DUII). Acknowledging that addiction is a medical disorder that postulates client-centered treatment, the purpose of this funding

is to have an array of medication treatment alternatives for individuals with an opioid use disorder.

The Division continues to offer trainings on MOUD and other Medications for Addiction Treatment (MAT) for licensed substance use disorder treatment providers as well as peer recovery specialists who work at licensed SUD agencies or through DMHAS-funded initiatives. DMHAS has also incorporated language requiring acceptance of clients on all forms of MOUD and MAT into contract requirements, as well as all applications for new funding, and has provided training on MOUD and MAT for systems to include, but not limited to the Department of Children and Families' Children System of Care, Psychiatric Hospitals and the New Jersey County Jail Wardens Association. DMHAS also contracts with Rutgers University, who has implemented a program called the Rutgers Interdisciplinary Opioid Trainers (RIOT). The RIOT has been designed as a train-the-trainer program by faculty who educate/train university students. The university students provide a free 1-hour training, either in-person or virtually, to community members/groups to educate them about the opioid epidemic in NJ, how to manage an overdose, and increase education and decrease stigma about Opioid Use Disorder (OUD) and the use of medications to treat the disease. Another training initiative, launched in CY 2023 is with Cooper Medical School of Rowan University (CMSRU), the State's Southern Center of Excellence (COE). CMSRU is contracted to provide tailored training and technical assistance on Addiction Medicine, specifically buprenorphine induction, throughout New Jersey. This includes various training topics, formats, office hour sessions, and "elbow to elbow" on-site consultation services. The training is aimed at increasing the use of buprenorphine to treat opioid use disorders, specifically at Emergency Departments, Federally Qualified Healthcare Centers and Primary Care offices.

From FFY 2018 to FFY 2020, New Jersey received a total of \$120.3 million from SAMHSA, the Center for Substance Abuse Treatment (CSAT) through the initial State Opioid Response (SOR) grant and supplemental SOR funding. In FFY 2021, NJ received approximately \$132 million through SOR 2.0 for FFY 2021 and FFY 2022. Subsequently, NJ received approximately \$136 million through SOR 3.0 for FFY 2023 and FFY 2024. Furthermore, NJ received approximately \$69 million in SOR 4.0 for FFY 2025. The goals of SOR 2.0 through 4.0 have been to address the State's opioid crisis as well as a rising issue of stimulant use disorder (new beginning in SOR 2.0) by providing treatment, family and peer recovery support, community prevention and education programs and training. The key objectives of funding have been to increase access to MOUD, decrease unmet treatment need, decrease opioid-related deaths, and most recently to provide services to address individuals who have a stimulant use disorder. Some of the activities of SOR grant activities are highlighted below.

Through SOR funding, DMHAS contracted with 10 licensed substance use disorder agencies to support the development of medical capacity to provide MAT to eligible individuals at their programs. DMHAS offered similar contracts for up to eight mental health agencies to ensure these services for individuals with a co-occurring mental health and substance use disorder.

DMHAS began funding Interim Services through its Fee-for-Service (FFS) Network in October 2019 for individuals on waiting lists at ambulatory and residential programs. This program offers individuals early intervention services prior to being admitted to a full array of treatment services.

DMHAS partners with both Rutgers University and Rowan University to ensure funding is available to support individuals at their clinics who are indigent, so they can be inducted and/or maintained on MOUD. Services for these individuals include other ancillary services such as care coordination and peer recovery services and commenced in July 2021.

DMHAS, in collaboration with the NJ Department of Corrections (DOC) and the NJ Department of Health (DOH) have jointly initiated a program to expand the use of MOUD for inmates with opioid use disorders in all New Jersey county jails (SOR funds support four of the county jails). The only jail not initially funded (Monmouth County) had a discretionary grant enabling them to provide this service which ended and commencing in CY 2023, DMHAS began funding. The medications utilized at all county jails at minimum include methadone, buprenorphine, naltrexone, extended-release naltrexone (Vivitrol). In efforts to support jails in this endeavor, DMHAS utilized funds through FFY 2025 to support the State Centers of Excellence (COE) so they could provide technical assistance to the county jails participating in the initiative.

Recovery Initiatives Based on Need

DMHAS implemented contracts in all 21 counties to support its Opioid Overdose Recovery Program (OORP) which utilizes recovery specialists and patient navigators to engage individuals, bedside, reversed from an opioid overdose and provide non-clinical assistance, recovery supports and appropriate referrals to substance use treatment services while also maintaining follow-up with clients for a minimum of eight weeks.

DMHAS contracts for Support Team for Addiction Recovery (STAR) programs in all 21 counties. This program provides case management and recovery support services for individuals with an OUD who are at risk for opioid overdose. All STAR programs continued to be operational during the pandemic and offered services virtually, through the phone, and in-person (where social distancing could be maintained). STAR teams obtain their referrals from community partners including treatment providers, state child welfare agencies, re-entry organizations, and community agencies, among many others. STAR providers also actively collaborate amongst themselves to ensure that individuals who leave one county can receive a warm handoff to another county's STAR program and continue to receive these vital recovery support services.

DMHAS funds 21 Community Peer Recovery Centers (CPRCs) to provide peer support recovery services and/or activities to the community that include, but are not limited to: access to resources on substance use disorder and behavioral health treatment; naloxone training and kits; peer recovery coaching; assistance in development of recovery plans; social events and/or recreational activities; support groups; wellness classes; and programs to address particular issues and concerns. During the COVID-19 pandemic, all CPRCs provided virtual community support services via phone and online service) and provide limited safe distancing in-person recovery support services.

DMHAS funds a Telephone Recovery Support (TRS) program. TRS is a peer check-in type service where staff help provide local recovery supports, including information about resources such as self-help meetings, food pantries, and sober living and treatment services, if needed. TRS

provides support and peer coaching to program participants. Participants receive weekly support calls and are connected to information on local recovery support services. Specialists assist in identifying resources such as housing, transportation, training programs, employment services, or recovery support groups.

Recovery Management Check-Up (RMC)

RMC is a service for discharged clients to support independent living and success with recovery and provide more methods of outreaching to clients. This will include virtual face-to-face visits, text messaging and chat features, and also the opportunity for actual in person contacts. This check-up service will help provide local recovery supports. RMC aims to identify and alleviate client problems before they derail recovery. Monthly contact forms the core of the proposed RMC. Problems are addressed using motivational interviewing techniques or connecting clients to appropriate community resources or treatment if needed. The conceptual framework of RMC is to treat addiction as a chronic disease, with long-term management to minimize the number of acute episodes of substance abuse and with prompt treatment when episodes occur to prevent them from becoming more severe and consequential. Three regional awards (North, Central and South) were awarded in March 2023 to two agencies (one agency will cover two regions) to provide this service.

Recovery Support Care Management (RSCM)

RSCM was established and became effective on March 7, 2023 and is a behavioral health service intended to support consumers who have a SUD with complex physical and/or psychosocial needs. RSCM provides direct and comprehensive assistance to consumers to ensure access to the necessary treatment, rehabilitative and recovery services with the intent of decreasing psychiatric and addiction symptoms, connect consumers with services, improve transitions between levels of care, implement strategies to address their unique needs, decrease opioid related deaths and sustain recovery in the community while supporting the consumers' continued stability and recovery throughout the continuum of care. This service is available as an enhancement in all levels of care. This service may be provided face-to-face or via a telehealth platform. Since Medicaid offers Care Management in outpatient, RSCM is excluded from reimbursement for individuals admitted into Ambulatory LOCs in Recovery Care Efficiency (RCE). As of March 31, 2025, there were 5,617 unduplicated clients who received this service.

Transportation Reimbursement and Invoicing Program (TRIP)

One obstacle frequently reported across all healthcare domains, including behavioral health, is transportation (Locatelli et al., 2017; Syed et al., 2013). According to Bellamy et al. (2016), unreliable access to transportation was the most frequently documented and reported non-medical obstacle to clients seeking substance abuse and mental health outpatient services. Transportation obstacles manifest themselves in several ways: a lack of independent car ownership, high cost of public transportation, travel distance, travel time, parking fees, a lack of public transportation, distance from agency to a bus stop, and cost of ride-sharing services (Locatelli et al., 2017). Without adequate and affordable transportation options, clients are unable to begin vital treatment nor consistently attend and complete treatment, resulting in suboptimal outcomes. NJ's 2018

Household Survey of Drug Use and Health indicated that of the clients surveyed who indicated they wanted treatment, transportation was an obstacle for 39% of the participants.

Transportation is a key recovery support. A reliable means of transportation is needed so clients can get to prevention, recovery and treatment support programs. As a result of this gap, DMHAS has developed a new program called the *Transportation Reimbursement and Invoicing Program (TRIP)*. This will enable transportation to treatment for individuals who do not have Medicaid, as well as enable transportation to and from non-healthcare facilities such as Community Peer Recovery Centers or prevention programs. TRIP is intended and designed to eliminate transportation obstacles and facilitate access to substance use disorder Treatment, Prevention and Recovery Support Services (RSS). SUPTRS Block Grant COVID-19 Supplemental funded this program and ARPA funds are currently being utilized. DMHAS plans to continue this initiative with SOR funds when the ARPA grant ends.

Critical partners are the County and Alcohol Drug Directors (CADADs), our various recovery support programs such as the Opioid Overdose Recovery Program (OORP), Support Team for Addiction Recovery (STAR), Community Peer Recovery Centers (CPRC), Intensive Recovery and Treatment Support (IRTS), Maternal Wrap Around Program (MWRAP), prevention and SUD treatment providers.

Needs Assessment: Prevention

Background

In December 1993, the SSA was awarded a three-year contract with the Center for Substance Abuse Prevention (CSAP) to conduct studies to assess needs for prevention of alcohol, tobacco, and other drugs misuse and abuse in the state and in its health planning regions. The contract included the Middle School Survey, the Mature Citizen Survey and the Community Leaders Survey. In addition, a social indicators study and companion chart books of social and health indicators for each of New Jersey's 21 counties and selected municipalities were completed. The data generated by these surveys and studies were utilized in policy formulation, resource allocation and the provision of revised data requested within the SUPTRS Block Grant Application.

Middle School Survey

DMHAS is a strong proponent of data driven planning. DMHAS shares the findings of its Middle School Survey of Risk and Protective Factors widely with various stakeholders and other government agencies to encourage collaboration and build public understanding of the prevalence of priority health risk behaviors among youth. This public understanding is an essential prerequisite to local decisions to adopt appropriate policies, implement programs, employ qualified staff and participate in local coalitions. These data are also utilized by our prevention agencies and our Regional Prevention Coalitions to support their prevention programming for children and adolescents. In addition to state-specific use, DMHAS reports this information to SAMSHA through its federal SUPTRS Block Grant plan and application.

The New Jersey Middle School Survey of Risk and Protective Factors (MSS) is a statewide student health survey designed to systematically collect information from middle school students about their school climate and safety, community, drug, alcohol, and tobacco perceptions and use; and other factors showing strong correlations to risky behaviors. Findings from this study are used to create tailored prevention programs for New Jersey's youth and complete the Federal application for block grant funding. All New Jersey public schools (including charter schools) with at least 40 students enrolled in grades seven and eight combined are eligible to participate. In previous administrations a random sample of schools was drawn, but going forward any school can participate. Considering the importance of monitoring levels of risk for substance abuse among New Jersey's youth, the SSA has supported continuation of the Middle School Survey beyond the initial CSAP funding period and has subsequently conducted a Middle School Survey approximately every 3 years since 1999. The survey has been conducted in 1999, 2003, 2007, 2010, 2012, 2016, 2020 and 2023. The next administration of the survey will occur in the fall of 2025.

DMHAS has retained the Center for Research and Evaluation on Education and Human Services (CREEHS) from Montclair State University to conduct the MSS since 2018. CREEHS also engages in semi-structured one-on-one phone interviews with over 70 key stakeholders, including state agencies, regional substance abuse prevention coalitions, student assistance counselors, community leaders, parent advocate groups, parent-teacher organizations, and school leadership. Stakeholders are geographically broad and represent a range of particular interest areas.

One of the state's challenges had been that active parental consent was required for students to participate in these surveys, which impacted response rates. The SSA supported a change in the legislation to require passive parental consent instead. The state passed new legislation NJ P.L.2021, c.156 that eliminates the need for active parental consent.

The survey is administered to 7th- and 8th-grade students across NJ and includes questions about substance use and antisocial behaviors, well as factors that encourage or discourage their participation in such behaviors. The current instrument is a revised and abbreviated version of the Communities That Care Youth Survey, which was designed as a tool for assessing prevention needs among students. The current MSS provides additional data related to core measures that are required by the Substance Abuse and Mental Health Services Administration (SAMHSA) for their Drug-Free Communities Grants. The survey is designed to collect data that helps identify youth needs, inform local and state prevention programs and related policies, evaluate outcomes of state investments in decreasing youth substance use and increasing protective factors. The detailed report for the 2023 MSS can be found at [2023.pdf](#).

Underlying factors related to community, family, school, and peer relationships contribute to a student's risk for using alcohol, tobacco, and drugs and participating in antisocial behaviors. These are known as "risk" and "protective" factors. Researchers Michael Arthur and J. David Hawkins, building on conceptual frameworks by others, such as John Coie, have provided evidence for the factors with the strongest correlations to drug use and antisocial behaviors among youth. Through their work, the factors included in the current MSS were conceived to facilitate prevention needs assessment.

Risk and protective factors are grouped into domains, or settings, where interventions can take place. Risk factors are characteristics of the students' community, family, school and peer relationships that predict the likelihood of experimentation with alcohol, tobacco, and other drugs and participation in antisocial behavior. Protective factors buffer students against these risks. Factors are clustered into six domains: four risk categories and two protective categories. The Risk category includes four domains - Community, Family, School and Peer/Individual - which have 20 factors, while the Protective category includes two domains- Peer/Individual and School- that encompass five factors. Research suggests that the more risk factors students are exposed to, the more likely they are to engage in substance use or antisocial behaviors. Certain risk factors are also associated with higher depressive symptoms among adolescents. Protective factors represent characteristics in the student's environment that protect them against these behaviors. Efforts to prevent substance use and antisocial behaviors generally aim to decrease the influence of risk factors, enhance the effectiveness of protective factors, or both. While one may not be able to eliminate risk factors, it is possible to increase protective factors.

Findings from the Middle School Survey are used by public health and education agencies, policy makers and community leaders to:

- Monitor trends and identify emerging issues
- Compare prevalence rates across states and regions
- Identify gaps in policies and practice that can affect adolescent health and academic performance
- Plan and evaluate prevention programs

The findings provide key insights into the needs of our youth, the variations in health outcomes. By tracking changes over time, one can better recognize emerging issues and prioritize areas of need. These results could inform the development and advocacy of policies, interventions, programming, and services at the statewide, county, and local levels. Participating in the survey allows students to share their perspectives to inform current understanding of health trends and improve student outcomes.

The survey gives 7th- and 8th-grade students a voice by allowing them to anonymously share their perspectives and experiences about alcohol and drug use, mental health, gambling, bullying, social media, and supportive environments. The survey captures the experience of 7th- and 8th-grade students, which can inform the development and advocacy of policies, interventions, programming, and services by prevention agencies, schools, and other youth-serving organizations at the statewide, county, and local levels. The New Jersey Middle School Survey provides valuable insights into what 7th- and 8th-grade students think, feel, and experience, allowing schools, parents, and community organizations to better identify the prevalence of important issues and efforts to help improve students' well-being and academic outcomes. By participating, schools help ensure student voices are heard, informing efforts to create healthier, safer, and more supportive environments. New this year, all New Jersey public schools that serve 7th- and/or 8th-grade students are invited to participate! Broader participation ensures more representative and actionable data.

However, school-based health surveys face several challenges with school recruitment due to a wide range of obstacles at the district, school, and parent levels, including similar survey efforts, concerns regarding class interruption, timing, and work necessary for administrations.

For the most recent 2022-2023 MSS, administrations began in February 2023 using a virtual administration design and continued through June 2023. There were 3,168 surveys collected from 59 participating schools across 19 counties in NJ; 2,792 surveys were eligible. Results from this survey are used to help communities plan and implement meaningful prevention and education programs at the state and local levels and inform NJ State investments in prevention initiatives.

Some key findings from the 2023 survey were:

- Alcohol remained the substance most widely used by seventh- and eighth-grade students in NJ in the past year (12%), followed by e-cigarettes (8.8%) and marijuana (5.7%). 10.9% of students have misused prescription drugs (i.e., used drugs not prescribed to them or differently from how prescribed to them) during their lifetime.
- Prevalence rates for alcohol and marijuana use increased among middle school students from 2021 to 2023. Rates for cigarettes, inhalants, and other illicit drugs have continued their decline since 2012 or plateaued.
- More than half (53.2%) of all responding students reported struggling with sadness during the past year.
- More than half (55.3%) of all students engaged in some form of gambling or betting in the past year. The survey revealed that 76.5% of all students have experienced some form of bullying in the past month.

DMHAS has retained the Center for Research and Evaluation on Education and Human Services (CREEHS) to conduct the MSS since 2018. CREEHS also engages in semi-structured one-on-one phone interviews with over 70 key stakeholders, including state agencies, regional substance abuse prevention coalitions, student assistance counselors, community leaders, parent advocate groups, parent-teacher organizations, and school leadership. Stakeholders are geographically broad and represent a range of particular interest areas.

New for 2024, an interactive data dashboard, the *New Jersey Middle School Survey Data Explorer*, is publicly available to enable users to explore areas of interest using various dashboard views to take a closer look at trends over time, results for different demographic subgroups, and county-level results. The link can be found at [NJ Middle School Survey – CREEHS - Montclair State University](#).

The next MSS will be administered from October 2025 to June 2026. Participation will be open to all NJ public schools that have at least 40 students in the 7th and/or 8th grade. Year 1 (July 1, 2024-June 30, 2025) was the planning year. Year 2 (July 1, 2025 to June 30, 2026) is the data collection year and Year 3 (July 1, 2026-June 30, 2027) is data preparation and weighting. Rolling registration is open through April 2026. A new website was designed for schools to enroll at [Survey Info & Registration | New Jersey Middle School Survey](#). It takes on average about 30

minutes to complete the survey. It is designed to be administered within one class period. CREEHS will administer the survey on day(s) selected by the schools and will support schools throughout the entire process, from registration to administration.

High School Survey

Implementation of the SSA's first High School Survey (PRIDE Survey) was completed in June 2008. It used the same survey instrument as the Middle School Survey and was the first New Jersey report at the county level for 9th through 12th grade youth. However, it was decided to not repeat this survey since the NJ Department of Education (DOE) conducted the High School Student Health Survey sponsored by the Center for Disease Control and Prevention (CDC). Instead, the SSA collaborated with DOE to provide financial assistance for the 2011, 2013 and 2016 surveys. While the DOE did not sample at the county level, due to CDC restrictions, the findings still provided important information regarding factors protecting and posing risk to adolescents concerning substance use.

Findings from the High School Survey can be used by public health and education agencies, policy makers and community leaders to:

- Monitor trends and identify emerging issues
- Compare prevalence rates across states and regions
- Identify gaps in policies and practice that can affect adolescent health and academic performance
- Plan and evaluate prevention programs

In early 2024, the NJ Department of Education inquired whether DMHAS was interested in assuming responsibility for the CDC High School Survey. DMHAS agreed and submitted an application to the CDC. Approval was received for the five-year award "Proposal for a Five-Year Cooperative Agreement Beginning August 1, 2024, Improving Adolescent Health and Well-Being Through School-Based Surveillance and What Works in Schools Program (CDC-RFA-DP-24-0139), Component 3: State, Territorial, and School-Based Surveillance, Tier 1 Adverse Childhood Experiences (ACEs) Questions". Terms of our CDC award are to administer the YRBS High School Survey every two years, starting fall 2025, and the Student Health Profiles every two years starting 2026. We received additional funding from the CDC to include eight adverse childhood experiences (ACES) questions to the survey.

Surveillance of adolescent health behaviors and risk factors through the Youth Risk Behavior Survey in New Jersey (called the New Jersey Student Health Survey, or NJSHS) and the New Jersey School Health Profiles (Profiles) will allow us to examine the need to improve adolescent health and mental health, decrease risk factors, adverse childhood experiences and substance use, and to provide interventions that address these needs for adolescents in NJ.

The New Jersey High School Student Health Survey (NJSHS) is designed for high school students, grades 9-12. The survey includes items concerning bullying and sexting; depression and suicide behaviors; eating habits and body weight; physical activity, physical health and general health behaviors; HIV and STD testing and sexual behavior; personal safety and violence-related behaviors; substance use including tobacco, marijuana, and other drugs; and risk perception. It will

be administered to the 40 NJ schools randomly selected by CDC. The school sample consists of regular public and vocational schools but no charter schools. Stakeholder engagement is central to this work (e.g., Advisory Committee, Working Groups). A YRBS coalition consisting of an interdepartmental working group and other stakeholders was established to support survey administration. It is part of the largest public health surveillance system in the U.S. dedicated to monitoring a range of health-related experiences among adolescents. All data must be submitted to Westat, the CDC's contractor, by December 2025. Results of the survey are anticipated in the summer of 2026 from the CDC.

School Health Profiles

The CDC established School Health Profiles (Profiles) in 1996 to monitor school health policies and practices in secondary schools in states and school districts across the United States. Profiles is a system of surveys conducted biennially in even-numbered years and provides data on the following topics: health education requirements and content, physical education and activity, safe and supportive environments, health services, and school health coordination. It is administered to middle and high school principals and/or lead health educators, every 2 years to assess school health policies and practices at state level.

The Profiles assist New Jersey agencies to monitor and assess characteristics of bullying prevention and mental health, chronic illness, health education, nutrition, physical education and physical activity, professional development, school connectedness, school organization to guide health policy, sexual health, and tobacco prevention. CREESH will administer the Profiles for DMHAS in 2026.

Chartbooks

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 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 Chartbooks are to: 1) Present an objective profile of New Jersey at the state, county, and municipal levels using key social indicators related to substance abuse; 2) Show the effect of substance use and related health consequences in New Jersey at the state, county, and municipal levels; and 3) Provide information to support needs assessment and prevention, as well as treatment planning, at the community level. Chartbooks have been published for 2003, 2005, 2013 and 2016. In 2016, the most recent updates to the *Chartbooks of Social and Health Indicators*' information which can be used to identify health problems directly or indirectly related to substance use and to aid in the assessment of needs for prevention and treatment services, and further enhanced the database of all prevention services and programs being delivered throughout the State. The 2022 Chartbooks are currently under review.

Prevention Coalitions

In 2012, DMHAS established nineteen prevention coalitions in New Jersey. The regions in which the coalitions are located were identified based the "Prevention Needs Assessment Using Social Indicators: State of New Jersey Substance Abuse Prevention County Level Needs Assessment". The "Prevention Needs Assessment" utilized archival data of social indicators to develop composite indices of risks to estimate the need for prevention services among New Jersey's 21 counties. Criteria including population, substance abuse treatment admissions and rates within the region as well as prevalence of alcohol and prescription drug misuse among middle and high-school students were also considered in identifying the 19 regions. Additional criteria used to determine the regions included that:

- Each region must be comprised of at least one county
- Each region must have reported a minimum of 2000 treatment admissions (according to the latest available data) for the previous year

Relative Needs Assessment Scale

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, A. and French, J. F. "On the Construction of a Relative Need Assessment Scale, 1996, Substance Use Misuse 31(6): 753-765" using social indicators with known correlations to the incidence and prevalence of substance abuse.

The Relative Needs Assessment Scale (RNAS) was developed for alcohol and drug prevention planning in 1995 and updated in 2008, 2013 and 2016. Archival data of social and health indicators were used to estimate the relative levels of need for prevention services among NJ counties. 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 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. The RNAS is used to identify prevention and treatment resources by location and statutory populations. It was utilized in the 2008 and 2014 RFP processes for awarding five-year prevention contracts utilizing SAPT Block Grant funding.

The risk indicators for AOD use or abuse are organized by two operational domains, namely, the Community-based Risk Index (CRI) and the Youth Risk Index (YRI). The CRI was calculated using the Relative Needs Assessment Scale (RNAS). The model involved social indicators data for the construction of the RNAS for both alcohol and drugs. Taken together they form an index of the relative level of risk operating in each county. The CRI is based on aggregated county-level risk factors that potentially influence all individuals within a community. The risk indicators used as a measure of community-level risk are: alcohol deaths, alcohol use, driving under the influence (DUI), drug deaths, child abuse/neglect, drug use and drug violation arrests.

The YRI index was constructed from indicators that operate within the realm of youth: the school, the family, and the individual. These indicators rely heavily on the empirically tested risk factors from the individual level, etiological studies of youth and their family's characteristics. County-level data were derived from the 2015-2016 New Jersey Middle School Survey and the New Jersey Department of Education (Commissioner's Annual Report on Violence, Vandalism, and Substance Abuse. Although prevention services are relevant throughout all stages of human development, this study focused on the AOD abuse risks and prevention needs of youth due to the greater cost-benefit ratios of preventing early use.

A study was conducted by DMHAS in 2016 to provide an estimate of needs for the prevention of alcohol and other drugs (AOD) abuse that county planners could use in resource allocation. Archival data of social and health indicators were used to estimate the relative levels of need for prevention services among New Jersey counties. Risk indices were derived based on substance abuse prevention theories regarding the predictive ability and the operational domains of risk. The Relative Needs Assessment Scale (RNAS) and Hawkins' etiological model are used as templates because of their relevance to prevention programming. A report was prepared in September 2017, "Substance Abuse Prevention Needs Assessment Using Social Indicators". Plans are underway to update this study in 2026 for ongoing prevention needs assessment.

New Jersey Regional Coalition Needs Assessment

The 19 New Jersey Regional Coalitions conducted an update to their needs assessment in 2018. Building on their initial needs assessment conducted five years prior, the Regional Coalitions built on that process to update their logic models and plans in order to capture current substance abuse prevention needs and trends. Using the Strategic Prevention Framework (SPF), the coalitions work on all steps (i.e., needs assessment, building capacity, implementation, etc.) at different times. Given the length of time that had passed since the coalitions' original needs assessment, an update was needed to assess their accomplishments so far and determine any changes in community needs.

The primary goals of these community needs assessment updates were to assess what the coalitions accomplished in the first several years of the statewide initiative, assess current community needs and readiness, prioritize strategies, and update logic models to reflect any changes in their plans to address current needs. The Rutgers Center for Prevention Science (RU-CPS) and New Jersey Prevention Network (NJPN) provided guidance, technical assistance, and training as the coalitions moved through their community needs assessment updates.

The overall needs assessment questions guiding the coalitions' process included the following:

- Which substance use problems (i.e., overdoses, alcohol poisoning) and related behaviors (i.e., prescription drug misuse and underage drinking) are occurring in your community?
- How often are these problems and related behaviors occurring?
- Where are these substance use problems and related behaviors occurring (i.e., at home or in vacant lots; in small groups or during big parties)?
- Who is experiencing more of these substance use issues and related behaviors? (i.e., are they males, females, youth, adults?)

The final step for all coalitions was to update their regional logic models based on their needs assessment update process. Across all coalitions, logic models were developed for the following substance priorities: underage drinking, marijuana, prescription drug misuse, illegal drugs, and tobacco. Coalition Needs Assessments will be updated during SFY 2024.

Prevention Initiatives Based on Need

Regional Coalitions

Effective January 1, 2012, 19 regional substance abuse prevention coalitions were funded under an RFP that was issued by the Division of Mental Health and Addiction Services in the fall of 2011. The goals of this project are to engage community stakeholders to address prevention priorities identified by DMHAS' Prevention Strategic Planning Committee in 2010 and to complement and reflect the first of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Eight Strategic Initiatives. The prevention priorities are:

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

The SSA identified 19 coalition regions in New Jersey. These regions were selected based the “Prevention Needs Assessment Using Social Indicators: State of New Jersey Substance Abuse Prevention County Level Needs Assessment.” The “Prevention Needs Assessment” utilized archival data of social indicators to develop composite indices of risks to estimate the need for prevention services among New Jersey’s 21 counties. Criteria including population, substance abuse treatment admissions and rates within the region as well as prevalence of alcohol and prescription drug misuse among middle and high-school students were also considered in identifying the seventeen regions.

The coalitions collaborate with Municipal Alliances in their region, which are funded and overseen by the Governor's Council on Substance Use Disorder. (GCSUD). Coalitions also coordinate their efforts with those of the 27 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 decrease the misuse and the harmful consequences of alcohol and drug use among the citizens of New Jersey.

Strategic Prevention Enhancement Grant

In May 2011, the SSA received a Strategic Prevention Enhancement (SPE) grant from SAMHSA. New Jersey's SPE Project served six high-need counties: Bergen, Camden, Essex, Hudson, Middlesex, and Monmouth. Archival data of social indicators were used to develop composite indices of risks to estimate need for prevention services among the 21 New Jersey counties. Risk factors related to alcohol and drug misuse in these identified counties were far more prevalent than in other counties throughout the State.

In addition to serving these high-need communities, New Jersey utilized SPE funding to make numerous enhancements to its prevention infrastructure by: addressing gaps in data regarding older adults and binge drinking rates among young adult women of child bearing age (21-29 years), expanding the capacity of the Prevention Outcomes Monitoring System (POMS), which DMHAS' prevention management information system, and to collect data on environmental strategies and programs. Additionally, DMHAS was able to update its *Chartbooks of Social and Health Indicators*, the information in which can be used to identify health problems directly or indirectly related to substance use and to aid in the assessment of needs for prevention and treatment services. Funding was also used to create a database of all prevention services and programs delivered throughout the State.

The training and services that DMHAS provided to high-need communities as well as the enhancements to its prevention infrastructure better enabled New Jersey to support more strategic, comprehensive systems of community-oriented care.

Partnership for Success

In October 2013, DMHAS received a five-year Strategic Prevention Framework - Partnerships for Success (SPF-PFS) cooperative agreement from CSAP. The goals of New Jersey's SPF-PFS initiative were threefold: 1) to strengthen and enhance the work of 19 DMHAS-funded regional prevention coalitions; 2) to further develop the prevention data infrastructure and information systems capacity at the state level; and 3) in collaboration with state partners and community stakeholders, to continue work in developing a unified statewide prevention planning and service delivery system. Specifically, New Jersey's SPF-PFS sought to 1) decrease underage drinking among persons aged 12 to 20; and 2) decrease prescription drug misuse and abuse among persons aged 12 to 25. As additional components of its PFS programming, New Jersey also focused on unhealthy drinking patterns and prescription drug abuse among adults age sixty and older; and served military families with prevention education, addressing military community risk levels, striving to alleviate the risk factors, and enhancing the protective factors to support military

members and their families in making responsible parenting and individual choices in regards to drug and alcohol use.

DMHAS utilized these funds for numerous prevention infrastructure developments and enhancements. For instance, New Jersey took advantage of emerging technologies to better promote prevention messaging and developed a prevention-focused mobile app called “Be the One”.

The Division was awarded another Strategic Prevention Framework Partnerships for Success Grant (PFS) in 2018. The focus of New Jersey’s newest Partnership for Success is twofold. First, the Department of Human Services, Division of Mental Health and Addiction Services (DHS/DMHAS) is focusing its efforts on providing prevention education and services to youth who are involved with the Department of Children and Families, Children’s System of Care (DCF/CSOC). New Jersey has a fully-developed, organized statewide children’s system of care, the Division of Children’s System of Care (CSOC), under the auspices of the Department of Children and Families (DCF), that provides a single point of entry 24/7, for youth (under 21) and their families, with behavioral health challenges, substance use challenges, intellectual/developmental disabilities, and autism. The Division of Mental Health and Addiction Services (DMHAS), within the Department of Human Services (DHS), provides services to adults who seek behavioral health and substance abuse treatment.

The Departments and their respective Divisions (CSOC and DMHAS) partner to implement prevention strategies that include outreach, education and training services to communities and families throughout the entire state of New Jersey. Concurrent with these services, the DMHAS-funded county coalitions provide community-based prevention services throughout their counties, resulting in a cohesive, unified statewide prevention system.

Prevent Drug Overdose

In September 2016, DMHAS was awarded a Prevent Prescription Drug/Opioid Overdose-Related Deaths (PDO) grant of \$1 million annually for five years. DMHAS used PDO funds to develop the Opioid Overdose Prevention Network (OOPN). DMHAS receives real-time, statewide information about drug overdoses, naloxone administrations, and opioid-related arrests and seizures from the NJ State Police Regional Operations Intelligence Center. This capability allows DMHAS to almost immediately alert front-line practitioners and to make data-driven decisions about where to deploy prevention interventions, which includes community education and distribution of naloxone.

OOPN implemented an Early Warning and Rapid Response System (EWRRS) that includes an extensive network of practitioners and community workers in a variety of healthcare settings (e.g., FQHCs, EDs, hospitals) who were informed when their communities were affected. The alerts mobilized opioid overdose prevention practitioners who provided emergency response training and distributed naloxone to at-risk individuals and their families, as well as disseminated information about addiction treatment services to the local communities that were affected. This grant ended in September 2021.

Prevent Drug Overdose Grant 2023

DMHAS was awarded a Grant to Prevent Prescription Drug/Opioid Overdose-Related Deaths (PDO) that began in the fall of 2023.

The goal of the PDO-NJ is to decrease the number of prescription drug/opioid overdose-related deaths and adverse events among individuals 18 years of age and older by training first responders and other key community sectors on the prevention of prescription drug/opioid overdose-related deaths and implementing secondary prevention strategies, including the purchase and distribution of naloxone to first responders and other groups. Goals include:

1. Provide increased access to services such as overdose education and naloxone distribution.
2. Promote use of best opioid prescribing practices among health care providers.
3. Identify and implement innovative strategies that decrease the risk of overdose to individuals.
4. Develop prevention and treatment strategies aimed at decreasing prescription drug abuse and its harmful consequences on college campuses.
5. Use existing data and enhance data collection efforts to identify the need for Naloxone distribution and other overdose prevention activities.

Strategic Prevention Framework Rx

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

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

DMHAS conducted an epidemiological analysis on NJPMP data and employed geographic information systems (GIS) to identify communities and issues that required interventions and public health initiatives. One of the goals of this project was to build capacity to strategically utilize the PMP to inform our prevention strategies. DMHAS purchased SAS® Visual Analytics software to analyze Prescription Drug Monitoring data. The product enabled us to identify suspicious or problematic patterns and develop prevention strategies. The SAS® Analytics tool

was used for anomaly detection and predictive modeling. This helped us achieve our goal of identifying drug misuse trends and developing appropriate prevention strategies. Reports identified those populations, practice settings and geographic areas, with the highest rates of nonmedical use of opioids and opioid prescriptions. The reports developed from DMHAS data analysis was shared with other state agencies and with DMHAS' Prevention Coalitions to inform planning in local communities, such as, identifying locales for naloxone distribution to prevent drug overdoses.

In September 2021, DMHAS received a second SPF-Rx grant, which enabled it to continue work with young athletes as well as the other ongoing projects described above.

Prevention Statewide Request for Proposals

A Request for Proposals (RFP) for Statewide Services and Projects for Substance Abuse Prevention was released in September 2014 for community-based substance abuse prevention services and two prevention projects described below. The guidelines and requirements of the RFP were developed by DMHAS in accordance with the DMHAS Substance Abuse Prevention Strategic Plan. Funding for all services is provided by the SUPTRS Block Grant. Each county in the state was assigned a funding allocation from the total funds available based on its relative need. The funding allocation was determined based on the presence and intensity of social indicators, 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 use prevention services within the community and population. From the 98 proposals that were received, 51 community-based contracts and two project contracts were awarded totaling \$5,700,200.

Prevention Services to Families of Military Veterans and First Responders

Working with the New Jersey National Guard Family Program and its eight Family Assistance Centers based at armories around the state, the SSA funds the New Jersey Prevention Network to provide programs to serve returning military personnel and their families through two evidence-based programs, Coping with Work and Family Stress and the Strengthening Families Program. Both programs are designed to enhance protective factors to support military members and their families in making responsible parenting and individual choices regarding drug and alcohol use. In 2022, the program was expanded to provide services to older veterans and first responders.

Prevention Services to At-Risk Youth

The SSA provides prevention services to at-risk youth. The SSA awarded funding to the North Jersey Community Research Initiative to expand their existing programs for high-risk youth using a "Street Smart" prevention model developed by the Centers for Disease Control and Prevention, as well as early intervention services, social marketing, and structured recreational activities.

During SFY 2023, two additional programs, to serve at-risk youth in Central and South New Jersey, were established.

Prevention Services for Older Adults

Originally as part of the STR grant, then continued with the SOR grants, primary prevention efforts are focused on community education programs for older adults with the goal of decreasing demand for opiate prescriptions by familiarizing them with alternative means of addressing pain other than opioid analgesics. Programs are available in 20 of the 21 counties. Most of the providers who are delivering the Approaches to Pain Management for Older Adults (AAPMOA) program use the evidence-based Wellness Initiative for Senior Education (WISE) program. WISE is a wellness and prevention program for older adults, which is designed to help them celebrate healthy aging, make healthy lifestyle choices and avoid substance abuse. It provides educational services to older adults on topics including medication management, stress management, depression, and substance misuse. Created by the New Jersey Prevention Network and implemented locally by prevention agencies across the country, WISE promotes health through education concerning high-risk behaviors in older adults. Since the program was launched in 1996, prevention programs presented by WISE facilitators have reached over 40,000 individuals.

Opioid Overdose Prevention Program

DMHAS issued a Request for Proposals (RFP) in June 2015 to establish three annually renewable regional opioid overdose prevention programs.

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

The statewide program provides education to individuals at risk for an opioid overdose, their families, friends and loved ones to recognize an opioid overdose and includes the distribution of naloxone kits and information on how to access treatment, including MAT, which is the best practice for someone living with an OUD. Federal funding received through STR, then continued with SOR, helped to expand these trainings and distribution of kits to populations including, but not limited to residential substance use disorder treatment agencies, schools, jails, prisons, fire departments, homeless shelters, offices of emergency management and HIV clinics. In addition to distributing naloxone, as of August 2022, the OOPPs can now also provide Fentanyl Test Strips (FTS), as an overdose prevention strategy, to those who request during the trainings.

Opioid Overdose Prevention Network

The Opioid Overdose Prevention Network (OOPN) was established by DMHAS in 2016 using funds from New Jersey's Prescription Drug Overdose ("PDO" grant). The purpose of OOPN is to decrease the number of prescription drug/opioid overdose-related deaths and adverse events among individuals 18 years of age and older by training first responders and other key community sectors on the prevention of prescription drug/opioid overdose-related deaths and implementing secondary prevention strategies, including the purchase and distribution of naloxone to first

responders. DMHAS provides funds to the Robert Wood Johnson Medical School, which conducts all OOPN trainings and accompanying naloxone distribution.

In 2019, OOPN staff developed a training of trainers specifically for Recovery Specialists (peers) who work in the hospital based DMHAS Opioid Overdose Recovery Network programs that operate in fifty-six hospital emergency departments in New Jersey and those who are employed in Support Teams for Addiction Recovery that operate in all 21 New Jersey counties. The training provides recovery specialists the knowledge and skills that enable them to train the clients with whom they work (and the client's family) how to recognize and overdose and administer naloxone.

Since its beginning in 2016, through July 31, 2025, the OOPN has trained 29,767 individuals (in-person and virtually) and provided 41,237 naloxone kits to trainees.

Opioid Overdose Recovery Program

A Request for Proposals (RFP) was issued in June 2015 to develop an Opioid Overdose Recovery Program (OORP) to respond to individuals reversed from opioid overdoses and treated at hospital emergency departments as a result of the reversal. This two-year initiative was funded by DMHAS, the Governor's Council on Alcoholism and Drug Abuse (GCADA) and the Department of Children and Families (DCF), funded programs in Atlantic, Camden, Essex, Monmouth and Ocean Counties. Since then, using funds appropriated by the Governor, as well as STR and SOR funds, the program is now provided in all 21 NJ counties, and in 73 percent of hospital EDs throughout the state. All programs are now funded by the SSA. The Opioid Overdose Recovery Program utilizes recovery specialists and patient navigators to engage individuals reversed from an opioid overdose to provide non-clinical assistance, recovery supports and appropriate referrals for assessment and substance use disorder treatment. The recovery specialists and patient navigators also maintain follow-up with these individuals. It is expected that, at minimum, recovery specialists will be accessible and on-call from Thursday evenings through Monday mornings. This initiative commenced in the fall of 2015. Additional OORP RFPs were released in 2016 and 2017. As of June 30, 2025, 31,814 individuals have been served by the OORP. While overdose and relapse prevention are key goals, the program is also intended to help individuals achieve recovery.

3. Planning Processes

County Planning

The county AEREF comprehensive planning process detailed under "Step 1: Assessing the strengths and needs of the service system...." contributes significantly to the SSA's planning for services across the full continuum of care by 1) applying state needs assessment data to four substate regions, the 21 counties and 565 municipalities, 2) comparing long term trends in statewide need, admissions, and gaps with trends in sub-state regional and county need, admissions, and gaps, 3) analyzing state, substate regional and county trends by level of care, primary drug, , and locational access, 4) and supplementing state-provided data analysis with needs assessment data developed at the community level. The counties obtain local data from 1) key informant and stakeholder focus group data, and 2) quantitative data produced from locally funded research or made available to county planners from multiple health and behavioral health care

planning initiatives occurring in their counties. The county level planning process is most informative regarding the identification of gaps in the delivery of services and recommendations for system level changes that can close these gaps. In addition to independent local planning and investment in local systems development, the SSA also relies on county level planning to provide “feedback” regarding the functioning of New Jersey’s behavioral health care delivery system and policy recommendations regarding improvement of its performance.

In the past county planning cycle, 2016-2019, there were several changes that lead to challenges in planning amongst the counties. With the approval by CMS of New Jersey’s 1115 Comprehensive Waiver permitting Medicaid billing for SUD residential treatment in an IMD, issued in July of 2018, Medicaid is now available to cover many of these expenses for most county residents enrolled in Medicaid. As the funder of last resort, the counties are trying to redirect their funding from clinical treatment to prevention, early intervention and post-treatment, and recovery support services. The addition of federal and state initiatives to the fight against the opioid epidemic has decreased the number of county residents that must rely on county funding to afford outpatient and intensive outpatient care.

Continuing in the upcoming 2024-2027 planning cycle, each county will be required to report on its quarterly progress implementing and measuring the outcomes of each year’s objectives as well as monitoring of system level changes following upon the state’s Medicaid expansion, the state’s move to managed care for substance abuse treatment and the waiver of the IMD exclusion. These developments have begun to change the demand for the use of county dollars to subsidize access to care for the medically indigent and this in turn is expected to permit counties to emphasize the development of prevention, early intervention and recovery support services and foster innovative programming to meet the needs of their constituents. Each county planning cycle is limited to four years with the current cycle beginning in calendar year 2024 and ending in calendar year 2027. New county comprehensive plans were received by DMHAS by the end of 2022. Despite the challenges of the COVID-19 pandemic that began in 2020, the counties have been able to continue through their planning cycle, implementing their plans by using technology to allow for virtual meetings and events when needed and create their new plans for the 2024-2027 cycle.

The State Outcomes Measures (SOMs) is a system created to help County Directors evaluate the performance of contracted providers. The SOMs scores were created to provide county directors with a tool to help them review providers for their programs in the AEREF. The county directors use the scoring to evaluate the performance of their current contracted providers. In addition, they also to help them choose which providers they would like to purchase for new programming in their planning. On occasion, counties have discontinued contracts with providers, influenced by poor performances seen in their SOMs scoring over a span of a couple years. The SOMs scores range from 1-4, worst to best. The system uses the percentiles of five categories which are the following:

- Alcohol Abuse: Absolute Percentage change of clients abstinent from alcohol at admission vs. discharge
- Drug Abuse: Absolute Percentage change of clients abstinent from other drugs at admission vs. discharge
- Employed: Absolute Percentage change of clients employed at admission vs. discharge

- Job Training: Absolute Percentage change of clients enrolled in school or job training at admission vs. discharge
- Arrested: Absolute Percentage change of clients arrested in prior 30 days at admission vs discharge
- Homeless: Absolute Percentage change of clients homeless at admission vs. discharge

The SSA collaborates with the County Alcohol and Drug Abuse Directors in the administration of the aforementioned AEREF program. In 2023, the states' 21 counties received \$10,406,953 from the AEREF program, based on county population size, per capita income and estimated treatment need. Additionally, each county received a \$20,000 planning grant, totaling \$10,826,953. The SSA supplemented these awards with an additional \$6,908,369 for a total state investment of \$17,735,322 in county provision of services. Further, each county is required to contribute 25% of its AEREF award to the program. In 2023, counties contributed an additional \$2,601,738 to this program for a total combined state and county investment of \$20,337,060.

According to the AEREF enabling legislation, each participating county is required to submit “an annual [county] comprehensive plan (CCP) for the provision of community services to meet the needs of alcoholics and drug abusers.”⁴ Further, this plan “shall...demonstrate linkages with existing resources which serve alcoholics and drug abusers and their families.” The law also stipulates that counties pay particular attention to the needs of youth, drivers-under-the-influence, women, persons with disability, workers, and others. Thus, the counties are mandated by statute to develop unified, data-informed, comprehensive plans for the coordinated provision of community-based prevention, early intervention, treatment, and recovery support services for all county residents at both state and local levels. The SSA provides counties with quality assurance planning protocols and is responsible to review each CCP to determine: 1) whether the plan complies in form and function with the requirements of Chapter 51 by rationally relating county resources with the needs of county residents, and 2) whether it is designed and developed in a manner consistent with the state’s quality assurance standards for county planning.

Local Citizen Advisory Planning Boards

A key component of the county comprehensive planning system is the county Local Advisory Committee on Alcoholism and Drug Abuse (LACADA), an independent, citizen’s advisory group. The LACADA is required to assist the governing authority to develop and present to the County Board of Commissioners the aforementioned CCP for adoption. The LACADA is also required to establish a County Alliance Steering Subcommittee (CASS). The CASS is the county-level planning body for each county’s GCADA municipal alliance which, in turn, is a coalition of municipal level residents and other stakeholder volunteers that recommend a set of local prevention priorities to the LACADA based on their own data analyses and prevention service inventories. Municipal alliance plans are coordinated by the CASS with a county’s comprehensive plan through a process known as Unification Planning. The SSA works closely with GCADA to prepare for and implement the Unification process. Additionally, the counties are required to allocate approximately 11% of the county AEREF dollars to support prevention education services.

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

Length of County Planning Cycle

In 2004, the SSA established a three-year planning cycle for the county AEREF program that allowed counties to submit multi-year plans for the period 2006-2008. In 2008, the SSA lengthened the planning cycle to four years from 2009 through 2012, in order to establish the principle that county RFPs for substance abuse services were to be published subsequent to SSA certification of the county comprehensive plan and in accordance with its goals and objectives. In January of 2011, the SSA extended the effective period of the current CCPs to a fifth year, through 2013, in order to coordinate with the scheduled implementation of federal health care reform. As a consequence of the devastating impacts of “Superstorm Sandy” in October 2012, the SSA, in collaboration with the county planners, extended the current planning cycle for an additional year through the end of 2014. An additional one-year extension was implemented in spring 2014 for reasons related to the storm’s impact and the focus of many counties on the implementation of Federal Disaster Relief Funds. The prior CCP governed the four-year period from January 1, 2020 through December 31, 2023. The upcoming planning cycle, which is four years, encompasses January 2024 to December 2027.

SSA Planning Standards

Additionally, in 2008, the SSA established planning processes and quality standards that required: 1) state certification of CCP compliance with all Chapter 51 and the SSA planning requirements as a condition of recommending the release of county AEREF and other state discretionary funding; 2) engagement of community stakeholders in a formal community needs assessment based upon state and local data describing substance abuse treatment needs and gaps in the delivery of services required to meet those needs; 3) a logic model of the interrelationships of needs, goals, objectives, strategies, resource allocations and outcomes for prevention, early intervention, treatment, and recovery services; 4) one system-level change to enhance the local continuum-of-care; 5) an action and resource allocation plan that implements the CCP according to its goals, objectives, strategies and intended outcomes; 6) a draft RFP for the provision of those services that would implement the CCP in accordance with its corresponding planned resource allocation; and 7) establishment of an annual plan implementation and outcomes monitoring procedure to document plan implementation obstacles encountered and corrective actions taken to overcome them.

Thus, the SSA, in collaboration with its partner county governments has established planning standards intended to produce rational, goal-oriented, data-driven county plans for the development of the full continuum of care from primary prevention through recovery support. The SSA supplies counties with data from the SSA’s needs assessment program. For instance, the counties review: a) primary data obtained from the household survey, b) secondary social indicator data from the county and municipal chart books, c) administrative data from sources like NJ-SAMS and facility licensure. The SSA’s County Planning Guidelines also encourage county behavioral health planners to incorporate local perceptions of substance abuse issues and treatment system capacity by means of county focus groups and other encouragements to citizen participation. The SSA provides planning education, training, and technical assistance to the county directors throughout the process.

Future Developments in the State-County Collaborative Planning Process

For the current 2020-2023 and upcoming 2024 – 2027 planning cycle, the SSA will continue to assist counties with planning data and analyses as well as understanding of federal and state level changes to health care delivery that will affect access to care for their residents. It will continue to help counties identify and implement a greater number of evidence-based prevention education programs and encourage counties to participate in planning environmental approaches to prevention at the county and municipal levels. It will encourage counties to increase their investments in recovery support services in order to help treated individuals maintain the benefits of clinical services, forestall relapses, and when necessary, return to treatment sooner before clinical treatment needs become severe.

Strategic Planning

SUD Prevention 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 evidence-based prevention strategies. Representatives from numerous state departments and divisions (Department of Health, Department of Children and Families, Law and Public Safety), representatives from community-based prevention and treatment agencies, and community members. The plan provides direction for all DMHAS-funded prevention services. As a result of the planning process, these prevention priorities were identified:

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

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 Strategic Prevention Framework (SPF) and undertake a rigorous needs assessment process to identify which of the statewide DMHAS prevention priorities identified in the Plan are the most significant in their region. Nineteen coalitions were awarded contracts.

The Municipal Alliances (community-based, volunteer-run coalitions) funded and overseen by the Governor's Council on Substance Use Disorder (GCSUD) also adopted the prevention priorities identified in the DMHAS Prevention Strategic Plan. The Plan will be updated during SFY 2026.

State Epidemiological Outcomes Workgroup.

The SSA was awarded a Strategic Prevention Framework State Incentive Grant (SPF-SIG) by SAMHSA in October 2006. The purpose of the grant was to develop a comprehensive Prevention Strategy for delivering and implementing effective substance abuse prevention services. The initiative served as a blueprint for state and community partners to apply the federal Center for Substance Abuse Prevention's (CSAP) Strategic Prevention Framework towards creating healthy communities for everyone. The NJ SPF aligned its work around CSAP's framework, providing tools that continue to guide state and local partners in conducting needs assessments, capacity development, strategic planning, plan implementation, and outcome evaluation.

As one requirement of the SPF-SIG, the SSA convened the New Jersey State Epidemiological Outcomes Workgroup (SEOW), comprised of individuals from various state departments including Health, Education, Human Services, Juvenile Justice, county offices, universities, community provider agencies and statewide organizations. The SEOW continues to meet quarterly to discuss ways to prevent the onset and decrease the progression of substance use disorder in New Jersey.

Current membership includes representatives from agencies/organizations such as the:

- NJ Division of Mental Health and Addiction Services (NJ DMHAS)
- NJ Dept of Health (DOH)
- Rutgers University Medical School
- Cooper Medical School
- National Center for Advocacy & Recovery (NCAAR)
- Prevention Links
- Governor's Council on Substance Use Disorder (GCSUD)
- North Jersey Community Research Initiative (NJCRI)
- NJ Dept of Corrections (DOC)
- NJ Coordinated Addictions Response Strategies (CARES)
- Center for Research on Evaluation of Education & Human Services (CREEHS)
- NJ National Guards - Drug Demand Red. Outreach (DDRO)
- NJ Housing & Mortgage Finance Agency (NJHMFA)
- Office of the Attorney General (OAG)
- Regional Operations Intelligence Center (ROIC)
- Rutgers University School of Social Work
- NJ DMHAS/Vital Strategies Overdose Prevention Program
- NJ SUD Prevention Regional Coalition Agencies
- County Alcohol and Drug Abuse Directors (CADADS)
- Robert Wood Johnson (RWJ)
- Department of Education (DOE)
- Law and Public Safety (LPS)
- Juvenile Justice Commission (JJC)
- Division of Criminal Justice (DCJ)
- Children's Aid & Family Services (CAFSNJ)
- NY/NJ High Intensity Drug Trafficking Area (HIDTA)
- NJ Department of Children and Families (DCF)
- Prescription Drug Monitoring Program (PMP)

Additionally, representatives from the prevention, early intervention, treatment, and recovery communities actively participate. The SSA continues to actively recruit for new SEOW members. There are approximately 50 members on the SEOW.

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 2014 and during SFY 2026 will be updated again.

Examples of datasets reviewed for production of the Epidemiological Profile included:

- The Behavioral Risk Factor Surveillance System (BRFSS)
- The Core Alcohol and Drug Survey (CORE)
- The New Jersey Household Survey on Drug Use and Health (NJHSDUH)
- The National Survey on Drug Use and Health (NSDUH)
- The New Jersey Middle School Risk & Protective Factor Survey (MSRPFS)
- The New Jersey Student Health Survey of High School Students (NJSHS)
- The Treatment Episode Data Set (TEDS)
- The Uniform Crime Report (UCR)
- The New Jersey Youth Tobacco Survey (NJYTS)

Other sources of governmental administrative data used to compile the above-mentioned profile included:

- The New Jersey Substance Abuse Reporting System (NJSAMS)
- The New Jersey Department of Children and Families (DCF)
- The New Jersey State Police Regional Operations and Intelligence Center (ROIC)
- The National Highway Traffic Safety Administration (NHTSA)
- The New Jersey Center for Health Statistics (NJCHS)
- The New Jersey Department of Health: Division of HIV/AIDS Services (NJDHSS)
- Violence, Vandalism and Substance Abuse in New Jersey Public Schools.
- The Commissioner's Annual Report to the Education Committees of the Senate and General Assembly (CRVV)

Initially, the profile served as the basis for identifying prevention priorities to be addressed through the SPF-SIG grant. The SEOW conducted an extensive review of data from a multitude of sources that describe substance use and its consequences. Using prevalence and incidence rates, severity ratings and trends, the SEOW developed a formula incorporating these variables to produce need scores and ranked the needs in order of importance. "Alcohol use/misuse by 18-25 year-olds in the past year", "drug use/misuse among 18-25 year-olds in the past year" and "past month use of illicit drugs by 18-25 year-olds" were the three highest ranked indicators. Based on these data, the priority "to reduce the harmful consequences of alcohol and drug use among 18-25 year-olds," was selected as the guideline for the SPF-SIG project. It was noted that there are very few prevention programs specifically for the 18-25 year-old population. In 2008, the SSA awarded 11 community contracts to address this prevention priority. As the projects were implemented, most

were focused on the harmful consequences of alcohol consumption and in particular, motor vehicle crashes. SPF-SIG funding ended in 2012, after which, most of the SPF-SIG communities received funding (from the SUPTRS) to continue their coalition work by focusing on the priorities identified in the prevention strategic plan.

The role of the SEOW was expanded in 2010 when the SSA charged the group with developing both treatment and prevention priorities. Upon further review of the data as described above, which included updated information, the SEOW then identified the following statewide prevention priority problems/issues in 2010: 1) Drug use/misuse by 18-25 year-olds in the past year; 2) Binge drinking by college students; 3) Use of illicit drugs by persons under age 25 in the past 30 days; and 4) Use of alcohol by high school students in the last 30 days.

Selecting indicators to describe the consequences of substance use and the consumption patterns associated with those consequences is a critically important aspect of the needs assessment process. The SEOW Epidemiological (Epi) Profile Workgroup identified various dimensions that could describe the extent of a problem, including the size of the problem, its magnitude relative to other states' problems, the severity of the problem's impact on an individual and/or community, trend characteristics, attributable risk to substance abuse, and availability of data. In addition, the Epi-Profile Workgroup identified additional criteria that could impact efforts to address a problem, including capacity/resources, perceived gap between capacity/resources and need readiness (political will/public concern), economic impact, and social impact. The SEOW Epi-Profile Workgroup compiled a list of the data gaps they identified in their process. Some of the data gaps identified by the SEOW Epi-Profile Workgroup included:

- Medical Examiner data - not all counties report to state; need to search for data on presence of AOD in the bodies of homicide victims; more collaboration / cooperation between New Jersey State Police and New Jersey Medical Examiners on ALL AOD related deaths
- Secondary cause of death due to alcohol
- Pedestrian fatalities and non-fatalities by age and substance
- Current use of ATOD by high school students
- General education referrals to school Student Assistance Counselors
- General education referrals to treatment
- High school dropout rate

In 2025, work began on a new Epi Profile. SEOW Epi Profile Workgroup members assumed responsibility for reviewing relevant data and writing first drafts of the five chapters of the Profile. The chapter topics were determined by a review of epidemiological, law enforcement, and Department of Education data. The review identified the substances that posed the most significant threat of harmful consequences throughout New Jersey. A representative from the Department of Health - Office of Tobacco Control and Prevention will be responsible for the Tobacco chapter. The Prescription Drugs chapter will be headed up by the Director of New Jersey's Prescription Drug Monitoring Program (PDMP). Staff from the Office of Drug Monitoring & Analysis at the NJ State Police – Regional Operations Intelligence Center (ROIC) will prepare the chapter on Illicit Drugs. The ROIC partners with federal, state, and local entities to collect crime, threat, and disaster related information, conduct analysis, develop intelligence products, and provide timely and relevant alerts, warnings, and notifications to law enforcement,

public safety and private sector entities to strengthen preparedness, prevention, enforcement, investigative, response, and resiliency efforts.

The Executive Director of the New Jersey Prevention Network will guide the work of the Alcohol chapter and a professor/researcher from the Rutgers New Jersey Medical School will be responsible for the Marijuana/Cannabis chapter. Workgroup members will use the Strategic Prevention Framework (SPF) as a guide when they review and analyze the data. The final version of New Jersey's Epi Profile will be available by the end of March 2026.

While the updated EPI Profile is a major task for the SEOW, it also receives presentations on major DMHAS prevention initiatives such as the Middle School Survey. Recently our partners at CREEHS, also SEOW members, did a presentation that took members through the dashboard that was developed and provides trend data on all the variables for planning purposes.

Naloxone Saturation Plan

The drug epidemic is a significant problem in New Jersey with 1,764 individuals dying from drug overdose in 2024. DMHAS has developed a Naloxone Saturation Plan to address this crisis. The programs NJ utilizes to distribute Naloxone to multiple end users and use multiple methods to increase the access to naloxone while an individual is experiencing an overdose.

Amount of Annual Naloxone Needed to Reach Saturation in NJ and the Estimated Gap in the Current Supply.

Naloxone is an important tool in preventing overdose deaths and many studies have demonstrated the value of naloxone distribution⁵ and that increased saturation in communities decreases overdose deaths.⁶ New Jersey is following research from Scotland⁷ that suggests "Take Home Naloxone" (THN) plans should aim to issue 20 times as many THN kits as there are opiate-related deaths per annum and at a minimum, 9 kits. Their study was based on opiate-related deaths with prison release as a 4-week antecedent and estimated plausible effectiveness was a 20-30% decrease in opiate related deaths.

For NJ this would be $1,764 \times 20 = 35,280$ at the recommended level, but no less than $1,764 \times 9 = 15,876$ at the minimum level. For the state overall we achieved saturation in 2024 in all 21 counties, which was 284,039 naloxone kits. The statewide saturation level was 805%. Our priority will be

⁵ Walley AY, Xuan Z, Hackman HH, Quinn E, Doe-Simkins M, Sorensen-Alawad A, Ruiz S, Ozonoff A. Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis. *BMJ*. 2013 Jan 30; 346: f174.

⁶ Irvine MA, Oller D, Boggis J, Bishop B, Coombs D, Wheeler E, Doe-Simkins M, Walley AY, Marshall BDL, Bratberg J, Green TC. Estimating naloxone need in the USA across fentanyl, heroin, and prescription opioid epidemics: a modelling study. *Lancet Public Health*. 2022 Mar;7(3):e210-e218. doi: 10.1016/S2468-2667(21)00304-2. Epub 2022 Feb 10. PMID: 35151372.

⁷ Bird SM, Parmar MK, Strang J. Take-home naloxone to prevent fatalities from opiate-overdose: Protocol for Scotland's public health policy evaluation, and a new measure to assess impact. *Drugs (Abingdon Engl)*. 2015 Feb;22(1):66-76. doi: 10.3109/09687637.2014.981509. Epub 2014 Nov 18. PMID: 26045638; PMCID: PMC4438351.

to first focus on the counties that fall in the top five overdose deaths category, then address the other indicators. Another article published in Lancet¹³ indicates that 4.5 deaths can be averted in New Jersey with 500 kits per 100,000 population.

Distribution and Communication Strategy to get Naloxone into the Hands of Those Most Likely to Witness an Overdose and in the Locations where they are Most Likely to Occur.

NJ will be using three major distribution points: community organizations, pharmacies and a web-based portal. Services funded by DMHAS are in accordance with SAMHSA's guidelines outlined in its "Dear Colleague" letter issued July 29, 2025. Attention will also focus on providing kits to individuals who are most likely to witness an overdose event. Intended community groups include: HRC, SUD and Mental Health Treatment Programs, Homeless Shelters, EMS, OORP, STAR, Recovery Centers, FSCs, Jails, Re-Entry Programs, Mobile Outreach Vans, Law Enforcement and Fire Departments, and Libraries. Additionally, the Scotland research suggests key 4-week periods recognized as high risk for opioid fatalities are: soon after prison release, hospital discharge, opioid substitution therapy and leaving abstinence-oriented drug treatment.

Our two community providers, the OOPP and OOPN, distributed 8,244 kits during CY 2024. NJ-DHS announced in April 2022 a new initiative to allow for the delivery of naloxone kits directly to eligible agencies and entities responsible for administering, distributing or leaving behind naloxone. To meet the ongoing needs of agencies across the State, NJ-DHS has developed an online portal where: (1) agencies will be able to register their entity to participate in the program and (2) utilize the order page to request naloxone. The program is called *Naloxone Direct*. *Naloxone Direct* is a website where approved agencies register through a website and request direct shipments of naloxone free of charge. After approval, the drug is shipped directly from the manufacturer to the provider organization. Orders are for naloxone cases (there are 12 kits to a case). It is paid for with grant funds sent to the state from the federal government. In CY 2024 there were 224,412 kits distributed through the portal.

Opioid addiction and overdoses continue to impact communities throughout New Jersey and across the country at an alarming rate. Since 2018, tens of thousands of New Jerseyans have experienced an overdose and more than 15,000 died of a suspected drug-related death. To combat and curb this epidemic, New Jersey has worked to bolster overdose prevention efforts throughout the state including expanding the availability of naloxone through statewide distribution days. In 2023, New Jersey took the next steps to make naloxone readily available every day of the year for free. The newest program, *Naloxone 365*, is a pharmacy-based distribution program which provides naloxone for free, anonymously, without prescriptions to whoever asks for it.

In January 2023, Governor Murphy announced a nation-leading program to allow anyone 14 years or older to acquire naloxone anonymously and at no cost at participating pharmacies across New Jersey. The Department of Human Services partnered with the New Jersey Board of Pharmacy and its Medicaid division to craft and implement this unique program. Since the program's launch in January 2023, the number of naloxone kits dispensed is 125,757 kits (as of March 23, 2025). Currently 709 pharmacies are participating and include national chains. To bolster efforts, the Regional Coalitions are engaged in the Help Everyone Reverse Overdoses (HERO) campaign to

encourage local independent pharmacies to participate. The website can be found at <https://nj.gov/humanservices/stopoverdoses>.

Partnerships with Existing Public and Private Efforts External to SOR such as through Medicaid, “Buyers’ Clubs”, and Recent Court Settlements.

In CY 2022, NJ-DHS received waiver approval for a Supplemental Waiver of Advertising necessary from the Division of Purchase and Property to provide a large amount of funding for the purchase of naloxone. NJ-DHS conducted a search of State contracts and the price for Narcan from Emergent Biosolutions (Emergent), was significantly lower than the equivalent item from other vendors. Specifically, the cost for a kit of the equivalent brand of Narcan containing two units was \$120.34. Emergent provided New Jersey a public interest rate of \$47.50 per carton, each containing two 4 mg. intranasal devices. This is a substantial savings and gives NJ-DHS the opportunity to make a larger quantity of this life-saving medication to entities across the State.

Other partnerships include our OOPN program with RWJ, and our OOPP program. In addition, NJ Medicaid reimburses the cost of Narcan for its beneficiaries.

Gambling Strategic Plan

In 2014, the New Jersey Legislature enacted legislation directing that \$250,000 be collected from each casino located in Atlantic City or their internet gaming affiliate(s) that were issued a permit to conduct internet gaming. The purpose of the legislation is to increase/enhance the scope of disordered gambling treatment services in New Jersey. There are currently 9 internet gaming licenses. With the introduction of legalized sports betting in 2018, DMHAS now receives \$100,000 as a portion of the licensing fee each gaming establishment is required to pay. These funds are also directed to the further development or enhancement of prevention programs or treatment services for gambling disorder. There are 12 licenses.

The compulsive gambling contract that DMHAS funds provides statewide assessment, treatment, prevention, and helpline services through the Council on Compulsive Gambling of New Jersey. The Council offers counseling by certified treatment providers; a helpline (1-800-GAMBLER) that provides information on problem gambling and connects callers to treatment programs and Gamblers Anonymous/Gam-Anon meetings; ongoing public awareness activities; and educational materials for compulsive gamblers, families, and others affected by gambling problems.

A workgroup was formed consisting of representatives from different areas of DMHAS to develop a Gambling Strategic Plan to best utilize these new state resources. The plan covers prevention, early intervention, treatment and recovery. One of the projects includes developing a GAMBIRT program, modelled after SBIRT. An RFP is in preparation. Some of the groups intended to be reached include seniors, high school and college students and veterans. Other projects include peer gambling training; reviewing the existing gambling treatment network; providing services to those in prison or jail; providing training to SUD providers on gambling treatment; outreach to more groups, such as faith-based organizations, recreation centers, schools; providing peer training; providing services to individuals who are incarcerated; conducting outreach to youth; survey of gambling behavior among college students etc.

Alcohol Use Disorder Strategic Plan

With all the emphasis on the opioid crisis, there still remains a need to address alcohol use disorder. In fact, in CY 2024, the primary drug at admission was alcohol (42%) exceeding heroin by 13%. This is a continuous trend that alcohol was reported as the primary drug of use at the time of admission to a withdrawal management or treatment program. Due to problem-drinking and diagnosed cases of Alcohol Use Disorder (AUD) within New Jersey showing an increasing trend following the COVID-19 pandemic, a workgroup of Division staff was convened to develop a strategic outline that would identify and prioritize areas of concern and objectives. Emphasis was given to objectives considered important for overall systems change, but that are also achievable in the short term and able to show a direct impact on positive client outcomes. For organizational purposes, the workgroup recognized priority areas across the prevention, early intervention, treatment and recovery continuum of care. The workgroup agreed that this strategic outline remains a fluid document that is revisited as new data is made available for analysis and updated accordingly. With the impact of COVID-19 on substance use within the state only now starting to take shape, flexibility in addressing issues must remain on the table. As such, an additional priority area is for on-going data and needs assessment.

The purpose of the AUD Strategic Outline is to provide a broad plan of action for the Division to deliver system level interventions during the designated timeframe with identified areas of focus carried out by separate DMHAS units to achieve their various objectives. The AUD Strategic Outline only includes the broad goals that are independent of other on-going projects. While it is noted that there will be overlapping and sharing of resources with other Division initiatives, the intent of the strategic outline is to define these distinct activities for further detailed and individual project management. It is noted that to accomplish the areas of focus, additional staffing and stakeholder involvement beyond what is indicated will be required to meet the desired objectives.

In the fall of 2025, NJ DMHAS was selected to participate in a Policy Academy focused on addressing alcohol use and alcohol use disorder. This initiative is a joint effort of SAMHSA's Center for Substance Abuse Prevention (CSAP) and Center for Substance Abuse Treatment (CSAT) in partnership with NASADAD to help states identify and address critical gaps to improve coordination and integration across the substance use continuum of care, spanning primary prevention, early intervention, treatment and recovery. A key goal of the Policy Academy is to have a holistic focus on improving state and local systems that address alcohol use and alcohol use disorders through integration, collaboration, and coordination across the continuum of care, including treatment with effective medications for alcohol use disorder. Policy Goals developed at the Academy by the NJ Team included:

- 1) Increase the utilization of MAUD in New Jersey through provider and workforce education, public awareness campaigns, and policy enhancements that decrease stigma and improve access.
- 2) Increased adoption of supportive programs for persons with AUD into existing public health and treatment systems.
- 3) Increased access to and navigation of AUD treatment, recovery support, and ancillary services tailored to the needs of statutory populations.

Participation in the Academy will enable DMHAS to further develop its Alcohol Policy Strategic Plan.

New Jersey Prevention Unification Process

The NJ Prevention Collaborative, previously called Prevention Unification, re-activated a committee in July 2018. The NJ Prevention Collaborative includes members from the New Jersey Division of Mental Health and Addiction Services (DMHAS), New Jersey Prevention Network (NJPN), Rutgers Center for Prevention Science (RU-CPS), and the Governor's Council on Alcoholism and Drug Abuse (GCADA). The Prevention Technology Transfer Center operated by RU-CPS provided state-level technical assistance to this state-level group as well. It was decided to re-brand "Prevention Unification" and now this workgroup is referred to as the NJ Prevention Collaborative. The overall aim of the NJ Prevention Collaborative was to align all state-funded substance abuse prevention initiatives. The primary goals include the development of state-level logic models for underage drinking, prescription drug misuse, marijuana, and tobacco. These logic models will be used to integrate with the coalition logic models and then more locally, the alliances would use these to fit in their efforts.

During the earlier meetings in the summer and fall of 2018, the team created a list of objectives, action steps, and an overall plan that included milestones through the end of 2019. In the early planning, some of the expectations for what the state-level logic model included: Minimize service duplication and complement each other's work; build upon past success of prevention unification processes; continue alignment of regional coalitions, "B" grant providers, Municipal Alliances, and Division Substance Abuse Directors; determine state-wide priorities and solidify desired outcomes for prevention system; and support a state-wide cohesive message about what effective prevention looks like. The NJ Prevention Collaborative decided on a scope for the state-level logic models, which included the 19 Regional Coalitions, all Municipal Alliances, individual and family program providers, and Drug Free Communities grantees. These are also the entities that would act as primary users of the state-level logic models.

RU-CPS initial step was to review data from the regional coalitions for incorporation into the state-wide logic models. This process began by examining problem statements, root causes, local conditions, strategies, and outcomes from all regional coalition logic models and organized databases with frequencies for each of the substance priorities: underage drinking, prescription drug misuse, marijuana, and tobacco. Once all of these data sources were integrated, the group began to populate a state-wide logic model.

Throughout the process, the members presented on the NJ Prevention Collaborative to different constituents in order to involve stakeholders in the process and to solicit feedback throughout the process. NJPN made multiple presentations to the regional coalitions; GCADA presented to the county municipal coordinators and alliances; and DMHAS presented at their meetings.

In June 2019, the NJ Prevention Collaborative provided a statewide logic model presentation followed by a focus group. Participants included regional coalition coordinators and municipal alliance coordinators whose agencies were representative of the state geographically and in terms of size (e.g. number of municipal alliances, funding resources, community partnerships, etc.). The

statewide logic model was presented as an opportunity to acknowledge efforts at the state, regional, and municipal level while incorporating important factors cited in prevention literature. The logic model was also cited as a useful tool for identifying any gaps in the work being done and serve as a resource for coalitions to strategically address health access in their communities at the local level. The presentation was followed by a focus group in which participants expressed overall impressions of the logic models, identified potential challenges to successful implementation, and communicated their expectations for their agency's role going forward.

The final steps of the state-level logic models included gathering state level data to complete the problem statement for each of the four logic models. The goal was to include multiple data points for consumption patterns and consequences (i.e., crime indicators, injuries, ER visits, overdoses) for each logic model. These are state-level data points. RU-CPS led this step and built a database of over 300 outcome measures. Each data point was tracked for a minimum of three years in order to observe trends across time. Data points were collected for New Jersey as well as for the US, in order to compare New Jersey and national trends. The NJ Prevention Collaborative reviewed all data elements and trends and created a prioritization process. Indicators were ranked: high, medium, and low priority based on the prevalence of the problem, trends over time, and how NJ compared to the nation. in order for the group to make final decisions on which high and medium priority measures to include in the final state-level logic models.

The group finalized the prioritization process and created a list of interventions to include in the final logic models. The NJ Prevention Collaborative completed the four state-level logic models in the summer of 2019 and shared them with the various state-funded groups and stakeholders. The efforts of the Prevention Collaborative were shared with the regional coalitions for their continued assessment, planning, and evaluation processes for their regionally based prevention strategies and with the municipal alliances as they conducted their needs assessment process in the Fall and Winter of 2019. Currently, the group is working on a systems-level logic model for the state.

4. Data Gaps

Older Adult Survey

During its strategic planning processes, DMHAS determined that one of the top data gaps in New Jersey was the lack of information on the older adult population and the prevalence of substance use, misuse, and mental health issues within this group. Among the reasons cited for the gap were lack of data, difficulty accessing existing data, inadequate technology for data tracking, and inadequate capacity to aggregate data in more meaningful and useful configurations. The New Jersey Department of Human Services, Division of Mental Health and Addiction Services (DMHAS) was awarded a State Prevention Enhancement (SPE) grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2012 and one of the key deliverables was to conduct a survey of older adults in New Jersey, which was conducted in 2012 with a total of 800 individuals living in New Jersey who were age 60 and older responding.

The goal of the New Jersey Older Adult Survey on Drug Use and Health (OASDUH) was to obtain data on the prevalence of substance abuse among older adults in New Jersey. The OASDUH is one of few to have focused on older adult health and drug use which gathered information about a

broad range of health indicators. Older individuals experience more chronic ailments than younger people and are prescribed more drugs, including powerful painkillers that carry a high risk of misuse or addiction. They experience changes in their metabolism that intensify the effects of alcohol and drugs, making them susceptible to falls, injuries, cognitive impairment, depression, overdose, and even death.

The survey instrument contained 44 items, comprised of several validated subscales and demographic items, and was conducted via telephone in 2012 and taking about 19 minutes. The sample was comprised of 801 people living in New Jersey who were aged 60 and older. Another measure contained in OASDUH included items assessing the participant's social network and potential for social isolation. Social isolation has been found to be a risk factor for heavy drinking and binge drinking. People who have high social support have been found to have less excessive alcohol use. It appears that social support can also alleviate excessive drinking as a response to loss.

Some key findings of the OASDUH were:

- 64.8% of the participants reported having smoked a cigarette during their lifetime and of those, 15.3% reported smoking cigarettes within the last 30 days
- A total of 92.4% of the participants reported drinking alcohol during their lifetime and of that group, a total of 57.3% reported drinking alcohol within the last 30 days;
- Of the 13.8% of participants who reported using marijuana during their lifetime, 7.8% used it within the past 30 days
- Of the 12.9% of participants who reported using pain killers or other opiates recreationally or not as prescribed during in their lifetime, 22.0% reported this use within the
- The majority (81.4%) of respondents rated their physical health as good to excellent, as well as their mental health (92.8%).

Using data from the New Jersey Older Adult Survey on Drug Use and Health discussed above, an article by Farmer, A., Wang, Y, Peterson, A., et al, "*Social Isolation Profiles and Older Adult Substance Use: A Latent Profile Analysis*"(Journals of Gerontology: Social Sciences, 2022, Vol.77, No. 5, 919-929, doi:10.1093/geronb/gbab078) aimed to determine substance use among older adults based upon their social isolation and loneliness profiles. Latent profile analysis (LPA) was used to determine the profiles of older adults ($N = 801$) based on 5 dimensions of social isolation and loneliness. The "connected and active" group had the lowest odds of cigarette use. The "alone but not lonely" group had the highest odds of cigarette use, alcohol use, and high-risk drinking. The "alone and lonely" group had the highest odds of nonmedical drug use. In working with older adults who are using substances, it is important to inquire about their social isolation and loneliness. Cognitive behavioral therapy for the "alone and lonely" group may be beneficial, as it has been deemed effective in decreasing loneliness and enhancing social networks.

DMHAS was then awarded the Partnerships for Success grant by SAMHSA in 2013 and allocated funding to address the need for further research on this population relating to substance use and mental health issues. The overall goals of the New Jersey Older Adult Survey (NJOAS) were three-fold: (1) to assess the prevalence, risk, and protective factors of substance misuse and mental health issues among New Jersey older adults; (2) to obtain enough data to create small-area estimates of the prevalence of substance abuse and mental health for the 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.

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 (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. The goal this time was to produce county-level data. 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, a 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.

Key findings of the survey were:

- Data showed that 63.2% of older adults smoked a cigarette at some point in their lives with most trying their first tobacco product before the age of 18 (64%).
- Of the older adults who currently smoke, 89% stated that they have smoked all 30 days of the past month (n= 312).
- On average, respondents had at least one drink for eight days of the month.
- Among older adults who responded that they used substances over 5 times in their lives, pain killers such as codeine, Demerol, or other opiates were the most frequently used substance (32%), with only 1% having used them without a prescription from a doctor.
- The highest proportion of older adults have received drug prescriptions from just one doctor (55.8%), followed by those who received drug prescriptions from more than one doctor (28.3%).
- Physical and mental health data indicate that the older adults felt that they were in very good physical health (33%), and that they had excellent mental health (43%).

A study by Gold, S., Gilmore Powell, K, Eversman, et al. (*High-Risk Obtainment of Prescription Drugs by Older Adults in New Jersey: The Role of Prescription Opioids*. (Journal of American Geriatric Society, 64:e67–e71, 2016) used data from this survey to explore the high-risk ways in which older adults obtain prescription opioids and to identify predictors of obtaining prescription opioids from high risk sources, such as obtaining the same drug from multiple doctors, sharing drugs, and stealing prescription pads. Items such as obtaining prescriptions for the same drug from more than one doctor and stealing prescription drugs were measured to determine high-risk obtainment of prescription opioids. Almost 15% of the sample used high-risk methods of obtaining prescription opioids.

To summarize, our efforts to fill in data gaps concerning older adults has helped guide us in better understanding the risk and protective factors surrounding this population and eventually led us to develop our Alternative Approaches to Pain Management for Older Adults (AAPMOR) program which is implemented in 20 of NJ's 21 counties.

Veteran's Survey

New Jersey continues to focus on returning Veterans as a priority population. This is another population for which there were limited data. DMHAS had reached out to the New Jersey Department of Military and Veteran's Affairs as well as the New Jersey National Guard to solicit their active participation on the SEOW and Advisory Council in light of this priority.

DMHAS commissioned Rutgers University School of Social Work (SSW) and to conduct a needs-based survey among the New Jersey veteran population which was funded under our PFS grant. Avalon Health Economics was contracted by the SSW in February 2014 to conduct the survey. The goals of the New Jersey Veteran Survey (NJVS) were two-fold: (1) to assess the issues of mental health and substance abuse in New Jersey veterans and (2) 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 veterans. The questionnaire asks veterans to report information regarding their service (when and where they served), types of substance abuse (alcohol, tobacco, prescription drugs), mental health (signs of depression, behavioral health, associations with substance abuse), and other signs of abuse such as gambling, as well as basic demographic information (ethnicity, education, current job status, etc.). Survey questions were adapted from several past surveys that were aimed at the general population. The sample pertained to all living New Jersey veterans. A total of 1,185 questionnaires were completed by New Jersey veterans. Data collection began on September 14, 2015 and ended on October 9, 2015. Data collection was multi-modal, with data collected via both the telephone and online. The average survey length was 20 minutes per respondent. Key findings were:

- A large majority of veterans had their first drink of an alcoholic beverage between the ages of 12 and 21 (91.9%),
- 64.2% of veterans had a drink of an alcoholic beverage within the last 30 days.
- A large majority of veterans feel that they do not have a problem with alcohol (82.9%).
- Among veterans who regularly use tobacco products, 39.7% have used a tobacco product 365 days a year.
- 65.9% of veterans have used a prescription drug within the past 30 days.
- An overwhelming majority feel that they have not had a problem with gambling within the last 12 months (93%)
- A majority of veterans responded to their mental health as being excellent (42%), compared to those who responded as very good (24%).

Results from the NJVS provided useful information into the alcohol, substance, and gambling use, as well as physical and emotional issues among the New Jersey veteran population. Our findings suggest higher rates of health risk behaviors but lower perceived needs and lower problem recognition reported by veterans. The need for outreach to increase perceived need is especially important given the demographic make-up of veteran populations – predominantly older adults who have been shown to be especially unlikely to seek mental health or substance use disorder

services. Further attention should be paid to pain medication use among veterans, including chronic opioid use. There is a need and opportunity for provider training related to the military, which is especially important as more Veterans are now seeking treatment outside of VHA.

Young Adult Survey

DMHAS conducted the New Jersey Young Adult Survey (YAS-NJ) for the first time in fall 2023. The survey, administered to young adults living in NJ, assessed experiences and perceptions related to substance use, mental health, and social media. The purpose was to design a survey instrument comparable to national surveys of substance use and demonstrate its utility for collecting data that could inform meaningful prevention programming for the young adult population for a hard-to-reach and under-reported population.

In partnership with DMHAS, the survey was developed and piloted by the Center for Research and Evaluation on Education and Human Services (CREEHS) at Montclair State University. Eligible survey participants were young adults between the ages of 18 and 25 years who lived in NJ for six or more months during the prior year. Participants were recruited using non-probability sampling methods, specifically convenience sampling. There were two main recruitment strategies: crowdsourcing platforms and email listservs. Survey information was posted to two crowdsourcing platforms (e.g., Prolific and Amazon Mechanical Turk via Cloud Research) and distributed by prevention partners, colleges and universities, young alumni associations, and trade schools to eligible participants through their existing listservs. The survey was made available via Qualtrics from September to December 2023.

More than 11,000 responses were received; however, more than 90% of these responses were flagged as ineligible and/or fraudulent. Extensive data cleaning was performed to determine which responses were eligible and valid, yielding 1,074 responses in the final analytic sample.

Key findings were:

- The most frequently reported substances used (*lifetime or past 30 days*) were alcohol, followed by tobacco (including cigarettes), marijuana, vapes (also known as e-cigarettes), and ecstasy.
- The majority of respondents reported first using alcohol (65%), tobacco (59%), and vapes (52%) before age 18. For all other substances listed, respondents most frequently reported first using between the ages of 18 and 20.
- More than a quarter (28%) of YAS-NJ Survey respondents reported that they have had a problem with their own drug or alcohol use in their lifetime.
- 77% of respondents reported daily binge drinking to be at least a *moderate risk*, while 39% reported monthly marijuana use to be at least a *moderate risk*.
- Almost half (46%) of all respondents reported having ever had a mental health problem.
- About four in 10 respondents felt nervous (45%), that everything was an effort (40%), and/or restless or fidgety (39%) *most of the time* or *always* within the past 30 days.
- Three-quarters of respondents (75%) reported using social media apps or sites *several times per day* or *almost constantly*.
- Only 2% of respondents said they have not seen content on their social media related to alcohol, marijuana, or other drugs.

Overall, the information gleaned from this survey can be used to inform future research as well as funding and programming for NJ prevention efforts that aim to decrease substance use amongst this age group. Future efforts to survey this young adult population should consider lessons learned from this survey related to effective recruitment, sufficient planning and coordination time, and open online data collection.

Municipal Level Data

A critical challenge for the 19 county prevention coalitions, as well as County Drug and Alcohol Directors, and Municipal Alliance Coordinators in New Jersey, has been the lack of available data at very specific and detailed geographic units of analysis (e.g., municipal, census tract, neighborhood, etc.). A social indicator database project was completed under the SPE grant which used a variety of methods to acquire new data and merge information from existing systems to provide a foundation for an integrated data infrastructure. Purposes of this database are: to help identify high need communities; promote data-driven planning; support funding allocation methods based on need; enhance capacity in local communities and strengthen their ability to identify meaningful local indicators; and to help produce community-level epidemiological profiles. Presently, the County Chartbooks contain a wealth of municipal level data.

5. Service Gaps in the Substance Use Disorder Continuum of Care

In order for clients who have or are at risk for a substance use disorder it is critical that there are recovery supports in place so clients can realize their full potential and clients have access to evidence-based treatment. The following areas have been identified by the SSA as areas that need enhancement.

Relapse Prevention

Drug and alcohol rehab statistics show that the percentage of people who will relapse ranges from 50% to 90%. Data from NJSAMS for CY 2024 indicated that of 43,415 individuals, 8,708 (20%) individuals experienced two admissions during the year and 8,516 (20%) had 3 or more admissions. Of these, 4,204 (11.7%) returned to care between 31 and 90 days, and 1,527 (8.9%) had a readmission 91 or more days later (within CY 2024). We define a new episode of care when admission to treatment exceeds 30 days, i.e., not within the existing episode where there may be movement to other LOCs within the continuum of care for that episode. Our goal is to provide recovery supports to help these individuals move to and remain in recovery for longer periods of time. Currently the Opioid Overdose Recovery Program, the Support Team for Addiction Recovery, Telephone Recovery Support and Peer Recovery Centers are helping to fill the gap. A new initiative was implemented in SFY 2023 to further support this effort: Recovery Management Check-Up (RMC).

Housing

Studies cited by the Corporation for Supportive Housing (CSH) indicate that supportive housing has positive impacts on decreasing or ending substance use. Once people with histories of substance use achieve sobriety, their living situation is often a factor in their ability to maintain

their recovery. According to the Kentucky Interagency Council on Homelessness (KICH), a one-year follow-up study of 201 graduates of the Eden Programs chemical dependency treatment programs in Minneapolis found that 56.6% of those living independently remained sober, 56.5% of those living in a halfway house remained sober, while 90% of those living in supportive housing remained sober.

There are also studies that documented positive impacts on health with decreases of more than 50% in tenants' emergency room visits and hospital inpatient days; decreases in tenants' use of emergency detoxification services by more than 80%; and increases in the use of preventive health care services. Positive impacts on employment have also been found, with increases of 50% in earned income and 40% in the rate of participant employment when employment services are provided in supportive housing.

Stable, affordable housing is a crucial component of recovery for individuals with substance use disorders. Supportive housing combines affordable housing with services that help people who face the most complex challenges to live with stability, autonomy and dignity. Supportive housing has been proven as an effective solution to ending homelessness for active substance users; housing provides a necessary platform to access a variety of services, participate in long-term recovery and give individuals the opportunity to engage in important community roles.

DMHAS only has 273 supported housing slots for individuals with a substance use disorder: two programs in Camden (31 beds) and Atlantic (32 beds) counties, a 10-bed program for women in Somerset County, and 200 supportive housing subsidies for those with an OUD. Supportive housing is a successful, cost-effective, combination of affordable housing with services that help people live more stable, productive lives. It offers permanent housing with services that work for individuals and families who face complex challenges such as homelessness and/or have serious and persistent issues that may include substance use, mental illness, and HIV/AIDS.

DMHAS awarded contracts in 2019 to provide individualized case management and supportive services to up to 200 individuals with an OUD, on average, up to 8 hours per month, billable in 15 units, based on individual needs. These services will assist individuals in seeking and connecting with behavioral health and or physical healthcare needs. DMHAS provides 200 rental subsidies, up to the fair market rate (FMR) as defined by the Department of Community Affairs (DCA) for lease-based housing. One-time funding will be available to consumers for security deposits, utility start-up costs and furnishings. Contracts were awarded four agencies to serve individuals in five counties: Atlantic, Burlington, Camden, Mercer and Monmouth. Since the awarding of the OUD contracts the number of referrals have reached approximately 225 referrals with a total of 95 subsidies currently occupied, and an additional 24 in housing search phase. The turnover of the OUD vouchers is approximately 10%, with consumers surrendering the subsidies. The onset of the COVID-19 Pandemic has resulted in the full payment of rent for some of the OUD consumers since they lost employment.

Contracts were awarded in 2019 for three pilot recovery-based housing residences (a minimum of five individuals in each residence), one in each region (North, Central and South), for individuals with an OUD who are homeless or at risk of homelessness. Individuals are in or recently discharged from treatment and are seeking a drug free, sober and supportive living environment,

with access and linkage to recovery community resources. Individualized case management and recovery-based housing services is provided for 15 individuals (a minimum of five individuals in each region) who have been identified as needing a safe, healthy, peer-lead, recovery-oriented environment. The housing provided must be licensed as a Class F, Cooperative Sober Living Residence (NJAC § 5:27). Accordingly, individuals are responsible for providing their own food and taking care of their own laundry. Treatment and counseling may not be provided in the residence; however, non-clinical recovery support services may be provided at the site and the agency may require, at its discretion, drug or alcohol testing of residents. (NJAC § 5:27-2.1). Although increased funded sober housing slots are needed, the pilots are thriving and continue to benefit those individuals seeking a stable recovery environment.

With the award of ARPA funding, DMHAS issued an RFP for an Interim Housing Program for individuals experiencing SUD challenges. The program would have allowed individuals an opportunity to have temporary stable housing for up to two months while the provider tried to arrange for more stable permanent housing. Unfortunately, the RFP issued in October 2022 had to be withdrawn for technical issues.

Opioid Settlement funds were used to fund an RFP for temporary housing for individuals being discharged from residential, inpatient, ambulatory SUD treatment and/or individuals with a history of SUD who may be or have become homeless. The funding through this RFP can serve as a bridge to permanent housing, allowing participants to receive the support and services they need around other challenges in their lives. DMHAS issued an RFP in October 2024 and made awards in February 2025 to six licensed 24-hour emergency shelters for a total of 150 beds. A companion RFP funded with opioid settlement funds was released for case management services for adult individuals placed in one of the 150 shelter beds. Case managers will help connect individuals with services/ resources in their area and entitlements and assist them in securing permanent housing as quickly as possible. It is anticipated that individuals will obtain permanent housing within four months of initial engagement. Individuals served in this program will have access to DMHAS funded housing subsidies. DMHAS issued an RFP in October 2024 and made awards in February 2025 to four agencies to provide these services in their region of the state.

It is an urgent issue to create housing opportunities for individuals with SUD. One of the negative outcomes is that homeless individuals who have overdosed and are in our OORP program are then discharged to costly inpatient care due to the lack of suitable community housing options.

DMHAS continues to explore potential residential opportunities for SUD clients. A possibility is implementing ASAM Level 3:1: Clinically Managed Low-Intensity Residential Services. Examples of this level is a halfway house, group home or other Supportive Living Environment (SLE) with 24-hour staff and close integration with clinical services. It only requires 5 hours of treatment per week. This level is suited for homeless individuals while their issue of homelessness is addressed. It is an appropriate setting for individuals who need time and structure to practice and integrate their recovery and coping skills in a residential, supportive environment.

Transportation

One of the obstacles to accessing services frequently reported across all healthcare domains, including behavioral health, is transportation (Locatelli et al., 2017; Syed et al., 2013). According to Bellamy et al. (2016), unreliable access to transportation was the most frequently documented and reported non-medical obstacle to clients seeking substance abuse and mental health outpatient services. Transportation obstacles manifest themselves in several ways: a lack of independent car ownership, high cost of public transportation, travel distance, travel time, parking fees, a lack of public transportation, distance from agency to a bus stop, and cost of ride-sharing services (Locatelli et al., 2017). Without adequate and affordable transportation options, clients are unable to begin vital treatment nor consistently attend and complete treatment, resulting in suboptimal outcomes. NJ's 2018 Household Survey of Drug Use and Health indicated that of the clients surveyed who indicated they wanted treatment, transportation was an obstacle for 39% of the participants.

Transportation is a key recovery support. A reliable means of transportation is needed so clients can get to prevention, recovery and treatment support programs. As a result of this gap, DMHAS has developed a new program called the *Transportation Reimbursement and Invoicing Program (TRIP)*. This will enable transportation to treatment for individuals who do not have Medicaid, as well as enable transportation to and from non-healthcare facilities such as Community Peer Recovery Centers or prevention programs. TRIP is intended and designed to eliminate transportation obstacles and facilitate access to substance use disorder Treatment, Prevention and Recovery Support Services (RSS). SUPTRS Block Grant COVID-19 Supplemental funded this initiative. ARPA funds are currently being utilized. DMHAS plans to fund TRIP with SOR funding after the ARPA grant ends.

Recovery Centers

There is a need for DMHAS to continue to support recovery support services at Recovery Centers. There were only two state funded centers prior to 2019, one in the northern region of the state, Eva's Village in Paterson, and one location in the southern region of the state, Living Proof in Voorhees. From 2019 to 2024 DMHAS was able expanded Recovery Centers to every county in New Jersey through the SOR funding. Funding was issued through Request for Proposals (RFP) to develop small scale Community Peer Recovery Centers (CPRC) in every county with \$100,000 startup funding. Recovery support is an essential part of the continuum of care since addiction is a chronic biologically based disease of the brain and as such requires a system of care designed to treat a chronic condition rather than an acute illness. With other chronic conditions, e.g., diabetes, hypertension, heart disease, that are characterized by periods of wellness and acute episodes of care, the care system and intervention are designed to manage the illness in order to promote sustained periods of wellness and eliminate or minimize the need for acute care. Similarly, the addiction treatment system must adapt so as to support the process of sustained recovery. The New Jersey Recovery Centers has been effective with many individuals seeking recovery.

DMHAS intends to continue to support 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 2024, there were 78,797 discharges from substance abuse treatment in New Jersey. Of these, 20,949 or 27%, dropped out of treatment. While all clients can benefit from recovery support services, those clients who did not complete treatment may find recovery support beneficial and a gateway back into treatment and/or sustained recovery. It is clear that there are significant numbers of people who could benefit from ongoing recovery programs. While these figures are drawn from those who enter the formal treatment system, there is a group of people of unknown size who have never accessed formal treatment who could also benefit from recovery services. This will also be an opportunity for those for whom access to treatment is not possible or delayed. The DMHAS Recovery Centers offer training, social, educational and recreational opportunities. There are classes focused on wellness, nutrition and illness management, including classes on self-care, stress management, financial management, literacy education, job, and parenting skills. Housing assistance (e.g., finding apartments and roommates) is provided, and telephone support is available to Recovery Center participants. It is expected that this peer-delivered service will result in improved social functioning, decreased substance abuse and an improved quality of life, including more social connectedness.

DMHAS has expanded Recovery Centers through the SOR funding and Opioid Settlement funding for Community Peer Recovery Centers (CPRC) to provide peer-to-peer recovery support services to prevent recurrent of substance use and promote sustained recovery. All activities and services through the CPRCs are led and driven by “peers”, individuals who have experienced addiction and recovery or co-occurring behavioral health issues, either directly or indirectly as a family member or friend. The overall goal of the CPRC is to provide a safe place for recovering individuals to gather in support of one another and experience recovery-oriented living in a community setting. The CPRC is a place where those in recovery can have the opportunity to give back to their community thereby fostering senses of empowerment and independence.

Since March 2020, CPRCs have found creative new ways to keep individuals engaged with their centers. They keep track and report quarterly of Traditional In-Person Groups and Individual Recovery Support Service as well as Virtual and Hybrid Services. Some centers also offer Community Activities In-Person, Virtual or Hybrid. Prior to 2024, the goal was for 50% of the centers use the Recovery Data Platform (RDP) to document individuals served. The goal for 2025 is for 100% of the Recovery Centers to use the RDP. The biggest obstacles reported by CPRCs is limited funding for Transportation, Recovery Support Housing, Overdose Prevention Supplies, and Recruiting and Retention of workforce.

Recovery Case Management

There were no formal case management services in the NJ addiction service system. Research indicates that substance-dependent individuals who have prompt access to a full continuum of services that address individual client needs and co-morbidities experience improved recovery outcomes. Kirk (2007) describes a client-centered service delivery model that promotes access to a broad array of services, decreases 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 decreases 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 incorporation of recovery case management within our current system of care to decrease service fragmentation, promote service continuity, and increase clients' capacity to manage their chronic health condition.

With State Targeted Response (STR) funding, DMHAS was able to initially create 10 Support Teams for Addiction Recovery (STAR). Additional SOR funding allowed the development of 11 more STAR programs. This resulted in statewide coverage.

DMHAS was able to create two new recovery support services, described below, with the award of SABG Supplemental and ARPA funding.

Recovery Management Check-Up (RMC). RMC is a service for discharged clients to support their independent living and success with recovery. This program provides more methods of outreach to clients that include virtual face-to-face visits, text messaging and chat features, and the opportunity for in-person contacts. This check-up service will help provide local recovery supports, including information about local resources such as self-help meetings, food pantries, and sober houses, if needed. RMC aims to identify and alleviate client problems before they undermine recovery. Monthly contact forms the core of RMC. During these contacts, staff will assess clients using a brief assessment tool to evaluate the individual's progress, current needs and check on recovery status. Problems will be addressed using motivational interviewing techniques, connecting clients to appropriate community resources and/or treatment, if needed. The conceptual framework of RMC is to treat addiction as a chronic disease, with long-term management to minimize the number of acute episodes of substance abuse and with prompt treatment when episodes occur to prevent them from becoming more severe and consequential.

Recovery Support Care Management (RSCM). RSCM provides direct and comprehensive assistance to consumers to ensure access to the necessary treatment, rehabilitative and recovery services with the intent of decreasing psychiatric and addiction symptoms, connect consumers with services, improve transitions between levels of care, implement strategies to address their unique needs, decrease opioid related deaths and sustain recovery in the community while supporting the consumers' continued stability and recovery throughout the continuum of care. This service is available as an enhancement in all levels of care and has been incorporated into the SUD fee-for-service system. This service may be provided face-to-face or via a telehealth platform. One unit of service is 15 minutes. The rate is \$24.97 per unit. The limits of this service are 4 units per diem and 16 units per month, with no annual limit per consumer.

Medication Assisted Treatment

NJSAMS data indicated while heroin plus other opiates were the primary drugs accounting for 36%, or 29,354, of New Jersey's treatment admissions during 2024, the use of either methadone (15%) or buprenorphine (10%), a total of just 25%, was in the treatment plan for these admissions, a difference of 11%. The number of people who entered either opioid maintenance -outpatient or -intensive outpatient was only 12% (9,393). This difference of 24% 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 decrease the demand for Inpatient Withdrawal Management (IWM) as well as other residential treatment services.

Ambulatory Withdrawal Management

Currently there are 18 licensed providers in NJ that provide Ambulatory Withdrawal Management (AWM). This is a service that has been a great benefit to individuals with an opioid use disorder (OUD) and has been used as an option to the costlier, and not always clinically indicated, Inpatient Withdrawal Management (IWM). A requirement for AWM agencies is that they minimally have to offer outpatient programming at their agencies.

Public Awareness Campaigns

In order to help decrease stigma surrounding addiction and increasing awareness of the dangers of new drugs as well as awareness of overdose life-saving products, there needs to be active public awareness campaigns throughout the state. To decrease this gap, DMHAS has made great strides in implementing new campaigns. DMHAS, with the support of the Department Human Services (DHS) Central Office, Office of Public Relations, secured a vendor that has been delivering a public awareness campaign to help decrease stigma around the use of MAT. The campaign was initially launched in the Spring of 2020 and continually refreshes its campaign. Most messaging continues around opioid use with the goal to bring public awareness that medication can support recovery and encourages viewers of the advertisements to call ReachNJ, the 24/7 Addiction Hotline in New Jersey. Messaging has continued to target multiple resident groups, such as student-athletes, pregnant women, older adults and prescribers. Various forms of messaging include TV ads, radio commercials, social media and billboards in the community. In addition to this initial campaign, DMHAS has launched several new campaigns (described in Step 1) funded through ARPA and SOR.

Family Support Services

Three regional Family Support Centers (FSC) continue to be funded through SOR Funding to provide peer to peer family support services to families in each region whose loved ones suffer

from an opioid use and/or stimulant use disorder. FSCs were the first formal family support service in the New Jersey's Substance Use Disorder continuum of care that offered direct family support, education, resources and advocacy in a safe and non-stigmatizing environment. Each regional center is staffed with Family Support Coordinators with lived experiences who are specially trained in the Community Reinforcement and Family Training (CRAFT) Model which teaches families self-protection along with non-confrontational skills to help empower their loved one to seek treatment; as well as helping each family member develop and work on their own Individualized Wellness Recovery Plan. The overall goal of the FSC Coordinator is to provide compassionate support to empower family members to have a better quality of life, improve their psychological health, decrease levels of stress, feel less isolated, and gain skills needed to cope with their loved one's use. Families who receive FSC services also receive Naloxone Training and Kits to assist their loved ones at risk of opioid overdose.

In 2021 each regional FSC expanded due to the increased numbers of referrals coming from OORPs, STARs, Connect4Recovery Call Center, Division of Children and Families, Probation, and Treatment Providers to assist family members of loved ones with or without an opioid use and/or stimulant use disorder. While the FSCs saw an increase in referrals, one the main obstacle continues to be difficulty recruiting family support peers who can connect and engage family members in accordance with NCLAS.

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 10,3446 Narcan administrations in New Jersey from January 1, 2024 to December 31, 2024, NJSAMS data indicated that during that same period, there were only 731 admissions who reported a Narcan administration "in the past 30 days." This difference of 9,615 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 decrease this gap. Using STR funding, brochures were printed which were given to individuals who refuse transport to the hospitals by EMS that provides a list of resources for follow-up help. The brochures are tailored by county. Using SOR funding, additional brochures were printed. DMHAS is also working with the Department of Health (DOH) to better connect our OORP teams with local EMS providers; a meeting was held between these two groups in February 2021. Also, several of our OORP staff attended the "Five Minutes to Help" training that was developed by the DOH for EMS providers.

Narcan Reversals Who Refuse Hospital Transport

Standard protocol specifies that, after reversing a person from overdose, the person should be transported to the emergency room for medical evaluation and observation. The Opioid Overdose Recovery Programs (OORP) in all 21 NJ counties provide supportive services for these individuals, with a goal of helping them find their way to recovery from their OUD. At times,

however, someone who's been reversed by Emergency Medical Services (EMS) or law enforcement refuses transport to the emergency room. In early 2024, DMHAS offered funds to OORP providers to engage these individuals and provide supportive services with, again, the goal of helping the person find their way to recovery.

EMS are key partners in reaching these persons. As such, OORPs use these funds to establish or enhance the relationship with EMS or law enforcement to identify and communicate with these persons in the communities they serve. Some examples of activities developed by OORPs for this initiative include:

- Providing educational opportunities for EMS to learn about recovery support services, overdose prevention and the stigma associated with problematic substance use.
- Providing Naloxone Rescue Kits to EMS/law enforcement for distribution to the survivor that includes information on how to contact the OORP for navigation to treatment, linkage to services, and information about community resources.
- Providing the survivor with literature that includes a QR code, in addition to the traditional contact information. Scanning the code brings the individual to the OORP website and a dedicated space where the individual may complete a short online form that will generate a call from a peer recovery specialist.
- Providing education to staff at motels that are utilized for temporary housing, as well as naloxone rescue kits including literature mentioned above.
- Offering transportation to individuals to recovery centers and to other services including treatment.

Since it began, this initiative has engaged more than 300 persons and connected them with some type of recovery services.

Linkage from Withdrawal Management to Other Levels of Care

One of DMHAS' concerns is the movement of clients from withdrawal management (WM) to the next appropriate level of care. Data for CY 2024 indicated that of 15,500 residential WM discharges, only 8,729 (56%) were linked to another level of care. The Single State Authority on Substance Abuse (SSA) is considering different strategies to improve the connection to treatment, such as the incorporation of peers in these programs, incentives for agencies and motivational interviewing to help decrease client refusal for continuing treatment.

Peers in Treatment Services

While the SSA has expanded the role of peers in prevention and recovery services, work was needed to incorporate peers in treatment settings. To address this gap, the DMHAS issued an RFP in March 2023 for residential providers to expand the peer workforce to include peer services in inpatient withdrawal management, short-term and long-term residential and halfway house settings. The successful bidders will hire peers who will assist with issues that often occur concurrently with SUD, such as homelessness, legal issues, employment, childcare, etc. In addition to linking individuals with the appropriate community resources, peers will also encourage individuals to remain in treatment as recommended in the treatment plan and modeling strategies on how to manage addiction successfully. Awards were made in June 2023 for 26 Peer Recovery

Specialists in residential treatment settings with COVID-19 Supplemental funding. Funding for this program continued with the ARPA grant and the program was further expanded when the RFP was reissued in 2024 to contract with an additional 8 provider agencies to hire 19 peers.

Buprenorphine Bridge Clinics

The Bridge model is a clinical model in which ED practitioners screen patients for opioid use disorder (OUD), provide short-term prescriptions for buprenorphine and then provide patients with warm handoff directly to a co-located, outpatient bridge clinic that provides medications for opioid use disorder. The Bridge model may be modified to establish a virtual bridge clinic utilizing telehealth.

School-Based Educational Prevention

Utilizing certified recovery specialists, individuals would share personal stories of their struggles and identify when they began using substances and how their substance use disorder escalated.

Screening for Substance Use Disorders and Adverse Childhood Experiences (ACEs) in Pediatric and Primary Care

Programs that provide interventions that are person-centered and resilience-focused to children impacted by addiction and that have ACEs are a key strategy in disrupting intergenerational SUDs and providing targeted services to arguably one of the most at-risk populations of children. Preventing ACEs can lead to a significant decrease in chronic health conditions and socioeconomic challenges, including obesity, depressive disorder, substance use, medically uninsured people and unemployment.

Gaps Observed by the New Jersey Behavioral Health Planning Council.

The partnership of community stakeholders with the SMHA is critical to the success of the Division. The New Jersey Behavioral Health Planning Council (NJBHPC, a.k.a., “The Planning Council”) is the primary (but by no means sole) voice of the community. Through the participation of the Planning Council, and its Advocacy subcommittee, the Division has obtained the following guidance on service needs and gaps within the current system of care. The Council has been concerned with the continuity and provision of behavioral health services. As mentioned in detail in other parts of this application, DMHAS provides the Planning Council with regular updates on the CMHSBG /SUPTRS.

The New Jersey Behavioral Health Planning Council (BHPC) previously developed a white paper expressing concerns with the wait to admission into residential withdrawal management. The SSA invested a significant amount of funding into residential withdrawal management in FY 17. Funds were added to the SAPTI fee-for-service initiative for this level of care and a new STORI treatment initiative was developed using STR funds which included residential withdrawal management. In addition, ambulatory withdrawal management was added to this initiative once the rates were finalized. While STR has ended, several of the SUD FFS initiatives now fund this level of care,

which has made it very accessible. Four initiatives reimburse (DUII, SJI and MAP-SPB) both AWM and IWM. AWM is also available in NJSI; MATI and SAPT both fund IWM.

At the June 2019 BHPC meeting, gaps identified were: 1) a key obstacle to MAT for opioid SUD is transportation and homelessness and 2) services for older adults with opioid addictions. With regards to older adults, DMHAS has made 20 awards for programs to educate older adults on alternate strategies for opioid prescriptions.

At the July 2021 meeting, gaps were once again addressed. The issue of transportation came up and we are exploring whether our FFS programs can provide transportation. The issue of homelessness and services was raised. We are currently in the process of developing programs in homeless shelters to deliver MAT in the shelters. A final issue was that housing is a number one priority. We will be expanding our Oxford House program to help address this issue.

At the July 2022 meeting, gaps were again addressed. One focused on the issue of older adults and the need to increase services to this population. DMHAS has been making progress in this area. We have a prevention-focused Adult Education program in 20 of 21 counties. We recently issued an RFP for treatment services to populations in need and one provider is focusing on serving older adults. Another concern is addressing feelings of isolation among our consumers and the negative impact this can have.

The latest observed gaps reported for 2025 by the Planning Council are based on the findings and recommendations of the Chair of the Planning Council, as was informed by the Chair of the Planning Council's Block Grant Committee. That committee was comprised of Council members who are: consumers, family members, advocates, providers, representatives from other parts of state government, and facilitated by the Chairwoman of the Council and State Mental Health Planner. To gather feedback from the entire, general membership of the Council, the Block Grant Committee solicited the thoughts of the general membership of the Council via a survey with open-ended responses. The results obtained from that survey, and other inputs from Council members were reviewed, synthesized, and summarized here. The eight general areas identified by the Council are presented here.

Issues related to Access to Care:

- Administrative complications posed by dual, separate licensing requirements (physical health, and behavioral health) pose challenges to truly integrated services.
- Anecdotally, members report that individuals seeking various community-based mental health services continue to experience long wait times
- BH staffing shortages have been reported on by community members; absences in unfilled positions may and contribute to disruptions in treatments.

Issues related to Housing:

- Affordable and accessible housing remains a foundational need for individuals with behavioral health conditions in the state of New Jersey.
- Some community members advocate for an expansion of recovery residences, (i.e., Class F sober living homes) to decrease recidivism, homelessness, and/or re-institutionalization.

Issues related to Peer Support & Navigation Services:

- Peer-run crisis alternatives may be lacking across some counties.
- When leaving any acute and/or long-term mental health or substance use facility, there is a gap in navigation and peer follow-up services for peer integration.

Issues related to Access:

- The current public transportation system is seen by many as an obstacle to access to primary, behavioral health and other services needed for self-sufficiency.
- Lack of non-English speaking services among some service providers may be an obstacle to access & engagement in care.
- Gaps in services for populations in need (i.e., deaf/hard of hearing, older adults, veterans, etc.)

Issues related to Criminal Justice & Reentry

- Continuity of care, access to treatment access, and stigma for recently incarcerated populations is seen as being essential in decreasing recidivism.
- Transitional planning for recently incarcerated populations with behavioral health issues (to prepare them for employment and reintegration into community life) which are supported by mental health services and SUD recovery supports are seen as important.

Issues related to Youth and Families:

- Lack integration and differentiation within the Children's behavioral health system. The patchwork of services and authorities (school-based services, services provided by the Children's System of Care, hospitals/clinics, and private providers) makes it difficult for families to navigate and access services for children. Youth may be swiftly routed to emergency departments, which inadvertently often leads to delays in getting the most appropriate services at the right time.
- Statewide shortage of mental health professionals (in both clinical, acute and school settings) with experience and expertise in children's issues.
- Disruptions/delays in services due to Medicaid reimbursement policies and outdated treatment models that do not reflect the current realities of adolescent SUD.
- Siloed data collection practices leading to difficulty in better understanding (and improving) the system of youth/adolescent behavioral health services.

Issues related to Aging & Dementia Services

- Older adults are particularly vulnerable to gaps in transportation services and community health navigation.
- Crisis and respite services tailored to individuals with dementia are important, to assist in the screening process.

Issues related to Program Oversight & Accountability

- Heightened evaluation of funded providers by the SMHA is recommended by the Council.

- Greater state oversight in the stability of staffing at contracted agencies is suggested, to better ensure continuity & access to care.

6. Addressing Needs and Gaps of Services of Priority Populations and Populations in Need

Pregnant Women and Women with Dependent Children.

In 2014, as a SAMHSA Prescription Drug Abuse Policy Academy State, New Jersey submitted a successful application for In-Depth Technical Assistance (IDTA) 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 was the lead State agency and partnered with the Departments of Children and Families and Health Department of Health (DOH). 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 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 identify low utilization areas to increase the prevalence of prenatal screening.

(3) *Labor, Delivery and Engagement (Infants) Workgroup* developed a comprehensive survey with input from the medical community and perinatal cooperatives. The Hospital Birth Survey was

disseminated statewide March 2017 to the labor and delivery hospitals. The survey sought to understand how pregnant women with SUD and substance-exposed infants are identified, treated, and triaged with partners at discharge, and if treatment for NAS was explored. The Hospital Birth Survey results was intended to guide Departments in establishing statewide guidelines for best practice; aid in the development of cross system models to ensure families get access to services; establish education needs on issues of SEI/NAS and identify high risk areas.

The IDTA commenced in 2017. DMHAS as the IDTA lead state agency, requested modified technical assistance from the NCSACW to support New Jersey to interpret the key findings from the *Birth Hospital Survey*, and apply these findings to the Project ECHO (Extension for Community Outcomes) program design. DMHAS Office of Treatment and Recovery Supports has a Memorandum of Agreement (MOA) with Rutgers Robert Wood Johnson Medical School, Office of Community Health to provide ECHO technical assistance and training. The ECHO series “*Maternal Child Health Pregnant and Parenting Women with Opioid Use Disorder (MCH PPW- OUD)*” started January 2020 through December 31, 2021. The MCH PPW-OUD ECHO provides education and training to primary care practitioners, SUD treatment providers, behavioral health practitioners, and other stakeholders in clinic settings and at home, utilizing a web-based video collaboration between a multi-disciplinary team of specialists and primary care practitioners on best practices for the assessment, case management, intervention, treatment and recovery support services for PPW with an OUD. The ECHO goal is to increase the capacity and competency of behavioral health providers, community support organizations, medical community, and child welfare to support prevention, treatment, and recovery of pregnant and parenting women with OUD and other substances. ECHO positions communities to decrease the NAS birth rates, improve use of medication assisted treatment, family formation and early infant development; improve access to physical and mental health care by educating more providers, midwives, doulas, and other health care professionals on best practices during prenatal and perinatal periods. The MOA was extended several times to continue technical assistance, including education and training. The most recent extension is from October 2023 through September 2025. This ECHO series held evening sessions in an effort to reach out to practitioners and prescribers, with sessions focused on the latest FDA approved techniques for Medication Assisted Treatment (MAT), integrated care, and wraparound services, stigma of mental health and substance use, screening protocols, improving access to substance use treatment, Plans of Safe Care, and coordinated care for pregnant women with OUD and their newborns. The new series which started January 2024 through August 2024 includes 18 sessions with five (5) community workshops and another 18 sessions with five (5) community education workshops through August 2025. The community education workshops focus on educating the audience on referral and linkages between providers, practitioners, and community services to support pregnant and parenting persons and their family. These series focus on maternal opioid intervention and care coordination. Didactic topics with the 18 sessions range from integrative approach to care for pregnant women; bridging the gap from patient to plan; implementation that is meaningful and impactful; prenatal care with an opioid/substance use disorder; addressing stigma; perinatal depression; navigating the system to maximize successful family formation, etc.

New Jersey submitted a successful application and was awarded IDTA through the National Center on Substance Abuse and Child Welfare (NCSACW) 2023 Policy Academy: *Advancing Collaborative Practice and Policy: Promoting Healthy Development and Family Recovery for*

Infants, Children, Parents, and Caregivers Affected by Prenatal Substance Exposure. NJ State Policy Academy representatives include the Department of Health (DOH) DCF, DHS and the Governor's Office. The DMHAS Women's Treatment Coordinator represents DHS. Representatives from the medical, addictions and perinatal community also participate on this IDTA. The overall goal was to increase awareness of pregnant women with SUD, through increased education and maximizing messaging through the perinatal work force, increase awareness and access to treatment, Plans of Safe Care, and improving screenings in hospitals and healthcare providers. Four goals have been established: *Goal 1:* Conduct a statewide landscape analysis of resources available to individuals with a SUD and understand how referrals are made to appropriate resources and levels of care. *Goal 2:* Address gaps in the SUD system of care to establish a comprehensive and fluid collaborative approach among state agencies, healthcare providers, and community-level and non-profit organizations to address substance use during and after pregnancy. *Goal 3:* By 2025, create and execute a state-wide prenatal Plans of Safe Care process that enables Community and Clinical Partners to formally support a birthing woman. *Goal 4:* Support birthing hospitals in updating their protocol related to screening and referring birthing women with SUD; and subsequently engaging in a comprehensive approach to implementing Plans of Safe Care in New Jersey.

In November 2021, a Memorandum of Agreement with the Rowan University, School of Osteopathic Medicine (SOM) was developed for Screening, Brief Intervention and Referral to Treatment (SBIRT) for persons receiving services at their internal medicine, family care, OB/GYN clinics, and the Rowan University Student Health Center. Utilizing national best-practice standards for substance use screening, Rowan SOM has developed and implemented a fully sustainable, integrated SBIRT model as part of routine medical care. Additionally, Rowan SOM will implement annual, universal screening protocol, and office-based risk interventions, as part of patient intake services in all OB/GYN clinical settings.

Child Welfare/Parents with Dependent Children Programs.

On July 1, 2015, the treatment contracts for parents with substance use disorders via a Memorandum of Understanding between the SSA and DCF Division of Child Protection & Permanency (DCP&P) transitioned over to DCF.

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

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 decrease the gaps in service delivery and improve coordination of services. The Consortia allow for cross systems collaboration with local treatment programs and other community partners who can provide the expertise needed to better serve families in the child welfare system.

Women's Intensive Supportive Housing Program.

The SSA developed a Women's Intensive Supportive Housing (WISH) Program. This program provides permanent supportive housing for pregnant and/or parenting women with a co-existing substance abuse disorder and mental illness who are homeless or at risk of homelessness and being discharged from a licensed long-term residential substance abuse treatment and/or halfway house facility. An RFP was developed and released in January 2015. The RFP was for the development of a WISH team to provide case management and supportive housing services for 10 women and their children. A contract was awarded in 2015 to a licensed treatment provider who specializes in women's treatment, offers a continuum of care, and has a longstanding history of providing supportive housing and has demonstrated success in managing permanent supportive housing programs.

Since 2014, DMHAS has a Memorandum of Understanding (MOU) with NJ DCF, DCP&P to fund ten (10) supportive housing subsidies annually for the "Keeping Families Together" (KFT) program for parents involved with the child welfare system who are homeless or at imminent risk and in which one or more adults in the family is diagnosed with a co-occurring mental health illness and substance use disorder. DCP&P contracts with a provider for the KFT program in Essex County.

Maternal Wraparound Program

The Maternal Wraparound Program (M-WRAP) is a program that provides intensive case management and recovery support services for pregnant and postpartum women with substance use disorder. Pregnant women are eligible for services through M-WRAP during pregnancy and up to one year after birth event. Intensive case management focuses on developing a single, coordinated care plan for pregnant/postpartum women, their infants and families. Intensive Case Managers work as liaisons to all relevant entities involved with each woman. Recovery Support Specialists provide non-clinical assistance and recovery supports while maintaining follow-up with the women and their infants.

Block Grant funding supports seven M-WRAP regions statewide. 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 obstacles to services for pregnant women with substance use disorder through comprehensive care coordination implemented within the five major timeframes when intervention in the life of the substance exposed infants (SEI) can decrease potential injury of prenatal substance exposure: pre-pregnancy, prenatal, birth, neonatal and early childhood. Care coordination also addresses screening, early intervention, assessment, treatment and recovery supports.

To ensure that the needs of the mother, infant and family receive coordination, access to and engagement in services, providers are required to develop Plans of Safe Care. Plans of Safe Care are developed prior to the birth event, whenever possible and in collaboration with treatment providers, health care providers, early childhood service providers and other members of the multidisciplinary team as appropriate. The M-WRAP model is intended to promote maternal health, improve birth outcomes for women, their infants and families, and decrease the risks and adverse consequences of prenatal substance exposure. Each MWRAP region is required to provide services to sixty (60) unduplicated women, a total of 420 unduplicated women.

In late fall, 2022 ReachNJ, the central call-in line for New Jersey residents seeking help with a SUD, dedicated their public service announcement campaign to reach pregnant women. MWRAP provided training to ReachNJ to offer MWRAP as a resource and to provide warm hand-offs. MWRAP services provides the support needed to help pregnant and parenting women maintain a healthy recovery, resulting in less overdoses, and improved birth outcomes and maternal child health.

Integrated Opioid Treatment Services and Substance Exposed Infants (IOT-SEI)

Five providers across the State submitted successful applications through a Referral for Proposals (RFP). The IOT-SEI Initiative is funded with Governor's State Opioid funds. This Initiative provides an array of integrated services for opioid dependent pregnant women, their infants and family. Providers are required to ensure a full continuum of services and to establish mechanisms to develop a coordinated and cohesive approach for working together across systems that include, SUD treatment, medical community, maternal child health, and child welfare. Initiative focuses on alleviating obstacles to services. Services range from: mother's medical/prenatal and obstetrical care, SUD treatment for OUD including MAT, new born/infant medical care, child welfare services as identified, intensive case management, recovery supports, assistance with housing, case management and other wraparound services. Providers must ensure that there is comprehensive care coordination from prenatal through the birth event, postpartum, and early childhood.

Mental Health First Aid and Perinatal Mental Health (MHFA)

Recognizing that some contributing factors among pregnancy associated, but not related cases for mental health and SUD can be lack of provider knowledge, DMHAS increased efforts to educate the perinatal workforce, medical community, and the behavioral health providers on services, resources and best practices that can have a positive impact on maternal health. SFY 2024, DHS through DMHAS provided funding to the New Jersey Quality Health Care Institute to partner with a provider to conduct statewide trainings to MWRAP staff and the perinatal workforce on MHFA

to raise awareness around the impact of perinatal mental health. The perinatal workforce is uniquely positioned to identify mental health symptoms early and intervene when needed on MHFA. The trainings focused on maternity-specific scenarios to teach participants how to assist pregnant and parenting persons experiencing mental health symptoms in crisis and non-crisis situations and intervene when needed.

Maternal and Child Health Policy Innovation Program (MCH PIP)

DMHAS Women's Services Coordinator participated on the Maternal and Child Health Policy Innovation Program (MCH PIP) Alumni Policy Academy from August 2023 through April 2024 convened by the National Academy for State Health Policy (NASHP) with support from the Health Resources and Services Administration, Maternal and Child Health Bureau (HRSA-MCH). State partners include DHS with Medicaid as the lead agency, DMHAS and representatives from the DOH and DCF. The overall goal is to improve maternal health outcomes by addressing obstacles (e.g., transportation, child care, language/low literacy) to accessing maternity care; effective referral processes for health-related needs of pregnant and parenting persons. DMHAS maternal child health initiatives (IOT-SEI and MWRAP) provide intensive case management, recovery supports, and services to assist pregnant and parenting persons with SUD and co-occurring to access care, address barriers to help improve maternal health outcomes.

Maternal Mental Health Learning Collaborative (LC)

January, 2024 SAMHSA's Center for Mental Health Services (CMHS) invited all states and territories to apply for the Maternal Mental Health LC, a competitive process where only eight (8) states/territories would be selected. The New Jersey Division of Mental Health and Addiction Services (DMHAS) submitted a successful application. Areas of focus included: building the existing integrated behavioral healthcare collaborations to address mental health issues and SUD for pregnant and parenting persons; strengthen coordinated care; improve continuity of care and linkages; identify obstacles to care; expand state capacity to address needs that impact perinatal and postpartum populations (e.g. housing, employment, legal, food security, etc.); address stigma, improve access to services; and build on the existing practices and current initiatives. The DMHAS LC goal was to improve collaboration and care coordination around mental health and SUD prenatally through postpartum, up to one year after the birth event.

Tuberculosis (TB) Services

Unlike some other communicable diseases, TB is not easily transmitted. It takes close and prolonged exposure for TB transmission to occur. Early detection and treatment of TB are essential to control the spread of the disease and to prevent outbreaks. The rate of TB in NJ for 2024 was 3.6 per 100,000 population with a count of 342 cases.

In line with this information, in New Jersey, all substance use disorder treatment facilities receiving contracts are required to conduct TB testing as part of the patients' admissions process. A provision of the guidelines requires that patients with TB, who were not admitted for treatment because the funded capacity at that facility had been exceeded, be referred to another treatment provider for services. DMHAS continues to have discussions with the NJ Department of Health,

Division of HIV/AIDS, STDs and Tuberculosis Services (DHSTS) to consider the latest best practices for this effort. DMHAS sent a letter to all SUPTRS Block Grant funded SUD treatment agencies regarding the tuberculosis evaluation requirement.

A need is to increase the compliance rate of DMHAS' SUPTRS Block Grant contracted agencies offering every client a tuberculosis evaluation. According to SFY 2025 Annual Site Monitoring Reports of DMHAS' SUPTRS Block Grant contracted agencies, 94% of the agencies that were monitored (34 of 36 agencies) were in compliance with offering every client a tuberculosis evaluation.

DMHAS will track compliance via quarterly surveys. Monitors will review compliance during quarterly surveys and at 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.

Persons Who Inject Drugs (PWID)

In CY 2024, 13,169 (16%) of 81,217 admissions used drugs intravenously. This particular group is at high risk for other infectious diseases such as HIV and hepatitis, indicating the need for linkage to primary care. One attempt to address this need was applying for, and being awarded, a Promoting Integration of Primary and Behavioral Health (PIPBHC) grant. The two awardees provided models of integration to serve individuals with opioid use disorder (OUD) and other health co-morbidities.

Another activity to address the need of PWID has been our partnership with Department of Health, the National Alliance of State and Territorial AIDS Directors (NASTAD) and the JSI Research & Training Institute, Inc. (JSI). One-time funds were provided to support activities related to the Strengthening Systems of Care for People with HIV and Opioid Use Disorder (SSC) project. These funds were designated to support concrete, time-based activities focused on enhancing systems of care for people with HIV and OUD and in alignment with state technical assistance plans developed for the project. Stigma and its effects contribute to the syndemics of HIV and opioid use disorder (OUD), acting as an obstacle to care for people seeking services. An area that has been explored is data sharing among the two Departments to determine the number of individuals in substance use disorder (SUD) treatment who have HIV and the number of individuals who have HIV that are in SUD treatment. If a plan can be executed for the data sharing, information could be utilized by both Departments to help improve health outcomes for this population by better engaging individuals to seek either HIV or SUD treatment.

The SSA requires all substance use disorder treatment agencies providing treatment to persons who inject drugs (PWID) to provide outreach activities to encourage PWID clients to seek and undergo treatment. The SSA incorporates a provision within the requirements section of each contract with the agencies providing treatment to PWID to ensure that these entities: 1) admit all individuals who request and are determined to be in need of treatment for intravenous drug use within 14 days of their request; or 2) make interim services available to the individuals within 48 hours of the request, and should the individual actively remain on the waiting list, admit the clients

within 120 days. To address the need for interim services for PWID, DMHAS utilizes funding to support individuals requiring interim services through its Fee-for-Service (FFS) initiatives.

An initiative to promote low induction medication is through mobile medication programming. Currently, DMHAS contracts with seven agencies to facilitate low induction medication, case management and other ancillary services for individuals with an OUD, which includes PWID, in counties with low access to MAT, as well as areas of the State with individuals who are homeless or at higher risk for homelessness.

Medication Assisted Treatment is the gold standard of care for individuals who suffer from an OUD. Data from NJSAMS for CY 2024 indicated that 15% methadone and 10% buprenorphine was planned for use in treatment, despite the fact that heroin and other opiates accounted for 36% of primary drug admissions. DMHAS is committed to decreasing the gap between the use of MAT for people with OUD, particularly PWID. DMHAS, in partnership with the Department Human Services (DHS), Office of Public Relations, secured a vendor that has been delivering a public awareness campaign to help address stigma around the use of MAT for OUD. The campaign was initially launched in the Spring of 2020 and continues to refresh with new ads. Various forms of messaging including TV ads, radio commercials, social media and billboards have been utilized.

In addition, DMHAS offers extensive training on the use of MAT in efforts to make this the standard of care. In CY 2023, DMHAS contracted with Cooper Medical School of Rowan University (CMSRU), the State's Southern Center of Excellence (COE), to provide tailored training and technical assistance on Addiction Medicine, specifically buprenorphine induction, throughout New Jersey. This includes various training topics, formats, office hour sessions, and "elbow to elbow" on-site consultation services. The training is aimed at increasing the use of buprenorphine to treat opioid use disorders, specifically at Emergency Departments, Federally Qualified Healthcare Centers and Primary Care offices.

At-Risk Youth

The SSA provides prevention services to At-risk youth. The SSA awarded funding to the North Jersey Community Research Initiative (NJCRI) to expand their existing programs for high-risk youth by using a "Street Smart" prevention model developed by the Centers for Disease Control and Prevention, as well as early intervention services, social marketing, and structured recreational activities. NJCRI provides services covering the northern NJ counties. In the spring of 2023, DMHAS (by means of a competitive RFP process) identified two additional organizations to provide services to at-risk persons in their communities: Prevention Resources in Central NJ and the Robert Wood Johnson-Barnabas Health Institute for Prevention and Recovery, in the south.

Homeless

DMHAS has developed numerous programs to address the needs of homeless populations. DMHAS has funded services in homeless shelters to increase access to buprenorphine and other ancillary services for individuals with SUD. Contractees provide these services regardless of whether people live in the shelter or drop in. The shelters have affiliations with primary care

providers to address physical health needs, including pain management, and implement evidence-based overdose prevention or other interventions to promote consumers' recovery and wellbeing. The prescriber is present at the shelter or available via telehealth when initiating the medication and maintains the person on medication at the shelter or transitions them to a community provider. Case managers and peer specialists support people on sustaining their medication treatment and helping them to overcome obstacles common to people who are homeless or at risk of homelessness. Shelters offering buprenorphine are located in Paterson, Trenton, Camden, East Orange, and Newark.

DMHAS operates Projects for Assistance in Transition from Homelessness (PATH) program using a combination of federal and state funds. The service 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 State Mental Health Authority (SMHA) contracts with non-profit agencies to operate PATH programs within the state's 21 counties. In SFY 2024, the PATH programs in New Jersey provided outreach to 2,559 individuals and served a total of 1,562 persons. There were 638 program participants that were linked to mental health services, 92 to substance use treatment services (an individual with a self-disclosed SUD is referred to SUD treatment resources and services), 166 to primary health/dental care, 368 to financial services, 299 to temporary housing/shelter, 250 to long term housing and 292 were linked to employment or vocational and educational services.

The Open Access to Medications for Opioid Use Disorder in Homeless Shelters is designed to increase access to buprenorphine and other ancillary services for individuals with a substance use disorder through current programming available at homeless shelters that are licensed by the NJ Department of Community Affairs. These providers have developed the capacity to provide medication and support services for individuals who reside or drop in at homeless shelters. The intent of the program is to provide low threshold medication services to individuals with SUD who present in these settings. The six participating shelters are located in Paterson, Trenton, Camden, East Orange and Newark. The shelters were awarded a contract from a competitive RFP process; two were awarded in December 2022 and four were awarded in May 2024.

Opioid Settlement funds were used to fund an RFP for temporary housing for individuals being discharged from residential, inpatient, ambulatory SUD treatment and/or individuals with a history of SUD who may be or have become homeless. The funding through this RFP can serve as a bridge

to permanent housing, allowing participants to receive the support and services they need around other challenges in their lives. DMHAS issued an RFP in October 2024 and made awards in February 2025 to six licensed 24-hour emergency shelters for a total of 150 beds. A companion RFP funded with opioid settlement funds was released for case management services for adult individuals placed in one of the 150 shelter beds. Case managers will help connect individuals with services/ resources in their area and entitlements and assist them in securing permanent housing as quickly as possible. It is anticipated that individuals will obtain permanent housing within four months of initial engagement. Individuals served in this program will have access to DMHAS funded housing subsidies. DMHAS issued an RFP in October 2024 and made awards in February 2025 to four agencies to provide these services in their region of the state.

Through an MOA with the Rutgers Northern Region MATx Center of Excellence (COE)'s, DMHAS funds a set of services and training designed to improve engagement in SUD and mental health services among unhoused individuals in Essex County. The COE's Outreach Partners program provides intensive case management to increase the success of individuals in achieving and maintaining their recovery goals through medications for addiction treatment (MAT). Shelter-based activities involve assisting residents with obtaining Medicaid and facilitating linkage/referral to community-based organizations that provide social services, mental health, substance use, and/or medical treatment for shelter residents with SUD. In addition, Rutgers team members lead a variety of thematic support groups for shelter residents on topics such as overdose prevention, relapse prevention, family/social network connection, mindfulness and stress mitigation. Shelter-based support includes assistance with cell phones to help people stay in communication with service providers and vouchers for transportation so individuals can attend treatment appointments. Shelter-based participants will also be offered a "Overdose Prevention Backpack."

This program also includes a statewide Learning Community and provides quarterly trainings on topics related to SUD and mental health, as well as providing "hands-on" support to housing stakeholders in Newark and Northern New Jersey in creating programming that is empathic and responsive to client needs.

Planning Tables

Table 1: Priority Area and Annual Performance Indicators

Priority #: 1

Priority Area: Pregnant Women/Women with Dependent Children

Priority Type: SUR

Population(s): PWWD

Goal of the priority area:

Maintain capacity of existing programs to make available recovery support services designed for pregnant women and women with dependent children.

Strategies to attain the goal:

Continuum of Care and Pregnant and Parenting Women's (PPW) Services.

- Contracted licensed substance use disorder (SUD) women's treatment providers receiving funding through the women's set aside block grant are required to address the full continuum of treatment services, ranging from prevention, women-specific treatment and recovery supports. Services include family-centered treatment, evidence-based parenting programs, trauma-informed and trauma-responsive treatment using Seeking Safety, Strengthening Families, evidence-based parenting classes, recovery supports, etc. and to provide assistance with housing supports by linking women to transitional, permanent and/or supportive or sober living homes such as an Oxford House.

- SUD treatment Levels of Care include: Intensive Outpatient/Outpatient; Methadone Intensive Outpatient/Methadone Outpatient; Long-Term Residential; Short-Term Residential and Halfway House. Interim Services.

- Fee for Service (FFS) Network licensed SUD treatment providers are required to provide Interim Services as an engagement service at all levels of care to ensure priority PPW consumers awaiting admission to their assessed level of care anywhere in the state could receive interim services within 48 hours at facilities closer to home. Interim services for PPW consumers are designed to decrease the adverse health effects of substance use, promote individual health, and minimize the risk of transmitting disease to sexual partners and their infants by providing individualized education, case management, referrals and medication assisted treatment (MAT) if needed, while awaiting admission.

Maternal Child Health Initiatives:

- Maternal Wrap Around Program (MWRAP). MWRAP is a statewide initiative that provides intensive case management and recovery support services for pregnant women with SUD 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 persons provide non-clinical assistance and recovery supports while maintaining follow-up with the women and their infants. The overall goal of the MWRAP is to alleviate barriers to services through comprehensive care coordination that is implemented within the five major timeframes when intervention in the life of the substance exposed infants (SEI) can decrease potential injury of prenatal substance exposure: pre-pregnancy, prenatal, birth, neonatal and early childhood. MWRAP is intended to promote maternal health, improve birth outcomes, and decrease the risks and adverse consequences of prenatal substance exposure. Each MWRAP region is required to provide services to 60 unduplicated women, a total of 420 unduplicated women.

- Integrated Opioid Treatment and Substance Exposed Infants (IOT-SEI) Initiative. There are five IOT-SEI programs across the State, funded with the Governor's State Opioid funds. This Initiative provides an array of integrated services for pregnant women with an opioid dependency, their infants and family. Providers are required to ensure a full continuum of services and to establish mechanisms to develop a coordinated and cohesive approach for working together across systems that encompass SUD treatment, medical community, maternal child health, and child welfare. Initiative focuses on alleviating obstacles to services. Services range from: mother's medical/prenatal and obstetrical care, SUD treatment for opioid use disorder (OUD) consisting of medication assisted treatment (MAT), newborn/infant medical care, child welfare services as identified, intensive case management, recovery supports, assistance with housing, case management and other wraparound services. Providers must ensure that there is comprehensive care coordination from prenatal through the birth event, postpartum, and early childhood.

- Data Collection (MWRAP and IOT-SEI). DMHAS Researcher collects and analyzes data from both initiatives to understand the impact of each program on outcomes for the mother and her child, to evaluate program effectiveness, and to make recommendations for program improvement and sustainability. While data specific to the COVID-19 pandemic was collected starting in July 2020 to capture participant experiences and challenges—consisting of housing, transportation, and healthcare—the current focus has shifted toward data collection guided by established protocols, with an emphasis on timely reporting, quality improvement, and the provision of technical assistance (TA) to data staff members. Monthly data support efforts are now central to ensuring continuous performance monitoring and program optimization.

- Provider Meetings. Biannual meetings are held with the maternal child health initiative providers: Maternal Wrap Around (MWRAP) and, Integrated

Opioid Treatment and Substance Exposed Infants (IOT-SEI) providers. State partners representing the Department of Children and Families (DCF) and Division of Child Protection and Permanency (DCPP) are invited to attend. A variety of topics such as information sharing, data collection, best practices, continuum of care, medication assisted treatment, referrals and access to services, recovery supports, Plans of Safe Care, systems collaboration, program accomplishments, challenges, and training needs are addressed.

Professional Development. All contracted pregnant and parenting women's (PPW) SUD treatment providers and maternal child health providers are requested to have new staff successfully complete the National Center on Substance Abuse and Child Welfare (NCSACW) online tutorials "Understanding Child Welfare and the Dependency Court: A Guide for Substance Abuse Treatment Professionals" and document completion of tutorials in their employee personnel files. In March 2024, the NJ DMHAS Office of Treatment and Recovery Supports contracted with agencies to provide pregnant and parenting women's licensed substance use disorder treatment. Maternal child health providers received training on Improving Clinical Recovery Services for Pregnant and Parenting People. The training was provided by SAMHSA's State TA provider, JBS International. The two-part virtual sessions consisted of Family Centered Treatment and Trauma Informed Care encompassing stigma education.

- Plans of Safe Care. Contracted PPW licensed SUD treatment and maternal child health providers (MWRAP and IOT-SEI Initiatives) require Plans of Safe Care. Plans of Safe Care 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 the pregnant woman and significant others as appropriate along with treatment providers, health care providers, early childhood service providers, and other members of the multidisciplinary team as appropriate. Documentation of the Plan must be in the woman's file. The DMHAS Monitoring Unit has updated their monitoring site review tool to encompass Plans of Safe Care under the women's set aside section for block grant funded providers.

- In-Depth Technical Assistance (IDTA) Neonatal Abstinence Syndrome and Substance Exposed Infants (NAS SEI): As a SAMHSA Prescription Drug Abuse Policy Academy State, in 2014, NJ applied for a unique technical assistance opportunity through the SAMHSA supported NCSACW to address the multi-faceted problems of NAS and SEI. NJ DHS/DMHAS as the lead State agency, partnered with Departments of Children and Families and Health. IDTA provided technical assistance to NJ to strengthen collaboration and linkages across multiple systems, addictions treatment, child welfare and the medical community to improve services for pregnant women with opioid use disorder (OUD) and other substances. Three goals were established, and workgroups were developed. Goals are to: Increase perinatal SEI screenings at multiple intervention points; leverage existing programs and policy mechanisms to collaboratively increase the rate at which women screening positive on the 4 Ps Plus get connected for a comprehensive assessment by establishing formal warm hand-offs and other safety net measures; and leverage existing programs and policy mechanisms to collaboratively increase the rate at which women delivering SEIs and their infants and other eligible children receive early support services for which they are eligible.

- IDTA Birthing Hospital Survey: One of the workgroups, (Labor, Delivery and Engagement-Infants) developed a comprehensive survey (Birthing Hospital Survey) with input from the medical and perinatal community. The survey was disseminated statewide in Spring 2017 to labor and delivery hospitals. Survey sought to understand how pregnant women with SUD and SEIs are identified, treated, and triaged with partners at discharge, and if treatment for NAS was explored. Results intended to guide Departments in establishing statewide guidelines for best practice; aid in the development of cross-system models to ensure families get access to services; establish education needs on issues of SEI/NAS and identify high risk areas. In an effort to increase access to SUD treatment and to curtail unmet treatment needs of PPW with an OUD, based on the Birthing Hospital Survey findings, DMHAS engaged Rutgers/Robert Wood Johnson Medical School (Rutgers/RWJ) to provide technical assistance and training through the Extension for Community Healthcare Outcomes (ECHO) Program.

- New Jersey was awarded another round of IDTA through the NCSACW 2023 Policy Academy: Advancing Collaborative Practice and Policy: Promoting Healthy Development and Family Recovery for Infants, Children, Parents, and Caregivers Affected by Prenatal Substance Exposure. NJ State Policy Academy representatives are from the Departments of Health, Children and Families and Human Services, and the Governor's Office. The DMHAS Women's Treatment Coordinator represents DHS. Representatives from the medical, addictions and perinatal community also participate on this IDTA. The overall goal is to increase awareness of pregnant women with OUD and other substances, through increased education, maximizing messaging through the perinatal work force, increase awareness and access to treatment, Plans of Safe Care, and improving screenings in hospitals and healthcare providers. Four goals have been established: Goal 1: Conduct a statewide landscape analysis of resources targeted at individuals with a SUD and understand how referrals are made to appropriate resources and levels of care. Goal 2: Address gaps in the SUD system of care to establish a comprehensive and fluid collaborative approach among state agencies, healthcare providers, and community-level and non-profit organizations to address substance use during and after pregnancy. Goal 3: By 2025, create and execute a state-wide prenatal Plans of Safe Care process that enables Community and Clinical Partners to formally support a birthing woman. Goal 4: Support birthing hospitals in updating their protocol related to screening and referring pregnant women with SUD; and subsequently engaging in a comprehensive approach to implementing Plans of Safe Care in New Jersey.

- Maternal Mental Health and Substance Use Disorder. Improving maternal child health outcomes is a major agenda for NJ through the adoption of Nurture NJ, led by First Lady Tammy Murphy. Nurture NJ is a statewide, multi-agency campaign dedicated to this issue. ReachNJ, the central call-in line for NJ residents who are looking for help with a SUD. MWRAP provided training to ReachNJ regarding program services. NJReach offers MWRAP as an additional resource to pregnant women seeking treatment and also provides warm hand-offs.

- Nurture NJ focuses on improving collaboration and programming between Departments, agencies and stakeholders to achieve its goal to make NJ the safest place in the country to give birth and raise a baby. Nurture NJ wants to ensure that all women are healthy and have access to care before pregnancy and is a high-quality system of care with services from prenatal to postpartum provided in a supportive community environment. NJ's Maternal Mortality Report (2016-2018) identified a total of 125 pregnancy associated deaths that had a temporal relationship to pregnancy within 365 days. 74 pregnancy-associated (not related deaths) were attributed to SUD occurring from day 43 postpartum to day 100. These deaths could have been prevented. Lack of continuity of care and/or proper care coordination was identified as the top contributing factor. Postpartum women with a history of SUD and co-occurring disorder are most vulnerable for relapse and should have access to resources that can help support her infant and families.

Supporting maternal mental well-being strengthens not only mothers, parents and women but also their families and their communities.

- Maternal Mental Health Learning Collaborative. SAMHSA has prioritized addressing maternal mental health conditions and co-occurring SUD. The DMHAS Women's Services Coordinator submitted a successful application January 2024 to the Center for Mental Health Services to participate on the Maternal Mental Health Learning Collaborative (LC). March 2024, the New Jersey DMHAS LC team attended an in-person kickoff meeting at SAMHSA facilitated by SAMHSA's state technical assistance team. Subsequent meetings were held monthly through virtual sessions and concluded September 2024.
- The DMHAS LC goal was to improve collaboration and care coordination around mental health and SUD prenatally through postpartum, up to one year after the birth event. Contributing factors in the majority of preventable, pregnancy associated, not related deaths consist of: limited access to services, obstacles to care, lack of continuity of care and coordination, complications from SUD and mental health conditions and stigma. In addition, DMHAS LC priority is to increase access to care to the MWRAP initiative that focuses on maternal child health.
- DHS through DMHAS provided funding 2024 to the New Jersey Quality Health Care Institute to partner with a provider to conduct statewide trainings to MWRAP staff and the perinatal workforce on Mental Health First Aid (MHFA) to raise awareness around the impact of perinatal mental health. The perinatal workforce is uniquely positioned to identify mental health symptoms early and intervene when needed on MHFA. The trainings focused on maternity-specific scenarios to teach participants how to assist pregnant and parenting persons experiencing mental health symptoms in crisis and non-crisis situations and intervene when needed.
- DMHAS will continue to support maternal mental well-being for pregnant and parenting persons with SUD and their families through collaborations with state systems, community partnerships, and other stakeholders. Lessons learned from the technical assistance provided through the Maternal Mental Health LC and the DMHAS case challenge will help to guide DMHAS to strengthen the current system. DMHAS anticipates building a foundation where there is a seamless and integrated approach across all systems to improve health outcomes, be sensitive to individual's experiences, and decrease maternal mortality related to mental health and SUD in the postpartum period.
- DMHAS collaborated with NJ DCF Division of Child Protection and Permanency (DCPP) case practice lead, to develop a Prenatal Pathway with SUD concerns. If a pregnant person has a positive screen for illegal substances prenatally or has substance misuse and does not have any other children in their care, and a call comes into the DCF State Central Registry system, known as SCR, that registry will generate referrals to the county-based MWRAPs.
- Currently, planning is underway between DMHAS and the New Jersey Department of Children and Families (DCF) to expand the current infrastructure to build the prenatal pathway for SUD and mental health concerns along with the statewide MWRAP initiative in the Connecting NJ (CNJ) system. Connecting NJ is a county level single point of entry (via telephone) for pregnant people county-based, that simplifies and streamlines the referral process for obstetrical and prenatal care providers, community agencies, and families. The goal is to increase referrals to support the intersection of SUD and mental health perinatally resulting in improved integration with community based behavioral health resources.

Supportive Housing:

- Women's Intensive Supportive Housing (WISH) Program. DMHAS developed the WISH Program that provides permanent supportive housing for PPW with a co-occurring SUD and mental illness who are homeless or at risk of homelessness and being discharged from a licensed long-term residential SUD treatment and/or halfway house facility. An RFP was developed and released in January 2015 for the development of a WISH team to provide case management and supportive housing services for 10 women and their children. The RFP was awarded in 2015 to a licensed treatment provider knowledgeable in women's specific treatment, offers a continuum of care, and has a longstanding history of providing supportive housing and has demonstrated success in managing permanent supportive housing programs.
- Keeping Families Together. Since 2014, DMHAS has a Memorandum of Understanding (MOU) with NJ DCF, DCP&P to fund 10 supportive housing subsidies annually for the "Keeping Families Together" (KFT) program for parents involved with the child welfare system who are homeless or at imminent risk and in which one or more adults in the family is diagnosed with a co-occurring mental health illness and SUD. DCP&P contracts with a provider for the KFT program in Essex County.
- Sober Living. New Jersey contracts with Oxford House Inc. which has dedicated women's homes and women with children homes. The contract has been expanded to develop additional homes for populations in need such as women with children. Women and Children Oxford Houses are required to provide lockboxes to each for medication storage. Residents in Oxford Houses is responsible for their individual medication lock boxes. Outreach staff conduct annual training (Overdose Specific) at each Chapter meeting at the annual state workshop. Currently, there are 14 Oxford House Chapters throughout the state. This is in response to the heroin overdose epidemic in the state of New Jersey and its effects related to Oxford House. Each home is required to maintain Naloxone kits on site. In 2022 Oxford House continued to see an increase in members applying for membership with OUD. This increase created a more significant need for naloxone training and information on access to Medical Assisted Recovery (MAR) options. The New Jersey Oxford House outreach team continues to educate members on MAR and the importance of being an active member of their recovery community. 2024 Opioid Settlement Funds supports expansion of Oxford Houses for up to 10-12 new homes annually. Homes will be dedicated to men, women and women with children. State Fiscal Year 2025, opioid settlement funds supported 12 new Oxford Homes; three (3) homes are for women and three (3) of the 12 homes are for women and children.

- Systems Collaboration PPW. Twelve (12) of New Jersey's 21 counties have monthly DCP&P Child Welfare Substance Use Disorder Consortia meetings which have moved to virtual meetings. Child welfare staff, DMHAS, Division of Family Development, SUD Provider Agencies, Work First New Jersey, Substance Abuse Initiative (WFNJ SAI) providers, and Boards of Social Services meet each month and plan on how to better serve families, leading to more effective policies and practices to meet the needs of infants, children and families. The Consortia also addresses ASFA timelines, Plans of Safe Care, and reunification for children in out of home placement. Through collaboration, multiple agencies working with the same family can improve

communication to decrease 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.

• Extension for Community Healthcare Outcomes (ECHO) and Maternal Child Health. DMHAS Office of Treatment and Recovery Supports has a Memorandum of Agreement (MOA) with Rutgers Robert Wood Johnson Medical School, Office of Community Health to provide ECHO technical assistance and training. The ECHO series “Maternal Child Health Pregnant and Parenting Women with Opioid Use Disorder (MCH PPW-OD)” started January 2020 through December 31, 2021. The MCH PPW-OD ECHO provides education and training to primary care practitioners, SUD treatment providers, behavioral health practitioners, and other stakeholders in clinic settings and at home, utilizing a web-based video collaboration between a multi-disciplinary team of professionals and primary care practitioners on best practices for the assessment, case management, intervention, treatment and recovery support services for PPW with an OUD. The ECHO goal is to increase the capacity and competency of behavioral health providers, community support organizations, medical community, and child welfare to support prevention, treatment, and recovery of pregnant and parenting persons with OUD and other substances. ECHO positions communities to decrease the NAS birth rates, improve use of MAT, family formation and early infant development; improve access to physical and mental health care by educating more providers, midwives, doulas, and other health care professionals on best practices during prenatal and perinatal periods. The MOA was extended several times in order to continue technical assistance, education and training. The most recent extension is from October 2023 through September 2025. This ECHO series held evening sessions in an effort to reach out to practitioners and prescribers, with sessions focused on the latest FDA approved techniques for MAT, integrated care, and wraparound services, stigma of mental health and substance use, screening protocols, improving access to substance use treatment, Plans of Safe Care, and coordinated care for pregnant persons with OUD and their newborns. The new series which started January 2024 through August 2024 consisted of 18 sessions with five community workshops and another 18 sessions with five community education workshops through August 2025. The community education workshops focus on educating the target audience on referral and linkages between providers, practitioners, and community services to support pregnant and parenting persons and their family. This series focuses on maternal opioid intervention and care coordination. Didactic topics with the 18 sessions range from integrative approach to care for pregnant persons; bridging the gap from patient to plan; implementation that is meaningful and impactful; prenatal care with an opioid/substance use disorder; addressing stigma; perinatal depression; navigating the system to maximize successful family formation, etc.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Maintain the number of individuals receiving recovery support services in the Maternal Wraparound Program (MWRAP).
Baseline measurement (Initial data collected prior to and during 2026):	SFY 2025: 381 individuals received recovery support services in the Maternal Wraparound Program consisting of 111 mothers, 45 babies/birth, 40 children under 1 year old and 185 children 1-17 years old.
First-year target/outcome measurement (Progress to the end of 2026):	Maintain the baseline number of individuals receiving MWRAP recovery support services.
Second-year target/outcome measurement (Final to the end of 2027):	Maintain the baseline number of individuals receiving MWRAP recovery support services.
Data Source:	

The number of individuals receiving MWRAP recovery services from SFY 2025 – 2027 will be tracked by five providers using the MWRAP intake survey, birth survey, discharged survey, and reported through the MWRAP reporting roster

Description of Data:

Data tract by the MWRAP reporting roster captures bio data, enrollment and admission data, follow-up contact data, maternal health related data, SUD and OUD related data, other care and support data, legal data, exit data, and summary of care.

Data issues/caveats that affect outcome measures:

Providers interactive program discussion showed that some data issues/caveats that affect outcome measures, which are being effectively addressed, encompassed the following:

- Referrals across services providers at all levels of care was Strengthened
- Advocacy on stigma was strengthened
- Mechanism improved to decrease staff turnover/attrition

Priority #:	2
Priority Area:	Persons Who Inject Drugs (PWID)
Priority Type:	SUT
Population(s):	PWID

Goal of the priority area:

To expand access to Medications for Opioid Use Disorder (MOUD), for individuals with an opioid use disorder, encompassing PWID, through mobile medication units and other innovative approaches.

Strategies to attain the goal:

- Technical assistance to SUD treatment providers emphasizing the importance of providing MOUD to PWID, which is an evidence-based practice.
- Mobile Medication Units. Providing services in convenient locations, specifically through existing and new mobile medication programming, in order to decrease obstacles and engage individuals in care as easily as possible.
- Expanded Hour Opioid Treatment Program (OTPs). Continuance of an expanded hour OTP initiative in efforts to provide increased (i.e. evening) hours that are not typically provided in efforts to assist individuals with easier access to services.
- Public Awareness Campaign. Educating providers and decreasing stigma and discrimination for individuals with an OUD, family members and the public about the benefits of MOUD through its public awareness campaign that was initially launched in 2020. Also, increased campaign efforts for Fentanyl Awareness to begin in 2025.
- Opioid Overdose Prevention Trainings. Contracts with regional Opioid Overdose Prevention Program (OOPP) providers and an Opioid Overdose Prevention Network (OOPN) provider to continue to offer community education and trainings for individuals at-risk for an opioid use disorder, their families, friends and loved ones to recognize an opioid overdose and to subsequently provide naloxone kits to individuals in attendance. A component of these trainings have been and will continue to be to discuss treatment, consisting of MOUD. In addition to populations listed above, training will continue to not be limited to other populations such as schools, jails, licensed SUD agencies, Offices of Emergency Management (OEMs), Emergency Medical Services (EMS), teams, fire departments, homeless shelters and community health clinics.
- Opioid Overdose Recovery Programs (OORPs). Linking individuals reversed from an opioid overdose, who are seen bedside by recovery staff and patient navigators at emergency departments, via the 21 county OORPs to treatment and/or recovery support services in their communities.
- Support Teams for Addiction Recovery (STAR). Statewide contracts awarded to providers in all 21 counties for a STAR program to provide case management and wraparound services for individuals with an OUD. Goals are: linking clients to needed services, housing, primary care and treatment consisting of MOUD.
- Telephone Recovery Supports (TRS). TRS is a statewide program to assist individuals to decrease relapse and to enhance the recovery experience. The service calls high risk participants with an OUD, for up to four months, longer if needed, to provide encouragement, support and information.
- Maternal Wrap Around Program (MWRAP). MWRAP is a statewide initiative that provides intensive case management and recovery support services for pregnant women with SUD 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 staff provide non-clinical assistance and recovery supports while maintaining follow-up with the women and their infants. The overall goal of the MWRAP is to alleviate obstacles to services through comprehensive care coordination that is implemented within the five major timeframes when intervention in the life of the substance exposed infants (SEI) can decrease potential injury of prenatal substance exposure: pre-pregnancy, prenatal, birth, neonatal and early childhood. MWRAP is intended to promote maternal health, improve birth outcomes, and decrease the risks and adverse consequences of prenatal substance exposure. Each MWRAP region is required to provide services to 60 unduplicated women, a total of 420 unduplicated women.
- Integrated Opioid Treatment and Substance Exposed Infants (IOT-SEI) Initiative: Integrated Opioid Treatment and Substance Exposed Infants (IOT-SEI) Initiative. There are five IOT-SEI programs across the State, funded with the Governor's State Opioid funds. This Initiative provides an array of integrated services for pregnant women with an opioid dependency, their infants and family. Providers are required to ensure a full continuum of services and to establish mechanisms to develop a coordinated and cohesive approach for working together across systems that encompass SUD treatment, medical community, maternal child health, and child welfare. Initiative focuses on alleviating obstacles to services. Services range from: mother's medical/prenatal and obstetrical care, SUD treatment for OUD consisting of MAT, newborn/infant medical care, child welfare services as identified, intensive case management, recovery supports, assistance with housing, case management and other wraparound services. Providers must ensure that there is comprehensive care coordination from prenatal through the birth event, postpartum, and early childhood.
- Strategic Prevention Framework for Prescription Drugs: In September 2021, DMHAS was awarded its second "Strategic Prevention Framework for Prescription Drugs (SPF Rx)" five-year grant from SAMHSA to implement the NJAssessRx initiative. NJAssessRx expands interagency sharing of the state's Prescription Drug Monitoring Program data and gives DMHAS the capability to use data analytics to identify prescribers, prescriber groups and patients at high risk for inappropriate prescribing and nonmedical use of opioid drugs. Informed by the data, DMHAS and its prevention partners will strategically target communities and populations needing services, education or other interventions. The service population is youth (ages 12-17) and adults (18 years of age and older) who are being prescribed opioid pain medications, controlled drugs, or human growth hormone (HGH), and are at risk for their nonmedical use.
- State Opioid Response (SOR) Grant. In FY 2023, New Jersey received just over \$133 million through SOR 3.0 for a two-year period. The goal of the SOR is to address the State's opioid crisis as well as a rising issue of stimulant use disorder by providing treatment, family and peer recovery support,

community prevention and education programs and training. The key objectives of funding are to increase access to MAT, decrease unmet treatment need, decrease opioid-related deaths, and provide services to address individuals who have a stimulant use disorder. In FY 2025, New Jersey received award for SOR 4.0, a three-year grant that would allow DMHAS to continue activities listed above.

- Jail MAT and Technical Assistance. As part of SOR and state funding, DMHAS collaborates with all 21 counties in NJ who have established Medication Assisted Treatment (MAT) programs or enhanced existing MAT services for inmates with OUD at county correctional facilities. DMHAS utilizes funds to have its two Centers of Excellence (COEs) provide technical assistance to correctional facilities to assist them in the provision of these services. These TA services will continue to the end of September 2025. In addition, DMHAS has worked with county correctional facilities to establish justice involved re-entry services for detainees where case managers at county jails conduct intake assessments and establish pre-release plans for needed services in the community.

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

- Homeless Shelter Initiative. DMHAS continues to increase access to buprenorphine and other ancillary services for individuals with a SUD through current programming available at homeless shelters. Contracted providers will continue to develop the capacity to provide low threshold medication as well as other support services for individuals who reside or drop in at the shelters, linking them to treatment and recovery services, when appropriate.

- Community Training. DMHAS will continue a train-the-trainer program through Rutgers University to educate the community on medications that can be utilized to support recovery and provide NJ-specific treatment and recovery resources. The goal of this project is to educate, support, and mentor graduate students to provide these free educational talks to community groups throughout the State.

- Paramedicine Initiative. DMHAS continues a pilot program to fund one of its university partners to develop pilot paramedicine programs in the State to administer buprenorphine for opioid withdrawal symptoms and provide next day linkage to care to community providers. There are plans to replicate the pilot in Camden City to other cities in NJ.

- Office Based Addiction Treatment. The Division of Medical Assistance and Health Services (DMAHS), in collaboration with DMHAS, continues a program to cover and support medications for opioid use disorder at Office Based Addiction Treatment (OBAT) providers. This program coordinates the delivery of multiple reimbursable services provided by primary care providers and community behavioral health staff to NJ FamilyCare members with an addiction diagnosis. OBAT providers link patients to OTPs or other treatment services, when appropriate.

- Long-Term Residential Incentive Payment. An innovation is paying Long Term Residential agencies for providing Medications for Addiction Treatment (MAT) to clients. Effective June 1, 2020, the Long-term Residential (LTR) reimbursement rate was increased, as well as the ability to pay for MAT and MAT-related services. On August 20, 2021, the Department of Health (DOH) issued Guidance 7-2021 that reported Long Term Residential (LTR) facilities do not need to seek approval from DOH to prescribe medication, other than Methadone, for the treatment of substance use disorders. As a result, effective October 15, 2021, the base rate for Long Term Residential [H0019HF] encompasses the MAT add-on of \$5.00 per unit and increased to \$152.60 per day consisting of Room and Board. Two increases to the base rate occurred since implementation: a 5.0% increase effective July 1, 2023 and a 5.7% increase effective July 1, 2024. The current base rate is \$161.33.

Beginning July 1, 2020, additional incentive payments became available for the utilization of MAT and MAT capacity in LTR. The incentive rate creates the capacity to prescribe and administer MAT, which minimally consists of Buprenorphine, but also may encompass Naltrexone and other FDA-approved products for Opioid Use Disorder (OUD) and for Alcohol Use Disorder (AUD). The rates and incentives are structured as follows:

- 1) The increased base LTR treatment rate with the MAT add-on plus Room and Board per diem.
- 2) When an LTR provider site has least 40% of eligible clients receiving an approved medication for treatment of an OUD or an AUD, the provider's rate will increase by \$10.00 per unit of service. This incentive threshold applies to medications arranged for using an external provider (e.g., Methadone from an OTP; Buprenorphine from OBAT) and provided by the LTR Provider.
- 3) The LTR provider can bill for medications, administration costs in addition to the new rates.

To qualify for the incentive rate, Medicaid and DMHAS will determine a 40% MAT utilization rate through NJSAMS reporting at client discharge. This benchmark is measured as those individuals who are medication-eligible who receive qualifying medications as reported in the NJSAMS Discharge data. The measurement will consist of all discharges, for duplicated and unduplicated individuals. The medications that qualify are FDA-approved for the treatment for OUD and AUD encompass Buprenorphine, Sublocade, Methadone, Naltrexone (for OUD), and Naltrexone for Disulfiram, Acamprosate (for AUD); note that, at a minimum, Buprenorphine must be provided to receive the incentive. The benchmark is measured by site based on the overall data, initially every three months starting July 1, 2020 for fiscal year 2021 and then every six months thereafter, which continues today. The applicable incentive rate applies to all billed LTR units for the prospective period when the provider site meets the 40% benchmark incentive criteria.

- Expanded Outpatient Hours. An RFP was issued in August 2022 to expand outpatient treatment services and enhance access to treatment by removing obstacles such as traditional service hours. Ten SUD outpatient treatment providers were awarded a contract to provide these services in October 2022. These expanded hours will provide increased access to outpatient treatment for individuals with an SUD. The purpose of this expansion for outpatient services is to support, enhance and encourage the emotional development and the development of consumer's life skills in order to maximize their

individual functioning during alternate times from standard business hours (after hours and weekends). Providers are required to expand their hours at a minimum of six days per week with the goal of extending hours into the evening and admitting new consumers for these services during these times. This program is funded with ARPA funding that will end September 2025.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the percentage of PWID in treatment receiving MOUD as indicated at discharge.

Baseline measurement (Initial data collected prior to and during 2026): SFY 2025: 39% of PWID received MOUD as indicated at discharge.

First-year target/outcome measurement (Progress to the end of 2026): Maintain a minimum of 39% of PWID treatment discharges for whom MOUD was received.

Second-year target/outcome measurement (Final to the end of 2027): Increase the percentage of PWID treatment discharges for whom MOUD was received by 2% from SFY 2026 by the end of SFY 2027. The change in SFY 2027 will be measured by calculating the percentage difference from SFY 2025 to SFY 2027.

Data Source:

The percentage of PWID for whom MOUD was received in SFY 2025 through SFY 2027 will be tracked by the SSA's New Jersey Substance Abuse Monitoring System (NJSAMS).

Description of Data:

All agencies licensed to provide substance use disorder treatment in New Jersey must report on NJSAMS, the SSA's real-time web-based client administrative data system. The system collects basic client demographic, financial, level of care, and clinical information for every client. All national outcome measures (NOMS) are incorporated into the system. Outcome measures are linked to the client at admission and discharge.

Data issues/caveats that affect outcome measures:

Outcome measures are collected at a client's admission and discharge per the approach used with TEDS and not at different periods of time during the course of treatment.

There is a decreased trend of heroin use as primary drug in recent years. DMHAS will monitor the trend in relation to its impact on our outcome measure.

Priority #: 3

Priority Area: Individuals who use Heroin/Opioid

Priority Type: SUT

Population(s): Other

Goal of the priority area:

To ensure medications for Opioid Use Disorder (MOUD) is provided as an option to individuals with an opioid use disorder (OUD) who are entering into substance use disorder (SUD) treatment.

Strategies to attain the goal:

- Technical assistance to SUD treatment providers emphasizing the importance of providing MOUD to PWID, which is an evidence-based practice.
- Public Awareness Campaign. Continue to utilize a public awareness campaign focusing on decreasing stigma/discrimination for individuals with an OUD, family members and the public about the benefits of utilizing medications to support recovery for an Opioid Use Disorder (MOUD).
- Vivitrol Enhancement. DMHAS will continue the Vivitrol Enhancement through its Fee-for-Service (FFS) Network. This enhancement allows providers to be reimbursed for the provision of Vivitrol as well as other ancillary services in FFS initiatives. Licensed SUD agencies can be enrolled in the enhancement if have proper approval of policies and procedures from the Department of Health, Certificate of Need & Licensing (CN&L).
- Buprenorphine Enhancement. DMHAS will continue the Buprenorphine Enhancement, similar to the one created for Vivitrol, that reimburses FFS Network providers for the provision of buprenorphine at their agencies. Licensed SUD agencies are able to participate in the enhancement with proper approval (MAT Waiver) issued by CN&L.
- Jail MAT and Case Management Initiative. DMHAS collaborates with the State's 21 county jails that established programs to encompass MOUD or

enhanced existing MOUD services for inmates. In addition, DMHAS works with county correctional facilities and have established justice involved re-entry services for detainees where case managers at county jails conduct intake assessments and establish pre-release plans for needed services in the community, which consist of linking individuals to community MOUD services.

- American Society of Addiction Medicine Booklets. DMHAS will continue to provide a statewide distribution of American Society of Addiction Medicine (ASAM) booklets entitled "Opioid Addiction Treatment: A Guide for Patients, Families and Friends" which provide facts about treatment, such as MAT as a best practice, and provides NJ-specific resources to accessing treatment and recovery services. These guides are provided in English, Spanish, Braille and several other languages that are prevalent in New Jersey. In addition to the written guides, DMHAS worked with the NJ Division of Deaf and Hard of Hearing (DDHH) to create a video link in American Sign Language (ASL).

- Community Training. DMHAS continues its Memorandum of Agreement (MOA) with Rutgers University, Robert Wood Johnson Medical School for a train-the-trainer program on Medications for Opioid Use Disorder (MOUD), the opioid epidemic (specific to New Jersey) and concepts of SUD (specific to OUD) for a minimum of 40 graduate students at Rutgers University. This project will continue to educate, support, and mentor graduate students to give free educational talks, through use of PowerPoint presentations, to community businesses and organizations in efforts to decreasing stigma/discrimination around medication to support an individual's recovery.

- Expanded Hour Opioid Treatment Program. Continue an expanded hour Opioid Treatment Program (OTP) initiative which provides increased (i.e. evening) hours that are not typically provided in efforts to assist individuals with easier access to services/care.

- Long-Term Residential Incentive Payment. An innovation is paying long term residential providers for providing Medications for Addiction Treatment (MAT) to clients. Effective June 1, 2020, the Long-term Residential (LTR) reimbursement rate was increased, as well as the ability to pay for Medication Assisted Treatment (MAT) and MAT related services. On August 20, 2021, the Department of Health (DOH) issued Guidance 7-2021 that reported Long Term Residential (LTR) facilities do not need to seek approval from DOH to prescribe medication, other than methadone, for the treatment of substance use disorders. As a result, effective October 15, 2021, the base rate for Long Term Residential [H0019HF] consists of the MAT add-on of \$5.00 per unit and increased to \$152.60 per day total of Room and Board. Two increases to the base rate occurred since implementation: a 5.0% increase effective July, 1, 2023 and a 5.7% increase effective July 1, 2024. The current base rate is \$161.33.

Beginning July 1, 2020, additional incentive payments became available for the utilization of MAT and MAT capacity in LTR. The incentive rate creates the capacity to prescribe and administer MAT, which minimally consists of Buprenorphine, but also may encompass Naltrexone and other FDA-approved products for Opioid Use Disorder (OUD) and for Alcohol Use Disorder (AUD). The rates and incentives are structured as follows:

1. The increased base LTR per diem rate for treatment plus Room and Board.
2. When an LTR provider site has least 40% of eligible clients receiving an approved medication for treatment of an OUD or an AUD, the provider's rate will increase by \$10.00 per unit of service. This incentive threshold applies to medications arranged for using an external provider (e.g., Methadone from an OTP; Buprenorphine from OBAT) and provided by the LTR Provider.
3. The LTR provider can bill for medications for administration costs in addition to the new rates.

To qualify for the incentive rate, Medicaid and DMHAS will determine a 40% MAT utilization rate through NJSAMS reporting at client discharge. This benchmark is measured as those individuals who are medication-eligible who receive qualifying medications as reported in the NJSAMS Discharge data. The measurement will encompass all discharges, consisting of duplicated and unduplicated individuals. The medications that qualify are FDA-approved for the treatment for OUD and AUD and encompass Buprenorphine, Sublocade, Methadone, Naltrexone (for OUD), and Naltrexone for Disulfiram, Acamprosate (for AUD); note that, at a minimum, Buprenorphine must be provided to receive the incentive. The benchmark is measured by site based on the overall data, initially every three months starting July 1, 2020 for fiscal year 2021 and then every six months thereafter, which continues today. The applicable incentive rate applies to all billed LTR units for the prospective period when the provider site meets the 40% benchmark incentive criteria.

- MOUD Survey. Johns Hopkins University worked with the DMHAS to develop a survey on the use of MOUD and was sent to all licensed SUD providers. The goal was to better understand the utilization of MOUD by providers, in regards to their reluctance to use MOUD and identify obstacles that exist. Results from the survey showed that although non-OTP substance use programs often offer clients access to MOUD. Most OUD clients do not actually receive MOUD. Buprenorphine uptake in these settings may require increased financial support for programs and clients, more robust education and training for providers, and efforts to decrease the stigma associated with medication among clients and their families.

- DMHAS finalized a Memorandum of Agreement (MOA) with the Rutgers Northern and Rowan Southern Centers of Excellence (COE) to provide technical assistance and training to the statewide county jails that participate in the County Correctional Facilities MAT and Case Management program. These TA services will continue to the end of September 2025.

- Homeless Shelter Initiative. DMHAS continues to increase access to buprenorphine and other ancillary services for individuals with a SUD through current programming available at homeless shelters. Contracted providers will continue to develop the capacity to provide low threshold medication as well as other support services for individuals who reside or drop in at the shelters, linking them to treatment and recovery services, when appropriate.

- Mobile Medication Units. Providing services in convenient locations, specifically through existing and new mobile medication programming, in order to decrease obstacles and engage individuals in care as easily as possible.

- DMHAS worked with the Department of Health, Certificate of Need & Licensing (CN&L) to eliminate the need for a MAT Waiver that was previously required at residential SUD treatment agencies.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increase the percentage of heroin/other opiate discharges for whom MOUD was received.
Baseline measurement (Initial data collected prior to and during 2026):	MOUD received for 39% of heroin/other opiate discharges.
First-year target/outcome measurement (Progress to the end of 2026):	Increase the percentage of heroin/other opiate discharges for whom MOUD was received by 1%.
Second-year target/outcome measurement (Final to the end of 2027):	Increase the percentage of heroin/other opiate discharges for whom MOUD was received by another 1%. The change in SFY 2027 will be measured by calculating the percentage difference from SFY 2025 to SFY 2027.

Data Source:

The number of heroin/other opiate admissions for whom MOUD was planned from SFY 2025 - 2027 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:

There is a decreased trend of heroin use as primary drug in recent years. DMHAS will monitor the trend in relation to its impact on our outcome measure.

Priority #: 4
Priority Area: TB
Priority Type: SUT
Population(s): TB

Goal of the priority area:

: Increase compliance rate of DMHAS' SUPTRS Block Grant contracted SUD treatment agencies offering every client a tuberculosis evaluation.

Strategies to attain the goal:

DMHAS sent a letter to all SUPTRS Block Grant SUD treatment funded agencies regarding the tuberculosis evaluation requirement. DMHAS will track compliance via quarterly surveys.

Ongoing monitoring. Monitors will review compliance during quarterly surveys and at 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' SUPTRS Block Grant contracted agency indicating that client was offered a tuberculosis evaluation.
Baseline measurement (Initial data collected prior to and during 2026):	According to SFY 2025 Annual Site Monitoring Reports of DMHAS' SUPTRS Block Grant contracted agencies, 94% of the agencies that were monitored (34 of 36 agencies) were in compliance with offering every client a tuberculosis evaluation.
First-year target/outcome measurement (Progress to the end of 2026):	An increase of 3% above the baseline measurement.
Second-year target/outcome measurement (Final to the end of 2027):	Maintain an increase of 3% above the baseline measurement.

Data Source:

Annual Site Monitoring Reports of DMHAS' SUPTRS Block Grant Contracted Agencies and quarterly surveys.

Description of Data:

The grants monitoring program at DMHAS monitor SUPTRS Block Grant recipients. Onsite visits are made to each SUPTRS 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, and Other contract requirements.

Data issues/caveats that affect outcome measures:

None

Priority #: 5
Priority Area: Tobacco
Priority Type: SUP
Population(s): Other

Goal of the priority area:

Decrease the percentage of persons aged 12 – 17 who report using any type of tobacco product in the past month

Strategies to attain the goal:

Beginning in January 2012, DMHAS funded 19 Regional Prevention Coalitions covering NJ's 21 counties, all of whom utilize the SPF model to guide their work. These coalitions are all required to address tobacco use among youth. The coalitions use, primarily, environmental strategies along with occasional individual approaches as appropriate. Below is a listing of approaches used by the coalitions to address tobacco use among adolescents in their regions.

Environmental Strategies

- Enhance Access/Decrease Obstacles – 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 Obstacles/Decrease Access - Increase education among merchants who sell tobacco products.
- Enhance Obstacles/Decrease Access – Work with municipal and county government to ban smoking from restaurants and other public places (e.g. schools, workplaces, and hospitals).
- Change Consequences/Enhance Access/Decrease Obstacles – 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 – Prevention coalitions will use the "Comprehensive School Tobacco Policy" and other developed by the New Jersey Prevention Network and work with county and/or municipal government to enhance or create policies related to smoking among 12-17 years olds.

Individual Strategies

- Provide information – Educate parents and youth on the dangers of tobacco use by youth through awareness efforts, workshops, and countywide events. These programs will be provided through county alcohol and drug funding, municipal alliances, and other community organizations.
- Provide Information – Educate youth on the dangers of tobacco use through by means of evidence-based middle and elementary school prevention programs and other community-based initiatives.

Legislation

- The State of New Jersey enacted a statute to raise the age to sell tobacco products from persons 19 years of age to 21 years of age effective November 1, 2017 (P.L.2017, Chapter 118).

Other

- DMHAS funds community-based prevention initiatives for high-risk individuals or groups in each of New Jersey's 21 counties. Many of these providers are also focused on the prevention of tobacco use among youth.
- DMHAS, the Department of Health, and the Department of Treasury collaborated in 2023 to develop strategies to decrease underage tobacco sales in New Jersey. One strategy that has been implemented in February 2023 is the addition of information on Treasury's online cigarette licensing application regarding the consequences of underage sales (fines, and/or suspension or revocation of tobacco license) and ways tobacco retailers can avoid underage sales at. Links to merchant education materials were also added to the licensing application's front page.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Past month tobacco product use (any) among persons aged 12 to 17.
Baseline measurement (Initial data collected prior to and during 2026):	According to 2022-2023 NSDUH data, 1.46 percent of persons aged 12 to 17 reported tobacco product use (any) during the month prior to participating in the survey.
First-year target/outcome measurement (Progress to the end of 2026):	A decrease of .03% below the baseline measure.
Second-year target/outcome measurement (Final at the end of 2027):	An additional decrease of .02% below the first year measure.
Data Source:	

2022-2023 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

Description of Data:

Data from the NSDUH provide national and state-level estimates on the use of tobacco products, alcohol, illicit drugs (as well as non-medical use of prescription drugs) and mental health in the United States.

Data issues/caveats that affect outcome measures:

None.

Priority #:	6
Priority Area:	Alcohol
Priority Type:	SUP
Population(s):	Other

Goal of the priority area:

A decrease in the percentage of persons aged 12 – 20 who report binge drinking in the past month.

Strategies to attain the goal:

Beginning in January 2012, DMHAS funded 19 Regional Prevention Coalitions covering NJ's 21 counties, all of whom utilize the SPF model to guide their work. These coalitions are all required to address underage drinking among youth. The coalitions use, primarily, environmental strategies along with occasional individual approaches as appropriate. Below is a listing of approaches used by the coalitions to address underage drinking among adolescents in their regions.

Environmental Strategies

- Enhance Access/Decrease Obstacles – 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 Obstacles/Decrease Access – Increase education among merchants, bars, and restaurants who sell alcoholic beverages. Also, provide education to parents and guardians.
- Change Consequences/Enhance Access/Decrease Obstacles – Work with municipal and county government to assure that underage drinking laws are enforced at the local level.
- Change Physical Design – Through the compliance check report and GIS mapping, provide municipalities and state Alcoholic Beverage Commission with details regarding how outlet density and location impact tobacco availability to youth.
- Modify/Change Policies – Enhance or create policies related to underage drinking among 12-20 years olds on a countywide level.

Individual Strategies

- Provide information – Educate parents and youth on the dangers of underage drinking by youth through awareness efforts, workshops, and countywide events. These programs will be provided through county alcohol and drug funding, municipal alliances, and other community organizations.
- Provide Information – Educate youth on the dangers of underage drinking by means of evidence-based middle and elementary school prevention programs and other community-based initiatives.

Alcohol Strategic Plan

Despite New Jersey's comprehensive array of prevention, treatment, and recovery services for alcohol use disorder (AUD), the state continues to face rising rates of unhealthy alcohol use, particularly among youth, older adults, and women. The COVID-19 pandemic exacerbated these trends, with

alcohol surpassing heroin as the most reported substance in treatment admissions. Systemic challenges persist, as well as limited utilization of medication-assisted treatment (MAUD), and fragmented coordination among systems of care. These gaps are compounded by stigma, limited provider participation in trainings, and underutilized early intervention services. New Jersey seeks to break down service silos and strengthen collaboration across state agencies, healthcare providers, and communities to build capacity for a more integrated, and effective alcohol care continuum.

To address these challenges, DMHAS developed an Alcohol Policy Strategic Plan to identify populations most in need of services and determine the most effective ways to address those needs. College students, older adults, and persons being released from state and county correction facilities were identified. Additionally, increasing the use of medication to treat alcohol use disorder was identified as a priority goal.

In the fall of 2025, NJ-DMHAS was selected to participate in a Policy Academy focused on addressing alcohol use and alcohol use disorder. This initiative is a joint effort of SAMHSA's Center for Substance Abuse Prevention (CSAP) and Center for Substance Abuse Treatment (CSAT) in partnership with NASADAD to help states identify and address critical gaps to improve coordination and integration across the substance use continuum of care, spanning primary prevention, early intervention, treatment and recovery. A key goal of the Policy Academy is to have a holistic focus on improving state and local systems that address alcohol use and alcohol use disorders through integration, collaboration, and coordination across the continuum of care, consisting of treatment with effective medications for alcohol use disorder. Participation in the Academy has enabled DMHAS to further develop its Alcohol Policy Strategic Plan.

Middle School Survey of Risk and Protective Factors

DMHAS commissioned the Center for Research and Evaluation on Education and Human Services (CREEHS) at Montclair State University to conduct the New Jersey Middle School Risk and Protective Factors Survey (NJRPFS) in the 2022-2023 school year. The survey is administered to seventh- and eighth-grade students across NJ and consists of questions about substance use and antisocial behaviors, as well as factors that encourage or discourage their participation in such behaviors. DMHAS has administered the NJRPFS once every three years since 1999. Results from this survey, posted on the DMHAS website, are used to help schools and communities plan and implement meaningful prevention and education programs at the state and local levels, and inform NJ State investments in prevention initiatives. The Survey will be conducted again in the fall of 2025.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Binge Alcohol Use in the Past Month by persons aged 12-20.

Baseline measurement (Initial data collected prior to and during 2026): According to 2022-2023 NSDUH data, 7.76 percent of persons aged 12-20 reported binge drinking during the month prior to participating in the survey.

First-year target/outcome measurement (Progress to the end of 2026): A decrease of .05% below the baseline measure.

Second-year target/outcome measurement (Final to the end of 2027): An additional decrease of .05% below the baseline measure.

Data Source:

Alcohol Use and Binge Alcohol Use in the Past Month among Individuals Aged 12 to 20, by Age Group and State: Percentages, Annual Averages Based on 2022-2023 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 (as well as non-medical use of prescription drugs) and mental health in the United States.

Data issues/caveats that affect outcome measures:

None.

Priority #: 7

Priority Area: Marijuana

Priority Type: SUP

Population(s): Other

Goal of the priority area:

Decrease the percentage of persons aged 12 – 17 who report Marijuana Use in the Past Year.

Strategies to attain the goal:

Beginning in January 2012, DMHAS funded 19 Regional Prevention Coalitions covering NJ's 21 counties, all of whom utilize the SPF model to guide

their work. These coalitions are all required to address marijuana use among youth. The coalitions use, primarily, environmental strategies along with occasional individual approaches as appropriate. Below is a listing of approaches used by the coalitions to address marijuana use among adolescents in their regions.

Environmental Strategies

- Enhance Access/Decrease Obstacles – 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/Decrease Obstacles – 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 (Initial data collected prior to and during 2026): According to 2022-2023 NSDUH data, 11.35 percent of persons aged 12-17 reported marijuana use during the year prior to participating in the survey.

First-year target/outcome measurement (Progress to the end of 2026): A decrease of .05% below the baseline measure.

Second-year target/outcome measurement (Final to the end of 2027): A decrease beyond the most recent rate (11.35 percent) reporting marijuana use during the year prior to participating in the NSDUH survey

Data Source:

Marijuana Use in the Past Year, by Age Group and State: Percentages, Annual Averages Based on 2022-2023 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 (as well as non-medical use of prescription drugs) and mental health in the United States.

Data issues/caveats that affect outcome measures:

None.

Priority #: 8

Priority Area: Prescription Drugs

Priority Type: SUP

Population(s): PP

Goal of the priority area:

Decrease the percentage of persons who were prescribed opioids in the past year.

Strategies to attain the goal:

Education: Educational programs and webinars regarding CDC Guideline for Prescribing Opioids for Chronic Pain.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Opioid Prescriptions in New Jersey.

Baseline measurement (Initial data collected prior to and during 2026): 2024 NJ PMP data for opioid prescription rate per 100 people: 22.6

First-year target/outcome measurement (Progress to the end of 2026): A decrease of .75% below the baseline measure.

Second-year target/outcome measurement (Final end of 2027): An additional decrease of 1.5% below the baseline measure.

Data Source:

New Jersey Prescription Monitoring Program (NJMP) data from the NJ Division of Consumer Affairs.

Description of Data:

New Jersey Prescription Monitoring Program (NJMP) data from the NJ Division of Consumer Affairs for opioid prescription rate per 100 people in NJ.

Data issues/caveats that affect outcome measures:

None.

Priority #: 9

Priority Area: Heroin

Priority Type: SUP

Population(s): Other

Goal of the priority area:

Increase the percentage of persons aged 12 – 17 who report perceptions of Great Risk from Trying Heroin Once or Twice

Strategies to attain the goal:

Beginning in January 2012, DMHAS funded 19 Regional Prevention Coalitions covering NJ’s 21 counties, all of whom utilize the SPF model to guide their work. These coalitions are all required to address the use of illegal substances (as well as 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/Decrease Obstacles – 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/Decrease Obstacles – 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.
- Modify/Change Policies – Enhance or create policies designed to increase perceptions of risk and injury 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 (as well as 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 (Initial data collected prior to and during 2026): According to 2022-2023 NSDUH data, 55.50 percent of persons aged 12-17 reported Perceptions of Great Risk from Trying Heroin Once or Twice.

First-year target/outcome measurement (Progress to the end of 2026): 56.0%, a .5% increase of baseline measurement

Second-year target/outcome measurement (Final end of 2027): 56.5%, an additional .5% increase or 1% increase from the baseline measurement

Data Source:

Perceptions of Great Risk from Trying Heroin Once or Twice, by Age Group and State: Percentages, Annual Averages Based on 2022-2023 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 (as well as non-medical use of prescription drugs) and mental health in the United States.

Data issues/caveats that affect outcome measures:

None.

Priority #: 10

Priority Area: Recovery Housing

Priority Type: SUR

Population(s): PRSUD

Goal of the priority area:

Increase the number of Oxford Houses for Persons in Need of Recovery Support Services to provide stable housing.

Strategies to attain the goal:

- 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.
- New Jersey contracts with Oxford House Inc. which has dedicated men and women's homes and women with children homes. The contract has been expanded to develop additional homes for populations as well as women with children.
- The Revolving Loan Fund is administered by Oxford House annually to establish new homes, with additional funding from the State and DMHAS treatment contracts. This funding supports Oxford House, Inc. outreach staff to establish homes exclusive for statutory populations such as women with children.
- Oxford Houses are required to provide lockboxes to each for medication storage. Residents in Oxford Houses are responsible for their individual medication lock boxes.
- Outreach staff conduct annual training (Overdose Specific) at each Chapter meeting at the annual state workshop. Currently, there are 14 Oxford House Chapters throughout the state. This is in response to the heroin overdose epidemic in the state of New Jersey and its effects related to Oxford House.
- Each home is required to maintain Naloxone kits on site.
- Oxford House has continued to see an increase in members applying for membership with OUD. This increase created a more significant need for naloxone training and information on access to Medical Assisted Recovery (MAR) options.
- 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.
- The New Jersey Oxford House outreach team continues to educate members on MAR and the importance of being an active member of their recovery community.
- 2024 Opioid Settlement Funds supports expansion of Oxford Houses for up to 10-12 new homes annually. Homes will be dedicated to men, women and women with children.
- State Fiscal Year 2025, opioid settlement funds supported 12 new Oxford Homes; three (3) homes are for women, three (3) homes are for women and children and six (6) homes are for men.
- Federal funding for the State Opioid Response (SOR) allowed for expansion of the Oxford House contract for three full-time Outreach staff employed by Oxford House, Inc. to establish 10 new homes per year.
- DMHAS expanded the Oxford House contract in State Fiscal Year 2022 with SUPTRS Block Grant Funds for two additional full-time Outreach staff employed by Oxford House, Inc., and to support separate start-up funds to cover additional costs associated with the development and opening of houses for at risk populations. Those served are: women with children and men with children, individuals re-entering from incarceration and individuals with a history of opioid use who are at high risk for an overdose death.
- In response to the opioid overdose epidemic, and its effects related to Oxford House, DMHAS requires Oxford House outreach staff to conduct annual trainings (overdose specific) for the 14 Oxford House Chapters throughout the state. Trainings are provided at the Oxford House annual state workshop.
- The DMHAS Program Manager and Oxford House, Inc. communicate on a regular basis and updates are provided regarding the current housing market or other challenges facing individuals seeking sober living. Oxford House, Inc. is part of the continued efforts to provide evidence-based recovery housing that was exacerbated during the pandemic.
- The Oxford House outreach team continues to be vigilant in exploring all possible ways of identifying new locations. The team is focused on maintaining the current network of Oxford Houses while simultaneously finding new and replacement Oxford Houses.

- Oxford House utilized online platforms for workshops during the pandemic to provide the following: expand overdose reversal and prevention trainings to houses with statewide partners; virtual platforms to assist residents with recovery meetings; accessing unemployment benefits; helping residents regain and maintain financial stability; establish virtual/teleworking; helping residents with Oxford House operations; New Jersey and Oxford House, Inc. guidelines.
- Oxford House maintains ongoing communication with treatment providers and other state systems regarding vacancies.
- Outreach staff, alums, and Oxford House members could visit each other in houses and hold face-to-face chapter and state meetings. These meetings have been a long-standing and stabilizing part of the Oxford House Model.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of Oxford homes by 5 annually.

Baseline measurement (Initial data collected prior to and during 2026): SFY 2025: There were 161 Oxford homes.

First-year target/outcome measurement (Progress to the end of 2026): Increase the number of Oxford homes from baseline by 5.

Second-year target/outcome measurement (Final to the end of 2027): Increase the number of Oxford homes by an additional 5.

Data Source:

Oxford House submits a monthly Project Status Report to the DMHAS Oxford House Project Manager

Description of Data:

The Oxford House Project Status Monthly Report of General Data: total number of houses (men, women, women and children and men and children); total beds (men women, total occupied, total vacant); and Admissions Data: Applications received and admissions for the month.

Data issues/caveats that affect outcome measures:

- The NJ housing market is still causing obstacles to finding affordable houses to be used as new Oxford Houses.
- The average cost to rent homes the size needed to be used as Oxford Houses has dramatically increased in recent years.
- These challenges have caused the teams to struggle to find houses in some regions of the state where the rental amounts are much higher.
- New Jersey Oxford House also faces challenges in maintaining existing homes due to rising costs in the housing market.
- Many current landlords are incentivized to sell their properties or lease them at higher rates to other renters, making it difficult to secure affordable housing.

Priority #: 11

Priority Area: Increase access to evidence-based services and supports across the CSOC service continuum.

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Increase access to evidence-based services and supports across the CSOC service continuum.

Strategies to attain the goal:

In order to increase capacity to provide this intervention to New Jersey youth and families, previous trainees that completed the "train-the-trainer" program will lead new cohorts for clinicians across the state.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: A cohort of clinicians will be trained in the Attachment, Regulation, and Competency (ARC) Model, a subset of whom will also be trained to provide ARC Model training to other clinicians.

Baseline measurement (Initial data collected prior to and during 2026): 0

First-year target/outcome measurement (Progress to the end of 2026):

10 clinicians previously trained in ARC will complete the train-the-trainer program. 60 clinicians will be trained in the ARC Model.

Second-year target/outcome measurement (Final to the end of 2027):

Data Source:

Internal Data

Description of Data:

The number of clinicians who successfully completed the ARC Model training and the Train-the-Trainer program.

Data issues/caveats that affect outcome measures:

None

Priority #: 12

Priority Area: Support the integration of physical health and mental health/wellness for all New Jersey youth.

Priority Type: MHS

Population(s): SED

Goal of the priority area:

To provide New Jersey pediatricians with the tools they need to support youth with mental health needs. The Pediatric Psychiatry Collaborative (PPC) provides quick access to psychiatric consultation and facilitates referrals for accessing ongoing behavioral health care. Pediatricians are encouraged to integrate behavioral health resources into their practices and work with child and adolescent psychiatrists as well as other behavioral health providers.

Strategies to attain the goal:

There are currently 1438 pediatricians who have partnered with the PPC; in FY25 48% of these physicians referred a youth to the PPC at least once. To improve upon this rate, additional training / reminders / opportunities for connection will be provided to member pediatricians.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The percentage of PPC-enrolled pediatricians who have made at least one referral for a youth to receive PPC services and/or supports will increase.

Baseline measurement (Initial data collected prior to and during 2026): For FY25, 48% of pediatricians enrolled in the PPC made at least one referral for a youth to receive services or supports from the PPC.

First-year target/outcome measurement (Progress to the end of 2026): For FY26, the rate of pediatricians enrolled in the PPC who made at least one referral for a youth to receive services or supports from the PPC will increase to 50%.

Second-year target/outcome measurement (Final to the end of 2027): For FY27, the rate of pediatricians enrolled in the PPC who made at least one referral for a youth to receive services or supports from the PPC will increase to 52%.

Data Source:

The New Jersey Pediatric Psychiatry Collaborative

Description of Data:

The provider will provide the percentage of pediatricians enrolled in the PPC who referred at least one youth to the PPC for services or supports.

Data issues/caveats that affect outcome measures:

None

Priority #: 13

Priority Area: Expanding system capacity to serve youth aged 0 to 5.

Priority Type: MHS

Population(s): SED

Goal of the priority area:

To increase capacity for youth-serving agencies to support families with children ages 0 to 5.

Strategies to attain the goal:

A cohort of clinicians and supervisors will be trained in the Clinical Practice Series in Infant / Early Childhood Mental Health, which includes professional formation and reflective supervision methods, providing capacity to support very young children and their caregiving system with urgent, and/or complex needs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: A cohort of clinicians and supervisors will be trained in the Clinical Practice Series in Infant / Early Childhood Mental Health.

Baseline measurement (Initial data collected prior to and during 2026): 0

First-year target/outcome measurement (Progress to the end of 2026): 40 clinicians and supervisors will complete the Clinical Practice Series in Infant / Early Childhood Mental Health training. An additional 25 clinicians and supervisors will begin the Clinical Practice Series.

Second-year target/outcome measurement (Final data to the end of 2027): 65 clinicians and supervisors will complete the Clinical Practice Series in Infant / Early Childhood Mental Health training. An additional 25 clinicians and supervisors will begin the Clinical Practice Series.

Data Source:

Internal Data

Description of Data:

The number of clinicians who successfully completed the training.

Data issues/caveats that affect outcome measures:

None

Priority #: 14

Priority Area: Early Serious Mental Illness (ESMI)

Priority Type: ESMI

Population(s): ESMI

Goal of the priority area:

Early treatment and intervention of psychosis helps to change the trajectory of psychotic disorders in young adults by improving symptoms, decreasing the likelihood of long-term disability and leading to productive independent meaningful lives.

Strategies to attain the goal:

Objectives are being addressed through the Coordinated Specialty Care (CSC) Program model. The CSC Program is a collaborative, recovery-oriented approach involving individuals, treatment team members, and when appropriate, family members as active participants. CSC provides comprehensive services that include evidence-based pharmacological treatment, supported employment and education services, individual and group psychotherapy, care management, family therapy, and recovery support in community and clinical settings. Services provided to individuals in a CSC program usually do not exceed 2 years.

In 2024, New Jersey expanded its CSC program for First Episode Psychosis to include Affective Psychosis. The Coordinated Specialty Care Community Integration (CSC CI) program is designed to address the need for the CSC continuum of care. The programs will provide continued treatment for the individual after they have completed the CSC program. The CI program will use the "Stepped-Care" treatment model for individuals with an ESMI diagnosis. The Stepped-Care treatment approach is a "3 tier" system where individuals can titrate up or down the level of service modality depending

on their recovery and/or the need for additional services and supports.

New Jersey's CSC and CI services are provided for youth and adults ages 15 and older who experienced symptoms of early psychosis. Individuals to be served by the CSC programs are 15-35 years of age and have an ESMI diagnosis for less than or equal to 2 years at the time of admission to the CSC program with or without treatment and their psychosis is non-organic. Those served in the CI program are individuals 15 years of age and older with an ESMI diagnosis that is non-organic. The New Jersey CSC CI awards were for 18 of the 21 counties, however the current programs will accept referrals from the remaining 3 counties (Monmouth, Mercer and Ocean) until a team is awarded for these counties.

The total program staffing model for the CSC and CSC CI programs contains the following staffing: (1) one team leader, (2) one outreach and referral staff, (3) five master's level licensed and certified clinicians (at least two with substance use disorder experience), (4) two supported employment and education staff, (5) one psychiatric mental health nurse practitioner, and (6) two peer recovery support staff. It is expected that the team leader will supervise the continuum of care for the CSC CI program. The New Jersey CSC model emphasizes treatment through the following components: outreach, low-dosage medications, cognitive and behavioral skills training, Individualized Placement and Support (IPS), supported employment and supported education, peer support, case management, and family psychoeducation.

New Jersey has utilized Community Mental Health Block Grant (CMHBG) Early Serious Mental Illness 10% Set-Aside, CMHBG COVID-19 Supplemental Funding, CMHBG ARPA (American Rescue Plan Act) funding, , and Bipartisan Safer Communities Act (BSCA) funding to support the CSC CI teams in providing evidence-based services for individual with Affective and Non-Affective Psychosis. The combined CSC CI caseload per program will be approximately 200 clients per agency. The provider agency caseload will be 200 in the first full year of operation (2025) and in year 2 (2026), 300 in year 3 (2027) and 400 in year 5 (2028) and remaining steady at 400 thereafter. Clinical Staff is at 12.0 FTEs beginning in 2024.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Medication adherence among individuals who need psychotropic medication prescribed for ESMI treatment.

Baseline measurement (Initial data collected prior to and during 2026): In SFY 2025, 448 individuals were served in the CSC CI programs. 372 of the 448 individuals were prescribed antipsychotic medication. 81% (302) of the 372 individuals were adherent to their medication regimen.

First-year target/outcome measurement (Progress to the end of 2026): In SFY 2026, it is anticipated that at least 83% of the individuals who are taking or in need of antipsychotic medication adhere to the medication regimen.

Second-year target/outcome measurement (Final to the end of 2027): In SFY 2027, it is anticipated that at least 85% of the individuals who are taking or in need of antipsychotic medication adhere to the medication regimen.

Data Source:

For this performance indicator, DMHAS will be using data from the new web-based USTF+ CLD data system going with data beginning in SF 2027 as DMHAS has programmed a new CSC CI module into the USTF+ data system. The new module includes data measures specific to CSC CI, including psychotropic medication adherence. For SFY 2025, DMHAS received information from the Team Leads who provided this information from their data systems. DMHAS will look to report length of stay in a CSC CI program along with the adherence rate for the current state fiscal year. DMHAS is currently discussing benchmark data that may provide other ways of evaluating New Jersey's data going forward including looking at medication adherence at different intervals based on length of stay.

Description of Data:

The five CSC and CSC CI service providers submit the client level clinical diagnostic data quarterly to DMHAS. The CSC and CSC CI 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 new web-based USTF+ CLD data system was released in July 2023 and includes data elements from all DMHAS contracted community programs. For CSC CI CLD, USTF+ system collects full range of demographic data; referral sources; source of income, insurance and reimbursement; service and needs; clinical information, problems and diagnosis; tobacco and drug use; assessment scale/scores including GLOF, GAF, MIRECC, CGI (optional), BPRS, ACES, PHQ-9, MDQ, as well as psychotropic assessment and medication adherence, hospitalization and screening history.

Data issues/caveats that affect outcome measures:

DMHAS is currently relying on provider reports of this data upon requests until the new USTF+ CSC CI module goes live in the fall of 2025 and the CSC CI providers are subsequently trained on its use. CSC CI providers have been trained in the use of the overall USTF+ system.

Indicator #: 2

Indicator:	Medication adherence among individuals who need psychotropic medication prescribed for ESMI treatment.
Baseline measurement (Initial data collected prior to and during 2026):	In SFY 2025, 448 individuals were served in the CSC CI programs. 372 of the 448 individuals were prescribed antipsychotic medication. 81% (302) of the 372 individuals were adherent to their medication regimen.
First-year target/outcome measurement (Progress to the end of 2026):	In SFY 2026, it is anticipated that at least 83% of the individuals who are taking or in need of antipsychotic medication adhere to the medication regimen.
Second-year target/outcome measurement (Final to the end of 2027):	In SFY 2027, it is anticipated that at least 85% of the individuals who are taking or in need of antipsychotic medication adhere to the medication regimen.

Data Source:

For this performance indicator, DMHAS will be using data from the new web-based USTF+ CLD data system going with data beginning in SF 2027 as DMHAS has programmed a new CSC CI module into the USTF+ data system. The new module includes data measures specific to CSC CI, including psychotropic medication adherence. For SFY 2025, DMHAS received information from the Team Leads who provided this information from their data systems. DMHAS will look to report length of stay in a CSC CI program along with the adherence rate for the current state fiscal year. DMHAS is currently discussing benchmark data that may provide other ways of evaluating New Jersey's data going forward including looking at medication adherence at different intervals based on length of stay.

Description of Data:

The five CSC and CSC CI service providers submit the client level clinical diagnostic data quarterly to DMHAS. The CSC and CSC CI 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 new web-based USTF+ CLD data system was released in July 2023 and includes data elements from all DMHAS contracted community programs. For CSC CI CLD, USTF+ system collects full range of demographic data; referral sources; source of income, insurance and reimbursement; service and needs; clinical information, problems and diagnosis; tobacco and drug use; assessment scale/scores including GLOF, GAF, MIRECC, CGI (optional), BPRS, ACES, PHQ-9, MDQ, as well as psychotropic assessment and medication adherence, hospitalization and screening history.

Data issues/caveats that affect outcome measures:

DMHAS is currently relying on provider reports of this data upon requests until the new USTF+ CSC CI module goes live in the fall of 2025 and the CSC CI providers are subsequently trained on its use. CSC CI providers have been trained in the use of the overall USTF+ system.

Priority #: 15

Priority Area: Behavioral Health Crisis Services

Priority Type: BHCS

Population(s): BHCS

Goal of the priority area:

Access to behavioral health crisis services through the 988 Suicide and Crisis Lifeline will help to de-escalate individuals in suicidal, mental health, or substance-use related crisis and connect them to appropriate mental and/or behavioral health services throughout New Jersey (NJ).

Strategies to attain the goal:

The objective of this project will be achieved through increasing capacity and expanding operations in the current 988 Lifeline centers throughout the state.

NJ currently has four (4) 988 Lifeline centers certified by Vibrant Emotional Health (Vibrant) for meeting the minimum clinical, operational and performance standards. Those centers are CONTACT of Mercer County (COMC), Caring Contact, Mental Health Association in New Jersey (MHANJ), and Rutgers University Behavioral Health Care (R-UBHC). Collectively, these centers offer statewide coverage for incoming calls. R-UBHC is the only center in NJ that currently offers 24/7 call services.

In calendar year 2021, the National Suicide Prevention Lifeline received 45,820 calls originating from NJ. In the first year of 988 (July 2022 – June 2023), NJ received 57,409 calls. In year two (July 2023 – June 2024), NJ received 77,378 calls. In year three (July 2024 – June 2025), NJ received 85,380 calls. In SFY 2023 and SFY 2024, NJ averaged a 79% in-state call answer rate. In SFY 2025, NJ 988 has increased its in-state response rate to 81% even with increases

in volume. Additionally, from June to July 2025, there was a 20% increase in call volume which yielded the highest volume since launch. To reach the goal of at least 90% annually, additional capacity is needed (staffing, technology, IT, space, overhead, etc.) and gaps in coverage hours (evenings, nights and weekends) must be filled.

NJ originally had one (1) center, COMC, providing in-state chat and text services at a limited capacity. In December 2024, R-UBHC began providing in-state chat and text services from 8am to 12am. As of March 2025, R-UBHC expanded its chat and text services to 24 hours a day, every day of the year and MHANJ began providing in-state chat and text services 7-days per week from 5pm to 9pm. This four-hour shift experiences the second highest volume, averaging between six and nine interactions per-hour in SFY 2025. Collectively, these centers offer statewide coverage for incoming chats and texts to NJ’s 21 counties.

In September 2023, NJ DMHAS was awarded the SAMHSA 988 State and Territory Improvement Grant. This grant provides NJ DMHAS with approximately \$12 million over the course of three (3) years (Sept 2023 – Sept 2026) for projects such as increasing the workforce to support the growing 988 demand and continuing both statewide and state-wide messaging about 988.

Additionally, funding of \$12.8 million was allocated in the State budget toward the expansion of the 988 Lifeline network. Of this total allocation, an RFP to award \$10 million in State funds was published in March 2024 with the goal of expanding 988 Lifeline center capacity sufficiently to answer 90% of state-based calls, chats and texts. In September 2024, approximately \$7 million from this State-funding opportunity was awarded to two (2) 988 Lifeline centers. With these funds, the two (2) centers were able to onboard additional staff, expand center hours, and begin providing 988 chat and text services for the state.

Using a portion of SAMHSA 988 Improvement Grant funding, NJ DMHAS was able to provide funding to the two (2) centers that did not receive awards to continue 988 services at their current levels.

In March 2025, with the remaining state funding and approximately \$1.3 million from the SAMHSA Improvement Grant, NJ DMHAS issued a Request for Letters of Interest (RLI) to provide ongoing funding to these two (2) centers for the purposes of not only maintaining their current level of operations but expanding their services to contribute towards a 90% in-state answer rate. Final awards were made April 24, 2025.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	988 Suicide and Crisis Lifeline statewide answer rate percentage
Baseline measurement (Initial data collected prior to and during 2026):	In SFY 2024, before the transition to the 988 Suicide and Crisis Lifeline, NJ’s five National Suicide Prevention Lifeline centers answered approximately 77% of calls statewide. Post-transition, in both SFY 2023 and SFY 2024, the annual average in-state answer rate was approximately 79% respectively. In SFY 2025 (July 2024 – June 2025), the average in-state call answer rate was 81%. SMHA is using the post-transition SFY 2024 annual average in-state answer rate of 79% as the baseline.
First-year target/outcome measurement (Progress to the end of 2026):	In SFY 2026, it is anticipated that at least 90% of calls coming into the 988 Suicide and Crisis Lifeline from NJ will be answered by a center in-state.
Second-year target/outcome measurement (Final 2027):	In SFY 2027, it is anticipated that at least 90% of all contacts (calls, chats and texts) coming into the 988 Suicide and Crisis Lifeline from NJ will be answered by a center in-state.
Data Source:	Vibrant, the contract administrator for the 988 Suicide and Crisis Lifeline, collects and distributes monthly answer rate data to the Division of Mental Health and Addiction Services (DMHAS). Carelon Behavioral Health (Carelon), the NJ DMHAS contracted 988 Managing Entity, will also be collecting and reporting individual center data and statewide center data, including contact answer rate, to NJ DMHAS on a monthly basis.
Description of Data:	Individual center and statewide data on Key Performance Indicators, including calls routed and those answered, are collected and reported monthly to NJ DMHAS by Vibrant. Vibrant collects this data utilizing its own internal data processes. Individual centers will collect data and report that data to Carelon monthly. Once compiled and analyzed, data reports will be shared with DMHAS staff.
Data issues/caveats that affect outcome measures:	Discrepancies currently exist between Vibrant data and data collected in-house by the individual centers. Vibrant is working with the centers to minimize these discrepancies.

Indicator #:	2
Indicator:	NJ 988 Suicide and Crisis Lifeline statewide average speed to answer
Baseline measurement (Initial data collected prior to and during 2026):	In SFY 2025, New Jersey's average speed to answer 988 Suicide and Crisis Lifeline calls was 26 seconds with 43% of calls being answered within the first 20 seconds of the call being routed and 72% being answered within the first 30 seconds. The SMHA is using this as the baseline.
First-year target/outcome measurement (Progress to the end of 2026):	In SFY 2026, it is anticipated that at least 80% of calls coming into the 988 Suicide and Crisis Lifeline from NJ will be answered within 30 seconds.
Second-year target/outcome measurement (Final to the end of 2027):	In SFY 2027, it is anticipated that at least 90% of calls coming into the 988 Suicide and Crisis Lifeline from NJ will be answered within 20 seconds.

Data Source:

Vibrant, the contract administrator for the 988 Suicide and Crisis Lifeline, collects and distributes monthly call average speed to answer data to the Division of Mental Health and Addiction Services (DMHAS).

Description of Data:

Individual center and statewide data on Key Performance Indicators, including calls routed and those answered, are collected and reported monthly to NJ DMHAS by Vibrant. Vibrant collects this data utilizing its own internal data processes.

Data issues/caveats that affect outcome measures:

NJ DMHAS relies on data provided by Vibrant for this metric.

Priority #: 16

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 Individuals served in Community Support Services (CSS).

Strategies to attain the goal:

Community Support Services (CSS) is a mental health rehabilitation service that assists individuals 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. Individuals 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. CSS supports an individual's ability to successfully live in independent, lease-based housing (e.g. supportive housing).

The SMHA will utilize a number of strategies to help attain the objective.
The SMHA will utilize a number of strategies to help attain the objective.

1. The Office of Planning, Research, Evaluation, Prevention and Olmstead works collaboratively with provider agencies, state hospital key personnel, DMHAS staff and other Divisions across the state to implement an overall paradigm of community integration.
2. Continued use of the Individual Needs for Discharge Assessment (INDA) facilitates the treatment and discharge planning processes. The INDA serves as both an assessment tool geared toward evaluating needs or barriers that the consumer may face upon discharge and a mechanism by which to assign state hospital Individuals 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 individuals to receiving housing from one provider and the requisite housing support services from a different provider. Individuals are not required to use a particular provider, and their refusal to receive services will not impact their state funded housing. This separation enables 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 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.

5. Provider Weekly Reports (PWRs) The PWRs are utilized to facilitate hospital discharges and diversions from admissions; reduce the current length of time to place state hospital clients into residential beds; identify complex issues impacting discharges from a state hospital; and provide a mechanism to gather information on agency capacity, census, vacancy, and specific information on pending assignments, including barriers to discharge. The PWR report contains information that is not included in the current BEDS system and assists with tracking and following up of referrals as weekly updates from agencies are provided which assists the DMHAS Olmstead/Diversion office with following up on those referrals that require assistance. A significant number of providers submit the PWRs on a weekly basis. The compliance from January 2025 through July 2025 averaged 97.6% and the median was 98.1% in terms of submission of the PWRs.

6. Assignment Process - In May 2015, New Jersey DMHAS revised its Administrative Bulletin 5:11 directing engagements of Individuals by community providers. Under this revision, assignments of individuals 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 serve the assigned consumer. The goal of this policy was the early familiarity of individuals 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).

7. SMHA staff monitors the continued development of new Supportive Housing opportunities. The BEDS data system fosters 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: Individuals who remain in Community Support Services (CSS) during the fiscal year as a proportion of total individuals served in Community Support Services.

Baseline measurement (Initial data collected prior to and during 2026): In SFY 2025, 93% of the total individuals served in Community Support Services remained in CSS service.

First-year target/outcome measurement (Progress to the end of 2026): In SFY 2026, no less than 93% of the total Individuals served in Community Support Services will remain in CSS service.

Second-year target/outcome measurement (Final to the end of 2027): In SFY 2027, no less than 93% of the total Individuals served in Community Support Services will remain in CSS services.

Data Source:

The number of Individuals served by Community Support Services is tracked by the SMHA's QCMR database.

Description of Data:

The QCMR Database collects quarterly, cumulative, program-specific data from each of the service providers contracted by 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. "Preventable terminations" includes individuals terminated from CSS due to: "lost to contact", "admitted to supervised housing", "hospitalized for great than 6 months", "jailed/incarcerated for greater than 3 months", "client refusals", and "other."

Terminations that are not preventable (and therefore are not calculated in this indicator) include: "no longer requires CSS", "moved out of catchment area", and "deceased".

In SFY 2024 and SFY 2025, 93% of the total Individuals served in Community Support Services remained in CSS service. The percentages were achieved using the QCMR data on the Community Support Services (CSS) Program. In SFY 2024, of the 5,777 Individuals served by CSS, 405 preventable terminations occurred. That is 5,372 individuals remained in CSS services. The percentage of individuals who remain in Community Support Services is 93%. Based on SFY 2025 QCMR data on the Community Support Services (CSS) Program, of the 5,894 individuals served by CSS, there were 383 terminations that were preventable. That is 5511 individuals remained in CSS services. The percentage of individuals who remain in Community Support Services is 93%. In calculating the percentage, numerator is numbers preventable, and denominator is total number served minus terminations that are not preventable. This percentage was achieved by various factors including quality of housing resources, staff-to-consumer engagement, and the need for housing in the state of New Jersey.

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. DMHAS Office of Planning Research Evaluation Prevention and Olmstead (OPREPO) created a data dashboard to provide leadership and program management with data for the number of individuals served and units of service for each CSS program as well as the contracted numbers served and units of service for each CSS program. The ability to provide a comparison of contracted and deliverables will enhance the ability for program management and leadership to monitor programs and contracts and inform future decisions.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Tables

Table 2: SUPTRS BG Planned State Agency Budget for Two State Fiscal Years (SFY)

ONLY include funds budgeted by the executive branch agency (SSA) administering the SUPTRS BG. This includes only those activities that pass through the SSA to administer substance use primary prevention, substance use disorder treatment, and recovery support services for substance use disorder.

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

Activity	Source of Funds							
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds
1. Substance Use Disorder Prevention ^a and Treatment	\$45,092,153.00		\$508,767,255.00	\$64,294,310.00	\$242,628,340.00	\$0.00	\$0.00	
a. Pregnant Women and Women with Dependent Children (PWWDC) ^b	\$12,079,766.00				\$14,671,918.00			
b. All Other	\$33,012,387.00		\$508,767,255.00	\$64,294,310.00	\$227,956,422.00			
2. Recovery Support Services ^c	\$24,414,780.00			\$42,194,234.00	\$19,130,706.00			
3. Primary Prevention ^d	\$24,976,064.00			\$31,696,350.00	\$17,194,002.00			
4. Early Intervention Services for HIV ^e								
5. Tuberculosis								
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)								
7. State Hospital								
8. Other Psychiatric Inpatient Care								
9. Other 24-Hour Care (Residential Care)								
10. Ambulatory/Community Non-24 Hour Care								
11. Crisis Services (5 percent Set-Aside)								
12. Other Capacity Building/Systems Development ^f	\$6,668,415.00							
13. Administration ^g	\$2,893,854.00			\$6,311,585.00	\$2,794,934.00			
14. Total	\$104,045,266.00		\$508,767,255.00	\$144,496,479.00	\$281,747,982.00	\$0.00	\$0.00	

^a Prevention other than primary prevention.

^b Grantees must plan expenditures for Pregnant Women and Women with Dependent Children in compliance with Women's Maintenance of Effort (MOE) over the two-year planning period.

^c This budget category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of planned expenditures allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only plan RSS for those in need of RSS from substance use disorder.

^d Row 3 should account for the 20 percent minimum primary prevention set-aside of SUPTRS BG funds to be used for universal, selective, and indicated substance use prevention activities.

^e The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (HIV) at the sites at which individuals are receiving SUD treatment.

^f Other Capacity Building/Systems development include those activities relating to substance use per **45 CFR §96.122 (f)(1)(v)**

^g Per **45 CFR § 96.135** Restrictions on expenditure of the SUPTRS BG, the state involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

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Planning Tables

Table 2: MHBG Planned State Agency Budget for Two State Fiscal Years (SFY)

States are asked to present their projected two-year budget at the State Agency level, including all levels of state and applicable federal funds to be expended on mental health and substance use services allowable under each Block Grant. When planning their budgets, states should keep in mind all statutory requirements outlined in the application Funding Agreement/Certifications and Assurances.

Table 2 addresses funds budgeted to be expended during State Fiscal Years (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027).Table 2 includes columns to capture state planned budget of BSCA funds (MHBG only)

Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

Activity	Source of Funds							
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds ^a
1. Substance Use Disorder Prevention and Treatment								
a. Pregnant Women and Women with Dependent Children (PWWDCC)								
b. All Other								
2. Recovery Support Services								
3. Primary Prevention								
4. Early Intervention Services for HIV								
5. Tuberculosis								
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award) ^b		\$5,643,798.00	\$3,274,328.00					\$370,866.00
7. State Hospital								
8. Other Psychiatric Inpatient Care								
9. Other 24-Hour Care (Residential Care)		\$17,398,416.00	\$796,119,979.00	\$7,700,442.00	\$136,210,035.00			
10. Ambulatory/Community Non-24 Hour Care		\$27,751,970.00	\$1,706,605,099.00	\$8,784,000.00	\$669,865,746.00		\$800,000.00	\$2,651,362.00
11. Crisis Services (5 percent Set-Aside) ^c		\$2,821,899.00	\$9,979,409.00	\$405,286.00	\$152,668,668.00			\$185,432.00
12. Other Capacity Building/Systems Development								
13. Administration		\$2,821,899.00	\$3,164,000.00	\$214,000.00	\$37,608,300.00			\$501,000.00
14. Total		\$56,437,982.00	\$2,519,142,815.00	\$17,103,728.00	\$996,352,749.00	\$0.00	\$800,000.00	\$3,708,660.00

^aThe expenditure period for the 3rd and 4th allocations of Bipartisan Safer Communities Act (BSCA) supplemental funding will be from **September 30, 2024 through September 29, 2026** (3rd increment), **September 30, 2025 through September 29, 2027** (4th increment). Column H should reflect the state planned expenditure for this planning period (FY2026 and FY2027) [July 1, 2025 through June 30, 2027, for most states].

^bRow 6 in Columns B and H: per statute, states are required to set-aside 10 percent of the total MHBG and BSCA awards for evidence-based practices for Early Serious Mental Illness (ESMI), including Psychotic Disorders.

^cRow 11 in Columns B and H: per statute, states are required to set-aside 5 percent of the total MHBG and BSCA awards for Behavioral Health Crisis Services (BHCS) programs.

^dPer statute, administrative expenditures for the MHBG and BSCA funds cannot exceed 5 percent of the fiscal year award.

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Table 3: Persons in Need of/Receiving SUD Treatment – Required for SUPTRS BG Only

This table allows states to present their estimated current need and baseline reach of the priority populations laid out in the SUPTRS BG statute. This information is intended to assist the state in demonstrating the unmet need of these populations that informs their plans for FY2026 - 2027. The estimates provided should represent the unmet need at the time of the application.

To complete the Aggregate Number Estimated in Need (Column A), please refer to the most recent edition of the [National Survey on Drug Use and Health](#) (NSDUH) or other federal/state data that describes the populations of focus in rows 1-5.

To complete the Aggregate Number in Treatment (Column B), please refer to the most recent edition of the [Treatment Episode Data Set](#) (TEDS) data prepared and submitted to the Behavioral Health Services Information System (BHSIS).

States should contact their federal points of contact for assistance in drawing these estimates from national and state survey data.

Estimates should utilize the most recent data from NSDUH, TEDS, and other data sources.

	A. Aggregate Number Estimated in Need of SUD Treatment	B. Aggregate Number in SUD Treatment
Pregnant Women	6076	714
Women with Dependent Children	18953	2065
Individuals with a co-occurring M/SUD	132597	41160
Persons who inject drugs	18880	9377
Persons experiencing homelessness	8115	7527

Please provide an outline of how the state made these estimates, including data sources and values used for each row. For any cell which the state is

unable to estimate the need or number in treatment, please provide an explanation for why these estimates could not be drawn.

1. The aggregate number in treatment is based on served client number reported in NJSAMS in year 2023 . 2. Number of Pregnant women is based on NJ Annual Estimates of the Resident Population, CDC Centers for Disease Control and Prevention, NJ House hold survey, and NJSAMS data. 3. Capture and Recapture estimation is based on NJSAMS 2022 and 2024 data. 4. Homeless number is based on Point-In-Time Count On the night of January 20th, 2024 and NIH study of Alcoholism, drug abuse, and the homeless.

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Planning Tables

Table 4: SUPTRS BG Planned Award Budget by Federal Fiscal Year

In addition to projecting planned budget by State Fiscal Year (Table 2b), states must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations and expenditure categories. Therefore, Plan Table 4b must be completed for the SUPTRS BG awarded for Federal Fiscal Year (FFY) 2026 and FFY 2027. The totals for each FFY planning year should match the SUPTRS BG Final Allotments for the state in that award year.

Note: The FFY presented in the table is that of the award year, however states have up to two years to expend the award received. For example, the FFY 2026 award may be expended from October 1, 2025 through September 30, 2027.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Expenditure Category	FFY 2026 SUPTRS BG Award
1 . Substance Use Disorder Prevention ^a and Treatment	\$19,621,616.00
2 . Recovery Support Services ^b	\$12,477,377.00
3 . Substance Use Primary Prevention ^c	\$12,062,084.00
4 . Early Intervention Services for HIV ^d	\$0.00
5 . Tuberculosis Services	\$0.00
6 . Other Capacity Building/Systems Development ^e	\$6,668,415.00
7 . Administration ^f	\$1,193,143.00
8. Total	\$52,022,635.00

^aPrevention other than primary prevention. The amount in this row should reflect the planned budget for direct services during the planning period. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

^bThis expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of budget allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only present the estimated budget for RSS for those in need of RSS from substance use disorder. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

^cThis row should reflect the state's planned budget of direct primary prevention activities that are intended to meet the SUPTRS BG 20 percent set aside. Activities include those used for universal, selective, and indicated substance use prevention activities. The budget for direct activities in this row should match the total budget planned in Table(s) 5a and 5b. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

^dThe most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment.

^eOther Capacity Building/System Development include those activities relating to substance use per [45 CFR §96.122 \(f\)\(1\)\(v\)](#). The amount presented here should reflect the total found in Planning Table 6 across treatment, recovery, and primary prevention.

^fPer [45 CFR §96.135](#) Restrictions on expenditure of grant, the State involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

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New Jersey chooses to use a portion (\$1,286,508) of the primary prevention set-aside to fund Non-Direct Services/System Development activities.

Planning Tables

Table 4: MHBG State Agency Planned Budget

Table 4 addresses the planned budget for MHBG. Please use this table to capture your estimated budget for MHBG-funded services and programs over a 24-month period (for most states, it is July 1, 2025 - June 30, 2027).

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

MHBG-Funded Services	MHBG Funds Budgeted for This Item
1. Services for Adults	
1a. EBPs for Adults	43902906.00
1b. Crisis Services for Adults	2821899.00
1c. CSC/ESMI program for Adults	5643798.00
1d. Other outpatient/ambulatory services for Adults	
1e. *Other Direct Services for Adults	
2. Subtotal of Services for Adults	52368603.00
3. Services for Children	
3a. EBPs for Children	
3b. Crisis Services for Children	
3c. CSC/ESMI program for Children	
3d. Other outpatient/ambulatory services for Children	
3e. *Other Direct Services for Children	
4. Subtotal of Services for Children	0
5. Other Capacity Building/Systems Development ^a	1247480.00
6. Administrative Costs ^b	2821899.00
7. *Any Other Cost	
8. Total MHBG Allocation ^c	56437982.00

Please provide brief explanation for services with an asterisk* below:

^a This row for Other Capacity Building/Systems Development should be equal to the total of your planned budget in Table 6

^b Administrative Costs should not exceed 5 percent of total MHBG allocation

^c The total budget should be equal to your MHBG allocation for the next two years.

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Planning Tables

Table 5a: SUPTRS BG Primary Prevention Planned Budget by Strategy and Institutes of Medicine (IOM) Categories

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Strategy	IOM Classification	FFY 2026 SUPTRS BG Award
1. Information Dissemination	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
2. Education	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
3. Alternatives	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
4. Problem Identification and Referral	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
	Universal	
	Selective	

5. Community-Based Processes	Indicated	
	Unspecified	
	Total	\$0
6. Environmental	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
7. Section 1926 (Synar)-Tobacco	Universal	
	Selective	
	Indicated	
	Unspecified	\$0
	Total	\$0
8. Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
Total Prevention Budget		\$0
Total Award ^a		\$52,022,635
Planned Primary Prevention Percentage		0.00%

^a Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year
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Planning Tables

Table 5b: SUPTRS BG Planned Primary Prevention Budget by Institutes of Medicine (IOM) Categories

States should identify the planned budget for primary prevention disaggregated by IOM Categories the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 and FFY 2027 SUPTRS BG allotments.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Strategy	FFY 2026 SUPTRS BG Award
1. Universal Direct	\$2,823,547
2. Universal Indirect	\$4,120,073
3. Selective	
4. Indicated	\$3,831,956
5. Column Total	\$10,775,576
6. Total SUPTRS Award ^a	\$52,022,635
7. Primary Prevention Percentage	20.71%

^a Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

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Planning Tables

Table 5c: SUPTRS BG Planned Primary Prevention Priorities

States should identify the categories of substances the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 SUPTRS BG award.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Priority Substances	FFY 2026 SUPTRS BG Award	FFY 2027 SUPTRS BG Award
Alcohol	☒	☐
Tobacco/Nicotine-Containing Products	☒	☐
Cannabis/Cannabinoids	☒	☐
Prescription Medications	☒	☐
Cocaine	☒	☐
Heroin	☒	☐
Inhalants	☒	☐
Methamphetamine	☒	☐
Fentanyl or Other Synthetic Opioids	☒	☐
Other	☐	☐
Priority Populations		
Students in College	☒	☐
Military Families	☒	☐
American Indian/Alaska Native	☒	☐
African American	☒	☐
Hispanic	☒	☐
Persons Experiencing Homelessness	☒	☐
Native Hawaiian/Pacific Islander	☒	☐
Asian	☒	☐
Rural	☒	☐

Footnotes:

Planning Tables

Table 6: SUPTRS BG Other Capacity Building/Systems Development Activities

Please enter the total amount of the SUPTRS BG budgeted for each activity described above, by treatment, recovery support services and primary prevention. In budgeting for each activity, states should break down the row budget by funds planned for SSA activities and those planned to be contracted out under other subrecipient contracts. States should plan their budgets on a single Federal Fiscal Year (FFY), specified in the table below.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Activity	FFY 2026			FFY 2027		
	A. SUPTRS Treatment	B. SUPTRS Recovery Support Services	C. SUPTRS Primary Prevention	A. SUPTRS Treatment	B. SUPTRS Recovery Support Services	C. SUPTRS Primary Prevention
1. Information Systems	\$2,079,623.00	\$0.00	\$9,384.00	\$0.00	\$0.00	\$0.00
a. Single State Agency (SSA)	\$2,079,623.00	\$0.00	\$9,384.00	\$0.00	\$0.00	\$0.00
b. All other subrecipient contracts	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
2. Infrastructure Support	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
a. Single State Agency (SSA)	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
b. All other subrecipient contracts	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
3. Partnerships, community outreach, and needs assessment	\$98,322.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
a. Single State Agency (SSA)	\$98,322.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
b. All other subrecipient contracts	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
4. Planning Council Activities	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
a. Single State Agency (SSA)	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
b. All other subrecipient contracts	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
5. Quality Assurance and Improvement	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
a. Single State Agency (SSA)	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
b. All other subrecipient contracts	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
6. Research and Evaluation	\$2,435,994.00	\$0.00	\$1,682,592.00	\$0.00	\$0.00	\$0.00

a. Single State Agency (SSA)	\$2,435,994.00	\$0.00	\$1,682,592.00	\$0.00	\$0.00	\$0.00
b. All other subrecipient contracts	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
7. Training and Education	\$362,500.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
a. Single State Agency (SSA)	\$362,500.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
b. All other subrecipient contracts	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
8. Total	\$4,976,439.00	\$0.00	\$1,691,976.00	\$0.00	\$0.00	\$0.00

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Footnotes:

Planning Tables

Table 6: MHBG Other Capacity Building/Systems Development Activities

MHBG Plan 6 address MHBG funds to be expended on other capacity building /systems development during State Fiscal Year (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027). This table includes columns to capture planned state budget for BSCA supplemental funds. Please use these columns to capture how much the state plans to expend over a 24-month period. Please document the planned uses of BSCA funds in the footnotes section.

MHBG Planning Period Start Date: 07/01/2025

MHBG Planning Period End Date: 06/30/2027

Activity	FFY 2026 MHBG ¹	FFY 2026 BSCA Funds ²	FFY 2027 MHBG ³
1. Information Systems	\$1,200,000.00	\$129,400.00	
2. Infrastructure Support			
3. Partnerships, Community Outreach, and Needs Assessment			
4. Planning Council Activities	\$47,480.00		
5. Quality Assurance and Improvement			
6. Research and Evaluation			
7. Training and Education			
8. Total	\$1,247,480.00	\$129,400.00	\$0.00

¹ The standard MHBG planned expenditures captured in column A should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [July 1, 2025 – June 30, 2027, for most states].

² The expenditure period for the 3rd and 4th allocations of the Bipartisan Safer Communities Act (BSCA) funding is **September 30, 2024 – September 29, 2026** (3rd increment) and **September 30, 2025 – September 29, 2027** (4th increment). Column B should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [July 1, 2025, through June 30, 2027 for most states].

³ The standard MHBG planned expenditures captured in column A should reflect the state planned budget for this planning period (SFY2027) [July 1, 2026 – June 30, 2027, for most states].

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Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required for MHBG & SUPTRS BG

Narrative Question

Across the United States, significant proportions of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not have access to or do not otherwise access needed behavioral healthcare. **States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it.** States have a number of opportunities to improve access, including improving capacity to identify and address behavioral health needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by **ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections.** SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: [The Essential Aspects of Parity: A Training Tool for Policymakers](#); [Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States](#).

The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.¹ Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. **States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings.** States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in an efficient and effective manner. **States should develop systems that vary the intensity of care coordination support based on the severity and complexity of individual need.** States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

¹Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604. Available at: https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx

1. Describe your state's efforts to improve **access to care for mental disorders, substance use disorders, and co-occurring disorders**, including details on efforts to increase access to services for:
 - a) Adults with serious mental illness (SMI)
 - b) Adults with SMI and a co-occurring intellectual and developmental disabilities (I/DD)
 - c) Pregnant women with substance use disorders
 - d) Women with substance use disorders who have dependent children
 - e) Persons who inject drugs
 - f) Persons with substance use disorders who have, or are at risk for, HIV or TB
 - g) Persons with substance use disorders in the justice system
 - h) Persons using substances who are at risk for overdose or suicide

- i) Other adults with substance use disorders
 - j) Children and youth with serious emotional disturbances (SED) or substance use disorders
 - k) Children and youth with SED and a co-occurring I/DD
 - l) Individuals with co-occurring mental and substance use disorders
- a) Adults with serious mental illness (SMI)

NJ DMHAS used Mental Health Block Grant COVID Supplemental and ARPA to fund a number of initiatives that help improve access to care for adults with SMI and children with SED. Here is the list of the initiatives.

ESMI Coordinated Specialty Care /Community Integration (CSC/CI)

Since its inception in November 2016, NJ CSC programs have gone through a rapid expansion. The Coordinated Specialty Care (CSC) program was initially awarded to 3 providers who would each serve a caseload of 35 individuals. The programs doubled in size and each CSC team served a maximum caseload of 70 individuals starting in FFY 2019. Each agency was serving seven counties. This presented as a challenge for providers in covering the vast territory as well as for individuals receiving services because of the time spent traveling to the provider agency. Telehealth was very helpful in the ability to serve individuals with psychosis and keeping clients engaged. Additional challenges included the need to address an increasing number of referrals. However, in order to meet the needs of individuals presenting with first episode psychosis as well as affective psychosis and individuals looking to move to a step-down service within coordinated specialty care, DMHAS expanded services available within CSC in FFY 2024. DMHAS has enhanced access to CSC services across the state by funding (5) five programs across the state increasing access for youth and young adults in remote and areas of need of services. Additionally, DMHAS expanded the admission criteria to also include affective psychosis. The CSC program has also been enhanced to include a step-down program based upon the identified gap in services. Each of the CSC CI programs have been funded to serve a caseload of up to 400 individuals between the CSC and step-down program. Each program is currently capped at a caseload of 200 and then will slowly transition to 400 over the next three years.

The DMHAS has identified a need for CSC Community Integration (CI) since Coordinated Specialty Care (CSC) originally opened in the state. DMHAS has funded (5) five CSC CI programs which provide treatment and supports to individuals after they complete the CSC program. There has been a rapid expansion of CSC services in the first few years due to demand for services; however, most outpatient programs do not specifically fit the programmatic needs of an individual discharged from a CSC program. Service needs should be flexible and comprehensive to meet the individual's needs. The need for a community integration program comes with the increasing number of individuals with early psychosis in need of a transitional support program post-CSC intensive treatment. Individuals that need fewer intensive services will be able to move to the transitional program and titrate services according to their need. Treatment and supports will be geared toward reintegration of the individual into the community, return to school/work, symptom stabilization, diversion from inpatient services and a decrease of screening center utilization. The step-down program will provide the opportunity to maintain a supportive environment where the person can access an array of services and remain connected in the community, thus decreasing hospital recidivism, integration of health and behavioral health via continuity of care between the CSC prescriber and the client's primary care practitioner, decrease in duration of untreated illness, increase in medication adherence, and increase in level of functioning.

Crisis Receiving and Stabilization

NJ DMHAS has made awards to develop five crisis receiving stabilization centers which will advance the development of the crisis continuum based on the National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit. The CRSCs will be located in the following areas: Morris, Bergen, Essex, Middlesex, and Camden Counties. The individuals to be served are 18 years of age and older with a primary SMI who are experiencing acute psychiatric symptoms that could interfere with community tenure. DMHAS will be using the "no wrong door" concept and partnering with community crisis responders. The goal is to develop an appropriate alternative to the use of local hospital emergency services and in-patient psychiatric hospitalization by providing crisis services and placement support for those in need of permanent housing. Crisis Receiving Stabilization Centers (CRSCs) will be open for referrals, walk-ins, and drop-offs by first responders 24 hours per day, 7 days per week, 365 days per year. At a minimum, services will include access to trained staff who can provide intensive supports, including assessment, crisis stabilization, engagement, psycho-education, identification of strengths, collaborative problem solving, and individualized crisis planning.

Services will be offered in a safe, clean, home-like environment conducive to the recovery process. Medication management, administration, and education will also be offered. Clinical staff in the program will strive to stabilize individuals and address mental health needs. The program will offer continuity of care promoting continued stability and ensuring linkages are arranged that meet the needs of the individual. Overall, the aim of this program is to decrease the utilization of local hospital emergency services and in-patient psychiatric hospitalization, while maintaining crisis stabilization treatment.

Psychiatric Emergency Screening Services (PESS) Peer Support Diversion

Diversionary efforts will be developed to serve individuals who frequently use acute care / crisis services. DMHAS will be looking at a similar model piloted by the Camden Coalition with promising outcomes. The goal of this initiative is to decrease emergency room admissions. Interdisciplinary care coordination teams will serve SMI adults 18 years and older in the community who require care coordination services, linkages and/or follow up to services such as primary care, mental health services, and peer supports. Service recipients will be assisted with navigating the mental health network and linking to treatment and appropriate supports and services. Treatment will be provided by licensed providers who will expand services to reach individuals in need.

Many of these consumers have co-occurring mental health issues, including co-existing medical conditions, co-occurring substance use disorders, co-occurring ID/DD issues, complex service needs and/or housing-related needs. Consumers are expected to be full partners in planning their own treatment and will identify and direct the types of activities that would help them maximize opportunities for successful community living. Staff support shall be provided through a flexible schedule, which must be adjusted as consumers' needs or interests change.

DMHAS provides this funding to contracted Psychiatric Designated Screening Center providers and Affiliated Emergency Services providers in each County. Providers submit a plan to DMHAS to prioritize the hiring of peer staff to work with individuals presenting to psychiatric screening services via the emergency room or via mobile outreach by screening staff, multiple times throughout the course of the year. Non-peer staff can be hired if the organization is unable to hire peer staff. Staff work with hospitals and systems partners to provide follow up services to high utilizers of the psychiatric screening services including to provide follow up calls, linkages to needed services, in person visits as needed, collateral contact and information services to family members and enhanced case management services to individuals presenting to the emergency rooms frequently utilizing psychiatric screening services, with the goal of decreasing emergency room visits and inpatient hospitalizations. Some medication services through the use of a prescriber may be provided as part of this initiative for follow up services. Through enhanced case management services linkages with services and supports, including mental health and other co-occurring needs will be provided.

Web-based Electronic Referral System and Crisis Management Module

DMHAS has procured a system called Bamboo Health utilizing Covid Supplemental and ARPA funding. The crisis management module expedites access to assessment and treatment for those in crisis, tracks their journey from call to treatment, and coordinates all stakeholders' information within a crisis management system. The module supports collaboration between the state 988 call centers, Mobile Crisis Outreach Teams, and behavioral health providers in their efforts to ensure the integrated delivery of evidence-based, and family-centered services. The system provides a real-time connection between crisis call center professionals, crisis response teams, and treatment providers. The Service Availability dashboard displays the availability and location of mobile crisis teams, along with the directory and availability of behavioral health providers at two distinct dashboard tabs. The Crisis Management professional at the call center can document their intake interview and perform a validated assessment, toggle between the Crisis Provider and Behavioral Health Provider dashboards, and select which pathway is necessary for the client. The dual dashboard expands and collapses as needed, bringing into focus the necessary services to quickly serve the consumer. Crisis teams are dispatched using GPS-enabled technology and can view the caller's information, accept the dispatch, and document their assessment and plan at the scene. The crisis teams will be able to, in turn, use the Service Availability dashboard to find available services or refer to outpatient assessment or treatment. The module's framework is based on SAMHSA's crisis management best practices and core elements of: 1) No "Wrong Door" Access; 2) Regional Crisis Call Centers; 3) Mobile Crisis Outreach Team Response; and 4) Crisis Receiving Stabilization Facilities. The technology provides real-time situational awareness and connection to all crisis stakeholders so that crisis professionals can connect consumers to care more quickly. Funding is requested through the term of the grant of 9/30/25.

The web-based data system will be able to provides a registry for behavioral health beds and services to facilitate access for persons with SMI. ?The data system will maintain information and communications on community and hospital referrals and provide the information needed to monitor referrals and intervene to facilitate placement and linkages to services.?The ability to manage behavioral health bed vacancies and ongoing referral communications in one system allows for timely response and efficiently managing diversionary efforts.?The electronic registry will assist in decreasing admissions from emergency rooms and inpatient settings including state hospitals. ?The electronic registry is necessary to enhance movement along the continuum. The data system will foster a continuum of community-based care that meets the needs of the individual where they live.

Crisis Diversion Homes Programs

In order to bridge the gap between homelessness and permanent housing, DMHAS has awarded two crisis diversion homes with 5 beds each which are staffed 24/7. At a minimum, staffing will include licensed clinical staff (LCSW and/or LPC), nursing coverage, behavioral health technicians, and prescriber services. Individuals experiencing a recent psychiatric hospitalization or relapse will receive the support they need from professionally trained and dedicated staff to continue their recovery in the community in a home like environment.?The services and supports will be prioritized for individuals with complex behavioral health needs that require significant services and supports to return to the community and who have received crisis intervention services in a Crisis Receiving Stabilization Center or from Mobile Crisis Outreach Teams. The length of stay of this transitional program is dependent upon individual need and is anticipated to be up to 30 days. The Crisis Diversion programs will include linkages to peer supports, clinical services, and housing with a goal of community re-integration to permanent or long-term housing for the consumer. The goal of this additional level of care to the crisis service continuum is to decrease the number of individuals in emergency screening longer than 23 hours.

Community Mental Health Law Project - Legal Assistance Due to Covid/Housing Stability

These resources will also be used to support legal needs of SMI consumers that have arisen as a result of COVID, e.g., evictions. New Jersey and the federal government have eviction moratoriums in place related to COVID. Once the eviction moratorium is lifted, landlords will be able to commence eviction proceedings. Housing stability is an important component of recovery. The DMHAS will use funds to support housing stability to avert homelessness through eviction. DMHAS will use the MHBG COVID Supplement to enter into a contract with an agency that is staffed to provide landlord/tenant legal services to individuals facing eviction. Services will be provided statewide. DMHAS will use ARPA grant to continue to fund the Community Mental Health Law Project for 1.5 years. The funding will not be used for rent. CHLP continues to provide legal services for DMHAS individuals facing eviction. These services continue to remain crucial in sustaining housing for our consumers. This contract continues to assist individuals facing eviction and require legal assistance.

Peer Wellness Program

The Whole Health Initiative was extended to assist the 3 new provider agencies for 4 new Community Wellness Centers. These were first attempts to create Wellness Centers from the new award recipients. Funds were used in a mentorship fashion to discuss current practices and demonstrate the goals of the 8 dimensions of Wellness, as well of some of the challenges that may occur. There was also a gathering that brought all Community Wellness Centers managers and some members together in a cross-training event. There were Wellness Dollars that the four new centers could apply for and utilize for books, décor, such as art, craft activities, etc. Each center devised a plan for the funds to be reviewed and approved through the DMHAS Office of Advocacy and Peer Services.

There is a separately funded program called CHOICES, that promotes Healthy Living Concepts, which includes multiple facets detailing smoking cessation. These modules are done over six months, meeting twice a week, in person or virtually at various Community wellness Centers to present the Learning About Healthy Living training manual, which has been recently updated and

republished by the Rutgers CHOICES professional Coordinators. All training activities are taught by individuals with lived Mental Health challenges, that have stopped smoking.

Recovery-Oriented Cognitive Therapy (CT-R) training

DMHAS has used funds to offer Recovery-Oriented Cognitive Therapy (CT-R) training to a wide range of behavioral health providers. Guided by Dr. Aaron T. Beck's cognitive model, CT-R is an evidence-based practice that helps individuals to take concrete, actionable steps to promote their recovery and resiliency. Originally developed to empower individuals given a diagnosis of schizophrenia, CT-R applies broadly to individuals experiencing extensive behavioral, social, and physical health challenges. CT-R is highly collaborative, person-centered, and strength-based, and tailored to those who have a history of feeling disconnected from and distrustful of mental health professionals. Through collaborative efforts, these individuals develop resiliency and the motivation to carry out their recovery plans and lead a meaningful life.

The primary CT-R initiative in DMHAS was to fund a statewide CT-R Center of Excellence (CT-R COE) led by Dr. Paul Grant and staff of the Beck Institute. DMHAS had previously worked with Dr. Grant for several years to bring CT-R training to behavioral health homes and peer support services, beginning during the early COVID years. The CT-R COE developed a dedicated website and provided consultation and training to significantly more settings, including residential and outpatient programs, and staff in a wide variety of roles (e.g., psychologist, social worker, nurse, case manager, residential counselor, peer and wellness staff, etc.) were trained. With funding for the CT-R initiative, over 280 mental health staff from fourteen (14) mental health agencies and (30) thirty discreet programs received training during the initial contract.

Towards the end of the COE CT-R contract, the funding was provided to extend trainings to other settings. One unique aspect of this was to pilot a training of direct care staff in CT-R who worked in nursing facilities that served individuals with SMI. Additionally, as the training had served the community system for several years, and were seen as helpful in empowering individuals towards recovery, DMHAS supported a collaboration between the state psychiatric hospitals with community providers who are familiar with CT-R; this continuity allows the hospital and the community agencies to continue to support individuals in their recovery goals through CT-R. The state psychiatric hospitals, which are managed by the NJ Department of Health (DOH), continue to work with the Beck Institute to receive the training.

Acute Care Systems Review Committee (SRC) Technical Assistance

The contract for this initiative was effective as of August 22, 2022. The agency has begun to work to hire staff that will provide technical assistance to county-based mental health system review committees in examining wait times in emergency rooms for psychiatric services. This program focuses on assisting the SRCs in developing performance improvement projects to create a structure for the SRCs to review and revise processes that lead to more expeditious outcomes for individuals requiring hospitalization. The SRC TA service will: review current data and propose other data to be collected; conduct resource mapping to identify all resources available in county; conduct needs assessment for the identified counties; produce report outlining each county's challenges and needs; support each SRC in design of a performance improvement project to address identified needs using the Plan, Do, Study, Act (PDSA) model; and support each SRC in data collection, analysis, and in the implementation of the performance improvement project. This project is being implemented as of September 1, 2022 and will begin to focus on a small group of SRC committees initially.

Older Adults

DMHAS awarded contracts through an RFP to expand outpatient services in 3 Counties that focused on serving older adult with SMI. Older adults are defined as 55 years and older. DMHAS will utilize census data as well as a survey on outpatient access to determine need based on which Counties that have a larger older adult census and have delayed access to outpatient services. One award was made in each region of the state (North, Central, South) for outpatient services designed for this age group. The services began on December 1, 2023 for an 18-month period. The initiative will address long waiting times and waits for services in

these regions and so has improved access to services for older adults.

Crisis Diversion Pilot Collaborative

A pilot program is to be implemented between a DMHAS crisis diversion funded program such as Early Intervention Supportive Services (EISS) program or Crisis Receiving and Stabilization program, and first responders. Individuals in crisis will be able to communicate with a clinician on the EISS or Crisis Receiving and Stabilization team via an IPAD for assistance and potentially avoid an emergency room admission or an inpatient psychiatric admission through this intervention. The use of electronic platforms such as Doxy.me is free for the minimum service. MOUs are in process. The requested funding for this initiative is from 10/1/22-9/30/25.?

Mobile Crisis Outreach Response Teams (MCORTS)

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

Provide timely access to crisis intervention services;

Stabilize person receiving services in their community;

Prevent hospitalization, re-hospitalization, and intervention by first responders whenever it is safe to do so;

Deliver behavioral healthcare to all New Jersey residents in all regions.

DMHAS procured for MCORTs and made nine (9) regional awards with multiple counties served in each region. Since March 2025, five (5) provider agencies have been delivering MCORT services throughout the state’s twenty-one (21) counties.

b) Adults with SMI and Co-occurring intellectual and developmental disability (I/IDD)

The state mental health authority funds three initiatives that serve adults with co-occurring mental illness and intellectual disabilities. First, the state’s Supportive Housing program includes (13) thirteen distinct contracted programs that serve individuals, which combined to serve 135 persons during state fiscal year 2025. Second, a consultation program operated by Trinitas Regional Medical center allows for the behavioral health workforce to receive case consultations related to challenging comorbid symptoms. Third, through Division public bidding and funding, a 24-hour supervised group home, for persons with a co-occurring mental illness and an intellectual disability, became operational in November of 2023. This five (5) bed transitional setting is designed for adequate throughput and the ability to take referrals from acute hospital settings, including emergency departments. Standard group home residence staffing is supplemented by access to advance practice nursing and behavior staff. To date, seven (7) persons have resided in the program, with four (4) moving on to lower intensity supportive housing settings.

c & d) Pregnant women with substance use disorders and Women with substance use disorders who have dependent children

NJ DMHAS has developed initiatives to improve access to care. DMHAS continues to contract with licensed women's treatment providers using women's set aside block grant funds. Providers are required to address the full continuum of treatment services. Services include family-centered treatment, evidence-based parenting programs, trauma-informed and trauma-responsive treatment using Seeking Safety, Strengthening Families, evidence-based parenting classes, recovery supports and housing assistance by linking women to transitional, permanent and/or supportive or sober living homes such as an Oxford House.

In 2019 the NJ DMHAS added Interim Services to ensure all substance use disorder Fee-for-Service (FFS) funded treatment agencies provide Interim Services as an engagement service at all levels of care. Pregnant and parenting women (PPW) consumers awaiting admission to their assessed level of care anywhere in the state can receive interim services within 48 hours at facilities closer to home. Interim services for PPW consumers are designed to decrease the adverse health effects of substance use, promote individual health, and decreased the risk of transmitting disease to sexual partners and their infants by providing individualized education, case management, referrals and MAT if needed, while awaiting admission.

The Integrated Opioid Treatment and Substance Exposed Infants (IOT-SEI) Initiative was implemented at five providers across the State with funding through the Governor's State Opioid funds. The IOT-SEI provides an array of integrated services for opioid dependent pregnant women, their infants and family. Providers are required to ensure a full continuum of services and to establish mechanisms to develop a coordinated and cohesive approach for working together across systems that include, SUD treatment, the medical community, maternal child health, and child welfare. This initiative focuses on alleviating barriers to services for pregnant women with opioid use disorder. Services include mother's medical/prenatal and obstetrical care, SUD treatment for OUD including MAT, newborn/infant medical care, child welfare services if identified, intensive case management, recovery supports, assistance with housing, case management and other wraparound services. Providers must ensure that there is comprehensive care coordination from prenatal through the birth event, postpartum, and early childhood. IOT-SEI providers are required to develop Plans of Safe Care.

The Maternal Wrap Around Program (MWRAP) is a statewide initiative that provides intensive case management and recovery supports to pregnant women with a substance use disorder. MWRAP is in seven regions in NJ, all 21 counties. Pregnant women are eligible for services during pregnancy and up to one year after the birth event. MWRAP providers are required to develop Plans of Safe Care. The MWRAP alleviates barriers to services through comprehensive care coordination implemented within the five major timeframes when intervention in the life of the SEI can decrease potential injury of prenatal substance exposure: pre-pregnancy, prenatal, birth, neonatal and early childhood. MWRAP is intended to promote maternal health, improve birth outcomes, and decrease the risks and adverse consequences of prenatal substance exposure.

Improving maternal child health outcomes is a major agenda for NJ through the adoption of NurtureNJ, led by First Lady Tammy Murphy.? NurtureNJ is a statewide, multi-agency campaign dedicated to this issue. Reach NJ, the central call-in line for NJ residents who are looking for help with a SUD, dedicated their public service announcement campaign to pregnant women during late Fall 2022. MWRAP provided training to ReachNJ If a pregnant woman contacts ReachNJ, MWRAP is offered as a resource and ReachNJ staff provide warm hand-offs. MWRAP services provides the support needed to help pregnant and parenting women with SUD maintain a healthy recovery, resulting in less overdoses, and improved birth outcomes and maternal child health.?

New Jersey continues its statewide advertising campaign centered around opioid use and bringing public awareness to call ReachNJ, the 24/7 Addiction Hotline, for treatment. This statewide campaign utilizes television and radio advertisements, bus wraps, billboards and social media to encourage New Jerseyans to access treatment. Pregnant women seeking treatment has been added to the campaign.

SAMHSA has prioritized addressing maternal mental health conditions and co-occurring SUD, with a particular focus on mental health and trauma-informed practices. SAMHSA continues to support states in this effort by offering the Maternal Mental Health Learning Collaborative (LC). January 2024 SAMHSA's Center for Mental Health Services (CMHS) invited all states and territories to apply for the Maternal Mental Health LC, a competitive process where only eight (8) states/territories would be selected. The New Jersey Division of Mental Health and Addiction Services (DMHAS) submitted a successful application. Areas of focus included: building the existing integrated behavioral healthcare collaborations to address mental health issues and SUD for pregnant and parenting women; strengthen coordinated care; improve continuity of care and linkages; identify barriers to care; expand state

capacity to address needs that impact perinatal and postpartum women (e.g. housing, employment, legal, food security, etc.); address stigma, improve access to services; and build on the existing practices and current initiatives.

New Jersey's application cited data from the New Jersey Maternal Mortality Report (2016-2018) where the New Jersey Maternal Mortality Review Committee (NJMMRC) identified a total of 125 pregnancy-associated deaths that have a temporal relationship to pregnancy (within 365 days). Of the 125 pregnancy-associated deaths, 44 (35%) were pregnancy-related, 74 (59%) were pregnancy-associated, but not related, and 7 (6%) were unable to be determined.

Timing of death among cases of maternal mortality were categorized into three periods: deaths that occurred during pregnancy, the early postpartum period (within 42 days of the end of pregnancy), and the late postpartum period (43 days up to one year of the end of pregnancy). Among these categories, the largest number of pregnancy related deaths occurred during pregnancy (40.9%, n=18), while 79.7% of pregnancy-associated, but not related deaths occurred in the late postpartum period (n=59).

The leading underlying causes of death among the 74 pregnancy-associated, but not related deaths were attributed to SUD (58.1%), injury consisting of unknown intent/suicide, homicide, or unintentional injury (12.1%), and cancer (whereby pregnancy was determined to not contribute to the disease progression, 10.8%). Deaths attributed to SUD were overdose deaths that are a result of substance use and nearly all the overdose deaths that the NJMMRC reviewed were due to SUD. Most deaths attributed to one of the top three underlying causes of death for pregnancy-associated, but not related deaths, occurred in the late postpartum period (43 days up to 1 year). Pregnant and parenting individuals are most vulnerable to relapse and overdose in the late postpartum period.

Leading contributing factors cited among pregnancy-related cases were lack of provider/patient knowledge, lack of continuity of care/care coordination, lack of standardized policies and procedures, substandard clinical skill/quality of care, and lack of assessment. Leading contributing factors among pregnancy-associated, but not related cases were lack of continuity of care/care coordination, complications of SUD, complications of mental health conditions, lack of provider/patient knowledge, and lack of standardized policies and procedures.

Best practice indicates that comprehensive care coordination should be implemented during key intervention points perinatally and up to one year and into early childhood to improve birth outcomes and sustain a healthy recovery for the mother. This is a critical period as pregnant individuals with mental health issues and SUD face complex challenges that can serve as barriers to treatment. Pregnant women fear seeking SUD treatment and prenatal care because of the stigma associated with substance use. They may experience elevated risks such as fear of child welfare involvement, legal repercussions, or experience increased psychological distress due to limited resources and supports that may have an impact on their needs.

March 2024, the New Jersey DMHAS LC team attended an in-person kickoff meeting at SAMHSA facilitated by SAMHSA's state technical assistance team. Subsequent meetings were held monthly through virtual sessions and concluded September 2024. The Maternal Mental Health LC states/territories were required to present a case challenge on how to improve their state maternal mental health services. Additionally, subject matter experts provided presentations on promising/best practices and federal partners presented on federal maternal mental health initiatives. Topics included: Stigma and Engagement; Access & Integrated Care; Implementation of Evidence-Based Practices/Dissemination of Research; Perinatal Supports; Funding/Reimbursement. State/territory awardees through the multi-session meetings were able to share and learn evidence-based, evidence-informed, and promising approaches to promote and support maternal mental health and SUD.

The DMHAS LC goal was to improve collaboration and care coordination around mental health and SUD prenatally through postpartum, up to one year after the birth event. The New Jersey case challenge was important because the contributing factors in the majority of preventable, pregnancy associated, not related deaths included: limited access to services, barriers to care, lack of continuity of care and coordination, complications from SUD and mental health conditions and stigma.

and the IOT-SEI Initiatives. The three (3) data sources capture pregnant women and co-occurring disorders. The MWRAP and IOT-SEI state fiscal year data for 2023 respectively indicates for MWRAP – 70% or 139 pregnant individuals had co-occurring mental health conditions with a 100% referral rate for mental health treatment; IOT-SEI state fiscal year data for 2023 indicated 69% or 72 individuals presented with co-occurring mental health conditions with a 100% referral rate for mental health treatment. NJSAMS pregnant women treatment admissions with co-occurring disorder indicated calendar year 2021 (n = 423) or (67%); calendar year 2022 (n = 413) or 66.4%; calendar year 2023 (n = 261) or 63%.

The DMHAS identified barriers, addressed challenges and strategies to remediate. DMHAS case challenge was to increase access to care to the MWRAP by improving referrals, addressing barriers to care, expand state capacity to address needs of perinatal and postpartum individuals, and support the intersection of substance use and mental health through pregnancy and postpartum. The DMHAS data supported that New Jersey's case challenge was worth remediating since DMHAS' maternal child health initiatives offer services geared towards recovery supports, case management, and wraparound services from pregnancy through one year postpartum. Building the existing integrated behavioral healthcare collaborations to address SUD and mental health concerns for pregnant and parenting women allows for care coordination and continuity of care during the prenatal and postpartum period. It is critical to provide recovery support services at key intervention points, prenatally through the postpartum phase, beyond the six to eight weeks after delivery. This can be a vulnerable period for relapse or overdose due to postpartum depression or other mental health concerns, or issues such as life challenges, lack of supports, child welfare involvement, housing, etc.

As a result of the DMHAS LC, several changes are currently underway to improve access to care, decrease barriers and expand state capacity for pregnant and parenting women with SUD and mental health issues. New Jersey submitted a successful application for In-Depth Technical Assistance (IDTA): "Advancing Collaborative Practice and Policy: Promoting Healthy Development and Family Recovery for Infants, Children, Parents, and Caregivers Affected by Prenatal Substance Exposure", through the National Center on Substance Abuse and Child Welfare (NCSACW). Goals established included: conduct a statewide landscape analysis of resources for individuals, and the families of individuals, with SUD; establish a comprehensive and seamless system of care among state agencies, healthcare providers, and community level and non-profit organizations to address SUD during and after pregnancy; increase the percentage of prenatal Plans of Safe Care that community partners develop; and develop and update protocols and policies that aim to prevent neonatal abstinence syndrome (NAS), substance exposed infants (SEI) and SUD to implement care coordination through the New Jersey Plans of Safe Care model.

Currently, planning is underway between DMHAS and the New Jersey Department of Children and Families (DCF) to expand the current infrastructure to build the prenatal pathway for SUD and mental health concerns by including the statewide MWRAP initiative in the Connecting NJ (CNJ) system. Connecting NJ is a county level single point of entry (via telephone) for pregnant people county-based, that simplifies and streamlines the referral process for obstetrical and prenatal care providers, community agencies, and families. The goal is to increase referrals to support the intersection of SUD and mental health perinatally resulting in improved integration with community based behavioral health resources. Since MWRAP services are provided during pregnancy and up to one year after the birth event, MWRAP should provide the supports to help mom sustain a healthy recovery, decrease relapse rates, and overdoses, including death.

DMHAS collaborated with NJ DCF Division of Child Protection and Permanency (DCPP) case practice lead, to develop a Prenatal Pathway with SUD concerns. If a pregnant woman has a positive screen for illegal substances prenatally or has substance misuse and does not have any other children in their care, and a call comes into the DCF State Central Registry system, known as SCR, that registry will generate referrals to the county-based MWRAPs.

Recognizing that some contributing factors among pregnancy associated, but not related cases for mental health and SUD can be lack of provider knowledge, DMHAS has increased efforts to educate the perinatal workforce, medical community, and the behavioral health providers on services, resources and best practices that can have a positive impact on maternal health.

DHS through DMHAS SFY24 provided funding to the New Jersey Quality Health Care Institute to partner with a provider to conduct statewide trainings to MWRAP staff and the perinatal workforce on Mental Health First Aid (MHFA) to raise awareness around the impact of perinatal mental health. The perinatal workforce is uniquely positioned to identify mental health symptoms early and intervene when needed on MHFA. The trainings focused on maternity-specific scenarios to teach participants how to assist pregnant and parenting women experiencing mental health symptoms in crisis and non-crisis situations and intervene

when needed.

The Project ECHO Maternal Child Health. Pregnant and Parenting Women with Opioid Use Disorder (MCH PPW OUD) provides education and training to primary care practitioners, SUD treatment providers, behavioral health practitioners, and other stakeholders in clinic settings and at home, utilizing a web-based video collaboration between a multi-disciplinary team of practitioners on best practices for the assessment, case management, intervention, treatment and recovery support services for PPW with an OUD. The goal of this ECHO is to increase access to care and the capacity and competency of providers, community support organizations and clinical teams to support prevention, treatment, and recovery of PPW with OUD. ECHO positions communities to decrease the NAS birth rates, improve use of medication assisted treatment, family formation and early infant development; improve access to physical and mental health care by educating more providers, midwives, doulas, and other health care professionals on best practices during prenatal and perinatal periods.

DMHAS renewed the MCH PPW-OUD ECHO series with 18 sessions through 2023. The curriculum covers the following areas: screening for SUD; new guidelines for prescribing buprenorphine; starting treatment: the patient contract, pharmacy partner and social services; managing buprenorphine treatment and follow-up; opioid dependency reporting guidelines; and hot topics. In an effort to reach out to practitioners and prescribers, the first of the ECHO 8 sessions was scheduled for an evening time with a focus on the latest FDA approved techniques for MAT, integrated care, and wraparound services.

The MCH PPW-OUD ECHO was renewed with the new series commencing January 2024 through August 2024 that includes 18 sessions with five (5) community workshops and another 18 sessions with five (5) community education workshops through August 2025. The community education workshops focus on educating the audience on referral and linkages between providers, practitioners, and community services to support pregnant and parenting women and their family. These series focus on maternal opioid intervention and care coordination. Didactic topics within the 18 sessions range from integrative approach to care for pregnant women; bridging the gap from patient to plan; implementation that is meaningful and impactful; prenatal care with an opioid/substance use disorder; addressing stigma; perinatal depression; navigating the system to maximize successful family formation, etc. The ECHO goal is to increase the capacity and competency of behavioral health providers, community support organizations, medical community, and child welfare to support prevention, treatment, and recovery of pregnant and parenting women with OUD and other substances.

DMHAS will continue to support maternal mental well-being for pregnant and parenting women with SUD and their families through collaborations with state systems, community partnerships, and other stakeholders. Lessons learned from the technical assistance provided through the Maternal Mental Health LC and the DMHAS case challenge will help to guide DMHAS to strengthen the current system. DMHAS anticipates building a foundation where there is a seamless and integrated approach across all systems to improve outcomes, be sensitive to individual's experiences, and decrease maternal mortality related to mental health and SUD in the postpartum period.

The Division of Medical Assistance and Health Services (DMAHS), in collaboration with DMHAS, continues a program to cover and support medications for opioid use disorder at Office Based Addiction Treatment (OBAT) providers. This program coordinates the delivery of multiple reimbursable services provided by primary care providers and community behavioral health staff to NJ FamilyCare members with an addiction diagnosis. OBAT providers help to increase access to treatment for pregnant women by linking to OTPs or other treatment services, when appropriate.

DMHAS participates in virtual monthly Division of Child Protection and Permanency (DCP&P) Child Welfare Substance Use Disorder Consortia meetings currently held in 12 of NJ's DCP&P local offices. Child welfare staff, DMHAS, Division of Family Development, Substance Use Disorder provider agencies, Work First New Jersey, Substance Abuse Initiative (WFNJ SAI) providers, and Boards of Social Services meet each month and plan on how to better serve families, leading to more effective policies and practices to meet the needs of infants, children and families. The Consortia also addresses ASFA timelines, Plans of Safe Care, and reunification for children in out of home placement. Through collaboration, multiple agencies working with the same family can improve communication to decrease the gaps in service delivery such as access to care and improved 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.

New Jersey contracts with Oxford House Inc. which has dedicated women's homes and women with children's homes. DMHAS expanded the Oxford House contract to develop additional homes for women with children. Women and Children Oxford Houses are required to provide lockboxes for medication storage. Residents in Oxford Houses is responsible for their individual medication lock boxes. Outreach staff conduct annual training (Overdose Specific) at each Chapter meeting at the annual state workshop. Currently, there are 14 Oxford House Chapters throughout the state. This is in response to the heroin overdose epidemic in the state of New Jersey and its effects. Each home is required to maintain Naloxone kits on site. The New Jersey Oxford House outreach team continues to educate members on Medication Assisted Recovery (MAR) and the importance of being an active member of their recovery community.

e) Persons who inject drugs

New Jersey historically has made persons who inject drugs one of its statutory requirements, specifically for their admission into statewide licensed substance use treatment programs. The current goal of the Division of Mental Health and Addiction Services (DMHAS) is to address substance use disorder, specifically the opioid epidemic confronting the State using a variety of strategies. The key objectives have been to increase access to medications for opioid use disorder (MOUD), decrease unmet treatment need and decrease opioid and other drug related deaths.

To address these objectives, DMHAS continues to fund traditional ambulatory and residential services (i.e., IWM, AWM, OP, IOP, PC, STR, LTR, HWH) through slot-based contracts and Fee-for-Service (FFS) funding that is made available through the DMHAS FFS Network. In addition, DMHAS has developed an infrastructure to support buprenorphine and Vivitrol (injectable naltrexone) in standard residential and ambulatory (SUD) treatment throughout the State. In most recent years, specifically through State Opioid Response (SOR) funding, DMHAS supported strategies for low-threshold buprenorphine induction programming, thus meeting individuals where they are at in the community and offering on-demand medication. A few of the innovative programs are listed below and serve persons who actively inject drugs.

In addition to four (4) mobile medication units operating in the State since 2008, DMHAS developed two new mobile van pilot initiatives to facilitate outreach and low induction medication, case management and other ancillary services for individuals with an opioid use disorder (OUD) in communities with low access to MOUD or areas of the State where participate in a traditional SUD program may be a barrier. Once all mobile vans are established, there will be a total of ten (10) operating throughout the State.

Development of an expanded-hour Opioid Treatment Program (OTP) initiative in efforts to provide increased (i.e., evening) hours that are not typically provided in efforts to assist individuals with easier access to services. Currently DMHAS contracts with six (6) OTPs that have expanded their operating hours six hours per day, six days per week.

Initiative which provides access to buprenorphine and other ancillary services for individuals with a substance use disorder through current programming available at homeless shelters. Contracted providers are working to develop the capacity to provide low threshold medication (i.e., buprenorphine) as well as other support services for individuals who reside or drop in at the shelters, linking them to treatment and recovery services, when appropriate.

In July 2024, through State-legislated funding, DMHAS entered into contract with Sonara Health for a pilot to implement a system for remote observation of take-home methadone. Sonara is a HIPAA- compliant, digital health solution that uses a web-based application to support patients who dose at home. The central goal of this contract is to safely increase the number of people who are eligible for take-home methadone by encouraging Opioid Treatment Programs (OTPs) to embrace and maximize the number of patients who can benefit from new federal and state regulations in regards flexibilities for take-home dosing. Objectives of the program are to increase access to take-home methadone and support low barrier methadone treatment in New Jersey, evaluate the effect remote methadone dosing has on patient outcomes and cost-savings in the treatment of Opioid Use Disorder (OUD), and ultimately develop recommendations for legislative or regulatory action concerning whether remote methadone dosing should be implemented and reimbursed in New Jersey.

f) Persons with substance use disorders who have, or are at risk for, HIV or TB

As of September 30, 2019, the State of New Jersey was no longer classified as a designated HIV Block Grant State by SAMHSA. As a

result, DMHAS was no longer permitted to utilize funds from its SAMHSA Substance Use Block Grant to support the continuance of HIV Early Intervention Services (EIS). Nevertheless, DMHAS continued to work closely with the NJ Department of Health, Division of HIV, STDs and TB Services (DHSTS) and its contracted providers encouraging the development of affiliation agreements with HIV testing and care agencies to ensure an integrated care approach for individuals with SUD who are at risk for HIV and other infectious diseases.

In CY 2021, 23,313 (24%) of 87,745 admissions used drugs intravenously. This particular group is at high risk for infectious diseases such as HIV and hepatitis, indicating the need for linkage to primary care. One attempt to address this need was applying for, and being awarded, a five-year Promoting Integration of Primary and Behavioral Health (PIPBHC) grant in March 2020. The two contractees provide models of integration to serve individuals with opioid use disorder (OUD) and other health co-morbidities. New Jersey completed the PIPBHC grant in March of 2025.

Another activity to address this need was recent partnership with NJ Department of Health, the National Alliance of State and Territorial AIDS Directors (NASTAD) and the JSI Research & Training Institute, Inc. (JSI). One-time funds for a three-year grant were provided in 2019 to support activities related to the Strengthening Systems of Care for People with HIV and Opioid Use Disorder (SSC) project. The funds were designated to support concrete, time-based activities focused on enhancing systems of care for people with HIV and OUD and in alignment with state technical assistance plans developed for the project. Goals were for strengthening systems of care to address HIV and OUD treatment, increase cross-sector collaboration, improve system-level coordination, enhance care and treatment services, and to ultimately improve health outcomes for people with HIV and OUD. One area that had been explored was data sharing among the two Departments to determine the number of individuals in substance use disorder (SUD) treatment who have HIV and the number of individuals who have HIV that are in SUD treatment. If a data sharing plan can be executed, information could be utilized by both Departments to help improve health outcomes for individuals by better engaging individuals to either seek HIV services or SUD treatment (cross-referrals).

In addition, DMHAS currently has 248 supported housing slots for individuals with a substance use disorder: two programs in Camden (31 beds) and Atlantic (32 beds) counties, a 10-bed program for women in Somerset County, and 175 supportive housing subsidies for those with an OUD. Supportive housing has proven to be a successful, cost-effective, combination of affordable housing with services that help people live more stable, productive lives.? It offers permanent housing with services that work for? individuals and families who face complex challenges such as homelessness and/or have serious and persistent issues that may include substance?use, mental illness, and HIV/AIDS.??

In regard to TB, New Jersey requires that all substance use disorder treatment facilities who receive contracts from DMHAS conduct TB testing as part of the patients' routine admissions process. A provision of the guidelines requires that patients with TB, who were not admitted for treatment because the funded capacity at that facility had been exceeded, be referred to another treatment provider for services. Through DMHAS program monitoring visits, monitors continue to ensure agency compliance with this requirement. In addition, the DMHAS' Office of the Medical Director continues to have discussions with the NJ Department of Health, Division of HIV/AIDS, STDs and Tuberculosis Services (DHSTS) to consider and operationalize any new practice guidelines in this regard.

g) Persons with substance use disorders in the justice system

The New Jersey Department of Human Services' Division of Mental Health and Addiction Services (DMHAS), in collaboration with the Department of Corrections (DOC), Department of Health (DOH) and our community partners, coordinates and delivers medication-assisted treatment (MAT) for opioid addiction to individuals serving within county based correctional facilities. Known as the JIS Jail Medication Assisted Treatment (JMAT) Initiative, this partnership will help facilitate the connections individuals will need in order to sustain treatment services post release.

This funding is being made available as part of Governor Murphy's State opioid initiative funds and SAMHSA State Opioid Recovery (SOR) Federal funds initiative to combat the opioid epidemic in New Jersey and designed to encourage increase use of MAT or enhance existing MAT services for individuals with an opioid use disorder (OUD) in county correctional facilities.? Nationally, 75 percent of inmates with opioid use disorder are reported to have relapsed within three months of release, and only 8 percent enter treatment after incarceration (Fox et al., 20151). Few inmates receive MAT during incarceration despite MAT being the clinical standard for OUD treatment.

In New Jersey, a recent survey conducted by the DMHAS, in collaboration with the County Jail Wardens' Association, indicates that an average of 17 percent of jail detainees screen positive for a substance use disorder with a range of 10 percent - 69 percent among the jails reporting (DMHAS/CJWA, 2018).? Of particular concern are the rates of opioid overdose immediately following release from incarceration. In response to overdose deaths in prisons/jails, the Rhode Island Department of Corrections initiated a model to screen and treat with MAT and sustain MAT post release through a community provider network.? Results published in JAMA Psychiatry, researchers compared the pre- and post-intervention periods and found that "In the 2016 period, 26 of 179 individuals (14.5%) who died of an overdose were recently incarcerated compared with 9 of 157 individuals (5.7%) in the 2017 period, representing a 60.5% decrease in mortality"(Green et al, JAMA Psychiatry, April 2018).

With the arrival of criminal justice reform in New Jersey, jail/prison wardens are seeing more rapid return of individuals to their communities, often within 24 - 48 hours.? Therefore, individuals are more likely to be released prior to or while experiencing the onset of opioid withdrawal symptoms. This can put individuals at an increased risk for overdose.? Nevertheless, MAT being introduced pre-release has been shown to improve the likelihood of recovery sustainability post-release and can mitigate the risk associated with shorter jail stays. This initiative seeks to support wardens in building the capacity to deliver and sustain MAT for individuals in need of services.

The Division funds the Intensive Recovery Treatment Support (IRTS) program in a collaboration with the NJ Department of Corrections (DOC), which is a peer service 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. Funding is braided so no pre-release services are funded with SUPTRS; DOC state funds are used for services provided pre-release and for supplies not permitted by the SUPTRS. Eligible individuals being released from DOC custody who are receiving FDA approved medication assisted treatment for an OUD and who will continue to receive medication assisted treatment after their release from prison, and those Eligible Offenders, with an OUD, being released from custody who choose not to receive medication assisted treatment while incarcerated are participants in the IRTS program. This program was developed through Memoranda of Agreement (MOA) with Rutgers University Behavioral Health Care and DOC. A key feature of this program is that the provider begins working with offenders six months prior to release.

Support Teams for Addiction Recovery (STAR) provide services according to a recovery-based philosophy of care to support individuals' continuing stability, recovery and wellness. STAR teams encourage self-determination and promote the realization that an individual can recover from an opioid use disorder and re-establish meaningful roles and relationships in the community. STAR teams support recovery by linking individuals to resources and services in the community, identifying factors that impact wellness and recovery, and modeling strategies on how to manage and maintain recovery.

In 2021, using SOR funds, DMHAS provided additional funding of \$175,000 to the providers who developed the first 10 STAR programs. Those STARs developed an additional team to provide services to individuals with opioid use disorder who are released from county or municipal jails. These county-based programs were identified using county data including overdose rates, arrests for opioid distribution offences, and unmet need for services in that county. In addition to all requirements specified in the general STAR Annex A (contract), providers are required to:

Maintain a caseload of twenty (20) individuals who have been released from county or municipal jails;

Hire an additional case manager and recovery staff; and

Establish or enhance relationships with jail personnel (warden, parole officers, etc.) to determine how to best engage clients to receive services from these STARs.

From July 1st, 2021 to June 30th, 2025, the STAR program has served 995 clients. For individuals served between FFY 2023 and 2024; abstinence rose 33%, employment increased 61.5%, Quality of Life increased 14.3% and recovery capital measured by the Recovery Empowerment Scale increased 4%.

h) Persons using substances who are at risk for overdose or suicide

DMHAS provides numerous programs for persons using substances who may be at increased risk of an accidental drug overdose. The services are provided to high-risk individuals, such as those being released from jails or prison, or from EDs and hospitals, after an overdose or drug-related event. The following programs highlight services to decrease overdose risks:

In addition to promoting the access to naloxone and education about addressing overdoses, DMHAS supports specific programs that educate the public and providers about how to respond to an overdose using naloxone. Since 2016, staff from the Robert Wood Johnson (RWJ) Medical School in New Brunswick, NJ have provided virtual and in-person training (known as the Opioid Overdose Prevention Network - OOPN) throughout NJ. Trainings focus on how to recognize an overdose and administer naloxone. In addition to these community trainings, RWJ developed a train the trainers model for recovery staff who work in the Opioid Overdose Recovery Programs (OORP) and Support Teams for Addiction Recovery (STAR) whereby the recovery staff train clients with whom they are working on how to recognize an overdose and administer naloxone. OOPN also provides naloxone to the OORPs and STARs, which the recovery staff give to their clients. DMHAS will provide additional funding (BG Supplement and ARP) to OOPN to enable its trainers to deliver the program and naloxone to individuals, including persons who work in the construction industry. To date OOPN has provided 1,894 trainings to 29,754 persons and distributed 40,982 naloxone kits.

The Division provides supports and case management services to individuals who have overdosed or who are at risk of overdose. The Opioid Overdose Recovery Program (OORP), which has peer staff respond to individuals who have been reversed from opioid overdoses (by police, emergency responders, or friends/family) or admitted for drug-related injury to a hospital emergency department. OORP utilizes Recovery Staff and Patient Navigators to engage the individuals reversed from an opioid overdose to provide non-clinical assistance, recovery supports and appropriate referrals for assessment and substance use disorder treatment. The Recovery Staff and Patient Navigators also maintain follow-up with these individuals for a minimum of 8 weeks after the initial contact. Recovery services provided for these individuals are fundamentally strengths-based. Additionally, Recovery Coaches and Patient Navigators deliver or assertively link individuals to appropriate services and provide support and resources throughout the process. Recovery Staff provide take-home naloxone kits to the persons with whom they've worked. OORP services are available 24/7 in 20 of New Jersey's 21 counties. As of June 30, 2025; 31,814 individuals have been served by OORP.

Support Teams for Addiction Recovery (STAR) provide case management and recovery support services for individuals in recovery from opioid use disorder (OUD). STAR recovery staff provide non-clinical assistance and recovery support services. Each STAR program team consists of a program supervisor, case manager and recovery staff who work with individuals to assist with issues that can occur when a person is suffering from an OUD, such as: homelessness, legal issues, employment, education, transportation, need for social services, health care and insurance, child welfare involvement, etc. The overall goal of STAR is to help individuals with an OUD maintain their recovery, help decrease the risk of recurring opioid-related problems and prevent overdose.

The STAR team encourages self-determination and promotes knowledge and hope that the individual can recover from an OUD and regain meaningful roles and relationships in the community. The STAR team supports recovery by linking individuals to resources and services in the community, identifying factors that impact wellness and recovery, providing assistance in managing crisis situations, and modeling strategies on how to achieve and maintain recovery. As of June 30, 2025, 6,189 persons have been served by the STAR teams.

Telephone Recovery Support (TRS) is a statewide telephone recovery support system for individuals discharged from SUD treatment and those trying to maintain recovery from an OUD. TRS trained staff and volunteers provide weekly phone calls to "check in" on how people are managing their recovery and provide support, encouragement and information about recovery resources. As of June 30, 2025, 2,374 distinct individuals have received TRS services.

New Jersey has developed several programs to both distribute naloxone as well as provide training in administering naloxone to first responders and members of the community. The Opioid Overdose Prevention Network has already been mentioned above. The Division of Mental Health and Addiction Services (DMHAS) contracts with two providers to support Opioid Overdose Prevention Programs (OOPP) operating in all of NJ's twenty-one counties for the purpose of providing education to participants so that they can recognize an opioid overdose and subsequently be equipped to provide life-saving rescue measures to reverse the effects of an opioid overdose. Funded OOPPs provide individuals at-risk for overdose, their family members, friends, and loved ones with naloxone rescue kits and educate and train them on how to prevent, recognize and respond to an opioid overdose. In addition, the OOPP providers organize trainings at schools, jails, prisons, substance use disorder treatment programs, homeless

shelters, Offices of Emergency Management, HIV primary care offices, fire departments and community health clinics. In FFY 2024; OOPPs provided 161 training sessions to 2,007 persons, distributed 1,404 naloxone kits and distributed 348 fentanyl test strips using federal funds. In FFY 2024; OOPPs provided 236 training sessions to 1,701 persons, distributed 1,450 naloxone kits and distributed 406 fentanyl test strips using state funds. In FFY 2024; using a combination of federal and state funds, OOPPs provided 397 training sessions to 3,708 persons, distributed 2,854 naloxone kits and distributed 754 fentanyl test strips. In FFY 2025 up to June 30th, 2025 the OOPPs provided 248 training sessions, distributed 2,202 naloxone kits, trained 2,266 participants in naloxone administration, distributed 1,149 fentanyl test strips and distributed 1,093 xylazine test strips using state funds.

Naloxone Direct allows local government agencies, first responders and other eligible entities to place orders for naloxone through an online portal for general distribution in the community, emergency administration, and to make "leave behind" naloxone available for individuals, post-overdose. Naloxone Direct was launched in June 2022; it has distributed 486,585 naloxone kits throughout its history. In FFY 2024 and FFY 2025 up to June 30, 2025; Naloxone Direct has distributed 367,645 naloxone kits throughout the state.

Naloxone 365 is a DHS naloxone distribution initiative for individuals in the community. Launched in January 2023, DHS partnered with its Medicaid division and the NJ Board of Pharmacy to develop and implement this unique program. Individuals 14 years or older may obtain naloxone anonymously and at no-cost to them at participating pharmacies across New Jersey. Anonymity, easy access, and free naloxone are the three cornerstones of the Naloxone 365 program. Individuals are not required to present a prescription for naloxone, nor are they asked to provide identification, personal information, or their insurance. They can simply walk into a participating pharmacy and ask the pharmacist for naloxone and they will receive a carton of naloxone 4mg nasal spray (2 doses per carton) for free. Pharmacies must complete the NJ Board of Pharmacy's Naloxone Pilot Agreement to participate in the program. Once signed up, participating pharmacies would procure naloxone through their normal network of wholesalers. After dispensing naloxone to an individual, pharmacies bill for reimbursement using the NJMMIS/Medicaid billing code by following the instructions in the pilot program agreement. Pharmacies are reimbursed for naloxone at the current Medicaid rate. This program is funded using federal grant dollars. Individuals can locate participating pharmacies and pertinent information on naloxone by visiting: www.StopOverdoses.nj.gov. In FFY 2024, Naloxone 365 distributed 54,314 kits throughout the state. In FFY 2025 up to June 30, 2025, Naloxone 365 distributed 31,456 kits. Overall Naloxone 365 distributed 139,003 kits since its inception up to June 30, 2025.

In regard to suicide risk in persons using substances, DMHAS has placed a focus on making all SUD and co-occurring providers aware of these risks in their clients. For several years, DMHAS has supported training and technical assistance to behavioral health agencies so that they can adopt the Zero Suicide approach, which is a SAMHSA-endorsed and evidence-based model of care that has seven main components that have been shown effective in decreasing suicide deaths and suicide attempts in a variety of systems and settings. DMHAS receives funding from the state legislature every year for its suicide prevention initiatives. The DMHAS funded training in the Zero Suicide model is offered to outpatient and residential services providers, although the majority who attend are providers of mental health or co-occurring disorder services. In response to the need for Zero Suicide training directed to SUD providers, future plans include training sessions directed to them. Fuller details on the statewide training on the model over the last several years and related activities are described elsewhere in this report.

DMHAS also hold an annual all-day conference on suicide prevention, and this routinely provides training for all behavioral health staff, including those with addiction agencies. In 2024, the annual conference has had over eighteen hundred registrants and had sessions related to suicide and substance use, as well as on the topic of suicide and problem gambling.

Notably, the 988 crisis call line and related crisis services now address all behavioral health crises. In addition to suicide and mental health crises, these now serve those individuals with needs that involve substance use. The following services address the needs of those at suicide risk or who are experiencing other behavioral health crises: The 988 Suicide and Crisis Lifeline, the new three-digit dialing code for individuals experiencing suicidal, mental health, and/or substance use crisis, was established nationwide in July, 2022. It is part of a larger crisis care continuum being developed in New Jersey known as the 988 system. This system is being set up with the guiding principle that there will always be someone to call, chat, or text; someone to respond; and somewhere to go.

New Jersey crisis call centers that respond to calls, texts and chats for the 988 Suicide and Crisis Lifeline are certified by Vibrant Emotional Health (Vibrant) for meeting the minimum clinical, operations and performance standards and together they provide

statewide coverage 24 hours a day, every day of the year.

In preparation for the transition to 988, NJ DMHAS was awarded approximately \$2.5 million from the SAMHSA 988 Capacity Building Grant. These funds were designed to support Lifeline centers as they prepared for the anticipated increase in call, chat and text volume. Funding from a combination of federal grants totaling \$3.7 million was awarded to the five (5) NJ Lifeline centers.

In December 2022, NJ DMHAS was awarded an additional \$1 million through the SAMHSA 988 Capacity Building Supplemental Grant. Of this award, approximately \$340,000 has been awarded to four of the five 988 Lifeline centers in New Jersey (one center declined additional funding). These awards continue to support centers as they onboard additional staff.

An additional \$12.8 million was allocated in the State Fiscal Year 2023 (SFY23) budget toward the expansion of the 988 Lifeline network to handle the increased volume of 988 calls, chats and texts. From these funds Carenton Behavioral Health was awarded a contract to act as the Managing Entity (ME) for the New Jersey 988 Suicide and Crisis Lifeline system. Among the ME's responsibilities will be to collect and report 988 Lifeline center data, establish and maintain a comprehensive resource and referral database, and to dispatch Mobile Crisis Outreach Teams (MCORTs) once they are operational.

The remaining \$10 million will go toward the expansion of 988 Lifeline center operations (for current and/or additional centers). This expansion will add capacity to the NJ 988 Lifeline system and allow a higher rate of response to calls, chats and texts originating in New Jersey. Funding was allocated from the SUPTRS Block Grant for implementation of the 988 Lifeline. Individuals with an SUD are susceptible to suicide and suicide attempts. Suicide is a leading cause of death among those that misuse substances (SAMHSA 2008). Deaths due to alcohol, drugs, and suicide have been on the rise for over the last two decades, doubling from 104,379 deaths in 2011 to 209,225 deaths in 2021 (Trust for America's Health 2023).

The goal is to reach a 90% in-state answer rate with a maximum of 10% of calls being routed to the national backup system. Data provided by Vibrant for the month of March 2023 shows that NJ had an in-state answer rate of 79%. NJ 988 Lifeline centers continue to recruit and onboard staff to expand the capacity for responding to calls, chats and texts. However, future funding opportunities and ongoing funding streams are vital to reaching and maintaining this goal.

The next step for the 988 system will be to develop a Mobile Crisis Outreach Response system with teams of trained professionals who will meet with people in crisis in the community. Mobile Crisis Outreach Response Teams (MCORTs) will be established as the "Someone to Respond" for the NJ 988 system. The SFY23 budget includes \$16 million for the establishment of statewide MCORTs. These teams are designed to respond 24 hours a day, every day of the year, to non-life-threatening mental health, substance use or suicidal crises in the community. Ongoing funding for this program will be critical to maintaining this community-based, lifesaving service.

i) Other adults with substance use disorders

Substance Use Disorder Prevention

DMHAS has developed the following initiatives for individuals in need, including student athletes and older adults. The prevention of the development of substance use disorders is the goal of these programs.

Young Athletes

A major component of New Jersey's SPF Rx project focuses on young athletes. A toolkit called "Tackling Opioids through Prevention for Athletes" (TOP) was developed by the New Jersey Prevention Network for use by providers. Literature suggests that when young athletes are prescribed opioid pain relievers for sports-related injuries, there is a risk of addiction and medication misuse. The 19 county coalitions that were established by DMHAS use the TOP to provide education regarding this issue to coaches, parents, prescribers, and young athletes. In SFY 2023, 5,200 individuals were served, and in SFY 2024 6,871 participated in the trainings.

The Alternative Approaches to Pain Management for Older Adults (AAPMOA) program funded with State Opioid Response (SOR) funds, includes 20 of 21 NJ counties, since one county did not apply for this funding. Program providers have implemented a comprehensive educational program specifically focused on providing older adults with practical information regarding (1) the appropriate use of non-opioid analgesic pain medication and (2) non-pharmacological approaches to dealing with acute and chronic pain. The goal of the project is to decrease the overuse, misuse and abuse of prescription opioid medications. Programs utilize current evidence-based treatment guidelines for non-pharmacological treatment modalities. The "efficacy" of the educational program on participants' knowledge about and understanding of alternative approaches to pain management is assessed by means of a pre and post-test. Most of the providers who are delivering the AAPMOA program use the evidence-based Wellness Initiative for Senior Education (WISE) program. WISE is a wellness and prevention program serving older adults, which is designed to help them celebrate healthy aging, make healthy lifestyle choices and avoid substance abuse. It provides educational services to older adults on topics including medication management, stress management, depression, and substance misuse. Created by the New Jersey Prevention Network and implemented locally by prevention agencies across the country, WISE promotes health through education concerning high-risk behaviors in older adults. Since the program was launched in 1996, prevention programs presented by WISE facilitators have reached over 650,000, individuals.

Providing information about the risks associated with prescription pain medications is a component of these trainings. However, the primary focus is on providing information and answering questions about proven, non-pharmacological means of addressing pain. Providers do not deliver actual services, but offer information about alternative approaches and information regarding how and where to access such services as: physical therapy, chiropractic care, yoga, massage therapy, etc.

At-Risk Youth

The SSA provides prevention services to at-risk youth. The SSA awarded funding to the North Jersey Community Research Initiative (NJCRI) to expand their existing programs for high-risk youth by using a "Street Smart" prevention model developed by the Centers for Disease Control and Prevention, as well as early intervention services, social marketing, and structured recreational activities. NJCRI provides services covering the northern NJ counties. In the spring of 2023, DMHAS (by means of a competitive RFP process) identified two additional organizations to provide services to at-risk persons in their communities: Prevention Resources in the central region of NJ and the Robert Wood Johnson-Barnabas Health Institute for Prevention and Recovery, in the southern region.

Expanded Hours

DMHAS released an RFP for the development of Expanded Hours for Substance Use Disorder (SUD) Outpatient Programs. The funds for this initiative are through the ARPA grant. These expanded services were developed to enhance access to treatment by removing barriers such as traditional service hours. These expanded hours will provide increased access to outpatient treatment for individuals with an SUD. The purpose of this expansion for outpatient services is to support, enhance and encourage the emotional development and the development of consumer's life skills in order to maximize their individual functioning during alternate times from standard business hours (after hours and weekends).

As of March 31st, 2025, the 10 Expanded Hours Outpatient Program providers have provided 10,943 times of service to a total of 2,815 unique clients. Out of 10,943 total client visits, 45.76% of visits happen during early morning before regular business open hours, 38.53% of visits happen during latter afternoon or evening after regular business hours. 15.71% of visits happen on weekends. For all the Expanded Hours visits, 6,717 client visits (61.53%) were for group therapy or family sessions. 1,791 client visits (16.41%) involved individual outpatient. 1,530 client visits (14.02%) were for other services not categorized elsewhere. 853 client visits (7.81%) were focused on medication monitoring. 25 client visits (0.23%) involved educational or administrative activities.

These services are designed to preserve or improve current functioning, strengths and resources. In outpatient services, consumers and staff work together to plan and implement effective treatment and offer individual, group and/or family sessions during these expanded hours. The expanded hours will also allow for an increase in medication monitoring, education and administration time that have all proven to decrease barriers for engagement and ongoing treatment. By increasing the access to treatment for consumers, they are more readily willing to seek treatment because services are available at times that accommodate their work, school and family obligations.

The expanded hours initiative is designed to increase treatment options through expanded operating hours to ensure all consumers are able to attend treatment uninterrupted and maintain personal as well as business obligations. This will assist consumers in fulfilling personal needs, employment, etc. Providers are required to expand their hours at a minimum of six (6) days per week with the goal of extending hours into the evening and admitting new consumers for these services during these times. The additional operating hours from providers can either be continuous or separated by times when their programs/facilities close and reopen for their doors for business.

The Open Access to Medications for Opioid Use Disorder in Homeless Shelters is designed to increase access to buprenorphine and other ancillary services for individuals with a substance use disorder through current programming available at homeless shelters that are licensed by the NJ Department of Community Affairs. These providers have developed the capacity to provide medication and support services for individuals who reside or drop in at homeless shelters. The intent of the program is to provide low threshold medication services to individuals with SUD who present in these settings. Participating shelters are located in Paterson, Trenton, Camden, East Orange and Newark.

j) Children and youth with serious emotional disturbances (SED) or substance use disorders

In New Jersey, all youth under the age of 21 who meet clinical criteria have access to the service array offered by the Children's System of Care. All services are available to youth who meet clinical criteria regardless of the youth or family's income. Youth who do not meet clinical criteria or whose need has been determined to not be of a moderate or high acuity are provided with connections to services and supports outside of the service array. For example, if a family calls the contracted system administrator and the youth's biopsychosocial indicates need, but not to the extent that additional CSOC services are indicated, the CSA may provide the family with information about outpatient providers in their geographical area, even though outpatient services are not a part of the CSOC service array. In this way, all New Jersey youth under 21 with mental health, substance use disorders or co-occurring disorders have access to services, based solely on the youth's need.

k) Children and youth with serious emotional disturbances (SED) a co-occurring I/DD

The New Jersey Children's System of Care (CSOC), under the Department of Children and Families (DCF), is responsible for providing a broad array of services and supports for children and youth with emotional and behavioral health challenges, substance use needs, and intellectual and developmental disabilities (IDD). Among the youth served are those who experience Serious Emotional Disturbance (SED), which includes significant emotional or behavioral disorders that substantially interfere with or limit a child's functioning in the family, school, or community. Recognizing that some youth have co-occurring IDD and SED, CSOC has worked to promote integrated and individualized care planning, ensuring that these children and families receive comprehensive, coordinated, and developmentally appropriate services. CSOC has prioritized cross-system collaboration to address the complex needs of individuals, engaging providers, schools, behavioral health staff, and developmental disability partners.

Historically, youth with co-occurring IDD and SED were often in need of services due to fragmented systems and siloed eligibility requirements. Since transitioning oversight of developmental disability services for children and youth to CSOC in 2013, New Jersey has worked to better align services for families navigating both behavioral health and IDD systems. Today, youth with SED and co-occurring IDD may access an array of services through CSOC's provider network, including care management, intensive in-home behavioral supports, family support services, mobile response and stabilization, outpatient therapy, and residential treatment, as needed. Service planning is driven by the wraparound model and guided by the Child and Adolescent Needs and Strengths (CANS) assessment to ensure that supports are tailored to the unique strengths and challenges of each child. CSOC

continues to work toward a system of care that is expansive and equipped to support the full spectrum of needs for youth with both SED and IDD.

I) Individuals with co-occurring mental and substance use disorders

Beginning in SFY 2010, the SSA established a Co-Occurring Services Network (COSN) comprised of 53 treatment providers to provide treatment to clients with co-occurring disorders on a Fee for Service (FFS) basis. Now, agencies eligible to join the SUD FFS Initiatives Network as a Co-Occurring Provider must meet New Jersey Department of Health (DOH) Office of Certificate of Need Licensing (CN&L) requirements for co-occurring licensing approval. As of SFY 2025, there are approximately 135 agencies in the COSN that represent approximately 247 individually licensed sites with co-occurring approval. Authorization to provide co-occurring services is predicated on agency's co-occurring licensing approval.

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

The SUD FFS Initiatives Network reimburses the following Co-occurring services: Case Management, Clinical Consultation, Comprehensive Intake Evaluation, Crisis Intervention, Family Therapy, Group Therapy, Individual Therapy, Medication Monitoring, and Psychiatric Evaluation. The COSN has helped community SUD agencies, advocates, as well as individuals who have a substance use disorder and co-occurring mental illness, realize "one-stop", "treatment on demand", or "no wrong door" access to care.

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance **parity enforcement and increase awareness of parity protections** among the public and across the behavioral and general health care fields.

Mental Health Condition and Substance Use Disorder Parity Laws – P.L. 2019, c. 58 was signed into law on April 11, 2019. The law requires health insurers to provide coverage for mental health conditions and substance use disorders under the same terms and conditions as provided for any other sickness and to meet the requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction 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. The Division of Medical Assistance and Health services reviews regulations and contract language on an ongoing basis to ensure services are provided and accessible. Language is reviewed to ensure limits can be overridden when medically necessary and that barriers to care are removed when possible. Each contracted managed care organization submits a complete review annually and the Department of Human Services posts the approved parity plans on the DHS webpage (<https://www.nj.gov/humanservices/dmahs/news/>).

3. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and substance use disorders**, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders.

Co-Occurring Services Network. Beginning in SFY 2010, the SSA established a Co-Occurring Services Network (COSN) to provide treatment to clients with co-occurring disorders on a Fee-for-Service basis. Agencies eligible to join the Substance Use Disorder (SUD) Fee-for-Service (FFS) Initiatives Network as a Co-Occurring Network must meet New Jersey Department of Health Certificate of Need Licensing Office (CN&L) requirements as a co-occurring provider. Currently, there are 135 agencies in the COSN. These agencies represent 247 individually licensed sites with COSN approval. Authorization to provide co-occurring services is predicated on agency's Co-occurring licensure approval.

Those agencies contracted for the South Jersey Initiative (SJI), Driving Under the Influence Initiative (DUII), New Jersey Statewide

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

Co-occurring Enhancement Services criteria in the SUD FFS Network is as follows:

Provider Agencies must satisfy the State licensure regulations as per N.J.A.C 10:161(A/B)-10.4 for the delivery of Co-occurring services and obtain approval from the Department of Health (DOH), Certificate of Need and Licensing (CN&L)

Implemented to advance the integration of Mental Health Services into client's SUD Treatment, an array of services is available to individuals with a mental health diagnosis

Services must be delivered by a licensed Behavioral Health Practitioner working within their professional scope of service with supervision according to the requirements of their professional license

Co-occurring Enhancement funded services include: Co-occurring Clinical (Individual*, Group*, Family*, Crisis Intervention* and Clinical Consultation*; Co-occurring Case Management; Comprehensive Intake Evaluation); Psychiatric Evaluation; Co-occurring Medication Monitoring. (*only available in Halfway House Level of Care)

CCBHC

CCBHC includes 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 less serious or chronic conditions. CCBHCs provide treatment for co-occurring substance use disorder and mental illness,

PIPBHC

DMHAS was awarded the Promoting Integration of Primary and Behavioral Health Care Collaborative Care Model (PIPBHC CoCM) grant by the Substance Abuse and Mental Health Services Administration (SAMHSA), effective September 30, 2024. This initiative aims to enhance the identification, assessment, and treatment of individuals with serious mental illness (SMI), serious emotional disturbance (SED), and co-occurring physical health and/or substance use disorders (SUDs) in primary care and pediatric settings.

a. Please describe how this system differs for youth and adults.

While the Adult and Children's systems provide for co-occurring disorders, they do this differently. DMHAS provides a broader range of such services for adults in its Co-Occurring Network (discussed below) and has had more experience with developing integrated models of mental health and addiction services in outpatient and residential settings. The Children's System of Care (CSOC) in the Department of Children and Families (DCF) provides co-occurring community-based services to eligible children and youth largely through Care Management Organizations (CMOs); the CMOs coordinate the care of children and youth with serious emotional disturbance (SED) through care managers who advocate, organize and arrange necessary supports. CSOC also is a partner with DMHAS in the certified community behavioral health clinics (CCBHCs) Demonstration grant, which provides co-occurring screening and treatment services that are described more fully below. New Jersey was one of the original states to receive the SAMHSA Demonstration grant for the certified community behavioral health clinics (CCBHCs) in 2017. The CCBHCs provide a range of outpatient services for children, youth and adults, which include mental health and addiction services in an integrated program in which care coordination is the linchpin. DMHAS has been working with the Department of Health to promulgate regulations that will remove agency licensing barriers and allow them to apply for a single license in order to deliver mental health and addiction services.

b. Does your state provide evidence-based integrated treatment for co-occurring disorders (IT-COD), formerly known as IDDT? Please explain.

No.

c. How many IT-COD teams do you have? Please explain.

N/A

d. Do you monitor fidelity for IT-COD? Please explain.

N/A

e. Do you have a statewide COD coordinator?



Yes



No

4. Describe how the state **supports integrated behavioral health and primary health care**, including services for individuals with mental disorders, substance use disorders, co-occurring M/SUD, and co-occurring SMI/SED and I/DD. Include detail about:

- a) Access to behavioral health care facilitated through primary care providers
- b) Efforts to improve behavioral health care provided by primary care providers
- c) Efforts to integrate primary care into behavioral health settings
- d) How the state provides integrated treatment for individuals with co-occurring disorders

- a) Access to behavioral health care facilitated through primary care providers

NJ DMHAS has a cooperative and working relationship with the Department of Health that is integral in our integration efforts. The Office of Primary Care and Rural Health (Office of Primary Care) has assisted with efforts to expand behavioral services in FQHCs. DMHAS worked with the Office of Primary care to assist them in adding state reimbursement to FQHCs for the provision of behavioral health services for the uninsured. Together DMHAS and the Office of Primary Care surveyed all FQHC providers to understand the services that they provide for addictive disorders and worked to publicize the results so that the public understood which of these primary care offices were available for those treatments.?????????

DMHAS works collaboratively with our sister division, the NJ Division of Medical Assistance and Health Services (NJ Medicaid) to expand access to medication services for addictive disorders in primary care services. Together DMHAS and NJ Medicaid developed the Office Based Addiction Treatment (OBAT) services and network. These OBATs are primary care offices which, with the support of enhanced funding as well as free technical assistance, are available to the public for medication, treatment and referral. Those providers are included in our statewide Substance Use Disorder Treatment Directory.

As a result of strong evidence that peer services are effective for individuals with a SUD or MH, NJ Medicaid, in collaboration with DMHAS, has added peer services to the Medicaid reimbursable services at FQHCs.?????

New Jersey is building an integrated regulatory rule that, when completed, will streamline the process whereby a behavioral health clinic can become a primary care clinic and vice versa. We expect that this will create access and a no wrong door network for individuals needing both primary and behavioral healthcare.

New Jersey has completed its 5-year PIPBHC grant. As part of that grant an FQHC in Atlantic City, Atlantic County has implemented SUD treatment and prevention services into their service array. Currently, the FQHC is working with DMHAS to sustain the services after the grant ends.

New Jersey was awarded an PIPBHC – CoCM grant in August of 2024. Through a memorandum of agreement with Rutgers Center for Integrated Care, these funds will be used to provide behavioral health screening, assessments and referrals for individuals being served at three primary care clinics. This program is designed to improve and sustain integrated care in these clinics through the use of psychiatrists providing consultation and mentoring to clinic's primary and family care physicians.

NJ is a CCBHC Demonstration State. The CCBHC providers are required to screen and coordinate referrals for appropriate medical services. Many of the CCBHC Demonstration providers have affiliated with local FQHCs and some have obtained their own primary care license. The CCBHC service has increased coordination of primary care and behavioral health care for the approximated 20,000 people that are serve each year.

b) Efforts to improve behavioral health care provided by primary care providers

New Jersey has developed two Centers for Excellence for Medication Assisted Treatment (COE) in Opioid Treatment. These centers maintain a provider hotline which is available to all primary care providers and other medical professionals, including prescribers. Through the contract with the Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), the COEs are required to advertise the hotline to physicians throughout the state.

Both COEs also contract with DMHAS to provide technical assistance and training for the twenty (20) county correctional facility medical vendors and staff in the participating County Correctional Facilities MAT and Case Management program, to ensure all inmates are receiving the appropriate medication for their Opioid Use Disorder.

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The Southern COE at Rowan Cooper Medical Center has implemented training and consultation services for Emergency Medicine and Primary Care providers throughout the state who have an interest in treating opioid use disorder (OUD). Leveraging expertise and lessons learned from previous trainings, the Southern COE provides educational sessions and consultation services both on-site ("Elbow to Elbow") and via office hours for physicians, nurses, and front-line staff to address practice based and logistical issues. The Southern COE has learned that a training presentation is only the first step, and that healthcare providers new to this work often need additional support and guidance to implement medications services to support individuals with Opioid Use Disorder (OUD) and other substance use disorders successfully. Pairing in-person, virtual and recorded trainings with consultation services and open office hours is hopeful to build greater capacity to address the opioid overdose epidemic throughout New Jersey.??

Project ECHO ("Extension for Community Healthcare Outcomes") is a collaborative model of medical education, training and care management that empowers front-line providers to provide better care to more people, right where they live, through access to additional resources, mentoring and community resources that support patient care. The ECHO program focuses on building provider capacity across a region by connecting a multi-disciplinary team of subject matter experts with local providers. In this way, the medical providers and addiction specialists along with their community partners expand their ability to provide access. Since January 2020, the New Jersey Rutgers Project ECHO Substance Use Disorder program, supported by the SUPTRS Block Grant, has provided training for primary care providers (PCPs) in the management of substance use disorders (SUD). Core focus areas include substance-specific education, best practices for the use of medications for opioid use disorder (MOUD), and implementation of screening, management, and treatment strategies in primary care settings.

In March 2020, Project ECHO adapted swiftly to the evolving needs of the community by temporarily expanding its curriculum to address COVID-19, mental health, and substance use challenges. While the SUD ECHO has since returned to its original training priorities, it continues to integrate infectious disease topics relevant to patients with SUD, ensuring that the curriculum remains responsive to ongoing public health developments.

Training delivery and participation metrics reflect sustained engagement and impact:

2021: 33 sessions conducted, training 406 unique participants, with an average of 55 attendees per session

2022: 33 sessions conducted, training 340 unique participants, with an average of 50 attendees per session

2023: 26 sessions conducted, training 231 unique participants, with an average of 42 attendees per session

2024: 27 sessions conducted, training 308 unique participants, with an average of 57 attendees per session

Participant evaluations consistently demonstrate increased competence and confidence in applying evidence-based guidelines for the treatment of substance use disorders within primary care.

Project ECHO remains a critical resource for building the capacity of front-line providers to deliver high-quality care to individuals affected by substance use disorders.

SBIRT was initially implemented by DMHAS in 2013 at the Henry J. Austin Health Center (HJAH), a federally qualified health center (FQHC) with several locations throughout Trenton. HJAH then expanded services to two partner emergency departments (EDs) in 2014. Services were further expanded to five additional NJ counties in 2016 through partnerships with Rutgers Robert Wood Johnson Medical Group and Rowan School of Osteopathic Medicine, Department of Family Medicine. SBIRT was delivered in various healthcare settings including primary care clinics, federally qualified health centers, emergency departments, dental clinics, and a student wellness center. The project was in operation between 2013-2017 and a total of 55,990 unique individuals were pre-screened. SBIRT interventions were provided for more than 1,750 of these individuals.

In November 2021, a Memorandum of Agreement with the Rowan University, School of Osteopathic Medicine (SOM) was developed for Screening, Brief Intervention and Referral to Treatment (SBIRT) for persons receiving services at their internal medicine, family care, OB/GYN clinics, and at the Rowan University Student Health Center. Utilizing national best-practice standards for substance use screening, Rowan SOM has developed and implemented a fully sustainable, integrated SBIRT model as part of routine medical care. Additionally, Rowan SOM implemented annual, universal screening protocol, and office-based risk interventions, as part of patient intake services in all OB/GYN clinical settings. Initial funding was provided by COVID Supplemental and continued with ARPA.

c) Efforts to integrate primary care into behavioral health settings

New Jersey works directly with the NJ DOH Infectious and Zoonotic Disease Program-Communicable Disease Service. They provide advice and assistance to the DMHAS to include primary health screening, assessment, referral and treatment into the Behavioral Health treatment network. This includes review and assistance with relevant funding opportunities offered to behavioral health providers to assure that they include necessary health services, working on joint public relations efforts, sharing data and provider educational activities.

DMHAS' work with primary care providers and the DOH has offered insights and opportunities for improvement of integrated services from both the primary care and the behavioral healthcare system. One such example that came to our attention through meetings with primary care providers, was that Medicaid funding rules made it more cumbersome and difficult for patients who are receiving care at substance use disorder providers to receive anti-viral medications. Our Medical Director was able to work with the NJ Drug Utilization Review Board to ultimately have those rules relaxed which created access to needed medical care.

NJ is the recipient of a SAMHSA PIPBHC grant that ended in March. That grant has focused on bringing integrated services to patients of both the FQHCs and the substance use disorder providers in the PIPBHC initiative. The program provides screening, assessment, treatment and referral to appropriate care with a focus on Hepatitis C and HIV. Through this initiative we were able to provide training and technical assistance of two Infectious Disease Consultants which has enhanced and improved the services of the providers. Significant efforts were made to sustain the program including the relaxation of Medicaid reimbursement rules mentioned above, the reimbursement of some Behavioral Health services in the uncompensated care fund for FQHCs, the addition of Peers as a separate reimbursable service in FQHCs and the addition of Peers and Case Management for licensed substance use disorder services. All providers in the PIPBHC planned to sustain their integrated services when the PIPBHC ended.

In August 2024, NJ was awarded a PIPBHC Collaborative Care Model (CoCM) grant. Through that grant NJ will provide screening, assessment, referral to individuals with behavioral health challenges at three primary care clinics in Essex and Union Counties. This program is designed to improve and sustain integrated care in these clinics through the use of psychiatrists providing consultation and mentoring to clinic's primary and family care physicians.

NJ was a CCBHC Demonstration State. Through the CCBHC, providers have screened, referred and followed patients with medical needs. NJ is considering the requirement of a more robust medical component in the CCBHC model as we embark on a Medicaid SPA for the service.

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NJ has utilized State Opioid Response funding to place Nurse Case Managers (NCM) in state Opioid Treatment Programs, and NJ

expanded that program to all ambulatory levels of SUD care through a competitive bidding process.? Through the program, NCMs are placed at the provider to screen, assess, treat and refer patients for medical issues. This program is specifically focused on Hepatitis C and HIV.

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NJ holds regular meetings with the Medical Directors of behavioral health treatment providers.? These provider meetings have been an opportunity for Medical Directors to bring issues of concern and share practices that improve the care provided at behavioral health clinics.

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As stated above, NJ is building an integrated regulatory rule that, when completed, will streamline the process whereby a behavioral health clinic can become a primary care clinic and vice versa.? We expect that this will create access and a no wrong door network for individuals needing both primary and behavioral healthcare.

Behavioral Health Homes are a Medicaid State Plan option that provides an opportunity to build a person-centered system of care that achieves improved outcomes and better services and value for the NJ Medicaid program.?

NJ is partnering with Medicaid to implement the Integration or Carve-In of Medicaid Behavioral Health Care Services into NJ's five Managed Care Companies (MCO). This change to the payment system is intended to integrate behavioral and physical health for whole person care with the potential to improve healthcare outcomes.

Phase I of this Integration was completed in January 2025. During that phase of the Integration, ambulatory SUD and MH treatment services were integrated into the MCO management. Phase II is expected no earlier than January 2026 and will include MH and SUD residential services and Opioid Treatment Program services.

In a partnership with the Division of Medical Assistance and Health Services (Medicaid) and the Department of Children and Families, DMHAS launched health homes in select counties in July of 2014.? Currently, there are nine BHHs in New Jersey: two each in Atlantic, Bergen and Mercer Counties and three in Monmouth County. The BHH is a high intensity service serves those with the most need. It is continuing standard of care that allows individuals to have all of their health care needs identified, addressed, and treated in a coordinated way.? The same team of clinicians and practitioners either deliver, or coordinate the delivery of, all the necessary medical, behavioral, and social supports required for the individual, acknowledging the impact each area has on the others.? It is not a residential program.? It is a whole-person care delivery model.

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Integrated care provides coordinated whole person care that addresses both the physical and behavioral health needs of clients. This care, particularly when co-located, increases access and decreases barriers. For example, integrated care can decrease the need for multiple appointments and the corresponding travel from provider to provider. Many behavioral health clients have experienced unwelcoming and even traumatizing care due stigma. For these clients the support of the behavioral health provider can help them overcome these experiences and get the services that they need. Many patients benefit because they can receive care at the behavioral health provider where they feel most comfortable.

In NJ the CoCM grant will provide integrated care in three communities in high need of medical services. and will specifically serve those individuals in need.

Through multiple training, technical assistance, regulatory and funding initiatives, NJ has a network of behavioral health providers who are co-occurring capable. Each integration initiatives identified above is open to all clients with co-occurring mental health illness and substance use disorder.

CSOC - Behavioral Health Homes.

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

CSOC Pediatric Psychiatry Collaborative

Launched in 2015, with support from the NJ Governor's Office and funding from the NJ Department of Children and Families, Hackensack Meridian Health, along with Cooper University Health Care and Atlantic Health System, and Rutgers University Behavioral Health Care have successfully established the New Jersey Pediatric Psychiatry Collaborative (NJPPC) across all 21 counties in New Jersey. There are 9 regional Hubs throughout the state ensuring that every county has improved access to pediatric mental/behavioral health care.

As a mental/behavioral health and substance use consultative and referral support program, the NJPPC has aimed to improve the comfort and competence of pediatric primary care clinicians to screen, identify and care manage their patients with mental/behavioral health concerns. Participating pediatric primary care and behavioral healthcare providers now have quick access to mental/behavioral health consultative and referral services for the children and families in their care.

The program is available for children and adolescents up to age 18 (or up to 21, if patient is still being seen by the pediatric practices) and requires participating primary care providers (PCP) to universally provide standardized mental/behavioral health and substance use screenings at each well visit. Participating pediatricians and pediatric clinicians can consult with the NJPPC Hub Child & Adolescent Psychiatrists (CAPs) and behavioral health staff. They can also refer patients with identified concerns to the Hub behavioral health staff for intake and referral to services in their community. As of 2020, patients who are referred to the Hub can also access psychiatry evaluation services via tele-psychiatry.

d) How the state provides integrated treatment for individuals with co-occurring disorders?

DMHAS supports Early Intensive Supports Service (EISS) programs, which essentially are a statewide system of behavioral health urgent care programs that are able to serve as a community-based treatment alternative for adults with acute psychiatric symptoms, including those with co-occurring conditions. EISS serves persons who are 18 years of age or older, who are experiencing acute symptoms of a mental illness. Services include assessment, psychiatric evaluation, pharmacologic interventions, short-term counseling and psychotherapy, psycho-education, time-limited case management, referral and linkage. The EISS programs are a resource for 988 and crisis centers needing a resource for intensive crisis follow-up services.

Another DMHAS program that fulfill this role is the Certified Community Behavioral Health Clinics (CCBHCs). In 2017, DMHAS was one of eight states that received SAMHSA Demonstration grants to begin operating CCBHCs, which offer comprehensive outpatient services for children, youth and adults who have mental health and or substance use treatment needs. They provide a range of required and core services, including integrated mental health, substance use, and primary care, crisis support, counseling, peer support, and case management, among others. The CCBHC model emphasizes the importance of community needs assessment, which informs the development of a service continuum and engages community partners. The provision of health screening and referral of clients to primary care who are on staff or who are affiliated consultants are core services that are critical to the care of their clients, as is the CCBHC's ability to outreach to individuals in their communities to connect them with

their services.

By integrating, CCBHCs provide a measure of integrated physical and behavioral health care. DMHAS had received two recent five-year SAMHSA grants that have also supported the integration of behavioral health and primary care services. In 2020, DMHAS received its first Promoting Integration in Primary and Behavioral Health Care (PIPBHC) to serve individuals with opioid use disorder (OUD) with health co-morbidities, especially those at high risk for infectious diseases such as HIV and hepatitis. The programs involved HCV/HIV screening and treatment services in methadone clinics affiliated with syringe access programs called Prevention Programs in New Jersey) with affiliated primary care clinics. The grants funded staff and services providing linkages to primary care and treatment of Hepatitis C with direct-acting antivirals, as well as prevention services that address risk factors associated with medical conditions, which in this case are IV and other high-risk drug use and unsafe behaviors.

New Jersey completed the first PIPBHC grant in March, 2025, but began a second five-year PIPBHC grant in September, 2025, that provided integrated behavioral health with coordinated care management (CoCM) for individuals attending three primary care clinics. DMHAS is partnering with Rutgers University Behavioral Health Care (RUBHC) in the NJ PIPBHC-CoCM initiative serves adults with a SMI who have co-occurring mental illness and physical health conditions or chronic diseases. One of the primary care clinics serves children and adolescents with a serious emotional disturbance (SED) who have a co-occurring physical health condition or SUDs. Clinical sites have psychiatric providers (psychiatrists, psychiatric clinical pharmacists, or psychiatric APNs), licensed behavioral health care managers (BHCs), nurse care managers, case managers, and peer navigation supports, and their workflows include warm handoffs to and from the medical team to prescribe medications for AUD and OUD.

In order to further promote and to sustain the integrated care model, DMHAS has begun supporting licensed ambulatory care clinics providing primary care services with the capability to serve individuals with behavioral health needs. Through co-located services, the primary care clinics will be able to provide behavioral health screening and assessment, psychiatric and addictions services MOUD and MAUD, as well as case management, care coordination, and brief interventions.

5. Describe how the state **provides care coordination**, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

- a) Adults with serious mental illness (SMI)
- b) Adults with substance use disorders
- c) Adults with SMI and I/DD
- d) Children and youth with serious emotional disturbances (SED) or substance use disorders
- e) Children and youth with SED and I/DD

- a) Adults with serious mental illness

Care coordination is not generally a billable service in NJ Medicaid for individuals with a serious mental illness (SMI) or any other individuals, with certain exceptions. There are two programs that do routinely provide care coordination as a service that is incorporated into their model of federal reimbursement. Many mental health agencies provide TCM through Medicaid reimbursed integrated case management services (ICMS) that incorporates care coordination and is provided to at risk clients with SMI, especially those who had been recently discharged from a psychiatric hospital.

The state was an original awardee of the Section 223 CCBHC Medicaid Demonstration Grants, has seven certified community behavioral health clinics (CCBHCs) that provide access to a comprehensive array behavioral health care. CCBHCs are required to serve anyone who requests care for mental health or substance use, regardless of their ability to pay, and this is provided to adults, as well as children and youth. In addition to a comprehensive array of behavioral health service, CCBHCs must provide care coordination to help people navigate behavioral health care, physical health care, social services, and the other systems they are involved in.

Behavioral Health Homes (BHHs) address overall health with a whole-person approach to care for individuals with SMI that is provided through care coordination. The services are directed to individuals with SMI who also have chronic medical illness. The BHHs are Medicaid and the original funding was through a Medicaid State Plan option with an enhanced federal match that was originally provided for eight quarters.

Coordinated Specialty Care Community Integration (CSC CI) - NJ has recently expanded its Coordinated Specialty Care (CSC) program for First Episode Psychosis to include Affective Psychosis. Additionally, a stepped care approach (Community Integration or CI) has been added to provide the opportunity for individuals in CSC to remain engaged with their current team. The CI step down program follows the CSC model. CSC is centered around evidence-based practices to optimize a client's overall mental and physical health. The CSC program is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, family members as active participants. CSC provides comprehensive services that include evidence-based pharmacological treatment, supported employment and education services, individual and group psychotherapy, care management, family therapy, and recovery support in community and clinical settings. The CI program is designed to address the need for the CSC continuum of care. The programs will provide continued treatment for the client after the client has completed the CSC program. The CI program will use the "Stepped-Care" treatment model where clients can titrate up or down the level of service modality depending on their recovery and/or the need for additional services and supports. Individuals in the CI program will receive more or less intensive care and units of service in accordance with their assessed need and treatment plan. Individuals will continue to receive CI services from their current treatment team in order to preserve continuity of care. CSC and CI programs provide a supportive environment where the client can access an array of services and remain connected in the community. Treatment and supports will be geared toward: reintegration of the client into the community, return to school/work, symptom stabilization, diversion from inpatient services, a decrease in screening center utilization, decrease in duration of untreated illness, increase in medication adherence, increase in level of functioning, decreasing hospital recidivism, and integration of health and behavioral health via continuity of care between the CSC-CI APN or psychiatrist and the client's primary care practitioner.

Individuals with a mental health issue can receive case management services through a myriad of services. The DMHAS, in collaboration with the Division of Medical Assistance and Health Services (DMAHS), submitted a State Plan Amendment to CMS requesting permission to provide a new Medicaid billable rehabilitation service. Community Support Services (CSS) is a rehabilitation service that provides consumers with the supports and services necessary to achieve their life goals. Included in the rehabilitative services that are part of the Individualized Rehabilitative Plan (IRP) is case management that is done any number of credentialed staff, but is usually done by a bachelor level staff or a certified peer. This service works to connect the consumer with medical, dental, behavioral health, housing resourced and entitlements.

Care coordination is structured so the consumer seeking assistance, is provided care coordination's through the staff such as PATH worker, Intensive Case Management Services (ICMS), PACT workers, etc. services are done with and on behalf of a consumer and is a Medicaid billable service.

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

As a long-term program, in which the course of treatment has no pre-determined end point, most New Jersey PACT teams are staffed with eight to ten full-time equivalent direct care staff and can serve between 70-75 person receiving services at any point in time. There are 31 PACT teams in New Jersey, serving all of the 21 counties. The SMHA contracts with 10 different non-profit agencies that operate these teams. Since state fiscal year (SFY) 2010, the SMHA has expanded 20 of the 31 teams with additional staffing. As an Evidence-Based Practice (EBP), ACT is endorsed by SAMHSA. PACT will continue to be integral to enhancing the network of community mental health services. Teams have responded to COVID-19 with strategies to maintain face-to-face services by utilizing personal protective equipment, telehealth interventions, and vehicle protective equipment.

b) Adults with substance use disorders

ReachNJ is a 24-hour helpline for people seeking help with substance use disorders.? A caller to ReachNJ receives a screening and, when appropriate, is given a referral to treatment.? The ReachNJ staff then track that referral. If the caller has not been contacted

by the provider within 72 hours, the ReachNJ Care Coordination staff reach out to the caller and to the provider to explore the lack of connection and offer assistance.? Care Coordination was offered to callers who were given a referral to treatment by the ReachNJ call center but did not attend their schedule appointments. REACH staff reach out to these callers to see if they can address any barriers to engagement or make a new referral.

NJ has several treatment initiatives that focus on coordinating services.? As mentioned previously NJ is a CCBHC Demonstration State.? CCBHC's offer significant care coordination to the clients enrolled in that service and NJ tracks the numbers of client who receive that service and in the most recent data analysis 77% of CCBHC enrolled clients were receiving the case management/care coordination.

NJ recognizes the value of care coordination for integrating physical health and behavioral health.? As mentioned above, the Nurse Case Manager program and NJ's PIPBHC teams include a care coordinator to assist in coordinating care and providing case management.?

Support Team for Addiction Recovery

Support Teams for Addiction Recovery (STAR) provide case management and recovery support services for individuals with opioid use disorders (OUD). The STAR initiative is comprised teams, with each team consisting of a program supervisor, two case managers and two recovery staff. The team maintains a caseload of 40 individuals. STAR case managers work with individuals to? assist?with issues that often occur concurrently with an OUD, such as homelessness, legal issues, employment, education, transportation, need for social services, health care, child welfare involvement, child care, health insurance, etc. The STAR recovery staff provide non-clinical assistance and recovery support services. The overall goal of STAR is to help individuals with an OUD achieve and maintain recovery, help decrease the risk of recurring episodes of opioid related problems, and prevent future overdose. STAR programs in all 21 NJ counties are funded by the SOR grant. In early 2020, services were expanded in 10 counties to enable STAR to serve individuals newly-released from county correctional facilities. As of June 30, 2025, 6,189 persons have been served by STAR teams.

Opioid Overdose Recovery Program

The Division provides supports and case management services to individuals who have overdosed or who are at risk of overdose. The Opioid Overdose Recovery Program (OORP), which has peer staff respond to individuals who have been reversed from opioid overdoses (by police, emergency responders, or friends/family) or admitted for drug-related injury to a hospital emergency department. OORP utilizes Recovery Staff and Patient Navigators to engage the individuals reversed from an opioid overdose to provide non- clinical assistance, recovery supports and appropriate referrals for assessment and substance use disorder treatment. The Recovery Staff and Patient Navigators also maintain follow-up with these individuals for a minimum of 8 weeks after the initial contact. Recovery services provided for these individuals are fundamentally strengths-based. Additionally, Recovery Coaches and Patient Navigators deliver or assertively link individuals to appropriate services and provide support and resources throughout the process. Recovery Staff provide take-home naloxone kits to the persons with whom they've worked. OORP services are available 24/7 in 20 of New Jersey's 21 counties. As of June 30, 2025; 31,814 individuals have been served by OORP.

DMHAS was able to provide Governor's Initiative funding to 17 OORPs to expand services. The funds enable them to serve individuals who did not experience an overdose, but who present in the emergency department with issues attributable to opioid use disorder. These individuals are also able to receive OORP services as described above. Effective July 2021, expansion services were funded by the SUPTRS.

Recovery Support Care Management (RSCM).

Recovery Support Care Management (RSCM) was established and effective on March 7, 2023 and is a behavioral health service intended to support consumers who have a SUD with complex physical and/or psychosocial needs. It is now available in the SUD Fee-for Service initiative. RSCM provides direct and comprehensive assistance to consumers to ensure access to the necessary treatment, rehabilitative and recovery services with the intent of decreasing psychiatric and addiction symptoms, connect consumers with services, improve transitions between levels of care, implement strategies to address their unique needs, decrease opioid related deaths and sustain recovery in the community while supporting the consumers' continued stability and recovery throughout the continuum of care. This service is available as an enhancement in all levels of care. This service may be provided face-to-face or via a telehealth platform. Since Medicaid offers Care Management in outpatient, RSCM is excluded from reimbursement for consumers admitted into Ambulatory LOCs in Recovery Care Efficiency (RCE). RSCM is being funded with SUPTRS Block Grant COVID-19 Supplemental and will continue with ARPA funding until September 30, 2025. As of March 31, 2025, there were 4,615 unduplicated clients who received this service.

c) Adults with SMI and I/DD

DMHAS, DDD and DBHS DOH work collaboratively to monitor adults with SMI and I/DD in the state psychiatric hospitals from the point of admission to discharge. DDD has 6 full time Transitional Case Managers (TCMs) assigned to the state hospitals. Their primary responsibility is to focus on adults with SMI and I/DD individuals 21 years and older eligible for Division services. The TCMs interface not only with the hospital treatment teams, but primarily with the DDD Hospital Liaison; a supervisory level Social Worker who tracks all of the patients with SMI and I/DD or who are applying for services from DDD in their respective hospital. The TCMs are also responsible for providing reports for the Conditional Extension Pending Placement (CEPP) hearings detailing referrals forwarded for community placement.

As individuals with SMI and I/DD are admitted into the state psychiatric hospitals, both the Olmstead Diversion Unit and the DDD Community Transitions Unit are tracking the admissions and ensuring that the hospital treatment teams are provided with the patients Community Care Program (CCP) eligibility status, ability to return to prior placement, and level of care so that joint discharge planning may begin. Individuals who are found not to meet level of care are routinely reassessed for eligibility.

On a monthly basis, meetings are held at each state psychiatric hospital with members of the Olmstead Diversion Unit, DDD Community Transitions Unit, state psychiatric hospital staff and representation from the Crisis Assessment Response and Enhanced Services (CARES) team. Each DD/MI case in the hospital is reviewed, discharge planning is discussed, and assistance is provided to address any discharge barriers or systems issues. In addition, bi-weekly conference calls take place with administration from the Olmstead Diversion Unit and DDD to discuss higher level systems issues and cases that are in need of administrative level intervention. Olmstead Diversion Unit works collaboratively with DDD's administration to decrease admissions to state psychiatric hospitals of adults with SMI and I/DD who are in the community or referred by DBHS DOH's Centralized Admissions Unit in need of housing.

d) Children and youth with serious emotional disturbances or substance use disorders

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

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

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.

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

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

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

Services are provided based on medical necessity.

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

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

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

e) Children and youth with SED and I/DD?

CSOC serves as the state entity that determines IDD eligibility for youth 0-18 and provides a full continuum of care for youth with IDD and SED. A broad array of treatment and habilitation services are available in the community including in-home habilitation, applied behavior analysis services, respite, summer camp, educational advocacy, assistive technology and we provide funding for home-based modifications to accommodate physical access needs. For youth who cannot be safely served in the community and who exhibit severe and challenging behaviors we have a continuum of out of home treatment programs designed to stabilize youth and develop skills necessary to transition back to their communities. In addition, we offer family/caregiver peer support through the MOM2MOM hotline and our Family Support Organizations. Lastly, we work seamlessly with our partners at the Division of Developmental Disabilities to facilitate transitions into the adult services continuum as needed.

6. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and substance use disorders**, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

The CY 2022 Substance Abuse Overview indicate that for individuals who were discharged from treatment, 49,635, or 59% had a co-occurring disorder. It is important for DMHAS to address SUD clients who also have a co-occurring mental health disorder.

One initiative that has increased care for individuals with COD is the CCBHC. New Jersey is a CCBHC Demonstration State. NJ serves a significant number of individuals in the CCBHC program. In Year 6 of the Demonstration (July 2022-June 2023), the most recent year for which we have data, 21,994 individuals were treated in the CCBHC. All individuals treated in the CCBHC receive an array of screenings including screening for SUD. Increasing numbers of individuals that when screened, can be identified and treated for a COD. In Year 3 of the CCBHC 21% of individuals who presented for care for SMI were identified as having unhealthy drug use. In Year 4 that number rose to 29%, in Year 5 it rose to 52%, and was at 42% in Year 6.

Beginning in SFY 2010, the SSA established a Co-Occurring Services Network (COSN) comprised of 53 treatment providers to provide treatment to clients with co-occurring disorders on a Fee for Service (FFS) basis. Now, agencies eligible to join the SUD FFS Initiatives Network as a Co-Occurring Provider must meet New Jersey Department of Health (DOH) Office of Certificate of Need Licensing (CN&L) requirements for co-occurring licensing approval. As of SFY 2025, there are approximately 135 agencies in the COSN that represent 247 individually licensed sites with co-occurring approval. Authorization to provide co-occurring services is predicated on agency's co-occurring licensing approval.

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

The SUD FFS Initiatives Network reimburses the following Co-occurring services: Case Management, Clinical Consultation, Comprehensive Intake Evaluation, Crisis Intervention, Family Therapy, Group Therapy, Individual Therapy, Medication Monitoring, and Psychiatric Evaluation.

The COSN has helped community SUD agencies, advocates, as well as individuals who have a substance use disorder and co-occurring mental illness, realize "one-stop", "treatment on demand", or "no wrong door" access to care.

Additionally, in March 2023, a Recovery Support Care Management (RSCM) service was introduced as a behavioral health service available to support consumers who have a SUD with complex physical and/or psychosocial needs. RSCM provides direct and comprehensive assistance to consumers to facilitate access to the necessary treatment, rehabilitative and recovery services. RSCM is designed to decrease psychiatric and addiction symptoms, connect consumers with services, improve transitions between levels of care, implement strategies to address their unique needs, decrease opioid related deaths, sustain recovery in the community and support the consumers' stability and recovery throughout the continuum of care.

Children's System of Care

The Children's System of Care offers an array of substance use treatment services for youth and young adults, including four withdrawal management beds, contracted outpatient/intensive outpatient services through 9 providers statewide, partial care

services through one provider, and short term out-of-home treatment through one provider with 19 beds.? In addition, residential treatment services for youth with co-occurring substance use needs and significant behavioral health needs can be accessed through the CMO from five providers with a total of 54 beds.

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

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

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

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

Substance use treatment services are authorized without regard to income, private health insurance, or eligibility for FamilyCare. The types of substance use treatment services offered through CSOC include:

Outpatient (Level 1) – consists of less than 6 hours of service per week for adolescents including individual, family, and group therapy/counseling, including co-occurring services.

Intensive Outpatient (Level 2.1) – consists of more than 6 hours per week of day treatment for adolescents including individual, family, and group therapy/counseling, including co-occurring services.

Partial Care (Level 2.5) – consists of 20 hours per week for adolescents including educational programming, individual, family, and group therapy/counseling, including co-occurring services.

Co-Occurring OOH Treatment (Level 3.5 and Level 3.7) – consists of residential services for adolescents/young adults providing 24-hour care with dually licensed clinicians including individual, family, and group therapy/counseling, including co-occurring services.? Level 3.7 also provides 24-hour nursing care and a more intense clinical program, offering more hours of clinical services including individual, family, and group therapies by a dually licensed clinician, as well as an increased ratio of direct care staff to youth.

Medically Monitored High Intensity Inpatient-Withdrawal Management (Level 3.7 WM) - Medically monitored withdrawal management, providing medical and nursing 24-hour care, evaluation, and withdrawal management in an agency with inpatient beds.

Co-Occurring Behavioral Health/Substance Use Treatment Program – provides 24 hours supervised, , 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.

7. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and intellectual/developmental disorders (I/DD)**, including screening and assessment for co-occurring disorders and integrated treatment that addresses I/DD as well as mental disorders. Please describe how this system differs for youth and adults.

Through Division public bidding and funding, a 24-hour supervised group home, for persons with a co-occurring mental illness and an intellectual disability, became operational in November of 2023. This five (5) bed transitional setting is designed for adequate throughput and the ability to take referrals from acute hospital settings, including emergency departments. Standard group home residence staffing is supplemented by access to advance practice nursing and behavior staff. To date, seven (7) persons have resided in the program, with four (4) moving on to lower intensity supportive housing settings.

In New Jersey, addiction services for children and youth primarily must provide a level of care and services that address their developmental and social needs. The Children's System of Care (CSOC) in the Department of Children and Families (DCF) oversees services for individuals under 21, focusing on family-centered, community-based care. PerformCare is a single point of entry, but services for those with SED are administered by Care Management Organizations (CMOs). While CSOC has treatment and prevention services, DMHAS provides services for adults across the continuum of care, including prevention, early intervention, treatment, and recovery support, and it may offer a wider array of outpatient and residential services to address adults' need for addiction services. Referrals to DMHAS contracted addiction services are made through ReachNJ call center, where a warm handoff may be made. Additionally, all adult admissions are entered into a client registry- the NJSAMS database. Many DMHAS contracted programs of which have peer staff and focus on recovery supports. Outpatient services outpatient, intensive outpatient, partial care, and opioid treatment programs, as well as a co-occurring services in certified Behavioral health clinics (CCBHCs) and a network of outpatient providers. Another difference of the adult system compared to the children's system is a greater focus on providing medication assisted treatment, as well as withdrawal management services.

Children's System of Care

The Children's System of Care (CSOC) is responsible for determining eligibility for Developmental Disability (DD) services for children under age 18. Families apply for DD eligibility through the CSOC established process. The CMOs and MRSS agencies work with family members enrolled with them to apply for DD eligibility determinations. The Division of Developmental Disabilities (DDD) continues to determine DD eligibility for individuals aged 18 and over, and the CSOC provides services to those youth until age 21. DDD and CSOC collaborate through an established protocol to provide a seamless transition to adult services once the youth turns 21.

Intensive In-Home: IIH Supports

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

Clinical and therapeutic interventions (IIH Clinical)- These services are rehabilitative, focused on the restoration of a youth's functional level after an acute episode or decline in functioning related to mental illness or a significant life stressor.

Behavioral-Applied Behavior Analysis (IIH Behavioral-ABA)- A set of habilitation services, designed to decrease dangerous behaviors while assisting youth in acquiring and retaining self-help, communication, and adaptive skills. Services focus on helping youth learn these skills while working with and training the youth's parent or caregiver to implement a behavior plan.

Individual Support Services (ISS)- ISS provides skill development for activities of daily living, including self-care tasks that enable an individual to live independently in the community.

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

Respite means "break" or "relief." Respite services are intended to provide temporary relief for the primary caregiver from the demands of caring for an individual with disabilities during the times when the caregiver would normally be available to provide care. The service relieves family members from care responsibilities on a temporary basis for short periods of time. There are several different settings for respite, including home-based, agency after-school, overnight stays, and weekend recreation. Please note that respite services are dependent upon funding and provider availability.

Assistive Technology is designed to increase the functional skills of a youth with a developmental disability and enhance their ability to live successfully in the community. An assistive device is an item to increase, maintain, or improve functional capabilities of the youth, and is not solely therapeutic. Vehicle and home (environmental) modifications are also included in this category. It must be an item not covered by medical insurance and cannot be used to restrain the youth.

Educational Advocacy is a service provided to youth and their families when the youth needs in-depth help with education-related needs.

Summer Camp offers limited financial support for eligible youth to attend summer camp. Youth can attend a mainstream camp, as long as the camp becomes qualified as a camp provider through CSOC. Funding for One-to-One Aide services may also be available for youth deemed eligible.

In new Jersey, services for children and adults with intellectual and developmental disabilities (ID/DD) differ primarily in the types of support offered and the focus of those services. Children's services emphasize early intervention and developmental milestones, while adult services focus on independent living, employment, and community integration. Adult services (age 21 and older) for ID/DD are administered and provided by the NJ Division of Developmental Disabilities, while the Children's System of Care (CSOC) in the Department of Children and Families (DCF) oversees services for those with ID/DD up to age 21.

8. Please indicate areas of **technical assistance needs** related to this section.

DMHAS seeks technical assistance for its CSC CI programs to develop a fidelity tool for the CSC CI model. DMHAS was utilizing the fidelity tool developed by OnTrackNY for the FEP programs. However, since the programs have expanded to include affective psychosis and a stepdown program using the CSC model, DMHAS would like to evaluate the appropriateness of CSC for these individuals and evaluate fidelity to the model.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

2. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) – 10 percent set aside – Required for 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 individuals 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 as soon as possible following initial symptoms and reducing possible lifelong negative impacts such as loss of family and social supports, unemployment, incarceration, and increased hospitalizations *[Note: 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 SMI or SED]*. The duration of untreated mental illness, defined as the time interval between the onset of symptoms and when an individual gets into appropriate treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be a negative prognostic factor. However, earlier treatment and interventions not only reduce acute symptoms but may also improve long-term outcomes.

The 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-5TR (APA, 2022). 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 the 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 experiencing first episode of psychosis (FEP). RAISE was a set of federal government- sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The 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.

States 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 experiencing 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.

Please respond to the following items:

- 1. Please name the evidence-based model(s) for ESMI, including psychotic disorders, that the state implemented using MHBG funds including the number of programs for each.

Model(s)/EBP(s) for ESMI	Number of programs
Coordinated Specialty Care RAISE Model: Manual I: Outreach and Recruitment and Manual II: Implementation.	5.00
	0.00
	0.00

	0.00
	0.00
	0.00

2. Please provide the total budget/planned expenditure for ESMI for FY 26 and FY 27 (only include MHBG funds).

FY2026	FY2027
2,795,673.80	2,795,673.80

3. Please describe the status of billing Medicaid or other insurances for ESMI services. How are components of the model currently being billed? Please explain.

Providers bill Medicaid and private insurance for CSC and step-down services, otherwise known as CSC CI (Coordinated Specialty Care Community Integration) services. DMHAS staff met with David Shern, NASMHPD requesting technical assistance for implementing HCPCS Codes for Coordinated Specialty Care through the Use of a State Plan Amendment. Intended Outcome of technical assistance: Development of a sustainable funding strategy using Medicaid bundled codes for reimbursement of the services rendered in the CSC program and the step-down program.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI.

The Division of Mental Health and Addiction Services (DMHAS) first implemented Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP) in 2016. Since inception, CSC programs have gone through a rapid expansion. The initiative was covered statewide by three providers and designed to serve 105 clients annually. The statewide CSC initiative was serving double the clients at 210 annually with some clients still receiving service after two years in the program. The three providers covered 7 counties each. This presented challenges for providers covering such a vast territory as well as for individuals due to time spent traveling to the agency and the lack of access in the county of residence. The original teams could not serve individuals with affective psychosis and were receiving many referrals and requests for services to those in need. Most outpatient programs did not specifically fit the programmatic needs of an individual discharged from a CSC program.

In 2023, NJ expanded its Coordinated Specialty Care (CSC) program for First Episode Psychosis to include Affective Psychosis. A stepped care approach (Community Integration or CI) was added to provide the opportunity for individuals to continue after the CSC two-year program and to remain engaged with their current team. There are currently five funded teams and a sixth region that is not currently covered. The staffing for each team has been increased to provide for a caseload of 200 in its first full year of operation (2025-2026), 300 in year two (2027) and 400 in year three and beyond (2028 and continuing). Individuals ages 15-35 are eligible for the CSC program that have an Early Serious Mental Illness diagnosis for less than or equal to 2 years at the time of admission to the CSC program. CSC-CI program is for individuals 15 years of age and older with an ESMI diagnosis that is non-organic.

The CSC program is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, family members as active participants. CSC provides comprehensive services that include evidence-based pharmacological treatment, supported employment and education services, individual and group psychotherapy, care management, family therapy, and recovery support in community and clinical settings. Services provided to individual clients in a CSC program usually do not exceed 2 years.

The CI program is designed to address the need for the CSC continuum of care. The Stepped-Care treatment approach is a "3 tier" system where clients can titrate up or down the level of service modality depending on their recovery and/or the need for additional services and supports. Individuals in the CI program will receive more or less intensive care and units of service in accordance with their assessed need and treatment plan. Individuals will continue to receive CI services from their current CSC clinicians, prescribers, Supported Employment and Education Specialist and Certified Peer Recovery Specialist, in accordance with assessed level of need in order to preserve continuity of care and support.

CSC CI programs have improved the quality of care for the First Episode and Affective Psychosis population in New Jersey. By the end of the fiscal year 2022, the CSC program had received approximately 1635 referrals and treated 719 clients. The psychotropic medication adherence rate was 91% in FY 2022, compared to the national average for medication adherence in FEP populations that can vary from 40 to 60%¹¹. By the end of the fiscal year 2025, the CSC CI program had received approximately 3466 referrals and treated 1285 clients. The psychotropic medication adherence rate was 81% in FY 2025.

CSC CI programs provide a supportive environment where the client can access an array of services and remain connected in the community. Treatment and supports will be geared toward reintegration of the client into the community, return to school/work, symptom stabilization, diversion from inpatient services, a reduction of screening center utilization, reduction in duration of untreated illness, increase in medication adherence, increase in level of functioning, reducing hospital recidivism, and integration

of health and behavioral health via continuity of care between the CSC-CI APN and the client's primary care practitioner.

5. Does the state monitor fidelity of the chosen EBP(s)? ☒ Yes ☐ No

6. Does the state or another entity provide trainings to increase capacity of providers to deliver interventions related to ESMI? ☒ Yes ☐ No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI.

DMHAS expanded the CSC program to include a step-down component as part of its continuum of care for early psychosis. The Community Integration program provides a seamless transition for individuals from the CSC program to less intensive service while remaining with their originally assigned team. Individuals can remain enrolled in the CI program as long as clinically indicated with the ability to step up to more intensive services if necessary. In order to address the referrals that the CSC programs were receiving for individuals with affective psychosis, DMHAS expanded the diagnostic criteria for admission to the CSC/CI programs to include both First Episode Psychosis and Affective Psychosis. The program expansion also increased coverage in the State from 3 CSC teams to 5 CSC/CI teams. Each of the 5 teams have an increased number of FTEs from 6 to 12.

8. Please describe the planned activities in FY2026 and FY2027 for your state's ESMI programs.

Planned activities for NJ CSC/CI providers are to participate in a CSC Learning Collaborative. DMHAS team leads plan to visit each of the CSC/CI sites for monitoring purposes. CSC CI providers are seeking to procure additional training for FY 2026.

9. Please list the diagnostic categories identified for each of your state's ESMI programs.

The current client diagnostic criteria for Coordinated Specialty Care (CSC) for First Episode Psychosis and Community Integration 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

- Affective Psychosis (onset generally early 20's) refers to: Major Depressive Disorder, Persistent Depressive Disorder (Dysthymia), Bipolar 1 Disorder, Bipolar II Disorder, Mixed Episode disorder, Mood disorder and Cyclothymic Disorder

10. What is the estimated incidence of individuals experiencing first episode psychosis in the state?

It is estimated that the FEP incidence rate in New Jersey per year is .0003 (3 per 10,000).

11. What is the state's plan to outreach and engage those experiencing ESMI who need support from the public mental health system?

Each agency providing CSC services has a master's level clinician that serves as an outreach coordinator whose sole responsibility is to disseminate information on CSC and CSC CI programs to potential referral sources such as Emergency Departments, schools, colleges, police departments, religious institutions, and other mental health agencies. Each of the five awarded agencies identified in their RFP submission details on how they will outreach and provide services to all individuals within their catchment area.

12. Please indicate area of technical assistance needs related to this section.

DMHAS CSC/CI team leads and NJ CSC/CI provider agencies received a 3-day training which covered Evidenced Based Practices for Early Serious Mental Illness (ESMI) including First Episode Psychosis (FEP) from OnTrack New York. The training included modules on developing strategies and incorporating methods utilized by providers on how to engage consumers in groups and family psychotherapy, and modules on EBP's including but not limited to CBT, CBT-Psychosis, CBT-TIC, Individual Placement and Support, Person-Centered Therapy, Motivational Interviewing, Cognitive remediation, Trauma treatment, Peer wellness coaching, Individual Resiliency Training (IRT), Psychoeducation, Supported Education and Employment.

Topics that we are requesting for our CSC CI programs to receive technical assistance including development of a Learning Collaborative with specific case examples that are discussed for team development, fidelity, sustainability and growth for CSC CI team members.

The DMHAS CSC CI program leads received TA from National Association of State Mental Health Program Directors (NASMHPD) to assist with working with Medicaid and third-party payers to set a bundled rate for CSC and speak with states that have been successful in working with third party payers in negotiating bundled rates and/or payment for CSC. Technical assistance in the development of regulations and state plan amendment for CSC is currently being provided.

The DMHAS CSC/CI team leads are requesting technical assistance in learning about and adopting effective Needs Assessment methods used in other CSC programs in the country and assistance with developing a benchmark for CSC programs against other CSC programs in the country when reporting performance measures.

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Footnotes:

Additional information for Question 1:

Total of 5 programs funded and operational. Covid Supplemental, ARPA, and MH Block Grant funds were utilized to implement the CSC CI programs. The 5 programs cover 5 of the 6 subregions of New Jersey. One region is currently not covered.

Additional information for Question 5:

DMHAS monitored fidelity prior to the pandemic and will be resuming its visits to the agencies in 2026. We are requesting further technical assistance from OnTrack NY to help us develop a new fidelity tool for the NJ model inclusive of the expanded diagnostic criteria for early affective psychosis as well as the tiered step-down model.

Additional information for Question 6:

Each provider agency was provided \$10,000 for training and recruitment upon award. OnTrack NY provided a 3-day training for the CSC/CI teams and DMHAS CSC/CI program leads.

Environmental Factors and Plan

3. Person Centered Planning (PCP) – Required for MHBG, Requested for SUPTRS BG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning (PCP) is a process through which individuals develop their plan of service based on their chosen, individualized goals to improve their quality of life. The PCP process may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. PCP resources may be accessed from <https://acl.gov/news-and-events/announcements/person-centered-practices-resources>

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 people with SMI and their caregivers in making health care decisions, and enhances 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 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 25 consumer-run Wellness/Self-Help Centers statewide, as well as many initiatives to train and support peer specialists (these are described elsewhere). DMHAS initiatives also encourage the engagement of caregivers. DMHAS empowers family members of those with a mental illness in its ongoing programs of Intensive Family Support Services (IFSS) that are situated statewide. Family members work with professionals to acquire the knowledge, skills and supports they need to improve functioning and gain a sense of control.

In the last year, DMHAS used a TTI grant for training in Recovery-Oriented Cognitive Therapy (CT-R) at four Behavioral Health Homes; the initiative implemented a "Train the Trainer" approach through a collaboration between the Aaron T. Beck Center, the New Jersey Division of Mental Health and Addiction Services (DMHAS) and Rutgers-University Behavioral Health Care (R-UBCH). The trainees included team nurses (LPNs), nurse care managers, wellness coaches, care managers, program directors, Behavioral Health Home (BHH) outpatient clinicians and therapists, partial care coordinators, dual disorder specialists, population health managers, mental health specialists, as well as peer support specialists of the BHH Team. This project demonstrated that training peers in CT-R in Behavioral Health Home settings improves the effectiveness of peer support specialist and empowers them in assisting consumers in recovery. DMHAS also has a contract with NAMI New Jersey to support their activities and efforts with family members.

After DMHAS saw the benefits of CT-R in this initiative, a TTI-funded initiative trained peer specialists to use CT-R in their work with individuals in outpatient programs who were adversely affected by COVID. From these initiatives, DMHAS recognized that CT-R had great potential in helping seriously mentally ill individuals meet their recovery goals. In 2023, DMHAS awarded funding from SAMHSA mental health block grant to the Beck Institute to develop a Center of Excellence for CT-R and began to provide training and technical assistance to outpatient providers statewide. Initially, Beck has initially CT-R focused training on Community Support Services and Group Home programs. A unique aspect of the program is the use of personalized incentives to help promote individuals' recovery-oriented goals. Beck is developing project components that will promote and sustain the COE

initiative, including a dedicated website, and it will also conduct a full evaluation of the project.

In cooperation with Rutgers University 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. The program emphasis the integration of physical health into behavioral health to prevent or decrease the risk of chronic disease and to promote positive behavioral changes (including smoking cessation, healthy diet, medical testing, and medication options) that reduce health risks. DMHAS also developed a 'Shared Decision Making around Medication' tool that guides consumers on how to prepare for medication appointments and create a record for future use. The tools are also posted on the DMHAS website for access and use.

DMHAS continues to support consumers' development of Psychiatric Advance Directives (PADs) to express their wishes about their mental health care and other assistance during a personal mental health crisis. DMHAS implemented an electronic registry of PADs by contracting with U.S. Living Will Registry, so that providers and consumers can retrieve PADs during episodes of crisis care. The database of PADs is held in a confidential and secure site, which is protected by the most up-to-date web and database security standards, and this can only be accessed by the consumer or by authorized individuals. Having PADS accessible through the electronic registry significantly increases the probability that an individual's PAD is available to providers when they are in crisis.

DMHAS also supports training to the provider community about how to engage consumers and promote their decision-making about their recovery. Illness Management and Recovery (IMR) training and follow up consultation and technical assistance is conducted by Rutgers-UBHC with the support of DMHAS. IMR includes: medication management; education and training on relapse identification, prevention and recovery; relapse prevention and behavior modifications in order to replace undesirable behaviors with healthy and productive behaviors designed to prevent relapse and promote recovery. Also, before DMHAS transfer to DHS, it held a Statewide Wellness Committee with representatives of each of the four state hospitals to promote person centered planning, and assist with wellness initiatives and programs. Individuals with lived experience were active participants on the committee.

4. Describe the person-centered planning process in your state.

DMHAS Vision

- DMHAS envisions an integrated mental health and substance use 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 access to appropriate and effective person- centered 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, hope and positive outcomes;
- evidence-based practices that show consumer-informed and peer-led services improve and enhance the prevention and treatment continuum;
- the public trust and believe that it is essential to provide effective and transparent services

A person-centered planning process is integrated in a number of services offered to individuals in New Jersey. Mental Health Services include Illness Management and Recovery (IMR), Supported Employment (SE), Coordinated Specialty Care Community Integration (CSC CI), Community Support Services (CSS), all licensed treatment services (Outpatient, PACT), ICMS and licensed residential Services. Substance Use Services include Support Teams for Addiction Recovery (STAR), Opioid Overdose Recovery Program (OORP), Recovery Management Check Up (RMC), Telephone Recovery Support (TRS), Intensive Recovery and Treatment Support (IRTS), Community Peer Recovery Centers (CPRC), all licensed ASAM-required level of care treatment services, and Prevention services. These services are described in depth in Step 1 of SUPTRS. 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/clients' goals are typically tied to a role and environment that they would like to attain or successfully remain in.

The SMHA has incorporated IMR into the foundation of principles and practices central to a recovery-oriented, person-centered system of community mental health services; decrease symptoms, reduce relapses and hospitalizations and make progress towards personal goals through recovery. IMR is incorporated into the partial care systems and it is supported by the regulations. It is incorporated into the supportive housing now CSS systems. SE begins with a discussion of consumers' preferences field of work, occupation and or job. The consumer's employment background is reviewed to determine transferable skills and then individualized job development initiated based upon the consumer's choice. While SE begins with paid support, natural supports provided by family, co-workers, friends or others are identified.

Coordinated Specialty Care Community Integration (CSC CI) 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. The core treatment methods address PCP in client care through engaging the client in weekly sessions to improve their quality of life while reducing symptomology. All of the CSC CI service modalities use PCP that include Supported Employment and Education, Peer Support, Medication Monitoring, family therapy, as well as individual and group psychotherapy.

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

New Jersey PACT's consumer-centered services begins with comprehensive assessment and recovery planning. Team members meet with the consumer to gather historical information and assess current functioning. The consumer is encouraged to actively participate in this process, sharing expectations and desired outcomes of their involvement with PACT services. Consistent with PACT's evidence base, consumers are involved in a collaborative goal-setting process that flows from the information obtained from the initial assessments into development of mutually agreed-upon goals and objectives.

Staff interventions are designed to support these goals and to help the consumer maintain focus on recovery. Incorporating consumers' lived experience is key to developing collaborative recovery plans, and at each recovery plan update, the consumer is invited to discuss their perception of their progress toward their goals and about any new directions they would like to explore. In the event that the consumer and the staff differ in their perspectives, the staff defer to the consumer to the greatest extent possible, with the goal of supporting successive approximations of shared goals.

New Jersey focuses on person-centered planning as the foundation of providing services to individuals with mental health needs. Regulation N.J.A.C. 10:37-5.59 1 specifies that each individual shall be involved in determining their service goals, and documentation of their participation (see below for reference). The use of Psychiatric Advance Directives to ensure the services are person-centered is also utilized in NJ for licensed services. For individuals enrolled in ICMS, PACT, Outpatient, residential and licensed and contracted services in NJ it is the expectation that the services are all person centered, with the individual having involvement in determining their treatment goals. Additionally, NJ is focused on a Wellness and Recovery model of service as evidence in our Mission statement (Below for reference). This is a person-centered approach that believes in the individuals ability recover and focus on their strengths and stated goals.

The State of NJ has Certified Community Behavioral Health Clinics (CCBHC) . One required element of the CCBHC is person centered treatment planning. NJ monitors and assesses the CCBHC providers on the delivery of PCP to the individuals that they serve. NJ is also developing a CCBHC Medicaid State Plan Amendment which will continue to require that the CCBHCs provide PCP to all individuals served.

DMHAS Mission

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

N.J.A.C. 10:37-5.59 1. Each client shall be involved in determining service goals, modalities of treatment and timetables, to the extent that his or her condition permits. Participation should be documented by having the client's signature on the plan. (See N.J.A.C. 10:37-6, Article VIII.) Client involvement shall include the development, modification, execution, and registration of an advance directive for mental health treatment if the consumer, after receiving complete information about such directives, wishes to designate either a mental health representative or to execute an instruction directive.

Person-centered planning by Children's System of Care (CSOC)

The goal of the Department of Children and Families' (DCF) 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. Protective of the rights of youth and their family/caregivers; and
- G. 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.
- Learning and incorporating the youth and family's values, preferences, and interests into the planning process
- Community Based – identifying and utilizing supports that are least restrictive, accessible, and sustainable to maintain and strengthen the family's existing community relationships.

Child Family Team (CFT)-Wraparound Approach

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

CFT members include, but are not limited to, the following individuals:

- Child/Youth/Young Adult
- Family Support Partner
- Parent(s)/Legal Guardian
- Care Management Organization
- Natural supports as identified and selected by youth and family
- Treating Providers (in-home, out-of-home, etc.)
- Educational Professionals
- Physical Health Providers (pediatrician, specialist)
- Probation Officer (if applicable)
- Child Protection & Permanency (CP&P) (if applicable)

Family Support Organizations

Family Support Organizations are operated by 15 agencies under contract with CSOC to: ensure that service plans developed for families are child-centered and family-focused; provide support to families through peer counseling, family training and workshops; advocate for families at the local level with other system partners; and cultivate and empower youth development consistent with the wellness and recovery model. The FSOs offer support to families of youth with behavioral health needs, substance use needs, and intellectual and developmental challenges. Family Support Partners within the FSOs are assigned to each family of youth enrolled in CMOs to offer and provide individual family peer-to-peer support. Additionally, the FSOs offer community-based supports to all youth and families in their service area. They provide community outreach and education on peer support and CSOC, family and youth support groups, youth partnership structure and activities, and telephonic support for families. The FSO NJ Alliance is contracted to provide training and technical assistance to FSOs.

Contracted System Administrator (CSA)

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

The CSA creates a common single point of entry for youth and families. The CSA registers all youth requesting services and authorizes services in a single electronic record. The CSA tracks and coordinates care for all New Jersey youth enrolled in CSOC.

CSOC retains all regulatory and policy-making authority. The CSA is not a pre-paid health plan; instead, it functions as and is inclusive of the activities of a non-risk Administrative Services Organization (ASO). As such, there are key functions that remain the responsibility of CSOC, including, but not limited to, network development, provider contracting, and provider outcome standards. As a partner to CSOC, the CSA provides administrative support and is encouraged to offer recommendations for improvements to the delivery of services which may be implemented with the approval of CSOC.

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

- Providing a Call Center with 24-hour/7-day intake and Customer Service capability;
- Providing a web-based application/interface with the CSA's Management Information System (MIS);
- Managing care, which includes utilization management, outlier management (including authorization of services), and care coordination; if youth are involved with a Care Management Organization, PerformCare reviews service requests based on the youth's comprehensive plan of care which is developed by the Child Family Team (CFT).

- Coordinating access to services for all youth, including facilitating access to specialized services for youth involved with the Division of Child Protection and Permanency (DCP&P);
- Coordinating Third Party Liability and medical coverages;
- Coordinating a transition to adult services for youth;
- Providing Quality and Outcomes Management, and System Measurement that supports CSOC's goal to promote best practices, and providing assistance to the State to assure compliance with State and federal guidelines;
- Providing training and training materials;
- Providing support for Provider Network Development; and
- Completing annual audit reviews.

To support these administrative services, the CSA provides an MIS called CYBER (Child and Youth Behavioral Electronic Record) that is backed by strong, clinical guidance and fosters flexibility, system integration, comprehensive information management, and production of management reports that support business decisions. The contract for PerformCare was renewed for five years upon RFP award in November 2017.

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as [A Practical Guide to Psychiatric Advance Directives](#))?

DMHAS largely promotes PADs through collaboration with peer and family organizations, such as the Mental Health Association of NJ (MHANJ) and NAMI, among others. DMHAS also contracts with MHANJ to serve as a hub for support and resources for individuals and family members regarding mental illness, and the organization promotes PADs and provides mental health consumers with information about how to develop a PAD and access the PAD registry. DMHAS is supporting peers from Collaborative Supports Programs of NJ (CSPNJ) to be PA trainers. The peers will be going out to mental health agencies to train their staff on how to assist consumers to develop PADs.

DMHAS contracts with the U.S. Living will Registry to store PADs electronically and make these immediately accessible when individuals receive crisis services. Data from the U.S. Living Will Registry on the numbers of newly developed PADs registered in in the state in recent years suggests that it is relatively low in comparison to the state population. Also, data on agencies' rates of accessing PADs for clients in crisis is also a concern. Consumers have also raised concerns to DMHAS about the fact that PADs are legal documents, and some have noted the difficulties of completing the required form and with submitting it online. Some consumers also have voiced mistrust around the confidentiality of the documents in the electronic registry.

As a result of these concerns, DMHAS has had a workgroup to develop strategies to support consumers with targeted education and assistance in writing PADS, which will include the development of more user-friendly PAD documents and resources. This group is still considering other ways to encourage and promote the development of PADs, as well as ways that ensure that the documents are utilized by crisis and hospital staff when individuals with PADs receive their services.

6. Please indicate areas of technical assistance needs related to this section.

DMHAS can benefit from technical assistance on psychiatric advanced directives as it enters into a new phase of implementation – post pandemic. Additionally, DMHAS is interested in how best to implement advanced psychiatric directives in the community and interested in resources for the creation of PADs that are meaningful and accessible to the individuals, providers and their caregivers.

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Footnotes:

Environmental Factors and Plan

4. Program Integrity – Required for MHBG & SUPTRS BG

Narrative Question

There is a strong emphasis on ensuring that Block Grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that the federal government and the states have a strong approach to assuring program integrity. Currently, the primary goals of the federal government's 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 behavioral health services, states are reminded of restrictions on the use of Block Grant funds outlined in [42 U.S.C. § 300x-5](#) and [42 U.S.C § 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\(g\)](#), there are periodic site visits to MHBG and SUPTRS BG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. The 20% minimum primary prevention set-aside of SUPTRS BG funds should be used for universal, selective, and indicated substance use prevention. Guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: <http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf>. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SUPTRS BG resources are to be used to support, not supplant, services that will be covered through private and public insurance. In addition, the federal government and states need to work together to identify strategies for sharing data, protocols, and information to assist Block Grant program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based substance use primary prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SUPTRS BG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and SUD benefits; (3) ensuring that consumers of mental health and SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of mental health and 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?

Technical assistance is provided through in-person trainings and webinars, specifically when implementing new initiatives/programming or discussing evidence-based or innovative practices throughout the State or any changes on a federal or state level that impacts providers (i.e., Implementation of Updated 42 CFR Part 8 Regulations, Best Practices for Drug Screening, Integrating Hepatitis C Treatment and Prevention, etc.). The Division of Mental Health and Addiction Services (DMHAS) is also working to apply to the National Association for Alcoholism and Drug Abuse Counselors (NAADAC) to be an educational provider which would enable the Division to offer its own training series to educate providers and others on various topics.

DMHAS worked with SAMHSA's contracted TA provider, JBS International to offer training in March 2024 on Improving Clinical Recovery Services for Pregnant and Parenting People to contracted pregnant and parenting women's licensed substance use disorder treatment and maternal child health providers. The two-part virtual sessions on Family Centered Treatment and Trauma Informed Care were offered by a subject matter expert. DMHAS has inquired JBS on providing training on SUPTRS Block Grant

funding restrictions. Training will provide background on the purpose of the SUPTRS Block Grant but will focus on expenditure restrictions and unallowable costs. This training will be provided to DMHAS staff that work with the SUPTRS Block Grant such as program, monitoring and fiscal staff members. DMHAS further requested development of a policy guide that DMHAS staff may easily refer to that outlines SUPTRS Block Grant unallowable costs.

The grants monitoring program at the DMHAS monitor SUD treatment agencies that receive Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant funds for treatment services. Onsite visits are made to each SUPTRS Block Grant recipient a minimum of one time per calendar year. More frequent reviews are conducted on an as needed basis for agencies recommended by the Contract Coordination meeting as needing additional technical assistance or monitoring because of violations, other deficiencies, or special grant requirements. The Contract Coordination meeting includes representatives from the Monitoring, Prevention, Fiscal and Treatment program units within DMHAS.

Site visits may be anywhere from one to five days in duration depending on the size and scope of the program. The reviewer conducts chart reviews for the selected sample and completes an Annual Site Monitoring Report. The Annual Site Monitoring Report addresses at a minimum five core areas of performance: Facility, Staff, Treatment Records, Quality Assurance, Specialized Services, and other contract requirements. A site visit report is submitted to the agency and a plan of correction (PoC) is required for areas found to be in noncompliance. Agencies are notified in writing of the acceptance or non- acceptance of the plan of correction and the monitoring staff continues to follow up until an acceptable plan of correction is submitted. Agencies who continue to submit an unacceptable plan of correction are referred to the Contract Monitoring Meeting for further action.

In addition to routine monitoring, a Contract Coordination meeting is held monthly to discuss issues such as outstanding PoCs, agencies needing technical assistance and other program concerns including underutilization. The Contract Coordination meeting includes representatives from the Monitoring, Prevention, Fiscal and Treatment program units within DMHAS.

The Office of Prevention and Early Intervention's Program Officers visit each contracted provider for prevention services a minimum of one formal and two informal site visits per year. Additionally, each contractee submits a quarterly narrative program report that details program activity and progress made towards achieving the goals and deliverables outlined in the contractee's Annex A. Contractees also submit process data that detail the number of individuals or families served each quarter. Prevention agency and coalition process data are submitted electronically in the DMHAS' Prevention Outcomes Monitoring System (POMS). For other programs these data are included in the monthly report.

Formal Site Visits may be a half -day to a full day in duration depending on the size and scope of the program. If warranted, extended or additional visits will be made to agencies exhibiting programmatic problems. Program Officers schedule a mutually agreed upon time to conduct the site visit. The County Alcohol and Drug Abuse Coordinator from the county in which the agency/organization is located is also invited to participate in Formal Site Visits.

In advance of the Formal Site Visit, Program Officers will send a letter or email describing the purpose of and agreed-upon date of the visit as well as a copy of the site visit report form that will be completed during the visit. All items listed on the Formal Site Visit Form are reviewed during the visit to assure that the contractee is in compliance with all Annex A requirements. Program Officers will also review process data that have been submitted on the POMS, Quarterly Reports, Year End Reports, the previous year's Program Evaluation, previous site visit reports and other pertinent program documentation.

Program Officers will meet with agency staff as a group and/or on an individual basis depending upon the need. They will review the agency's specific program curricula, program evaluation forms, class sign-in forms, staff resumes, program expenditure reports, etc. The Program Officer may also observe an actual program session being delivered on the same or subsequent day. At the completion of these reviews the Program Officer will assign a rating based upon the review of the agency's documentation and personal observations made during the visit. Possible ratings are either: Pass, Needs Improvement, or Plan of Correction Required. After discussion with the agency director and upon completion of the visit, the agency director and Program Officer sign the form and copies are made on-site for the agency and the County Alcohol & Drug Coordinator. DMHAS retains the original copy.

These reports are given to Prevention and Early Intervention Program Manager for review and approval and are then placed in the agency's file. If a Corrective Action Plan is required, the Program Officer shares his/her observations and details the deficiencies that necessitate the creation of the Plan. A subsequent meeting is convened at DMHAS with all relevant DMHAS programmatic and fiscal staff and agency staff to address DMHAS specific concerns. If necessary, the Offices of Quality Assurance and Contract Administration provide additional guidance and oversight in the development of the Corrective Action Plan. The contractee will be required to submit the Corrective Action Plan to the Program Officer at DMHAS within fifteen business days of meeting. The Program Officer then makes quarterly in-person visits to the agency to monitor progress on the plan until all deficiencies have been satisfactorily addressed. Once deficiencies have been addressed/corrected, the Program Officer will prepare a letter to the contractee indicating that all deficiencies have been satisfactorily addressed.

The Office of Prevention and Early Intervention works closely with DMHAS' Fiscal Office and invites them to the meeting described above. These procedures are all a component of agency quality assurance activities at DMHAS.

and the Contract Reimbursement Manual, that contain the various State and Federal grant policies and procedures with which the Division complies. These policies (promulgated by the State Office of Management and Budget and the State Department of Human Services, and informed by SAMHSA policy and regulation) cover payments and obligations to third party vendors, required documentation to support payments, federal grant reporting, general contracting policies, grant monitoring activities, etc. The Manuals are informed by and align with SAMHSA policies and federal grant requirements and regulations, and are updated, as applicable and appropriate.

The State, through its Department of Treasury, Office of Management and Budget (OMB), maintains two policy circulars, 07-05-OMB "Grant Agreements – Agency Contracts" and 25-12-OMB "Single Audit Policy for Recipients of Federal Grants, State Grants and State Aid" provide instructions to agencies to ensure that intermediaries and providers are aware of and subject to both federal program requirements, as well as those of the State of New Jersey.

With respect to monitoring, the Division engages in various activities designed to confirm that third party providers are complying with established policies and that expenditures are proper. For example, with respect to Mental Health Fee for Service (FFS) payments (a portion of which is charged to the Mental Health Block Grant), the Division conducts quarterly reviews of expenditures to confirm that consumers were not Medicaid-eligible. Letters are sent to all providers to recover funds for all clients who were identified by our staff as Medicaid-eligible. Since the Division's transition to FFS in 2017, roughly \$5.3 million of recoveries have been realized through these efforts. Provider compliance with billing the appropriate funding source, specifically billing Medicaid for Medicaid-eligible clients has increased over time given the Division's consistent monitoring and communications on this matter. Similarly, paid claims reviews are conducted by the Division's SUD Fee for Service Network Management unit by verifying Medicaid coverage for Medicaid-enrolled clients, for Medicaid covered services that were claimed against the SUD FFS Initiatives funded by SUPTRS Block Grant and state appropriations. Recoveries are realized by making formal, written demand to the Provider Agencies with identified improper billing and requiring repayment. In CY 2024 (4 Quarters), there was approximately \$900,000, identified for recoveries due to improper billing of the two FFS initiatives funded by the federal SUPTRS Block Grant.

More generally, the Division has been consistent in informing providers of the need to identify all other payer sources, e.g., Medicaid, private insurance, prior to charging the Division under State-funded, or federal grant-funded (either Block Grant or Discretionary) agreements. This is effected by standard NJ DHS contract language, Budget Language in the Appropriations Act and other communications. In addition, DMHAS has made efforts to train providers in Presumptive Eligibility. Presumptive Eligibility training and certification for agencies continues to be scheduled through the State's Medicaid agency, i.e., the Division of Medical Assistance and Health Services, as needed or requested by providers.

The Division also engages in regular monitoring of our cost-reimbursement contracts and Memoranda of Agreement (MOAs), many of which are funded by federal grants. With respect to the former, Contract Administrators review Reports of Expenditure (ROE) that are submitted on a quarterly basis to check for compliance and consistency with provider budgets. A sample of providers is also selected on an annual basis to be audited by the Department of Human Services Audit staff. These audits consist of very detailed reviews of provider spending during the contract year. In addition, more recently, the Division's own Audit staff have started to also conduct detailed reviews of provider expenditures, e.g., review of payroll records, invoice support for a sample of expenditures. With respect to MOAs, analysts in our Budget office are responsible for conducting detailed reviews of each invoice submitted by our third part providers. Wage and personnel records, including General Ledger support, as well as invoice support for significant expenditures, are provided and reviewed before payment is made.

The Division's Budget staff are also in regular communication with program leads to ensure agreement with the detailed budgets submitted by providers and to identify specific policies (e.g., on limitations to administrative/indirect costs) that may be in place for specific grants.

The Senate and General Assembly of the State of New Jersey enacted an Act concerning substance use treatment facility performance (N.J.S.A. 26: 2G-38.) requiring the annual preparation of Substance Use Treatment Provider Performance Report. The performance report shows and compares the overall performance of each substance use treatment provider in the State with the statewide average performance based on national outcome measures for each level of care. The performance report includes the following national outcome measures: (1) percentage of clients abstinent from alcohol on admission and discharge; (2) percentage of clients abstinent from drugs on admission and discharge; (3) percentage of clients employed on admission and discharge; (4) percentage of clients enrolled in school or a job training program at admission and discharge; (5) percentage of clients who are homeless on admission and discharge; and (6) average length of client treatment.

By publicly reporting these outcomes, the DMHAS hopes to provide individuals with information on the outcomes achieved so they can make informed decisions about choosing a provider, and to help providers see how they are doing compared to their New Jersey peers and to the state so that they can identify areas that might need improvement. These performance reports are one strategy that DMHAS has adopted in its continuous quality improvement efforts focused on helping to improve services to the clients we serve. The NOMs are one way to monitor client outcomes, help direct system improvements and achieve better accountability. Reports are published annually for each fiscal year.

The following activities are done for program integrity of the Mental Health Block Grant (MHBG). Letters are sent to provider agencies, on a state fiscal year basis, notifying them of their MHBG award amount, the CFDA number, and the restrictions on the

use of the funds.

These agencies are also monitored by the DMHAS Office of Community Services (OCS) and other offices within DMHAS. One of the responsibilities of the OCS is to ensure that the services provided by contracted programs meet contractual expectations, and that appropriate action is taken to address performance issues. For licensed programs, the Office of Licensing validates that standards are met to achieve and maintain licensure, which include standards for quality and life safety. The OCS, however, has a role in the review of staff qualifications, particularly if a waiver is sought, access to services, and also in monitoring the implementation of awards and best practices. Additionally, the OCS receives and responds to complaints and concerns from constituents, which often address issues of compliance with standards, safety considerations and access to services. By monitoring access to services, the OCS ensures that the target population is prioritized to receive contracted services.

OCS as well as the DMHAS Office of Treatment Recovery and Supports (OTRS) conduct periodic site visits to monitor program performance and adherence to policy, billing practices, and programmatic performance. As a result of these monitoring visits, contracted providers will receive a summary of the visit, and may be required to submit corrective plans when deficiencies are noted.

The OCS uses Quarterly Contract Monitoring Reports (QCMRs) to compare actual volume of service to contracted volume of service where applicable. When discrepancies are noted, follow-up occurs to identify the reasons for the discrepancies, and to require corrective action as needed. If a Corrective Action Plan is required of a provider agency, the regional office monitors the implementation of the plan until such time as either satisfactory improvement is achieved, or alternatively, contract modifications are made. The OCS may issue a contract contingency where a contract will be renewed contingent on meeting stipulated requirements. The OCS may provide technical assistance to providers to help them to achieve the desired service outcomes and may engage other DMHAS staff to render technical assistance. It may be necessary to reduce or terminate a contract if the expected level of service is not achieved.

Technical assistance is provided through in-person trainings and webinars, specifically when implementing new initiatives or programming throughout the State and includes Medicaid and non-Medicaid services and providers.

The Medical Assistance Customer Service Centers conducts site reviews for Medicaid behavioral health providers that include chart reviews, program monitoring and regulatory compliance. Technical assistance is provided if warranted. Serious and extreme violations of a requirement are reported to the Office of Licensing or other governing authority, and if appropriate, the Medicaid Fraud Division for additional follow up with the agency. Site visit report is sent to the provider with a plan of correction (PoC) for areas found to be in noncompliance.

4. Please indicate areas of technical assistance needs related to this section.

DMHAS would benefit from technical assistance to ensure program integrity in monitoring proper expenditure of BG funding. This would include areas such as best practices for monitoring and compliance, education on funding restrictions and guidelines, and reporting.

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Footnotes:

Environmental Factors and Plan

5. Primary Prevention – Required for SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. 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, misuse and substance use disorders 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 priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. **Problem identification and Referral** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions to prevent further use.
5. **Community-based processes** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use 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 serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup (SEOW)? ☒ Yes ☐ No
2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply):
 - a) ☒ Data on consequences of substance-using behaviors
 - b) ☒ Substance-using behaviors
 - c) ☒ Intervening variables (including risk and protective factors)
 - d) ☒ Other (please list)
Social Indicator Data
Treatment Data
NJ State Police Data
NJ Prescription Drug Monitoring Data
State Medical Examiner Data – Drug-related Deaths
Naloxone Reversal Data
3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)
 - a) ☒ Children (under age 12)
 - b) ☒ Youth (ages 12-17)

- c) ☒ Young adults/college age (ages 18-26)
- d) ☒ Adults (ages 27-54)
- e) ☒ Older adults (age 55 and above)
- f) ☐ Rural communities
- i) ☐ Other (please list)

4. Does your state use data from the following sources in its primary prevention needs assesment? (check all that apply):

- a) ☒ Archival indicators (Please list)
New Jersey Chartbook of Substance Abuse Related Social Indicators
- b) ☒ National survey on Drug Use and Health (NSDUH)
- c) ☒ Behavioral Risk Factor Surveillance System (BRFSS)
- d) ☒ Youth Risk Behavioral Surveillance System (YRBS)
- e) ☒ Monitoring the Future
- f) ☐ Communities that Care
- g) ☒ State-developed survey instrument
- h) ☒ Other (please list)

New Jersey Middle School Risk and Protective Factor Survey
New Jersey Household Survey of Drug Use and Health
New Jersey High School Survey (YRBS)
Young Adult Survey
Older Adult Survey
Survey of Returning Veterans

5. Does your state use needs assessment data to make decisions about the allocation of SUPTRS BG primary prevention funds? ☒ Yes ☐ No

- a) If yes, (please explain in the box below)
DMHAS utilizes a Relative Needs Assessment Scale (RNAS) using social indicators with known correlations to estimate state and county substance use prevention and treatment needs. The scale calculates an index of risk for each jurisdiction of the same size (county, municipal, zip code, etc.) for which the indicators can be obtained. Because the scale is an interval level of measurement that sums to one, scores are comparable and easily interpreted across jurisdictions.
- b) If no, please explain how SUPTRS BG funds are allocated:

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that serve 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 primary prevention workforce? ☒ Yes ☐ No
 a) If yes, please describe.
 The Addictions Certification Board of NJ administers and awards the International Certification and Reciprocity Consortium (IC & RC) recognized Certified Prevention Specialist Credential.
2. Does your state have a formal mechanism to provide training and technical assistance to the substance use primary prevention workforce? ☒ Yes ☐ No
 a) If yes, please describe mechanism used.
 Contracts with the New Jersey Prevention Network, Rutgers University School of Social Work – Center for Prevention Science, and the Northeast Prevention Technology Transfer Center.
3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? ☒ Yes ☐ No
 a) If yes, please describe mechanism used.
 Various Instruments such as Community Prevention Readiness Index or Community Readiness Model are provided by the Rutgers Center for Prevention Science.

Narrative Question

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Planning

1. Does your state have a strategic plan that addresses substance use primary prevention that was developed within the last five years? ☐ Yes ☒ No
If yes, please attach the plan in WebBGAS
2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG?
☒ Yes
☐ No
☐ Not applicable (no prevention strategic plan)
3. Does your state's prevention strategic plan include the following components? (check all that apply):
 - a) ☒ Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
 - b) ☒ Timelines
 - c) ☒ Roles and responsibilities
 - d) ☐ Process indicators
 - e) ☒ Outcome indicators
 - f) ☐ Not applicable/no prevention strategic plan
4. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? ☒ Yes ☐ No
 - a) Does the composition of the Advisory Council represent the demographics of the State? ☒ Yes ☐ No
5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? ☒ Yes ☐ No

- a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

The SAMHSA Guidance Document on "Identifying and Selecting Evidence-Based Interventions" (January 2009), and SAMHSA's Evidence-Based Practices Resource Center.

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SUPTRS BG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- a) ☐ SSA staff directly implements primary prevention programs and strategies.
- b) ☒ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- c) ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- d) ☒ The SSA funds regional entities that provide training and technical assistance.
- e) ☒ The SSA funds regional entities to provide prevention services.
- f) ☒ The SSA funds county, city, or tribal governments to provide prevention services.
- g) ☒ The SSA funds community coalitions to provide prevention services.
- h) ☒ The SSA funds individual programs that are not part of a larger community effort.
- i) ☒ The SSA directly funds other state agency prevention programs.
- j) ☒ Other (please describe)

The state provided SUPTRS Block Grant Supplement and ARPA funds to New Jersey's three non-federally recognized tribal communities to provide prevention services within their communities. Discontinuation of these funds required that DMHAS discontinue providing that support.

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SUPTRS BG primary prevention dollars in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

- a) Information Dissemination:
Resource Directories, Health Fairs, Media Campaigns at County Level - Underage Drinking
- b) Education:
Strengthening Families, Life Skills, WISE, Positive Parenting, etc.

- c)** Alternatives:
Drop-In Centers at the Mall, Drug/Alcohol Free Parties and Dances, Community Service Activities
- d)** Problem Identification and Referral:
Work in middle and high schools to provide education (in lieu of disciplinary action) to students who violate campus tobacco possession or use policies. Prevention coalitions operate Prevention Warm Lines community members can access to get information about local prevention services and how those services can help address individual, family and community needs.
- e)** Community-Based Processes:
Recruitment and Training of Coalition Members, Collaboration with the Governor's Council on Alcoholism and Drug Abuse
- f)** Environmental:
Regional Coalitions: Work has led to 800+ Policy Changes in NJ
Cops in Shops
Sticker Shock
Server Training

3. Does your state have a process in place to ensure that SUPTRS BG dollars are used only to fund primary prevention services not funded through other means? ☒ Yes ☐ No

- a)** Yes (if so, please describe)
Program Managers conduct quarterly reviews of each funded agency's programs to assure that providers adhere to the program deliverables specified in the agency or coalition's contract.

Narrative Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. 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, misuse and substance use disorders 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 priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. **Problem identification and Referral** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions to prevent further use.
5. **Community-based processes** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use 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 serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use primary prevention that was developed within the last five years?

☒ Yes ☐ No

If yes, please attach the plan in WebBGAS
2. Does your state's prevention evaluation plan include the following components? (check all that apply):
 - a) ☒ Establishes methods for monitoring progress towards outcomes, such as prioritized benchmarks
 - b) ☒ Includes evaluation information from sub-recipients
 - c) ☒ Includes National Outcome Measurement (NOMs) requirements
 - d) ☒ Establishes a process for providing timely evaluation information to stakeholders
 - e) ☐ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
 - f) ☐ Other (please describe):
 - g) ☐ Not applicable/no prevention evaluation plan
3. Please check those process measures listed below that your state collects on its SUPTRS BG funded prevention services:
 - a) ☒ Numbers served
 - b) ☒ Implementation fidelity
 - c) ☒ Participant satisfaction
 - d) ☒ Number of evidence based programs/practices/policies implemented
 - e) ☒ Attendance
 - f) ☒ Demographic information
 - g) ☐ Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SUPTRS BG funded prevention services:

- a) ☒ 30-day use of alcohol, tobacco, prescription drugs, etc
- b) ☒ Heavy alcohol use
- c) ☒ Binge alcohol use
- d) ☒ Perception of harm
- e) ☒ Disapproval of use
- f) ☒ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- g) ☐ 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 two modules:

- Environmental: in which coalitions report on environmental approaches that they are using to address DMHAS' prevention priorities. Includes details about activities, dates, number of participants.
- Curriculum-Based: collects demographic and process data about individual and family, curricular programs (i.e., Strengthening Families, LifeSkills) being delivered by DMHAS-funded prevention agencies throughout the state. These data are used when preparing the Block Grant reports and application.

DMHAS has individual evaluation plans for its substance use prevention programs not an overall evaluation plan.

Environmental Factors and Plan

6. 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-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

SMHA funds eight levels of service along the mental health continuum of care with Community Mental Health Block Grant, and other federal or state funds. They are: Prevention and Early Intervention Services, Crisis Stabilization Services < 24 hours, Crisis Stabilization and Diversionary Services > 24 hours, Acute Care Services, Peer Recovery Support, Family Support, Treatment and Rehabilitative Services, and County and State Psychiatric Hospitals. NJ funds four State Psychiatric Hospitals, operated by the Department of Health and partially funds four County Psychiatric Hospitals, operated independently of the state. The SMHA Office of Olmstead and Diversion, works collaboratively with the state and county hospitals to help integrate patients back into the community. Additionally, DMHAS houses a unique unit called the Disaster and Terrorism Branch (DTB) which coordinates the state's mental health response to disasters and public health emergencies by activating the state's mental health disaster plan, training volunteers as Disaster Response Crisis Counselors (DRCCs), and offers training and consultation on various mental health topics.

Consistent with current law, these services outlined in the level of care below provide the opportunity for individuals with mental illness, serious mental illness, and co-occurring SUD to live in the most appropriate setting possible in accordance with their clinical needs, level of function and individual's preference.

Prevention and Early Intervention includes Coordinated Specialty Care Community Integration (CSC CI) services and Suicide Prevention. New Jersey has utilized the MHBG 10% set-aside funds for providing service to individuals with first episode psychosis (FEP) since FY 2017 and has increased access to CSC services in FY 2024 by funding five CSC CI programs.

Crisis Stabilization Services < 24 hours: 988 Call centers, Mobile Crisis Outreach Response Teams (MCORTS), Crisis Receiving and Stabilization Centers (CRSCs). New Jersey has utilized the MHBG 5% set-aside funds to partially fund five providers to develop CRSCs.

Crisis Stabilization and Diversionary Services > 24 hours: Crisis Diversion Homes, Crisis Diversion Beds, Peer Respite Beds, Diversionary Beds,

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), ARRIVE Together co-responder model; 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), Short-Term Care Facility (STCF) beds and inpatient diversion beds (diverts individuals from state psychiatric hospital admission).

Peer Recovery Support.

Extended/ongoing Recovery Supports: Consumer-operated Services including Self-help Centers and Wellness Recovery Centers. There are currently 33 Community Wellness Centers/Self-Help Centers/Recovery Centers throughout the 21 counties of the state funded by DMHAS, including 3 centers located on the grounds of the state psychiatric hospitals.

Family Support.

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

Treatment and Rehabilitative Supports.

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

State and County Psychiatric hospitals.

State hospitals, county hospitals, Olmstead initiatives (validation of vacancy tracking systems; enhancements to community capacity, expansion of the Olmstead unit; collaboration with state hospitals including continued utilization of the Intensive Case Review Committee (ICRC) and project team meetings, utilization management of statewide residential vacancies and community referrals, hospital diversion initiative).

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	☒ Yes	☐ No
b)	Mental Health	☒ Yes	☐ No
c)	Rehabilitation services	☒ Yes	☐ No
d)	Employment services	☒ Yes	☐ No
e)	Housing services	☒ Yes	☐ No
f)	Educational services	☒ Yes	☐ No
g)	Substance use prevention and SUD treatment services	☒ Yes	☐ No
h)	Medical and dental services	☒ Yes	☐ No
i)	Recovery 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-occurring M/SUDs	☒ Yes	☐ No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

Agencies providing the various levels of community treatment are required by regulation and contract to arrange for, and coordinate care, with other providers (including primary medical services) to help ensure SMI individuals have access to the full scope of services needed to effectively address their holistic needs. Warm handoffs are used to help integrate the individual into the community, on a continuing basis, to sustain community tenure.

The New Jersey's CSC programs for individuals with FEP emphasize a team approach with the following components: outreach, low-dosage medications, cognitive and behavioral skills training, individualized placement and support, supported employment and supported education, case management, and family psycho-education. Each CSC team is comprised of a Master's level clinical team leader, Master's level clinicians, a supported employment and education staff, a prescriber , a Master's level outreach and referral clinician; and a certified peer support staff. APN/Psychiatrist is

responsible care by coordinating individual's medical needs by the prescriber as well as other behavioral needs. CSC teams have been effective in keeping individuals engaged,

PACT (Programs for Assertive Community Treatment) 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 groups 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 individuals, 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 (Projects for Assistance in Transition from Homelessness) 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.

Certified Community Behavioral Health Clinics (CCBHCs) is an evidence-based practice that delivers community-based and substance use disorder services while advancing integration of behavioral health and physical health care. They improve access to care for individuals with serious mental illness (SMI), serious emotional disturbance (SED), or co-occurring mental health, substance use or physical health needs. CCBHCs provide patient-centered and family-centered care as well care that is trauma informed and recovery oriented.

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, CCBHC, Behavioral Health Homes and CSC programs also provide case management services. Finally, the NJ Division of Medical Assistance and Health Services (Medicaid) in collaboration with DMHAS integrated ambulatory behavioral health services into managed Medicaid (MCOs) in January 2025. The MCOs provide care management services across mental health, substance use and primary care treatment services.

4. Describe activities intended to reduce hospitalizations and hospital stays.

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

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

DMHAS has enhanced its Supported Employment services to include an in-reach pilot within the three regional state hospitals. Implemented in July 2015, this pilot program serves individuals who are ready for discharge and examines their interest in competitive employment outside the hospital. This in-reach is supplemental to the Division's existing Supported Employment

services, which are available in each of New Jersey's 21 counties. Supported Employment services include assistance accessing benefits counseling; identification of occupational skills and interests; and the development and implementation of a job search plan based on the consumer's strengths, interests, needs, and abilities. The ultimate goal for person receiving services receiving Supported Employment services is to obtain meaningful and competitive employment as a means of further ensuring sustained integration within the community.

The Home-to-Recovery II Plan includes outcomes geared toward monitoring sustainability of the Division's community integration efforts. These outcomes include but are not limited to enhanced utilization of Supportive Housing, expansion of CSS opportunities, a decrease in census, fewer admissions to state hospitals, and a decrease in the number of individuals on Conditional Extension Pending Placement (CEPP). In NJ the status of CEPP was created by a 1983 New Jersey Supreme Court decision, In RE: S.L., 94 N.J. 128 (1983), for individuals who no longer met the standard for involuntary commitment but for whom there was not present appropriate placement in the community.

The state hospital census on 6/30/2008 for the 4 regional state hospitals in SFY 2008 (year of the settlement agreement) was 1859 and there was a total of 2,763 admissions.

The CEPP census on 6/30/2008 was 938. The percentage of individuals on CEPP of the total census was 49.9% on 6/30/2008.

There were four regional hospitals in SFY 2008 until Hagedorn Psychiatric Hospital closed in SFY 2012.

The state hospital census for the three regional state hospital in SFY 2025 was 982 (a decrease of 47.18% from 2008) and there was a total of 587 admissions (decrease of 78.75% from 2008).

The CEPP census on 6/30/25 was 195 (decrease of 79.2% from 2008). The percentage of individuals on CEPP of the total census was 19.9% on 6/30/2025 (decrease of 60.1% from 2008).

In SFY 2008, there were 3,051 individuals receiving services in supportive housing. In 2022, there were 5,658 individuals served by CSS. The average state hospital census for the three regional state hospital in SFY 2023 was 964 (a decrease of 53% from 2008), there were an average of 563 admissions (decrease of 79.62% from 2008), and the CEPP census on 6/30/23 was 244 (decrease of 74% from 2008).

Vacancy Tracking Systems. The Bed Enrollment Data System (BEDS) was developed in 2013 for the furtherance of deliverables to the Olmstead lawsuit settlement agreement with Disability Rights NJ1 to facilitate the communication of accurate information between state hospitals and community residential providers regarding bed needs and available housing inventory. The system replaced the process of cold calls to agencies and the utilization of quickly outdated paper tracking sheets. In the Spring of 2021 BEDS was updated to contain many functional improvements, including streamlined search features, and the addition of short-term care facility (STCF) beds, to give the SMHA a better view of the acute care system.

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

In 2023, DMHAS began utilizing Covid Supplemental and ARPA funding to procure a web-based electronic referral system and crisis management module. The crisis management module expedites access to assessment and treatment for those in crisis, tracks their journey from crisis call to treatment, and coordinates all stakeholders' information within a crisis management system. The crisis module, combined with the treatment and referral system, supports collaboration between the state, law enforcement organizations, local community organizations, faith-based organizations, and other behavioral health stakeholders in their efforts to ensure the integrated delivery of evidence-based and family-centered services. The system provides a real-time connection between crisis call center professionals and crisis response teams

Enhancements to Community Capacity. From 2010 through 2014, DMHAS was charged with the creation of 695 beds expressly for the community placement of person receiving services on CEPP status in the regional state hospitals and 370 beds to be created for person receiving services who are already in the community and at high-risk for hospitalization and/or homelessness. This equates to a total of 1,065 placements to be created over the five-year period covered by the settlement. The SMHA met and exceeded this goal, creating 1,436 new placements. Of these, 941 were set aside for the discharge of CEPP person receiving services from state hospitals (exceeding the settlement goals of 695 by 246 or 35%), and 495 were reserved for person receiving services at risk of hospitalization (exceeding the goal of 370 by 125 or 33.78%). In total, the SMHA exceeded its goals for placement creation by 34.83%, which amounts to 371 placements above its required deliverable. The Division continued creating new placements for individuals, reaching a total of 1,808 new placements by the end of SFY 2016, with 1,274 reserved for CEPP discharges and 534 set aside for person receiving services at risk of hospitalization. There were 1060 new placements created from

Expansion of the Olmstead Unit

The Office of Planning, Research, Evaluation, Prevention and Olmstead (OPREPO) has continued to grow in scope and responsibility with the addition diversion staff and the formation of a diversionary unit that reports to the DMHAS Olmstead Office. The DMHAS Olmstead/Diversion unit is responsible for the management and intervention of diversion referrals; monitoring data for individuals on Conditional Extension Pending Placement (CEPP) at the state psychiatric hospitals, providing training to state hospital treatment teams and community providers, production of reports to help drive planning and decision making, as well as actively participate in Intensive Case Review Committees and Project Team meetings providing support, guidance and technical assistance that will help to facilitate discharge of individuals on CEPP.

Olmstead Unit Collaboration with State Hospitals

The Regional Olmstead Coordinators (ROCs) and Program Specialists facilitate referrals from the state hospitals to community funded programs, including providing assistance in navigating systems issues as well as working to meet the needs of the individuals and build upon their strengths. The ROC works with the state hospital treatment team, placement entity and the patient in identifying resources available for patients at the state hospital. The ROC is also responsible for reviewing Medicaid, Guardianship, DDD, and Providers Vacancy Tracking Grids on a regular basis to monitor for delays in discharge.

The ICRC meetings occur once every month to ensure that individual assignments have been made in preparation for discharge in a timely manner. The ROC and hospital treatment team discuss barriers to discharge, as well as systemic issues that may arise and potential strategies. The ROCs also serve as a resource for placement opportunities and services in the community. The Olmstead/Diversion staff interface with provider agencies, DMHAS leadership and other state Divisions/Dept. leadership in coordinating benefits, placements and services.

Project Team meetings are higher-level meetings that occur immediately after ICRC and are typically chaired by the hospital CEO/DCEO or Medical Director. Follow-up on systems raised by ICRC and discussion of resolution strategies are discussed. In addition, policy or systems that may involve collaboration with another Division or state Department, are discussed at these meetings and elevated to Olmstead leadership to address. Olmstead staff also use these meetings to update the hospital leadership on any new administrative bulletins, requests for proposals, updates or changes to the vacancy tracking system, and/or trends identified in the data.

Olmstead Diversion Unit

In 2016, the DMHAS Olmstead office initiated a diversion pilot with the Centralized Admissions Unit (CAU) located at TPH for individuals that do not meet criteria for commitment to the state hospital and are in need of less restrictive community settings. Requests for assistance for diversion came into the Olmstead on a regular basis to the Deputy, ROC Supervisor, and to the central ROC. Diversions from the state hospital were successful and the central ROC was made the point person for this pilot until additional staff could be hired. Contacts with providers spurred additional diversion requests and the central ROC began managing referrals from DMHAS Diversion beds, county hospitals and STCFs. The Diversion Unit has expanded in scope and includes additional staff to provide coverage for the regions. As of 2025, the Diversion Unit now manages referrals from the DBHS Centralized Admissions Unit, Ann Klein Forensic Center, residential referrals for DMHAS Diversion Beds, referrals from STCFs, County Hospitals, STU, community referrals, and various other sources of referral. The Diversion Unit manages referrals from the DBHS Centralized Admissions Unit, all residential referrals for DMHAS Diversion Beds, referrals from Short-Term Care Facilities (STCFs), County Hospitals, The Diversion unit follows up on referrals and communicates with providers utilizing vacancy tracking documents including the Provider Weekly Report. This initiative has contributed to a decrease in the hospital census as well as enhanced community re-integration of persons receiving services.

State Hospital and Community Training

The SMHA, through DMHAS Olmstead unit provided level of care trainings to the treatment teams at each of the three regional state hospitals. The Olmstead unit staff facilitated discussions on community treatment options and social service programs to support individualized discharge planning. Training was also provided to Community Support Services providers in a joint training between DMHAS Olmstead Unit and DBHS.

Recently the state hospitals have begun formative discussions with the community providers on collaborative discharge planning through on-site events such as provider open houses and expanded in-reach along with hospital tours of community provider agencies.

5. Please indicate areas of technical assistance needs related to this section.

NJ is currently receiving technical assistance for Coordinated Specialty Care Community Integration (CSC CI). DMHAS has also received technical assistance for the Crisis Receiving Stabilization Centers. DMHAS will continue to need technical assistance for CSC CI, CRSC, Olmstead/Diversion, Crisis Diversion and the continued development and implementation of the crisis continuum. The SMHA also seeks technical assistance for DMHAS providers including training, implementation and reporting outcomes of evidence-based practices.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

1. In order to complete column B of the table, please use the most recent federal prevalence estimate from the National Survey on Drug Use and Health 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	402,228	N/A
2.Children with SED	164,175	N/A

2. 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 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 2024 adult population of New Jersey was 7,448,667. The size of the New Jersey child population was 2,052,184. 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 2024 was 402,228. Using the upper SMI limit of 7.1%, the estimated number of adults with SMI in New Jersey in 2024 was 528,855. Accordingly, using the lower SMI limit of 3.7%, the estimated number of SMI adults in New Jersey in 2024 was 275,600.

Using the SAMHSA's SED prevalence rate (8.0%), the estimated number of children with SED in New Jersey in 2024 was 164,175.

3. Please indicate areas of technical assistance needs related to this section.

Utilization of URS data for planning

Accessing and use of Medicaid data and including Medicaid data in URS reporting

Exploration of other state models and their use of client level data

How are states developing a unique provider and site ID

How are states dealing with the issue of submitting CLD data timely so that discharges are entered when a person is discharged and it does not back up another agency from entering an admission into another program as the system is showing that the person is still admitted somewhere else.

Technical Assistance on how states prepare data dashboards of their URS data and how far back are they trending the data.

Criterion 3

1. Does your state integrate the following services into a comprehensive system of care?^[1]

a)	Social Services	☒ Yes	☐ No
b)	Educational services, including services provided under IDEA	☒ Yes	☐ No
c)	Juvenile justice services	☒ Yes	☐ No
d)	Substance use prevention and SUD treatment services	☒ Yes	☐ No
e)	Health and mental health services	☒ Yes	☐ No
f)	Establishes defined geographic area for the provision of services of such systems	☒ Yes	☐ No

2. Please indicate areas of technical assistance needs related to this section.

None needed.

^[1] A system of care is a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

- a. Describe your state's tailored services to rural population with SMI/SED. See the federal [Rural Behavioral Health](#) page for program resources.

The SMHA defines a county as "rural" if, according to U.S. Census figures, 25% or more of its census live 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 individuals in rural areas 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). The CCBHC Demonstration was extended several times from the original two-year period. Currently the Demonstration is scheduled to end in September of 2025.

New Jersey selected seven CCBHCs in six counties, including six CCBHCs in five metropolitan counties plus AtlantiCare in Hammonton, a rural pocket of Atlantic County. The CCBHCs offer services within an integrative behavioral and primary health 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. Individuals served by CCBHC 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.

Atlanticare's CCBHC has served an increasing number of clients through the CCBHC Demonstration Project, the numbers are below:

Demonstration Year Numbers Served in the CCBHC

Year 1 575

Year 2 549

Year 3 479

Year 4 772

Year 5 652

Year 6 765

Year 7 1194

AtlantiCare has also demonstrated success in the very important performance metric on time to care. AtlantiCare was above average in both percentage of clients seen within 10 days of initial contact as well as average days from first contact to evaluation in DY4 and again in DY 5 (July 1 2021- June 30 2022) they continued to perform well on this important metric, and they were well above average on this metric again in DY6 July 1, 2022 to June 30, 2023, the most recent year for which we have this information.

AtlantiCare provides significant amounts of case management services. 95% of AtlantiCare CCBHC consumers received case management in Demonstration Year 4 which spanned the time period July 1, 2020 to June 30, 2021. DY5 which is July 1 2021 to June 30 2022, AtlantiCare provided case management to 98% of their clients and in DY 6 97%. The CCBHC Demonstration Program is scheduled to end on September 2025. The state is currently pursuing plans to sustain the program through Medicaid.

- b. Describe your state's tailored services to people with SMI/SED experiencing homelessness. See the federal [Homeless Programs and Resources](#) for program resources¹

SMHA operates Projects for Assistance in Transition from Homelessness (PATH) program using a combination of federal and state funds. Individuals served by PATH are 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 2024, the PATH programs in New Jersey provided outreach to 2,559 individuals and served a total of 3,727 persons. 638 program participants were linked to mental health services, 92 to substance use treatment services, 166 to primary health/dental care, 368 to financial services, 299 to temporary housing/shelter, 250 to long term housing and 292 were linked to employment or vocational and educational services.

Services provided under the CCBHC initiative are available to all who meet programmatic criteria. 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. In DY6 the average of 1.6% of CCBHC participants reported being homeless or living in a Shelter, much less than the initial rate of homelessness seen in DY1 which was 3%. 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 integration and wellness and recovery.?

- c. Describe your state's tailored services to the older adult population with SMI. See the federal [Resources for Older Adults](#) webpage for resources²

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 appropriate services to assist screening centers and nursing homes to respond to an increasing number of older adults with behavioral problems being screened and hospitalized. In 2012, DMHAS awarded a contract for the development of a program to provide appropriate 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. Trinitas Medical Center later merged with RWJ Barnabas Health Care but continues to support S-COPE services.

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 master's level clinicians. Outcomes are carefully monitored and reported to DMHAS on a monthly basis.

The S-COPE program was initially available 24 hours/7 day a week to offer face-to-face clinical consultative services. However, effective 07/01/2025, S-COPE no longer was operating afterhours, as the budget for the initiative was decreased and they could only operate Monday-Fridays during regular business hours. S-COPE staff continue to 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. 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 2024, centers. There were 1800 consultations provided in response to referrals. S-COPE continues to provide support in maintaining clients in facilities by closely working with nursing staff, helping them to support individuals in order to avoid acute care and hospitalization. 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 have been 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 2024, there were 100 trainings completed statewide. Trainings are open to all professionals including, but not limited to, Social Workers, Nurses, Psychiatrist, CNAs, and other professionals. While the S-COPE services have been curtailed by budget limitations, the program continues to be responsive to agencies, consumers and families.

- d. Please indicate areas of technical assistance needs related to this section.

DMHAS is seeking technical assistance for our Olmstead/Diversion management team and staff regarding community re-

integration for older adults with an SMI as well as an SMI and co-occurring SUD or medical comorbidities, followed by trainings for our community providers based upon evidence-based practices.

¹ <https://www.samhsa.gov/homelessness-programs-resources>

² <https://www.samhsa.gov/resources-serving-older-adults>

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

1. 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 2025, State appropriations for mental health community providers were \$421million. A significant portion of which has been dedicated to 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 eight 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 many providers and clients to Fee for Service reimbursement, and away from fixed cost or overall cost reimbursement contracts. DMHAS believes that the combination of more attractive Medicaid rates and the transition to a direct Fee for Service reimbursement approach for non-Medicaid services (with enhanced rates), will lead to greater access for clients and a more transparent, accountable and efficient behavioral health service delivery system. DMHAS continues its commitment to consumers and providers, by ensuring reimbursement opportunities to providers when staff resources are deployed. DMHAS reimburses MH FFS contracted providers for non-Medicaid covered services. This reimbursement accomplishes two important things: 1. these ancillary but critical services support consumers' community tenure and 2. it limits reimbursements to the services provided.

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 2025 was approximately \$5.7 million. In addition, DMHAS hosts quarterly meetings and webinars that served as training opportunities for the provider community. DMHAS staff deliver these trainings, which are funded by our State General Fund appropriations.

Goals

While New Jersey currently has cost-based contracts and Fee for Service arrangements with approximately 118 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 22 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 \$38 million for state fiscal year 2025. Consequently, the Block Grant funding for contracted services is then allocated to each of the agencies in the selected group, based on the relative percentage of their eligible costs to the total eligible costs of all agencies in the group.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access the federal resource guide [Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders](#).

2. Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

The state has full capability to use telehealth to provide services, including for individuals with SMI/SED. Outpatient mental health providers and licensed mental health practitioners continue to utilize telehealth as an option in the provision of services, as a result of the flexibilities allowed for telehealth by state and federal regulations in response to the COVID-19 pandemic and the Public Health Emergency (PHE). The state's temporary rules have relaxed requirements regarding which technologies could be used to provide telehealth services, who may provide telehealth services, how the services are paid for, and where practitioners and patients may be located when the services are provided. A critical stipulation is that the telehealth services must be performed to the same standard of care as if the services were rendered in person

The state is complying with changes in the federal requirements, as some federal telehealth relaxations ended on May 11, 2023, when the PHE ended. However, other relaxations have remained in place, as described above. Thus, HIPAA rules are back into full effect, as the Office of Civil Rights (OCR) ended its previous relaxation of penalties for HIPAA violations against health care practitioners when providing telehealth in good faith while using non-public facing audio or video communication products, such as, Zoom or Skype, as well as smart phones and other devices. It is too soon to determine if the end of this capability will affect those with SMI or SED. Meanwhile, SAMHSA and the DEA have specifically extended some of the flexibilities for medication assisted treatment for opioid use disorder because of the critical need to treat individuals with co-occurring disorders ongoing in the opioid crisis.

The state has also passed legislation that has extended the requirements adopted at the outset of the pandemic that Medicaid and health benefits plans reimburse health care providers for telehealth and telemedicine services at the same rate as in-person services, with limited exceptions. This will be helpful for those with commercial insurance. At the same time, the legislation charged the NJ Department of Health with conducting an in-depth study of the outcomes resulting from these changes.

Feedback from outpatient behavioral health providers suggests widespread satisfaction with the expansion of telehealth services, since it is an efficient way of providing services during a period when the programs are having significant staffing shortages. They do not believe that such use has had adverse effects on the quality of care and believe that they can actually monitor individuals with SMI and SED who are at risk of relapse, as the technology provides real-time information about their clinical status. Providing telephone support and remote telemonitoring can also lead to improvements in medication adherence.

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Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders.

Telehealth and telepsychiatry services are a recognized method of delivering behavioral health (BH) care treatment and other services and is routinely utilized by a wide variety of BH providers. Outpatient BH providers have found that telehealth provides quality care, is well accepted by most clients, and decreases the rate of no shows, all of which have been particularly helpful because of staffing shortages. Telehealth is supported by insurers, including NJ Family Care (Medicaid), with specific coding for reimbursement for telehealth, audio-only, and virtual/digital visits.

Any healthcare provider utilizing telehealth or telemedicine in N.J. must be validly licensed, certified, or registered to practice in the state. They are also subject to regulation by the relevant professional boards. If licensed in other states, they can practice in New Jersey, either through full licensure in the state or by obtaining a specific purpose license, telemedicine license, or license to practice medicine across state lines. No recent changes in telepsychiatry or telehealth rules have been issued in regard to mental health services. The federal restrictions of prescribing CDS, methadone and buprenorphine in particular, have been rdecreased considerably, and these changes have been implemented in the state's SUD programs.

In April 2024, the Substance Abuse and Mental Health Services Administration (SAMHSA) finalized a modification to 42 CFR Part 8, allowing additional telehealth and take-home methadone dose flexibilities For OTPs, these flexibilities allow the use of audio-visual telehealth for initiation of treatment with methadone. The OTPs in N.J. may also provide up to 28 days of take-home medication to stable patients and 14 days of take-home medication to less-stable patients and the Drug Enforcement Association (DEA) has announced a separate proposed rule to permanently extend some telemedicine flexibilities originally introduced during the pandemic.

In January, 2025, the DEA's announced its final rule for the telemedicine prescribing of buprenorphine, and this enables prescribing up to a six-month initial supply of Schedule III-V medications to treat OUD via audio-only telemedicine interaction without a prior in-person evaluation. Practitioners can then prescribe additional medication via other telemedicine encounters (real-time, two-way audio-visual) or after an in-person encounter. The agency also finalized a stipulation that providers will need to complete a review of the PDMP for the state where the patient is located. Requirements for the registration proposed rule would not apply to clinicians prescribing buprenorphine for OUD.

3. Please indicate areas of technical assistance needs related to this section.

No technical assistance is needed at this time, but the state would welcome input about policy, research, and practice standards that would assist it with providing telehealth services to individuals with SMI.

Footnotes:

Environmental Factors and Plan

7. Substance Use Disorder Treatment – Required for SUPTRS BG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services (with medications for addiction treatment included in v-x):

i) Screening	☒ Yes ☐ No
ii) Education	☒ Yes ☐ No
iii) Brief intervention	☒ Yes ☐ No
iv) Assessment	☒ Yes ☐ No
v) Withdrawal Management (inpatient/residential)	☒ Yes ☐ No
vi) Outpatient	☒ Yes ☐ No
vii) Intensive outpatient	☒ Yes ☐ No
viii) Inpatient/residential	☒ Yes ☐ No
ix) Aftercare/Continuing Care	☒ Yes ☐ No
x) Recovery support	☒ Yes ☐ No

b) Services for special populations:

i) Prioritized services for veterans?	☒ Yes ☐ No
ii) Adolescents?	☒ Yes ☐ No
iii) Older Adults?	☒ Yes ☐ No

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and or maintain new programs or expand programs to ensure treatment availability? ☒ Yes ☐ No
2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? ☒ Yes ☐ No
3. Does your state have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? ☒ Yes ☐ No
4. Does your state have an arrangement for ensuring the provision of required supportive services? ☒ Yes ☐ No
5. Has your state identified a need for any of the following:
 - a) Open assessment and intake scheduling? ☒ Yes ☐ No
 - b) Establishment of an electronic system to identify available treatment slots? ☒ Yes ☐ No
 - c) Expanded community network for supportive services and healthcare? ☒ Yes ☐ No
 - d) Inclusion of recovery support services? ☒ Yes ☐ No
 - e) Health navigators to assist clients with community linkages? ☒ Yes ☐ No
 - f) Expanded capability for family services, relationship restoration, and custody issues? ☒ Yes ☐ No
 - g) Providing employment assistance? ☒ Yes ☐ No
 - h) Providing transportation to and from services? ☒ Yes ☐ No
 - i) Educational assistance? ☒ Yes ☐ No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The Division of Mental Health and Addiction Services (DMHAS) Monitoring Unit's Program Management Officers (PMO) conduct annual site visits to the women's set aside funded licensed substance use disorder treatment providers. The DMHAS Women's Treatment Coordinator (WTC) is invited to attend the annual site visits. The Annual Site Monitoring Report has questions specific to Specialized Services. The PMO provides a copy of the Annual Site Monitoring Report findings to the WTC. If a women's set aside funded provider is in noncompliance, a plan of correction (PoC) is required, and the PMO provides a copy of the PoC to the WTC on the status of the findings. The Monitoring Unit's PMO and DMHAS WTC will reach out to the provider if there continue to be areas of concern. The WTC will provide technical assistance in an effort to address areas of concern. Additionally, DMHAS holds monthly contract coordinating meetings to discuss any new or ongoing issues and concerns across all DMHAS units.

The DMHAS grants monitoring program unit monitors Substance Use Prevention, Treatment and Recovery Services Block Grant (SUPTRS BG) recipients. Onsite visits are made to each SUPTRS BG recipient a minimum of one time per calendar year. More frequent reviews are conducted on an as needed basis for agencies recommended by the contract coordination meeting for additional technical assistance or monitoring because of violations, other deficiencies, or special grant requirements. The contract coordination meeting includes representatives from the Monitoring, Prevention, Fiscal and Treatment program units within DMHAS.

Site visits may be anywhere from one to five days in duration depending on the size and scope of the program. The reviewer conducts chart reviews for the selected sample and completes an Annual Site Monitoring Report. The Annual Site Monitoring Report addresses at a minimum five core areas of performance: facility, staff, treatment records, quality assurance, specialized services, and other contract requirements. A site visit report is submitted to the agency and a Plan of Correction (PoC) is required for areas found to be in noncompliance. Agencies are notified in writing of the acceptance or non- acceptance of the PoC and the monitoring staff continues to follow up until an acceptable PoC is submitted. Agencies who continue to submit an unacceptable PoC are referred to the contract monitoring meeting for further action.

In addition to routine monitoring, a contract coordination meeting is held monthly to discuss issues such as outstanding PoCs, agencies needing technical assistance and other program concerns including underutilization. The contract coordination meeting includes representatives from the Monitoring, Prevention, Fiscal and Treatment program units within DMHAS.

Criterion 4,5&6**Persons Who Inject Drugs (PWID)**

1. Does your state fulfill the:
 - 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) 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 activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.
 - DMHAS requires licensed SUD treatment agencies to submit their Interim Services Policies.
 - DMHAS requires contracted SUD treatment agencies to submit monthly rosters.
 - DMHAS requires that treatment agencies provide timely reporting on the Service Capacity Management System (SCMS) that is reported to Rutgers University Behavioral Health Care (UBHC), the entity that operates the Interim Managing Entity (IME) Addictions Access Center.

Tuberculosis (TB)

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 contracted SUD treatment programs where compliance to TB Services is monitored.
 - TB Surveillance Procedures devised by the NJ Department of Health are incorporated into the residential and ambulatory regulations followed by all licensed SUD treatment agencies.
 - DMHAS works closely with the Senior Public Health Advisor at the NJ Department of Health, Division of HIV/AIDS, STDs and Tuberculosis Services (DHSTS) to keep updated on any updates to the Center of Disease Control (CDC) guidance that may affect clients or staff at licensed SUD agencies.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring such service delivery? ☐ Yes ☐ No
2. Has your state identified a need for any of the following:
- a) Establishment of EIS-HIV service hubs in rural areas? ☐ Yes ☐ No
- b) Establishment or expansion of tele-health and social media support services? ☐ Yes ☐ No
- c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS? ☐ Yes ☐ No

Hypodermic Needle Prohibition

1. Does your state have in place an agreement to ensure that SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes for the purpose of injecting illicit substances ([42 U.S.C. § 300x-31\(a\)\(1\)\(F\)](#))? ☒ Yes ☐ No

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 members, veterans, tribal entities, older adults, persons experiencing homelessness)? ☒ Yes ☐ No
 - e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, such as primary healthcare, public health, VA, and community organizations? ☒ Yes ☐ No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered 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 system, adult criminal justice system, 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

Patient Records

1. Does your state have an agreement to ensure the protection of client records? ☒ Yes ☐ No

2. Has your state identified a need for any of the following:
- a) Training staff and community partners on confidentiality requirements? ☒ Yes ☐ No
 - b) Training on responding to requests asking for acknowledgement of the presence of clients? ☒ Yes ☐ No
 - c) Updating written procedures which regulate and control access to records? ☒ Yes ☐ No
 - d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure? ☒ Yes ☐ No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? ☒ Yes ☐ No
2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act ([42 U.S.C. §300x-52\(a\)](#)) and [45 CFR 96.136](#) require states to conduct independent peer review of not fewer than 5 percent of the Block Grant sub-recipients providing services under the program involved.
- a) Please provide an estimate of the number of Block Grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.
FFY 2026: 3
FFY 2027: 3
3. Has your state identified a need for any of the following:
- a) Development of a quality improvement plan? ☐ Yes ☒ No
 - b) Establishment of policies and procedures related to independent peer review? ☒ Yes ☐ No
 - c) Development of long-term planning for service revision and expansion to meet the needs of specific populations? ☐ Yes ☒ No
4. Does your state require a Block Grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for Block Grant funds? ☐ Yes ☒ No
- If Yes, please identify the accreditation organization(s)**
- i) ☐ Commission on the Accreditation of Rehabilitation Facilities
 - ii) ☐ The Joint Commission
 - iii) ☐ Other (please specify)

Criterion 7&11**Group Homes**

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ☒ Yes ☐ No
2. Has your state identified a need for any of the following:
 - a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service? ☒ Yes ☐ No
 - b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing? ☐ Yes ☒ No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:
 - a) Recent trends in substance use disorders in the state? ☒ Yes ☐ No
 - b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services? ☒ Yes ☐ No
 - c) Performance-based accountability? ☒ Yes ☐ No
 - d) Data collection and reporting requirements? ☒ Yes ☐ No

If the answer is No to any of the above, please explain the reason.
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^[1] (TTCs)?
 - a) Prevention TTC? ☒ Yes ☐ No
 - b) SMI Adviser ☒ Yes ☐ No
 - c) Addiction TTC? ☒ Yes ☐ No
 - d) State Opioid Response Network? ☒ Yes ☐ No
 - e) Strategic Prevention Technical Assistance Center (SPTAC) ☒ Yes ☐ No

Waivers

*Upon the request of a state, the Secretary may waive the requirements of all or part of the sections **42 U.S.C. § 300x-22(b), 300x-23, 300x-24, and 300x-28 (42 U.S.C. § 300x-32(e))**.*

1. Is your state considering requesting a waiver of any requirements related to:
 - a) Allocations regarding women (300x-22(b)) ☐ Yes ☒ No

2. Is your state considering requesting a waiver of any requirements related to:

a) Intravenous substance use (300x-23)

☐ Yes ☒ No

3. Is Your State Considering Requesting a Waiver of any Requirements Related to Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus (300x-24)

a) Tuberculosis

☐ Yes ☒ No

b) Early Intervention Services Regarding HIV

☐ Yes ☒ No

4. Is Your State Considering Requesting a Waiver of any Requirements Related to Additional Agreements ([42 U.S.C. § 300x-28](#))

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.

<https://www.nj.gov/humanservices/dmhas/regulations/regulations/>

^[1] <https://www.samhsa.gov/technology-transfer-centers-ttc-program>

Footnotes:

Criterion 3/ Question 5. NJ identified these needs and is currently providing these services.

Criterion 7/ Question 2a. NJ identified this need and is currently providing these services.

Criterion 6/ New Jersey is not a "Designated State."

Criterion 8, 9 and 10/ DMHAS has formal agreements with other governmental agencies, universities, community provider agencies, agencies in other branches of government to review and ensure that treatment services are identified in areas of primary health care, veterans services, justice involved services, community-based organizations, community-based provider agencies among other resources.

Environmental Factors and Plan

8. Uniform Reporting System and Mental Health Client-Level Data (MH-CLD)/Mental Health Treatment Episode Data Set (MH-TEDS) – Required for MHBG

Narrative Question

Health surveillance is critical to the federal government's ability to develop new models of care to address substance use and mental illness. Health surveillance data provides decision makers, researchers, and the public with enhanced information about the extent of substance use 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. Title XIX, Part B, Subpart III of the Public Health Services Act ([42 U.S.C. §300x-52\(a\)](#)), mandates the Secretary of the Department of Health and Human Services to assess the extent to which states and jurisdictions have implemented the state plan for the preceding fiscal year. The annual report aims to provide information aiding the Secretary in this determination.

[42 U.S.C. §300x-53\(a\)](#) requires states and jurisdictions to provide any data required by the Secretary and cooperate with the Secretary in the development of uniform criteria for data collection. Data collected annually from the 59 MHBG grantees is done through the Uniform Reporting System (URS), Mental Health Client-Level Data (MH-CLD), and Mental Health Treatment Episode Data Set (MH-TEDS) as part of the MHBG Implementation Report. The URS is an initiative to utilize data in decision support and planning in public mental health systems, fostering program accountability. It encompasses 23 data tables collected from states and territories, comprising sociodemographic client characteristics, outcomes of care, utilization of evidence-based practices, client assessment of care, Medicaid funding status, living situation, employment status, crisis response services, readmission to psychiatric hospitals, as well as expenditures data. Currently, data are collected through a standardized Excel data reporting template. The MHBG program uses the URS, which includes the National Outcome Measures (NOMS), offering data on service utilization and outcomes. These data are aggregated by individual states and jurisdictions.

In addition to the aggregate URS data, Mental Health Client-Level Data (MH-CLD) are currently collected. SMHAs are state entities with the primary responsibility for reporting data in accordance with the reporting terms and conditions of the Behavioral Health Services Information System (BHSIS) Agreements funded by the federal government. The BHSIS Agreement stipulates that SMHAs submit data in compliance with the Community Mental Health Services Block Grant (MHBG) reporting requirements. The MH-CLD is a compilation of demographic, clinical attributes, and outcomes that are routinely collected by the SMHAs in monitoring individuals receiving mental health services at the client-level from programs funded or provided by the SMHA.

MH-TEDS is focused on treatment events, such as admissions and discharges from service centers. Admission and discharge records can be linked to track treatment episodes and the treatment services received by individuals. Thus, with MH-TEDS, both the individual client and the treatment episode can serve as a unit of analysis. In contrast, with MH-CLD, the client is the sole unit of analysis. The same set of mental health disorders for National Outcome Measures (NOMs) enumerated under MH-CLD is also supported by MH-TEDS. Thus, while both MH-TEDS and MH-CLD collect similar client-level data, the collection method differs.

Please note: *Efforts are underway to standardize the client level data collection by requiring states to submit client-level data through the MH-CLD system. Currently, over three-quarters of states participate in MH-CLD reporting. Starting in Fiscal Year 2028, MH-CLD reporting will be mandatory for all states. States that currently submit data through MH-TEDS are encouraged to begin transitioning their systems now and may request technical assistance to support this transition process*

This effort reflects the federal commitment to improving data quality and accessibility within the mental health field, facilitating more comprehensive and accurate analyses of mental health service provision, outcomes, and trends. This unified reporting system would promote efficiency in data collection and reporting, enhancing the reliability and usefulness of mental health data for policymakers, researchers, and service providers.

Please respond to the following items:

1. Briefly describe the SMHA 's data collection and reporting system and what level of data are reported currently (e.g., at the client, program, provider, and/or other levels).

New Jersey's Unified Services Transaction Form Web Application (USTF+) is a real time, MH-CLD data collection platform. The USTF+ collects client demographic information, service programs, provider agencies, admissions and discharges. It also collects service episode details including various assessment, referral source, marital status, employment, education, hospitalization, living situation, residential arrangements, arrest, financial, services and needs, clinical and diagnoses, tobacco and drug information, etc., at every admission and discharge. The collected data is used to complete the Universal Reporting System (URS) data tables which are focused on client demographics, National Outcome Measures (NOMS) and MHBG requirements. Clients who received a

service in the state fiscal reporting period are included in the reports. The USTF+ system was rolled-out statewide in July 2023. Community provider agencies have been trained and provided access. There have been over twenty live, virtual training opportunities, as well as additional “one on one” training video conferences to agency users. DMHAS has also produced a quarterly user newsletters and been very active in responding to user Help Tickets. The full use of the system among all agency partners remains a work-in-progress, which leads to an incomplete dataset. DMHAS regularly monitors the data submission and compares the data submitted into the USTF+ by program and agency with the data submitted into the Quarterly Contract Monitoring Report (QCMR) system for validation purposes. Evaluation staff works with the providers and the provider administrators to identify issues with submitting data. DMHAS has also been meeting with the designated lead person for each agency on a regular basis. State Hospital – Client data such as treatment status, residential status, mental health diagnosis and client demographic information for individuals treated in the state hospitals is collected through the state hospital database. Collected data is also used in various reports and data dashboard for planning purposes. Beds Enrollment Database (BEDS) provide real-time access to vacancy information, which helps to facilitate assignments, in a more streamlined manner, and facilitate better communication with state psychiatric hospitals. New Jersey Mental Health Application for Payment Processing (NJMHAPP) allows agencies contracted with DMHAS for mental health services to submit eligible encounters/billing for all fee for service (FFS) programs for payment processing. It does not replace other contractually obligated data requirements by DMHAS such as QCMR and USTF. NJMHAPP will only be accessed for services that are NOT covered by Medicaid or other insurance since the state is the payer of last resort.

2. Is the SMHA 's current data collection and reporting system specific to mental health services or it is 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 SMHAS current data collection is specific to mental health services. When developing reports, we also use the State Psychiatric Hospital Census Data as a supplement.

3. What is the current capacity of the SMHA in linking data with other state agencies/entities (e.g., Medicaid, criminal/juvenile justice, public health, hospitals, employment, school boards, education, etc.)?

Source of Reimbursement including Medicaid and state hospital data is also collected. Even though other data sources with other state agencies/entities data are also collected and used in reporting, there's no systematic or programmatic interoperability between data collected in USTF+ and the other data repositories.

4. Briefly describe the SMHA 's ability to report evidence-based practices (EBPs) including Early Serious Mental Illness (ESMI) and Behavioral Health Crisis Services (BHCS) outcome data at the client-level.

A module is in the process of being built for the CSC CI program in order to collect information on assessments and outcome measures. Initial diagnostic outcomes that can be gleaned from the initial release of the module include four diagnostic outcomes: Suicidality, Quality of Life, Social & Global Functioning, and Severity of Depression. Additional measures include client demographics, medication monitoring/adherence, psychiatric hospitalization, discharge information, length of stay, re-admission dates, and substance use. Provider agencies employ 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 CSCCI programs. MIRECC GAF is the primary assessment tool used to determine symptom progress in the CSC CI client base. Scores are collected on a quarterly basis and compared against previous quarter scores. The Colombia Suicide Severity Index is used at intake, after each hospitalization, and on a discretionary basis to assess client suicidality. These measures have also been used by other RAISE programs outside New Jersey and proven to be sound measures for symptom severity among the FEP population. Clinical Global Impressions Rating Scale is used to measure severity of illness, global improvement and therapeutic response. WHODAS (World Health Organization Disability Assessment Schedule) has been programmed for use into the USTF+ system for all DMHAS funded programs to measure disability and functional impairment. DMHAS plans to utilize the WHODAS and remove the requirement for providers to complete the Global Level of Functioning Scale (GLOF). DMHAS would like technical assistance for community providers to learn how to complete the WHODAS. BPRS (Brief Psychiatric Rating scale) is used to gather information about the presence and severity of psychiatric symptoms.

5. Briefly describe the limitations of the SMHA 's existing data system.

USTF+ is a web based, real time and stateless data collection platform. Due to program compatibility rules, not all service programs can and should be provided to the same client at the same time. When a “backdated” service record needs to be entered in the system for a client but the client is currently enrolled in a “non-compatible” program, there's no systematic solution other than manual workarounds to address that.

The USTF+ system is commendable for being expansive and comprehensive—able to include an ever-growing array of programs and a seemingly-unending stream of new data elements necessary to satisfy myriad federal reporting requirements. However, with the gift of hindsight, the complexity & comprehensiveness of the system has sacrificed its intuitiveness, user-friendliness and overall adoption by the user-community.

6. What strategies are being employed by the SMHA to enhance data quality?

Quarterly releases of USTF+ (<https://dmhas.dhs.state.nj.us/USTFPlus/>) to add new and update existing service programs, add new and improve existing features, functionalities and user experiences followed by a release of a quarterly newsletter.

Weekly “Ticket Resolution” roundtable meetings to discuss common issues and share solutions.

Weekly ticket analysis to analyze ticket categories, status, trends and loads.

Validation comparison reports of admission/discharge numbers between USTF+ and QCMR.

Periodic audit and update of system settings for service providers, programs, service sites and contacts

Provider admin user meetings, webinars, trainings, newsletters. Provider Administrator meetings are facilitated by the SMHAS on a monthly basis via video conference and serve as a two-way informational exchange forum wherein the SMHA provides guidance on new developments on the USTF+ system and also fields questions from the system user community. Each new update of the USTF+ system is accompanied by an invitation to all system users to participate in a videoconference where the new updates are discussed. The SMHA releases quarterly Newsletters to the USTF+ user community to discuss: recent system updates, helpful hints, and suggested best practices.

7. Please describe any barriers (staffing, IT infrastructure, legislative, or regulatory policies, funding, etc.) that would limit your state from collecting and reporting data to the federal government.

When SAMHSA makes CLD changes (split Race – “Asian and Pacific Islanders” into “Asian” and “Pacific Islanders”, for example), the following reporting period would inevitably include considerable number of “NULL” values in the new categories, because many of the existing data in our system will not get chance to be updated unless the clients are returning.

In the long-term, the statewide roll-out of the USTF+ system opens up improved possibilities in the SMHA’s ability to collect/report data due to the comprehensiveness of the system and the broad range of data elements it can collect. However, the novelty and complexity of this system hinders the SMHA’s efforts in collecting truly complete datasets in the immediate future. Additionally, DMHAS needs time to reconfigure our system when changes are made to the URS tables or other block grant requirements. DMHAS will notify providers of the changes in our system, provide training, and then they will need time to alert their EHR companies to make changes in their systems which collect client information and ultimately provide the information that they report to the state. Both DMHAS and the provider agencies will most likely experience an increase in costs due to the programming and training in order to be compliant with the new requirements.

8. Please indicate areas of technical assistance needs related to this section.

New Jersey evaluation team would like technical assistance to see how other states are using their URS data/client level data for planning purposes.

New Jersey has not established a methodology to estimate incidence of SMI among adults and would like to request technical assistance in developing this methodology.

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Footnotes:

Environmental Factors and Plan

9. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

There is a mandatory 5 percent set-aside within MHBG allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

.....to support evidence-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.

CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to fund some or all of the core crisis care service components, as applicable and appropriate, including the following:

- *Crisis call centers*
- *24/7 mobile crisis services*
- *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*

STATE FLEXIBILITY: In lieu of expending 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence-based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.

A crisis response system has 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. The expectation is that states will build on the emerging and growing body of evidence, including guidance developed by the federal government, for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization services to support reducing distress, and the promotion of skill development and outcomes, all towards managing costs and better investment of resources.

Several resources exist to help states. These include [Crisis Services: Meeting Needs, Saving Lives](#), which consists of the [National Guidelines for Behavioral Health Coordinated System of Crisis Care](#) as well as an [Advisory: Peer Support Services in Crisis Care](#). There is also the [National Guidelines for Child and Youth Behavioral Health Crisis Care](#) which offers best practices, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth, and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by the 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

When individuals experience a crisis related to mental health, substance use, and/or homelessness (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

Crisis Contact Center. In times of mental health or substance use crisis, 911 is typically called, which results in police or emergency medical services (EMS) dispatch. A crisis call center (which may provide text and chat services as well) provides an alternative. Crisis call centers should be made available statewide, provide real-time access to a live crisis counselor on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess, coordinate, and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social

services, government agencies, and non-profit organizations.

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember, and they receive a quick response. Many of the crisis systems in the United States continue to use 911 for several reasons such as they are still building their crisis systems or because they have no mechanism to fund a call center separate from 911. However, they recognize that the sure way to minimize the involvement of law enforcement in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911-based system with dispatchers who forward calls to either law enforcement's responder team (law enforcement officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with law enforcement officers who have received Crisis Intervention Training, including awareness of mental health and substance use disorders, and related symptoms, de-escalation methods, and how to engage and connect people to supportive services; (2) the 911-based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers may then refer appropriate calls to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Contact Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Mobile Crisis Response Team. Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be resolved by phone alone. Historically, law enforcement has been dispatched to the location of the individual in crisis. But in an effective crisis system, mobile crisis teams, including a licensed clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be connected to the appropriate level of care, if needed, as deemed by the clinician and response team.

Crisis Receiving and Stabilization Facilities. In a typical response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a "no wrong door" policy that supports all individuals, including those who need involuntary services. When anyone arrives, including law enforcement or EMS who are dropping off an individual, the hand-off should be "warm" (welcoming), timely and efficient. These facilities provide assessment for, and treatment of mental health and substance use crisis issues, including initiating medications for opioid use disorder (MOUD), and also provide wrap-around services. The multi-disciplinary team, including peers, at the facility can work with the individual to coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system, including follow-up care.

Currently, the 988 Suicide and Crisis Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of individuals who are trained to utilize best practices in handling behavioral health calls. Local call centers automatically engage in a safety assessment for every call; if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

988 – 3-Digit behavioral health crisis number. The National Suicide Hotline Designation Act ([P.L. 116-172](#)) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 Suicide & Crisis Lifeline, but the 1-800-273-TALK is still operational and directs calls to the Lifeline network. The 988 transition has supported and expanded the Lifeline network and will continue utilizing the life-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.

Building Crisis Services Systems. Most communities across the United States have limited, but growing, crisis services, although some have an organized system of services that provide on-demand behavioral health assessment and stabilization services, coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.

1. Briefly describe your state's crisis system. For all regions/areas of your state, include a description of access to crisis contact centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.

NJ's 3 Core Elements:

New Jersey is in the process of expanding its continuum of crisis services. The 988 Lifeline Crisis Centers and Mobile Crisis Outreach Response Teams (MCORTs) are currently operational. There are plans to implement Crisis Receiving Stabilization Centers (CRSCs).

Crisis Call Centers:

New Jersey has four (4) 988 Lifeline crisis centers - Caring Contact, CONTACT of Mercer County (COMC), Mental Health Association in New Jersey (MHANJ), and Rutgers University Behavioral Health Care (R-UBHC). Collectively, these centers offer 24/7 primary and secondary coverage statewide for calls. Three (3) of these four (4) centers also provide in-state response to 988 chats and texts. Those centers are: COMC, MHANJ, and R-UBHC. Collectively, these centers offer statewide coverage for incoming chats and texts. Lifeline centers offer access to trained crisis counselors who assess individuals contacting 988 for risk of suicide, help to de-escalate the crisis, provide support, and offer referrals to mental health and/or substance use services as appropriate. Crisis counselors are trained to practice active engagement, use the least invasive interventions available, and initiate life-saving services to secure the safety of individuals who are at risk.

Mobile Crisis Response Teams

Mobile Crisis Outreach Response Teams (MCORTs) have been established as the "Someone to Respond" for the NJ 988 system. The state budget includes \$16 million for statewide MCORTs. These teams are designed to respond 24 hours a day, every day of the year to non-life-threatening mental health, substance use or suicidal crises in the community. MCORTs are comprised of a two-person unit in the field under remote supervision by a third professional from a centralized location. The professionals include: trained peer support staff, bachelor's level staff with related educational and professional experience (in the field), and master's level supervisors providing clinical consultation. MCORTs are dispatched by the NJ 988 Managing Entity, Carelon, after a 988 Lifeline Center determines a community-based response, without emergency responders, is necessary and appropriate. MCORT is a voluntary service and the individual must provide consent prior to dispatch.

MCORTs support individuals 18 or older by de-escalating crises, providing linkage to ongoing community services, and follow-up support. MCORTs collaborate with family members or loved ones to assist and support the individual in crisis when appropriate. The goals of the MCORT system are to: provide timely access to crisis intervention services; stabilize consumers in their community; prevent hospitalization and re-hospitalization whenever possible; decrease intervention by law enforcement whenever it is safe to do so; and deliver behavioral healthcare to all New Jersey residents.

For the MCORT program, the state has been divided into nine (9) Regions based on geography and census. This information was also used to determine the minimum number of teams to operate in each Region. One of the goals of the MCORT program is to provide an in-person response within one-hour of the initial dispatch. NJ DMHAS has contracted with five (5) provider agencies to operate MCORTs in the nine (9) Regions. On March 3, 2025, MCORT services were launched statewide with limited hours of operation. On August 11, 2025, MCORT services expanded to full 24/7 availability. From March 3rd through July 31st, MCORT completed 247 dispatches. In SFY 2025, there were 148 individuals served by MCORT and 197 units of service.

Crisis Receiving Stabilization Centers

The DMHAS has awarded five (5) crisis receiving stabilization centers (CRSCs) to advance the development of the crisis continuum in NJ based on the National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit. The CRSCs will provide an appropriate alternative to the use of local hospital emergency services and in-patient psychiatric hospitalization, by providing crisis services and linkages to services and supports. The goal of this program is to decrease the utilization of local hospital emergency services, designated screening centers, and in-patient psychiatric hospitalization while maintaining crisis stabilization treatment. The comprehensive crisis stabilization services of a CRSC provided in the community setting will result in better care, better improved outcomes and individual experience while accessing services. The program will also result in cost savings through the decrease in avoidable emergency department visits, psychiatric inpatient admissions, police engagement, and 911 calls.

The Crisis Receiving Stabilization Centers (CRSCs) will serve individuals 18 years of age and older with a primary SMI and/or SUD or co-occurring disorder, experiencing a suicidal, mental health, or substance use crisis. DMHAS will be using the "no wrong door" concept and partnering with community crisis responders, operating much like a hospital emergency department that accepts all walk-ins, law enforcement and fire drop offs, fire, police drop-offs (Note that EMS transfers to the program may not be made until arrangements for this are made). Services will be available 24 hours per day, 7 days per week, every day of the year and include access to trained staff who can provide assessment, crisis stabilization, intensive supports, engagement, psychoeducation, identification of strengths, collaborative problem solving, and individualized crisis planning. Services

will be offered in a safe, clean, home-like environment conducive to the recovery process. Medication management, administration, and education will be offered. Medication-Assisted Treatment will also be available at the CRSCs. Clinical staff in the program will strive to stabilize individuals and address their needs for further treatment or linkage. The program will offer continuity of care promoting continued stability and ensuring linkages are arranged that meet the needs of the individual.

Other Crisis Services in NJ Outside the Core Elements

Beyond the core elements of NJ's Crisis Continuum, the SMHA has implemented a comprehensive crisis system including peer-run warmlines, crisis diversion homes, inpatient diversion, peer support diversion, and collaboration with law enforcement. The SMHA also provides technical assistance to improve the efficiency and effectiveness of crisis care services.

Crisis Diversion Homes

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

Crisis Diversion Beds

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

Peer Respite Beds

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

Diversory 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 decrease 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.

New Jersey offers a service called ReachNJ which is a 24/7 addiction helpline for New Jersey residents who are seeking treatment for a substance use disorder. ReachNJ calls are answered by staff who are trained to provide a caller with referrals to local treatment providers and/or other support services. ReachNJ is also available to people who are seeking support for a loved one with substance use disorder.

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

NJ 211 is a subsidiary of the United Ways of New Jersey. NJ 211 offers free, confidential 24/7 public information for individuals who require health and social service resources. NJ 211 provides referrals for housing, food, utility assistance, family services, behavioral health needs, and disaster support.

Finally, two (2) other call lines support the New Jersey crisis system. NJ Mental Health Cares is NJ's mental health information and referral service staffed by mental health professionals. The Peer Recovery Warmline is a peer-run service providing telephonic support to people in recovery from mental illness.

Designated Screening Centers

To ensure access to psychiatric emergency services statewide, there are 23 Designated Screening Centers (Screening and Screening Outreach) operating 24/7 in 21 Counties. These centers offer screening, assessment, crisis intervention, mobile screening, referral, linkage, and crisis stabilization services in all areas of the state.

Affiliated Emergency Services

Twelve (12) Affiliated Emergency Service (AES) programs are present in high-volume emergency departments. These programs provide immediate crisis intervention and support to individuals in distress, focusing on stabilizing their condition and facilitating their active involvement in service planning. The AES programs work in partnership with the Designated Screening Centers through formal agreements.

Early Intervention Support Services (EISS)

EISS programs are community-based mental health clinics that are open 6-7 days per week to deliver rapid access to short-term crisis intervention and stabilization services. They provide a comprehensive range of services, including medication, therapy, recovery support, and other supportive interventions, aiming to serve as a diversion to emergency room use and the need for inpatient treatment.

Crisis Services Provided by the Children's System of Care

Mobile Response and Stabilization Services (MRSS)

MRSS is the CSOC's urgent response service designed to help families stabilize youth in home and community settings. MRSS are available 24 hours per day, 7 days a week, year-round. MRSS provides immediate (within one hour) intervention designed to minimize risk, maintain the youth in his/her current living arrangement, prevent repeated hospitalizations, stabilize behavioral health needs, and improve functioning in life domains such as school and home routines. Mobile Response and Stabilization Services (MRSS) deliver services to youth vulnerable to or experiencing stressors, coping challenges, emotional or behavioral symptoms, difficulties with substance use as a coping strategy, or traumatic

circumstances that may compromise the youth's ability to function optimally and thrive within their family/living situation, school, and/or community environments. MRSS is designed as an upstream intervention available to support families and youth when they first identify they need assistance based on their definition of need. Care is individualized, strengths-based, youth-centered, family-driven, community-based, and trauma-informed. MRSS provides engagement, crisis intervention, assessment, and planning designed to stabilize presenting stressors, behaviors and/or emotional challenges, maintain youth in their home environment and community, build formal and informal supports, and prevent unnecessary psychiatric hospitalization, out of home care, and legal involvement. CSOC has collaborated with DHS to ensure access to CSOC services, including crisis intervention services delivered by system partners, i.e. Mobile Response Stabilization Services, in the event that a youth or their family member contacts 988.

Youth Suicide Prevention Resources

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

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

The Traumatic Loss Coalitions for Youth Program (TLC) at Rutgers-University Behavioral HealthCare is an interactive, statewide network that seeks to decrease suicide attempts, deaths by suicide, and to promote recovery of persons affected by suicide by offering collaboration and support to professionals working with school-age youth and direct crisis response services to staff and youth at youth-serving organizations following a traumatic event. The TLC offers county, regional, and statewide conferences, training, consultation, on-site traumatic loss response, and technical assistance. Since its inception, the TLC has trained thousands of individuals throughout the state with the purpose of saving lives and promoting post trauma healing and resiliency for the youth of New Jersey. In state fiscal year 2024, the TLC launched the HOPES Program to help others process the experience of a suicide loss. Adapted from the LOSS Team model, HOPES provides support and hope to families bereaved by the suicide loss of a child (21 and under); empowering survivors so they can thrive and lead meaningful lives. The TLC website can be accessed at <http://ubhc.rutgers.edu/tlc/http://ubhc.rutgers.edu/tlc/>

Project Connect

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

2NDFLOOR Youth Helpline

Accredited by the American Association of Suicidology, 2NDFLOOR is a confidential call/text helpline and message board platform serving youth and young adults. Youth who contact the 2NDFLOOR are assisted with their daily life challenges by professional staff and trained volunteers. The 2NDFLOOR launched a mobile application in 2024 that allows youth to anonymously connect to their services via the app. The app allows call, chat, and message board and has additional features such as resources, polls, and emojis. The launch of the app significantly increased utilization of the message board and clicks to resources. The website can be accessed at <http://www.2ndfloor.org/http://www.2ndfloor.org/>

Dialing 988 will connect you with the Suicide & Crisis Prevention Lifeline, which provides 24/7 free confidential support to anyone in emotional distress or suicidal crisis. Calls, texts, or chats to 988 will connect you with a trained counselor who will listen, understand, and provide support and access to resources to address your immediate needs as well as your ongoing care. Additional information is available at: www.njhopenline.com

New Jersey Youth Suicide Prevention Advisory Council

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

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

- a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.
- b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the published guidance. This includes coordination, training and community outreach and education activities.
- c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the published guidelines.
- d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.
- e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.

Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to contact	☐	☐	☐	☐	☐	☒
Someone to respond	☐	☐	☐	☒	☐	☐
Safe place to be	☐	☒	☐	☐	☐	☐

3. Briefly explain your stages of implementation selections here.

Someone to call - NJ currently has four (4) 988 Lifeline centers certified by Vibrant Emotional Health (Vibrant) for meeting the minimum clinical, operational and performance standards. Those centers are CONTACT of Mercer County (COMC), Caring Contact, Mental Health Association in New Jersey (MHANJ), and Rutgers University Behavioral Health Care (R-UBHC). Collectively, these centers offer statewide coverage for incoming calls. R-UBHC is the only center in NJ that currently offers 24/7 call services.

In calendar year 2021, the National Suicide Prevention Lifeline in NJ received 45,820 calls. In the first year of 988 (July 2022 – June 2023), NJ received 57,163 calls. In year two (July 2023 – June 2024), NJ received 75,664 calls. In year one and year two, NJ averaged a 79% in-state call answer rate even with increases in volume. In year three thus far, NJ is on track to receive at least 10,000 more calls and is currently averaging an 82% in-state answer rate.

NJ originally had one (1) center, COMC, providing in-state chat and text services at a limited capacity. In December 2024, R-UBHC began providing

in-state chat and text services from 8am to 12am. As of March, R-UBHC expanded its chat and text services to 24/7. As of March 2025, MHANJ also began providing in-state chat and text services 7-days per week from 5pm to 9pm. Collectively, these centers offer statewide coverage for incoming chats and texts to NJ's 21 counties.

From SFY23 to SFY24, NJ saw an 89% increase in text demand. According to Vibrant, in SFY24, NJ 988 was routed 12,508 chats and texts of which 1,656 were answered for a 13% in-state answer rate. In SFY25 thus far (July 2024 – March 2025), NJ 988 was routed 17,989 chats and texts of which 6,667 were answered for a 37% in-state answer rate. Answer rates are expected to continue to increase as chat and text services further expand in the coming months.

Funding of \$12.8 million was allocated in the State budget toward the expansion of the 988 Lifeline network. Of this total allocation, an RFP to award \$10 million in State funds was published in March 2024 with the goal of expanding 988 Lifeline center capacity sufficiently to answer 90% of state-based calls, chats and texts. In September 2024, approximately \$7 million from this State-funding opportunity was awarded to two (2) 988 Lifeline centers. With these funds, the two (2) centers were able to onboard additional staff, expand center hours, and begin providing 988 chat and text services for the state.

Using a portion of SAMHSA 988 Improvement Grant funding, NJ DMHAS was able to provide contract extensions to the two (2) centers that did not receive awards to continue 988 services at their current levels. In March 2025, with the remaining state funding and approximately \$1.3 million from the SAMHSA Improvement Grant, NJ DMHAS published a Request for Letters of Interest (RLI) to provide ongoing funding to these two (2) centers for the purposes of not only maintaining their current level of operations but expanding their services to contribute towards a 90% in-state answer rate. Final awards are anticipated June 2025.

Someone to respond – Mobile Crisis Outreach Response Teams (MCORTs) have been established as the “Someone to Come/Respond” for the NJ 988 system. The state budget includes \$16 million for the statewide MCORT program. MCORTs are designed to respond in person, 24 hours a day, every day of the year to non-life-threatening mental health, substance use or suicidal crises in the community. MCORTs are dispatched by the NJ 988 Managing Entity, Carelon, after a 988 Lifeline Center determines a community-based response, without emergency responders, is necessary and appropriate. For the MCORT program, the state has been divided into nine (9) Regions based on geography and census. This information was also used to determine the minimum number of teams to operate in each Region. One of the goals of the MCORT program is to provide an in-person response within one-hour of the initial dispatch.

In October 2023, NJ DMHAS published an RFP to award approximately \$16 million in state funds to up to nine (9) agencies establish a total of 62 MCORTs across the 21 NJ counties, based on the regional system identified above. Through this procurement process, four (4) agencies were awarded contracts to operate MCORTs in eight (8) of the nine (9) regions while Region 9 went unawarded. In May 2024, NJ DMHAS posted an additional RFP to establish an MCORT program in Region 9. The successful bidder was awarded a contract in September 2024.

On March 3, 2025, MCORT services were launched statewide operating weekdays from 7am to 3pm. On March 31st, 2025, MCORT expanded its hours to weekdays from 7am to 7pm. As staffing permits, NJ will continue to expand its MCORT services incrementally until 24/7 operation is achieved.

In December 2024, DMHAS received approval of its Medicaid State Plan Amendment (SPA) requesting for MCORT to be Medicaid-supported under Section 1947 of the U.S. Social Security Act. The SPA will provide an enhanced match for 3 years, then move to a standard 50% reimbursement through the federal medical assistance percentage (FMAP) for MCORT services.

Safe place to go - Approximately \$10,970,090 has been allocated from State and federal funding for the development of up to five (5) Crisis Receiving and Stabilization Centers (CRSCs). The federal being used is from the Mental Health Block Grant 5% crisis set-aside, Covid Supplemental Funding, funding from the ARPA Plan, and funding from the Bipartisan Safer Communities Act. CRSCs will offer statewide service 24 hours a day, every day of the year. CRSCs will provide short-term (less than 24 hour) community-based services to individuals experiencing a suicidal, mental health or substance use crisis. The CRSCs will be staffed by professionals, including professionals with prescription authority (Psychiatric Mental Health Nurse Practitioners and/or Psychiatrists), mental health and substance use clinicians, registered nurses, behavioral health technicians, and trained peer counselors. Licensed clinicians will screen for suicide risk and conduct more comprehensive violence risk assessments when clinically indicated. Individuals will be linked to aftercare services and offered follow-up support. DMHAS has awarded 5 Crisis Receiving Stabilization Centers. The programs are in the process of hiring and training staff, initiating construction and renovations to the CRSC buildings, and

developing policies and procedures.

DMHAS has awarded 2 Crisis Diversion Homes. One home is awaiting licensing approval in order to open and the second home is in the renovations phase. Once renovations are complete the home can move forward with requesting licensing approval to begin preparations to open.

4. Based on the National Guidelines for Behavioral Health Crisis Care and the [National Guidelines for Child and Youth Behavioral Health Crisis Care](#), explain how the state will develop the crisis system.

DMHAS plans to develop 5 Crisis Receiving Stabilization Centers (CRSC) statewide to serve individuals with a serious mental illness (SMI) diagnosis experiencing acute psychiatric symptoms and individuals with a substance use disorder (SUD) related crisis aged 18 and over. CRSC offers a no-wrong-door access to crisis stabilization, operating much like a hospital emergency department that accepts all walk-ins, law enforcement and fire drop offs, fire, police drop-offs. The individuals served in the CRSCs will receive community-based treatment and supportive services in an effective and timely manner 24 hours a day, 7 days a week. DMHAS is currently drafting a State Plan Amendment (SPA) for the CRSC program. As of August 2025, the 5 centers are not operational.

DMHAS has awarded 2 provider agencies that will develop 2 Crisis Diversion Homes. The CDHs will serve individuals who have recently experienced a crisis and will prioritize referrals from Crisis Receiving Stabilization Centers (CRSC) or Mobile Crisis Outreach Response Teams (MCORT). The goal is to provide further stabilization, to decrease hospital admissions and decrease emergency department (ED) visits. Crisis diversion can "promote access to less restrictive settings for residential crisis intervention and more effective utilization of scarce resources and expensive psychiatric beds¹. CDHs offer recovery oriented temporary transitional housing for up to 30 days, within a 24-hour supervised setting that includes therapeutic and social supports in a warm and safe environment to individuals who do not need further hospitalization. DMHAS has awarded 2 provider agencies that are developing residential capacity in an A+ service level structure which will provide 24/7 onsite staffing in the home for eligible individuals (in accordance with N.J.A.C. 10:37A).

New Jersey (NJ) has awarded approximately \$7 million in state allocations for additional 988 Lifeline operations. NJ DMHAS is in the process of procuring additional services for the NJ 988 Lifeline through the use of state and federal grant funding. NJ's goal is to expand the number of crisis counselors as well as the hours of current Lifeline centers to ensure a 90% in-state answer rate for calls, chats and texts to the 988 Lifeline in NJ. NJ DMHAS with the Department of Human Services (DHS) has contracted with the marketing agency, Positive Solutions, for a statewide 988 public awareness campaign. Plans for the campaign include billboards, streaming ads, social media content, public transit ads, posters, etc. NJ's goal is to promote 988 to ensure all New Jersey residents are aware of this new service and have immediate access to crisis care.

In SFY25, NJ DMHAS launched its 988 Mobile Crisis Outreach Response Team (MCORT) Program statewide. While the program is intended to operate 24/7, services have begun on a limited basis as agencies continue to hire and onboard staff. In December 2024, DMHAS received approval of its Medicaid State Plan Amendment (SPA) requesting for MCORT to be Medicaid-supported under Section 1947 of the U.S. Social Security Act. The SPA will provide an enhanced match for 3 years, then move to a standard 50% reimbursement through the federal medical assistance percentage (FMAP) for MCORT services

5. Other program implementation data that characterizes crisis services system development.

Someone to contact: Crisis Contact Capacity

- a. Number of locally based crisis call Centers in state
- i. In the 988 Suicide and Crisis lifeline network:
- ii. Not in the suicide lifeline network:
- b. Number of Crisis Call Centers with follow up protocols in place
- i. In the 988 Suicide and Crisis lifeline network:
- ii. Not in the suicide lifeline network:
- c. Estimated percent of 911 calls that are coded out as BH related:

Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the total number of communities)

- a. Independent of public safety first responder structures (police, paramedic, fire):
- b. Integrated with public safety first responder structures (police, paramedic, fire):
- c. Number that utilizes peer recovery services as a core component of the model:

Safe place to be

- a. Number of Emergency Departments:
- b. Number of Emergency Departments that operate a specialized behavioral health component:
- c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis):

6. Briefly describe the proposed/planned activities utilizing the 5% set aside. If applicable, please describe how the state is leveraging the CCBHC model as a part of crisis response systems, including any role in mobile crisis response and crisis follow-up. As a part of this response, please also describe any state-led coordination between the 988 system and CCBHCs.

With the mental health block grant 5% crisis set-aside and other funding sources, the DMHAS will be leveraging funding from the Covid Supplemental, ARPA, and Mental Health Block Grant to develop 5 crisis receiving stabilization centers (CRSCs). The objective is to develop and fund the third pillar of the crisis continuum. The CRSCs will be an alternative to the use of local hospital emergency services and in-patient psychiatric hospitalization, by providing crisis services and placement support for those in need.

7. Please indicate areas of technical assistance needs related to this section.

New Jersey is requesting technical assistance for setting its rate for the CRSC and looking at the funding model and sustainability. Addressing billing, calculating rate per chair, billing for costs outside the bundled rate, and moving toward sustainability and expansion.

New Jersey is requesting technical assistance in order to develop a learning collaborative for the Crisis Receiving and Stabilization Centers. The learning collaborative model is an effective way for providers to receive training and ongoing support for the new programs, to disseminate and implement innovative treatments, improve quality of care and to promote implementation of evidence-based practices (EBPs). Providers would benefit from training and support in the following areas to enhance the smooth rollout and implementation of CRSCs:

Developing a therapeutic facility design

Development of effective service models

Adding to providers' therapeutic toolkit with treatment methods such as CBT and DBT for crisis intervention, suicide prevention, trauma informed care, and psychosis.

Developing skills to promote accurate assessment of individuals and how to efficiently triage, treat, stabilize, and then discharge from the CRSC to an appropriate level of care.

Program evaluation and development of outcome measures for national benchmarking with similar programs across the country.

Use of Medicaid data and analyzing data from the Medicaid warehouse.

Compliance with federal regulations

Policy development

Development of a fidelity scale to ensure adherence to the best practices in crisis stabilization and receiving center programs.

Workforce development and strategies for retention.

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Footnotes:

Environmental Factors and Plan

10. Recovery – Required for MHBG & SUPTRS BG

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality behavioral health care. The expansion in access to; and coverage for, health care drives the promotion of 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 health and substance use disorders.

Recovery is supported through the key components of health (access to quality physical 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 a recovery- guided approach to person-centered care is inclusive of shared decision-making, culturally welcoming and sensitive to social needs of the individual, their family, and communities. Because mental and substance use disorders can be chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management of recovery and personal success over the lifespan.

The following working definition of recovery from mental and/or substance use disorders has stood the test of time:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, there are 10 identified 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 [Working Definition of Recovery](#).

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 several federally supported national technical assistance and training centers. States are strongly encouraged to take proactive steps to implement and expand recovery support services and collaborate with existing RCOs and RCCs. Block Grant guidance is also available at the [Recovery Support Services Table](#).

Because recovery is based on the involvement of peers/people in recovery, their family members and caregivers, SMHAs and SSAs should engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing organizations and direct resources for enhancing peer, family, and youth networks such as RCOs and RCCs 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 behavioral health treatment system.

1. Does the state support recovery through any of the following:

- a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?

☒ Yes ☐ No

- b)** Required peer accreditation or certification? ☒ Yes ☐ No
- c)** Use Block Grant funds for recovery support services? ☒ Yes ☐ No
- d)** Involvement of people with lived experience /peers/family members in planning, implementation, or evaluation of the impact of the state's behavioral health 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.

Recovery Support Services are non-clinical services that assist families of, and individuals with, a mental illness (with or without a co-occurring SUD). They include social supports, linkage to and coordination among a full range of service providers that facilitate recovery and wellness for an improved quality of life. Services are flexible and may be provided prior to, during, and after treatment. They may be delivered by peers, professionals, faith-based and community-based groups, and others; they are key components of the state's behavioral health system, and include Community Support Services (CSS), Supported Employment, Supported Education, Family Support Services, trainings, and Peer Staff.

Community Support Services (CSS) provide rehabilitation and supports to individuals living in the community; various levels of staff in CSS help individuals attain their individualized recovery goals in social, employment, educational and housing domains, so they achieve independent living and community integration. CSS also helps to administer State-funded rental subsidies and tenancy support services (housing search assistance, utility set up, financial budgeting, etc.), that help individuals live in the community and sustain community tenure. Staff also assist and support efforts to secure available financial assistance (food stamps, utility discounts), navigate public transportation, linkage to legal assistance, access and use of primary medical care, etc.

Supported Employment is provided statewide and allows individuals to obtain and sustain integrated employment in jobs of their choosing within their skill set.

Supported Education is designed to help individuals pursue their individual educational goals by helping them gain access to education and training opportunities and maintain their student status until they can complete basic education, remedial education, General Educational Development (GED), technical programs, college, and graduate school.

Intensive Family Support Services (IFSS) provides support, education, and advocacy for families with a member who has a mental illness. Services include multi-family support groups, family advocacy services, educational conferences, and referrals and linkages to other resources.

DMHAS also supports statewide training in evidence-based practices that support recovery, such as on illness management and recovery (IMR), and it also supports a center of excellence that offers training on recovery-oriented cognitive therapy.

Mental health peer staff have front line roles in many treatment settings and help individuals to set and develop recovery skills and as well as in make connections to treatment and resources. Peer staff have a major role in mental health crisis programs, where they serve on mobile crisis outreach teams and in screening/crisis centers. Peer support services are a required component of the state's certified community behavioral health clinics, as well as in other outpatient services, and peers supported housing and in various community settings, ensuring a person-centered approach and addressing individuals' recovery needs. DMHAS also established peer-operated organizations that provide a range of recovery supports, including a peer warm line, peer wellness (drop in) centers, respite housing, and a peer-to-peer program that assists individuals with cessation of tobacco use.

DMHAS also supports peer led trainings to help individuals achieve peer certification, training in the development of psychiatric advance directives, and training on wellness coaching, supervision, and whole health wellness.

For a complete description of peer recovery supports and services, please see the attachment entitled, "NJ DMHAS Peer Recovery Supports"

Behavioral Health Planning Council and Citizens Advisory Board

The NJ Behavioral Health Planning Council (NJ BHPC) / NJ Mental Health Citizens Advisory Board (CAB) is a unified body of volunteer advocates drawn from all parts of New Jersey's system of behavioral health care. Incorporating the interests of adult and youth mental health, substance use prevention, and treatment, the members of the council include consumers, family members, provider agency staff, stakeholders, representatives from state and county government and the general public.

The core functions of the NJ BHPC/CAB are: 1. the Review of the Block Grant, 2. System Advocacy, and 3. System Monitoring. The BHPC/CAB receives updates on the development of the CMHSBG & SUPTRS applications and Implementation Reports several times a year. In addition, the BHPC/CAB composes a key "Gaps in Services" Section of this application and are invited to read and share feedback on the block grant materials via WebBGAS. Systems Advocacy is conducted and advanced by this group in the course of their monthly open public meetings where members, guests (and the general public) are encouraged to share their experiences with the state-funded system of care, and have direct, candid discussions with the State Mental Health Planner of the SMHA. The Planning Council/CAB monitors New Jersey's behavioral health care system vis-a-vis receiving formal reports/presentations from a wide range of system partners (e.g. units within the SMHA, portions of state government that impact the system of care, provider agencies and stakeholder organizations). The sum of these, and related activities puts the NJ BHPC / CAB in a central role in New Jersey's overall system of behavioral health care.

Division of Mental Health and Addiction Services (DMHAS)

Peer Services

Division of Mental Health and Addiction Services (DMHAS) Office of Advocacy and Peer Services (formally Consumer Affairs); has direct oversight of most peer-operated services delivered in the New Jersey community. This Peer run office is supervised by the Division's Office of the Medical Director.

The office employs two individuals with lived expertise within the office. One peer, who has been part of DMHAS since 2011 serves as the manager of the office and as the Division's Mental Health Ombudsman. The managers purview includes the Community and Hospital based Wellness Centers, the Peer Respite program, CHOICES (Smoking Cessation), Peer training for mental health, Peer operated Warmline, NJ Mental Health Cares information line. The other lived expertise person has been with the Division for one year and is in a full-time role. She has been a tremendous addition to the Office of Advocacy and Peer Services and has made great connections with the peer workforce across New Jersey.

DMHAS works in tandem with people having lived experience, family members, providers and other stakeholders, to promote recovery and wellness for persons managing a mental illness, substance use challenge or co-occurring issues, through a sequence of prevention, early intervention, treatment and recovery services provided by a well-trained and skilled workforce.

State-wide Consumer Advisory Committee (SCAC) meets virtually on a quarterly basis. Virtual meetings are facilitated by the Office of Advocacy and Peer Services personnel. SCAC membership consists of the 22 Community Wellness Center peer managers, three hospital-based Wellness Center peer managers. These meetings generally include a presence by DMHAS executive leadership, including the DMHAS Medical Director and the Division's Deputy Assistant Commissioner. There is also attendance by Office of Community Services Regional staff.

DMHAS shares recent updates with the attendees and answers individual questions. The Community Wellness Center peer managers are asked to share updates about their centers and discuss needs of the community members they serve. Topics include individual accomplishments, community challenges, concerns and ideas, and participants are comfortable asking questions and learning innovative skills from their fellow Peers.

The SCAC members have provided the Division of Mental Health and Addiction Services with feedback that they find the quarterly meetings helpful, but they would like some of the meetings to be in person. The Division benefits from hearing from these front-line service providers to better understand the communities needs and discuss any short-comings.

In 2024, DMHAS rebid the Community Wellness Centers (CWCs) and added funding dollars to provide more competitive salaries for the Center's Peer workforce, to enhance programing and expand community outreach. Many centers have added marketing strategies and provide a vast variety of community outreach. There have also been many centers adding additional satellite sites. These services take trained staff members into their communities to work with individuals who may not get to the centers or that don't know about the services offered at the Wellness Centers. Each Community Wellness Center is expected to be open at minimum 25 hours at the primary location. Those hours of operation must include two nights and one weekend day. In SFY 2024, the Wellness Centers served 31,291 individuals and 33,364 individuals in SFY 2025.

As the world has moved beyond the pandemic, DMHAS has made certain all centers are returning to in person activities, as well as still providing some virtual recovery groups to their participants who had gotten used to the virtual model. These hybrid centers allow more participants to engage in activities offered. The centers are an essential part of their individual community. Many operate in the structure of a "home" with living rooms, kitchens, game rooms, libraries, rooms with exercise equipment and craft rooms, to name a few. They are a place where participants can engage in social interactions, by sitting in a cozy welcoming space and having conversations with each other. They can eat together and build the ties of a family environment.

Wellness Centers provide a space that is non-stigmatizing and always works to be respectful of one another's similarities and understanding of each other's differences. Members can play a game of pool or air hockey, as well as chess or board games. The centers offer wellness and recovery groups and other group activities such as healthy cooking classes or arts and crafts. Outside trips are taken regularly to places like the grocery store, food pantries or Walmart. Staff from the centers also go into the communities and bring wellness-related activities with them, as well as marketing items to introduce people who have lived experience or have family members with mental health or co-occurring needs to available services and other resource opportunities. They visit other types of Human Services centers, Veteran's centers, libraries and churches and will sometimes hold scheduled wellness-focused groups or similar activities at these locations.

The peer staff represented within DMHAS Office of Advocacy and Peer Services make frequent visits across the State to better support the varieties of activities that people sharing their lived experience provide to the Community. It is also an opportunity to share the impact of peer work and engage to support each other. Site visits have included both Community-based and Hospital based Wellness Centers, 988 call centers, Peer Warmline centers and Mobile Community Outreach Team (MCORT) work sites. As new centers (provider agencies) have opened their doors, the Office of Advocacy and Peer Services staff have attended these Grand Opening events. It has brought joy and support to work in a collaborative manner and for the community service providers to be aware that their services are appreciated and supported by the Division of Mental Health and Addiction Services.

Currently, DMHAS Office of Advocacy and Peer Services is working on a plan to have a state-wide, yearly, in person SCAC meeting that would allow the peer Wellness Center managers engage and network face-to-face. The Whole Health Learning Community Initiative, funded by DMHAS, has already started this multi-agency engagement across the Wellness Centers. The initiative has created an environment of comradery and built wonderful collaborations between providers. Plans are being made to invite the peer managers of the Substance Use Recovery Centers to come together with the Office of Advocacy and Peer Services staff and share their lived experience to initiate quarterly meetings for Substance Use peer programs.

A long-term objective of this office is to allow both groups of peer managers to gather collectively and meet their counterparts who operate DMHAS Substance Use Recovery Centers and Community Wellness Centers. This will build an environment that could potentially create seamless transitions from one service center to the other, for participants in need of Community-based services from either or both operating community service center.

RFP Reviews. As part of the internal DMHAS Request for Proposal review process, DMHAS includes staff members with lived-experience to sit on all of the reconciliation committees to review and score any proposals that are submitted by an agency. Peers use the value of lived experience, as recipients of mental health services and/or co-occurring services, to bring their unique perspective to the review meetings. The awareness that peers bring to the review teams has impacted other staff's viewpoints when scoring proposals, creating an understanding that leads to open discussion, which may impact scoring decisions and final awards. The Division has included Peers in the review process for over fourteen years.

Community members with lived experience and family members of persons receiving services, also participate in the RFP process, in the capacity of paid consultants. These community members review proposals and provide a written and oral summary of each proposal to the RFP Team Lead. The representatives are compensated for their input. The Team Lead's discuss each review with the community member, and responses are shared with the DMHAS internal review committee before each proposal is scored. The perspective of the community members is shared and considered, as part of the overall process.

DMHAS Mental Health Ombudsman is a DMHAS staff person with lived experience. The Ombudsman responds to callers who use the Division of Mental Health and Addiction Services (DMHAS) Ombudsman Line, which is a non-crisis line, that is monitored Monday through Friday from 9:00 am to 5:00 pm. The line accepts recorded messages 24/7. It is important for the Ombudsman to develop trust with the caller to allow the caller to feel comfortable being open and honest about their call. For this, the Ombudsman must possess learned engagement strategies which they use to work with the caller. The Ombudsman begins the conversation by letting the caller know it is the formal complaint line for DMHAS services. A process is in place to resolve most issues in a swift, confidential and effective manner.

This role requires outstanding communication and interpersonal skills, knowledge of resources of other professionals, problem solving skills and the ability to be empathetic. The DMHAS Ombudsman role is filled by a Peer with lived Mental Health service experience, who is also a family member of a person(s) who has received Mental Health and co-occurring services.

DMHAS Secret Shopper Initiative, at the Assistant Commissioner's directive, Consumer Affairs introduced the DMHAS Secret Shopper Program. The purpose of this project was to generate feedback about how our provider agencies are responding to calls made by persons who pose as clients. The program has provided the Division with valuable information about the experience when calling a provider, the availability of appointments and challenges clients may face when trying to access services.

The Program currently has two community-based callers. One with mental health lived experience and one who has co-occurring challenges. The participants divide the phone calls between MH agencies and SUD agencies. Each participant is issued a state cellular phone to use when making calls to providers. This is important because they are asked to leave a message for a call back when they reach an answering machine. Each participant also receives a state email account connected to the Division's network.

The Secret Shopper sends a synopsis of each call to the Initiative Supervisor at the end of each month. A total requirement of 15

outreach calls per month are expected per participant. In past periods the expectations were greater and it was found to be an overwhelming demand on individuals making calls. They are paid by the state as consultants for their services.

The feedback from such calls to agencies is tracked and monitored. In the past the agencies received a letter detailing the Shopper's experience. There is a plan to once again alert provider agencies of the outcome of each of these calls. The initiative has no intention to create blame for a problematic call. The Secret Shopper Initiative has been used to enhance services and to make systemic awareness of a DMHAS expectation to demonstrate respect, knowledge and to offer support an individual seeking services for any behavioral health related condition.

Some issues identified by the Secret Shoppers have included:

Calls being answered by an answering machine rather than speaking to a live person.

Long wait times to get an appointment for emergent issues.

Having to call another number to make an appointment.

An outcome of this initiative, was a pro-active group of providers met with DMHAS Executive Leadership to resolve some of the concerns expressed to DMHAS. One of these concerns was the regular use of answering machines and calls not being returned in a timely manner or not returned at all. The agencies didn't like this practice either, however, the providers communicated that they could no longer afford the cost of having a receptionist available to take calls.

Both groups brainstormed and some resolutions were discussed and implemented. The agencies stated that using an answering machine was necessary due to staffing and funding constraints. The DMHAS Medical Director then put forth a change to state regulations that stipulated, if a recording system was in use, any voice messages left on any agency system, must be outreached within 24 hours of regular business hours.

Some more issues identified by the Secret Shoppers included:

Answering systems were malfunctioning or went to random unmonitored mailboxes.

Agencies went out of business or merged and the directory numbers were no longer valid.

Legacy Treatment Services

Legacy Treatment Services operates Crosswinds, a peer-run mental health crisis respite center in Toms River, NJ. This program provides crisis respite services for 7-14 days for adults who need a supportive residential environment to work towards wellness and recovery and avoid psychiatric re-hospitalization. The program has several peers on staff who work with consumers to develop WRAPs and PADs and run peer support groups. Consumers have access to staff on a 24/7 basis to receive needed supports, while working to be linked with essential services, such as housing, financial assistance, physical health care and mental health care. The program also has peers in substance use recovery on staff who can assist consumers who have both mental health and substance use concerns work towards their own recovery. The success of the program is such that consumers have graduated from the program and worked to obtain peer certificates to come back as volunteers or employees in Crosswinds.

Legacy also operates several programs that have peer staff available to provide support. Kairos House, a similar residential program to Crosswinds, also employs peer workers on staff to provide support. Crisis programs include 988 Mobile Crisis Outreach Response Teams, in which a certified peer is part of a response team for in-person community crisis outreach. The Screening and Crisis Intervention Program (SCIP) employs peers to provide support for in-person outreach, emergent case management, and follow-up supports to those experiencing psychiatric crisis. Involuntary Outpatient Commitment programs employ peer case managers who use their own story of wellness and recovery to connect with consumers who are court-ordered to outpatient mental health treatment.

Community Support Services has peers on staff specifically to work with individuals developing WRAP plans and Psychiatric Advance Directives. Lastly, the Outpatient department has peers on staff to provide individual peer to peer sessions to those who receive therapy and medication management.

Consumer Parent Support Network

The purpose of the Consumer Parent Support Network is to support parents with a diagnosis of a mental illness in their parenting efforts and to promote the healthy functioning within their families.

The Consumer Parent Support Network uses traditional case management, combines it with support groups, education and advocacy, using mentors. Each program participant has the opportunity to select from a variety of support services that can strengthen their role as a parent. Our Parent Support Staff assists with needed referrals and case management. Our Parent Advocates are both parents and people with lived experience. They can help a person negotiate the challenges of parenting by acting as a mentor, sounding board and source of encouragement.

Statewide Mobile Crisis Outreach Support Teams (MCORTS)

The Peer Support Staff employed in the Mobile Crisis Outreach Response Team (MCORT) provide evidence-based crisis services, to an individual identified by 988 Lifeline center staff, as experiencing a mental health or substance use disorder crisis in the community and is agreeable to outreach. The person in the community experiencing a crisis can get non-clinical support from MCORT. The MCORT teams employ peers who offer support beyond the resolution of any immediate crisis. The peer team member can follow up with the person, making connections to social services and other services that increase access to needed supports. When appropriate there is collaboration with family members, friends or loved ones to assist and support individuals in crisis.

Statewide Peer to Peer Support Warmline

MHANJ's Peer to Peer Support Line is a peer-operated warm line that offers emotional support, hope, encouragement and resources to callers. Peer to peer Support line is staffed by people with lived experience with mental health challenges who provide supportive communication with callers who share mental health challenges. The warmline provides Intention Peer Support, a model developed by Shery Mead, to individuals with mental health difficulties, in lieu of using more traditional emergency psychiatric services. All Peer Line staff receive training and have monthly team meetings to discuss caller issues and receive additional support.

Mental Health Association of Essex and Morris

Mental Health Association (MHA E&M) embeds Peer Led services throughout several programs within the agency as it recognizes the importance of the ability to connect with the individuals served through shared life experience.

The Forensic Peer Support Staff provides off-site and in-home, hands-on support to mental health individuals playing a role in supporting these individuals from start to finish. Peer support helps individuals transition out of the justice system and build stability in their mental health and everyday lives, increasing socialization and successful reintegration into the community. Peer Support Staff offer guidance, encouragement, and advocacy to keep participants engaged and connected to needed resources. The Peer Support Staff co-facilitate peer groups which help individual receiving services develop coping skills and navigate the ups and downs of recovery. Sharing the lived experience of navigating mental health challenges and a similar history, provides participants with motivation, builds trust, and creates an ability to relate to one another.

Peers with lived experience are employed at the Community Wellness Centers to provide appropriate services. They partner with community providers for available services and coordinate resource events at the Community Wellness Centers. Lived experience professionals share life experiences, provide engagement and promote skill-building services, creating a collaborative and caring relationship, that focuses on strengths-based, person-centered services. Additionally, the lived experience professionals provide support in recovery planning through evidenced-based practices, such as Motivational Interviewing, and through advocacy. Lived Experience Professionals are equipped to assist with managing crisis, de-escalation, and promoting the integration of physical and mental health wellness which nurtures growth and development.

Peer-operated wellness centers are community-based organizations run by individuals with lived experiences of mental health or substance use challenges. These centers provide various interventions aimed at supporting recovery, wellness, and empowerment. Some common interventions include:

1. Peer Support Groups: - Facilitated by trained peers, these groups offer mutual support and shared experiences to help individuals manage their mental health or substance use challenges.
2. One-on-One Peer Support: - Personalized support sessions where peers offer guidance, encouragement, and resources based on their own recovery journeys.
3. Wellness and Recovery Education: - Workshops and classes focused on topics like stress management, coping skills, nutrition, exercise, mindfulness, and other wellness strategies.
4. Resource Navigation: - Assistance in connecting with community resources, such as housing, employment, healthcare, and social services.
5. Social and Recreational Activities- Organized events and activities to promote social interaction, decrease isolation, and build a sense of community.

?6. Advocacy and Empowerment - Training and support for individuals to advocate for their own needs and rights, as well as to participate in broader advocacy efforts for systemic change.?

7. Skill-Building Workshops: - Training sessions on practical skills such as financial management, job readiness, communication, and problem-solving.

8. Holistic Health Services: - Access to complementary therapies like yoga, meditation, art therapy, and other holistic practices that support overall well-being.

9. Outreach and Community Engagement: - Efforts to reach statutory populations and raise awareness about mental health and wellness within the broader community.

?These interventions are designed to create a supportive environment where individuals can share experiences, gain new skills, and build a network of supportive relationships, all of which are crucial for sustaining long-term recovery and wellness.

Catholic Charities of Greater Trenton

Riverbank Community Wellness Center

Since its inception in 1997, the Riverbank Community Wellness Center (RCWC) has been at the forefront of the Community Wellness Center initiative, significantly impacting the lives of individuals dealing with mental health and co-occurring issues.

A key aspect of the RCWC is its peer-led model, which involves staff members who have first-hand experience with mental health and substance use challenges. The center offers a wide range of life skills, training and educational programs that focus on self-care, and help decrease isolation. RCWC empowers its members to lead healthier and more balanced lives. Monthly groups are tailored to address the specific needs of individuals, including those with mental health concerns, co-occurring challenges like, substance use, chronic medical issues, aging, and individuals experiencing homelessness.

Positioned as a central resource hub, the RCWC is dedicated to helping individuals navigate the complexities of mental health services and co-occurring challenges. A team of trained peer counselors is available to assist members in accessing vital resources, such as housing assistance, SNAP benefits, health insurance, tax preparation aid, and vocational support. Additionally, the center collaborates with the South Jersey Food Bank, collecting 300 pounds of food every two months, which includes fresh produce and nutritious items for community meals that are served three times a week. There is also a food pantry available to members and the public at any time for those in need.

In late 2024, the RCWC was awarded a new contract from DMHAS, which facilitated an expansion of services. As a result, the center has extended its operating hours at our Burlington location to five days a week, in addition to providing services one night a week at two satellite sites, one in Browns Mills and one in Maple Shade. Furthermore, the acquisition of a 15-passenger van enables transportation for up to 40 members to and from various center activities, enhancing accessibility for those in the community.

The RCWC is pleased to report that for FY 2024-25, as of March 24, 2025, it has welcomed nearly 150 consumers, providing 813 self-help activities and 428 wellness and recovery activities to them.

Riverbank Transportation & Roads to Recovery

Since 2001, the peer operated Riverbank Transportation program (RBT) has been offering transportation to individuals with mental health challenges who aspire to pursue employment or education but face difficulties accessing public transportation. Recognizing that transportation often poses a significant obstacle to achieving vocational goals, RBT serves as a reliable and cost-effective alternative to rideshare options, playing an essential role in promoting independence. The program averages 75 rides per month and charges \$2.00 per trip.

Roads to Recovery (RTR) is another peer-run transportation initiative that provides rides for participants of community recovery groups like Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Gamblers Anonymous (GA). This service caters to co-occurring peers, located within a ten-mile radius of Westampton and is offered at no cost. In 2024, RTR facilitated nearly 100 rides for those engaged in their recovery efforts. However, due to financial constraints and staffing shortages, the RTR program has been temporarily put on hold until further notice.

Both RBT and RTR are peer-operated programs employing three part-time drivers along with one dispatcher, which allows them to achieve their own recovery objectives. Additionally, it is important to note that all bi-annual satisfaction surveys conducted among RBT and RTR consumers indicate complete satisfaction with the services provided.

Center for Family Services

Better Future Community Wellness Center (BFCWC) is a peer-operated wellness center providing support, connection and

recreation for adults with mental health issues who seek community, friends, social outlets, and relaxation. It provides a warm and welcoming environment where individuals access needed community-based social services, receive peer support, and are informed about mental health, substance use disorder, and co-occurring issues in a supportive environment. No individual is denied full access to or participation in services or activities. This safe and non-restrictive environment provides participants from all backgrounds with a sense of hope and allows them to come together to engage in peer-to-peer support and be offered social, educational and recreational opportunities.

Better Future Community Wellness Center provides members with meaningful activities to decrease co-occurring substance use and mental health issues in a place where they will feel accepted and valued. It is equipped with trained, compassionate staff and community-based resources in a safe environment, consumers receive welcoming, non-institutional services from peers with similar experiences who overcame their debilitating issues. Social connection influences an individual's educational attainment, workplace satisfaction, economic prosperity, and overall feelings of well-being and life fulfillment. Social isolation and loneliness have repeatedly been linked to negative physical and mental health outcomes across studies nationwide. Risk factors associated with social isolation include living in rural and/or urban areas where resources are limited, having a chronic physical or mental illness, and lack of transportation, among others. BFCWC's goal is to reach all individuals and offer non-restrictive, peer support for consumers with long-term physical and mental health conditions in various locations to significantly improve their quality of life, social functioning, and knowledge, skills and confidence to manage their health and physical functioning.

The BFCWC is a vital community-based initiative aimed at empowering adults who are recipients of mental health services to take control of their well-being, foster resilience, and support one another on their journey to recovery. It is operated by peers who have experience with mental health challenges and provide one-on-one or group support to program participants. The center offers regular workshops and educational sessions covering a variety of topics such as stress management, emotional regulation, mindfulness, and self-care. There are also organized social events, group outings, and recreational activities that foster a sense of community and provide opportunities for social interaction and recreation. The center holds various support groups facilitated by peers that focus on specific mental health conditions or common challenges, providing a space for sharing and mutual support. This program plays a significant role in decreasing stigma, fostering recovery, and promoting well-being for all participants.

The Mental Health Association in New Jersey; Peer Services

Atlantic Community Wellness Center (Originally called ICE: Individuals Concerted in Effort) has over four decades of experience in providing people access to meaningful activities in a place where individuals are accepted and valued. MHA staff have an intimate understanding of the value of social connections which contribute to members' health, feeling of safety, prosperity, and ability to be resilient. ACWC became the first center to adapt to the need within the community and offer "center without walls" concept and modality of services which allowed greater access to people living throughout the county. The ACWC provides four core services, peer support activities, wellness recovery classes, training/education workshops, and community engagement. Peer support activities include?supportive counseling, information/referral/linkages, end-to-end application & paperwork assistance, system navigation, promoting coping skills/selfcare, boundary/limit setting, and others. Wellness Recovery Classes include topics such as healthy behaviors: physical activity & nutrition, health literacy of use of substances (e.g., tobacco, alcohol, drugs, caffeine, sugar), social isolation/supports (community connections), healthy relationships/belonging, and mental health: stress, anxiety, depression management/emotions, grief/trauma, self-esteem/motivation/self-care, and recovery. Training and education workshops focus on unmet needs (food/ housing/utility instability, financial resource strains, employment, and education). ACWC is an integral partner in providing training to first responders to produce better outcomes for our residents in crisis providing peer delivered training and perspective.

Ocean County Community Wellness Center; Journey to Wellness (JTW), provides a holistic approach to mental wellness, offering free peer support and wellness services to individuals looking to enhance their mental health, well-being, and self-care. Through structured support groups, wellness coaching, skill-building workshops, and socialization activities, JTW fosters resilience, self-advocacy, and personal growth in a non-clinical, stigma-free environment. Staffed by individuals with lived experience of mental health and/or co-occurring challenges, JTW fosters a community of understanding and empathy, allowing participants to connect with others who have similar journeys. Peer support staff serve as mentors and advocates, guiding participants in navigating their recovery paths while providing encouragement and motivation. Utilizing recovery-oriented, person-centered, trauma informed , and responsive approaches, JTW creates a safe space where individuals can openly discuss their struggles and triumphs without fear of stigma, empowering community members to take charge of their mental health, build resilience, and develop a sense of belonging, ultimately contributing to a healthier and more connected community. JTW's mobile wellness unit, "Wellness on Wheels" (WOW Van) offers curbside wellness and support throughout Ocean County, truly embodying "meeting a person where they are at" in all ways possible, by providing access to information, referrals, wellness & support out in the community. By meeting people where they are, the WOW Van breaks down impediments and ensures that individuals who may not otherwise seek support can connect with peer staff in a safe, non-judgmental environment. The WOW Van is deployed throughout the week and whenever needed, including scheduled community events and outreach efforts.

Ocean County Community Peer Recovery Center; ROADS Recovery Center Recovery, Opportunities, Acceptance, Dignity, and Support (R.O.A.D.S.) offers a supportive space where individuals are accepted and valued, regardless of stage, phase, or recovery pathway. ROADS provides appropriate, participant-centered support encouraging individuals to be in the driver's seat of their own recovery.? ROADS is designed to offer support, help prevent recurrence of SUD, and promote sustained recovery from substance use and co-occurring disorders by being recovery-orientated, person-centered, trauma-informed, and focused on peer

support.? ROADS offers services that address the members' recovery, wellbeing, and unmet needs.? ROADS follows SAMHSA's Recovery Oriented System of Care Principles & focuses services food, housing, utilities, transportation, finance, substance use, mental health, & co-occurring, education/employment, isolation/connections, healthy behavior, etc..? ROADS also offers a community-driven approach, having strong partnerships across Ocean County?to?connect individuals with additional recovery resources.?

United by Wellness (UBW) was designed and built by MHANJ Peer Leadership Team to expand access to peer-to-peer support on a virtual platform for peers across New Jersey and beyond. Peer staff, interns and volunteers working with MHANJ's wellness centers, Individuals Concerted in Effort (ICE), and Journey to Wellness (JTW) combined resources along with other MHANJ to create a virtual wellness center that was launched in 2022. UBW currently provides free access to over 50 support groups weekly, which are offered 7 days a week to over 1800 current active members. A comprehensive array of groups offer support, wellness, spiritual, education, socialization, training, community meetings for both mental health and co-occurring individuals in recovery. UBW has recently expanded to partner with a Center for Independent Living to engage those with disabilities dealing with behavioral health challenges.

The Peer Recovery Warmline (PRW) has been an integral part of NJ peer services since 2009. The warmline is fully staffed and supervised by experienced peer staff who provide support, education, advocacy and "personal peer to peer support". Utilizing WRAP (Wellness Recovery Action Planning) and IPS (Intentional Peer Support) models, the team operates 7 days a week, and volunteers to work holidays. Each year over 40,000 calls are answered. The PRW offers an optional text/chat component that provides daily text messages of support throughout the day and week. This provides another level of support and connection. PRW operates as part of the MHANJ Call Center that has multiple behavioral health lines – that provides easy access warm transfers to information and referral- through NJ Mental Health Cares- that also provides the PRW with a vast database of community recovery support services to share with peer warmline callers. In 2022 MHANJ became an anchor of the NJ 998 Lifeline network- leading and advocating for peers to play a major role in crisis response. As a result, peers have been hired on 988 and facilitate easy warm transfers to PRW for 988 crisis callers. MHANJ continues to expand the role of peers in the operation of the call center – with many peers integrated across all service lines in partnerships with strong support, supervision, and clinical backup- proving their value to NJ's crisis response network.

Building a strong peer workforce has been the goal of MHANJ's Consumer Connections since it was founded in 1997. Consumer Connections has been training peers to work in paid positions within New Jersey's mental health system for over 25 years. Over time, the program has evolved into a comprehensive workforce development initiative, supporting the growth of the Certified Recovery Support Practitioner (CRSP) credential, New Jersey's only mental health peer certification recognized by Medicaid. Consumer Connections continues to strengthen the peer workforce by providing all required CRSP training, including the 84-hour Core Training and WRAP Seminar I, offering scholarships for credentialing fees, and assisting peers throughout the credentialing process. Additionally, the program serves as a liaison to the state certification board, offers career counseling and vocational services to programming alumni, and delivers a full range of technical assistance and training to peer employers in mental health and co-occurring services within the adult system of care. Recognizing the importance of co-occurring capacity in the peer workforce, Consumer Connections is committed to expanding expertise in this area. To that end, the program provides Core Training graduates with access to the Certified Peer Recovery Staff (CPRS) training, which leads to New Jersey's substance use disorder (SUD) peer credential. Consumer Connections has secured additional funding through ARPA federal dollars to expand programming in 2025. This funding has enabled the program to increase the number of Core Trainings from three to five, WRAP Seminar I workshops from six to ten, and CPRS trainings from one to three. Additionally, this expansion has allowed the program to hire two additional full-time peer trainers, further strengthening training capacity. Funding to support CRSP credentialing scholarships has significantly increased the number of credentialed individuals in New Jersey, more than doubling the total within just one year. With continued funding and strong policy leadership, MHANJ has established a solid foundation to meet the evolving needs of New Jersey's peer workforce and to drive sustainable growth in the field. However, a significant challenge is that ARPA funding is a one-time allocation that will end in September 2025. It is already clear that there is sufficient demand to continue operating at this expanded capacity, but without sustained funding, it is uncertain how the program will be able to maintain its staffing levels and training capabilities beyond the third quarter of 2025.

The Whole Health Learning Collaborative: NJ Peer Connections is a program of the Mental Health Association in New Jersey, that is funded and designed to assist and support the 20+ Division funded Community Wellness Centers (CWC) in the state of New Jersey. This program unifies and unites all NJ CWCs for the cause of Whole Health Care by prioritizing the eight dimensions of wellness in all centers and the services provided to the community in which they serve. Whole Health is based on SAMHSA's 8 Dimensions of Wellness, which promotes mental health care is more than just psychological but covers many different aspects of life (social, spiritual, emotional, intellectual, vocational, financial, and physical health). In WHLC's 1st year of programming, WHLC assisted each CWC create wellness-based goals to implement whole health initiatives in their centers. All centers were given in-person and virtual technical assistance, a liaison for feedback with the Division, and communal support and education through regionalized events across the state. Each CWC was awarded Wellness Dollars to fund these initiatives and given an opportunity to share their successes and best implementation practices at the programs ended statewide event.

The regionalized events, offered in the North, Central, and Southern parts of the state, offered great educational and networking opportunities for all CWCs helping to create a network of support cross organizationally and statewide for the staff of the Wellness Centers. Educational workshops included: PADS, Choices, Recovery-Based Solutions, Creative Minds, Peer Advocacy, WRAP, Resource Sharing, and more. Due to its success, the Whole Health initiative was funded through ARPA (until March 2025)

with funding to sustain the momentum and collaborative efforts of the centers and focus and prioritize the integration of the four newly awarded CWCs. This round of funding allowed for on-going in-person and virtual technical assistance to the newly awarded centers and other CWCs who needed assistance integrating their newly established goals and priorities resulting from the new CWC contracts. It also allowed for an additional two in-person regional events welcoming in the new Community Wellness Centers to the statewide community and in an effort to help each center reach its full potential. This program enhanced the CWCs by allowing them the opportunity to learn, network, and advocate for each other to better the people they serve. It can only be hoped this initiative can continue in some way in the future as this tie between all the CWCs is long overdue and extremely necessary in the success of the CWCs.

Collaborative Support Programs of New Jersey (CSPNJ)

Hospital-based Wellness Centers

CSPNJ's Hospital Wellness Centers at Greystone, Ancora, and Trenton Psychiatric Hospitals serve as essential, recovery-focused spaces led by individuals with lived experience. These centers provide peer support, wellness activities aligned with the 8 Dimensions of Wellness, and advocacy opportunities through The Coalition of Mental Health Consumer Organization (COMHCO) and the NJ Behavioral Health Planning Council. Programs such as the Hearing Voices Network, skill-building workshops, and the Hospital Cell Phone Project empower individuals to navigate their recovery journey with greater autonomy. We receive an average of 10 referrals to the Hospital Cell Phone Project (HCPP) monthly, effectively engaging and enrolling more than four-fifths of those interested. Additionally, CSPNJ's Program Aide roles and Unit Wellness Providers strengthen transition planning by participating in Life Management and Community Integration Meetings, offering advocacy in treatment team discussions, and expanding peer support sessions for those facing complex discharge challenges. Through structured wellness activities, peer support calls, and Health & Well-Being Surveys, CSPNJ ensures individuals receive personalized, continuous support that fosters a successful transition from hospitalization to independent living.

Recognizing the critical role of stable housing in recovery, CSPNJ has partnered with Ancora State Psychiatric Hospital to launch the Community Housing Options Tour, an innovative initiative that enhances discharge planning by connecting hospital staff and individuals served with real-world housing solutions. This program introduces participants, including supported housing providers, wellness center staff, and individuals preparing for discharge, to various housing models such as Residential Health Care Facilities, boarding homes, and independent supported housing. By improving understanding of recovery-oriented housing that emphasizes safe reentry into the community, this initiative strengthens collaboration between hospital discharge teams and community-based providers. As a result, there has been a marked increase in proactive engagement in discharge planning, leading to more successful transitions. Given the measurable success at Ancora, CSPNJ is expanding this initiative to Trenton Psychiatric Hospital, with plans underway to bring it to Greystone Park Psychiatric Hospital.

Looking ahead, CSPNJ is dedicated to scaling and strengthening its hospital wellness centers with innovative programming designed to enhance recovery outcomes and community reintegration. Planned initiatives include the relaunch of virtual Community Wellness Center groups, an employment pilot program incorporating Indeed job search training, and the expansion of Program Aide roles at Trenton Psychiatric Hospital. To foster engagement across centers, CSPNJ will introduce a statewide basketball tournament, expand Peer Gatherings featuring CSPNJ Wellness Institute workshops, and provide Peer Certification training for staff pursuing CPRS and CRSP credentials. To recognize member achievements, CSPNJ will implement a Certificate of Achievement program for vocational and wellness milestones. Additionally, contingent on funding, CSPNJ will organize community integration trips and conference opportunities, further reinforcing the organization's commitment to holistic recovery. With sustained investment, CSPNJ's hospital wellness centers will continue to serve as transformational spaces that empower individuals, decrease hospital recidivism, and build a bridge to lasting independence.

Wellness Respite Services

Respite is a safe, peer-run alternative to an inpatient psychiatric hospitalization and our services are at no cost to guests. Our Wellness Respite House is staffed 24 hours a day, 7 days a week by people who are trained and experienced in supporting others to transform a crisis into an opportunity for enhancing personal wellness and recovery. During the final quarter of the 2024 calendar year, all three of our respite houses averaged occupancy rates of over 98%.

The mission of our Wellness Respite Services is to provide an alternative to hospitalization which instills a sense of hope, empowerment, and self-determination in people experiencing emotional distress and fosters recovery and wellness to pursue valued life roles and personal goals. Each Respite House is a clean, safe, supportive, tranquil and non-judgmental environment in a residential community.

We offer intensive peer support and involvement in wellness activities to help guests to restore balance, and plan for adjustments when they return to their home, their associated valued roles, and their community activities. Guests meet with staff for one hour every day to learn coping skills for their wellness goals. Guests can stay at the house for a maximum of 10 days. If there is a

waiting list or if a guest chooses to remain at home, we can provide wellness planning and intensive phone contact and outreach in the community for up to 10 days. After completing a Respite House stay or Intensive Outreach, all guests are offered up to 30 days of continued support through a follow up wellness plan and phone contact and outreach in the community for up to 30 days. Respite staff have developed a robust and intentional marketing plan designed to raise awareness among potential guests, families, service providers, and key community partners. Beyond traditional outreach, staff take an active and engaged role in the community, consistently promoting the lifesaving and life-changing support that Wellness Respite offers. For example, in 2025, Respite staff presented at the Whole Health event, sharing insights about Wellness Respite's mission, services, and impact on the lives of those seeking alternatives to hospitalization. Thus, as of March 2025, we have supported over 3,950 guest stays. Lastly, despite limited capacity (15 beds), the impact is profound: 84.38% of Respite guests avoided hospitalization during their stay. And 91.62% felt valued and respected by peer staff; while 95.48% reported improved ability to manage their emotional and practical needs.

Community Wellness Centers

The Community Wellness Centers (CWC's) at CSPNJ provide a welcoming and supportive environment where individuals can access a range of peer-operated services to support their journey toward wellness. These centers are dedicated to fostering a sense of belonging and empowerment through personalized peer support, wellness activities, and community engagement. Whether in-person or virtual, peer mentors and support staff offer compassionate guidance, ensuring that every visitor has access to encouragement, advocacy, and resources that align with their unique needs. By centering services around the eight dimensions of wellness emotional, physical, social, intellectual, occupational, environmental, financial, and spiritual CWC promotes holistic well-being that extends beyond traditional healthcare models to over 16,000 unique members across our 15 locations.

The comprehensive services offered at CWC's go beyond immediate wellness support by addressing essential life needs. Through wellness groups, substance use support, and advocacy connections, members and visitors receive structured guidance tailored to their specific challenges. Linkages to crisis intervention, housing, healthcare services, and community resources ensure that individuals have a strong support network during difficult times. The centers also assist with obtaining identification, applying for mainstream benefits, and navigating the complexities of services. These offerings create a foundation for self-sufficiency and stability, allowing individuals to regain control over their lives while feeling supported by a compassionate community.

What sets CWC's apart is the quality of care and dedication embedded in peer-operated services. Every interaction is rooted in lived experience, empathy, and a deep understanding of the challenges individuals face. Peer mentors not only provide resources but also foster meaningful connections that encourage self-advocacy and resilience. By emphasizing the uniqueness of each member's journey and integrating the eight dimensions of wellness into all services, CWC's ensures that every person who walks through its doors receives individualized, respectful, and comprehensive support. This person-centered approach makes the Community Wellness Centers a vital resource for those seeking to improve their well-being and transform their lives.

COMHCO

COMHCO continues to lead innovative and high-impact peer advocacy efforts across New Jersey, demonstrating the power of lived experience in shaping policy and service delivery. Over the past year, we have expanded engagement through monthly virtual membership meetings, providing real-time updates on critical issues such as Medicaid waivers, the integration of behavioral health services, and the expansion of involuntary commitment laws. Notably, we saw a significant increase in participation from individuals currently residing in state psychiatric hospitals, reflecting the success of our outreach and the growing demand for peer-led advocacy. Our quarterly leadership meetings have also strengthened peer involvement in county mental health boards and state and national stakeholder groups, ensuring that individuals directly affected by policies have a seat at the table. A cornerstone of our work is the Annual Statewide Conference, which in 2024 brought together over 300 participants to engage in workshops on legal advocacy, voting rights, psychiatric advanced directives, and cross-disability advocacy. This event has become a vital platform for educating and empowering peers while fostering community connections. In preparation for our 2025 conference, we have implemented membership pulse surveys to ensure programming aligns with the needs and priorities of our community. In tandem with this, we have expanded our coalition to reach young adults, individuals with co-occurring substance use challenges, and communities throughout the state. These efforts are reinforced by our structural growth, with updates to our by-laws establishing a 13-person board with regional representation, ensuring leadership and input from all areas of the state.

In September 2024, COMHCO partnered with the National Disability Rights Network to host screenings of Accessing Democracy by Jack Rosen at the CSPNJ Annual Fall Fest and at local community wellness centers. This powerful film was part of a broader effort to promote civic engagement. During the same month, we collaborated with the REV UP campaign to increase voter registration and education, emphasizing bi-partisan voter education and accessibility for individuals with disabilities.

As part of our continued commitment to peer engagement, we will also be holding two statewide town halls to gather feedback from peers, as recommended during our monthly membership meetings. These town halls will serve as open forums for individuals to share their experiences and shape advocacy priorities. In addition, we will conduct workshops focused on telling your story and coalition building, equipping peers with tools to effectively share lived experiences and strengthen collaborative efforts across the state.

Looking ahead to the 2026–2027 funding period, COMHCO is committed to sustaining and expanding these initiatives to further elevate the voice and impact of peer advocacy. Our focus will be on strengthening our infrastructure, increasing accessibility to advocacy opportunities, and continuing to challenge policies that diminished individuals with behavioral health conditions. SAMHSA funding will be critical in supporting these efforts, allowing us to enhance virtual engagement, develop new leadership pipelines, and expand peer-led initiatives that promote recovery. By investing in peer- driven solutions, we can continue to drive systemic change and improve outcomes for individuals navigating behavioral health challenges in New Jersey.

Certification training for staff pursuing CPRS and CRSP credentials. To recognize member achievements, CSPNJ will implement a Certificate of Achievement program for vocational and wellness milestones. Additionally, contingent on funding, CSPNJ will organize community integration trips and conference opportunities, further reinforcing the organization’s commitment to holistic recovery. With sustained investment, CSPNJ’s hospital wellness centers will continue to serve as transformational spaces that empower individuals, decrease hospital recidivism, and build a bridge to lasting independence.

Prevention Resources

The Community Wellness Center (CWC) in Hunterdon provides individualized peer services focused on holistic well-being and personal empowerment. Each guest meets with a Peer Advocate to develop a personalized “wellness plan,” setting goals and tracking progress across the Eight Dimensions of Wellness—physical, emotional, occupational, spiritual, financial, mental, environmental, and intellectual well-being. This tailored approach ensures that each person receives support that meets their specific needs while fostering personal growth and self-sufficiency.

Beyond individual plans, the CWC emphasizes a strong sense of community, where guests actively contribute by cooking for one another, offering support, and sharing resources. This community of mutual aid promotes dignity and pride while creating a welcoming, home-like atmosphere rather than a traditional service facility. The center operates six days a week, offering activities such as yoga, meditation, journaling, nutrition classes, and recreational programs. ?

Adding to the sense of community, the CWC offers Peer-led programming and services at several satellite locations; wellness classes at the Fisherman’s Mark food bank in Lambertville, yoga and meditation at the Hunterdon County libraries, as well as wellness programming offered to the residents of Veterans Haven North, in Glen Gardner. The CWC also distributes food both on site and in the “Little Free Food Pantries” located throughout the town in conjunction with the Flemington Food Pantry.?

All programs and services are provided by a Peer, or an individual with lived experience in mental health.

CHOICES & LAHL 2024-2025 DMHAS Report Introduction

CHOICES (Consumers Helping Others Improve their Condition by Ending Smoking) is an innovative peer outreach program dedicated to addressing tobacco use among individuals with mental illness in New Jersey. For two decades, CHOICES has been at the forefront of delivering education, resources, and motivation to smokers with mental illness. The program employs trained mental health peer counselors, known as Consumer Tobacco Advocates (CTAs), who work tirelessly to support smokers in their journey toward a healthier lifestyle. The program was originally conceptualized to use peer counselors to reach out to smokers with serious mental illness living in the community. This approach was an advantage in reaching individuals who might not be motivated to talk to a health care provider.

Program Achievements

Entering its 20th year, CHOICES has continued to evolve its approach to tobacco education and intervention. While the program maintains its core mission of providing educational presentations to consumers in mental health treatment across all levels of care, the 2024-2025 grant year has seen a significant expansion. This year, CHOICES introduced Learning About Healthy Living (LAHL) Groups at four Community Wellness Centers, enhancing peer-led support and education. The centers include; Moving Forward CWC (New Brunswick), CARE Center (Neptune), Riverbank CWC (Burlington), Freedom Trail CWC (Somerville). These biweekly groups meet for 12 sessions and provide structured education, linkage to tobacco treatment resources, referrals, and continued peer support. The LAHL curriculum, developed by CHOICES founder and medical director Dr. Jill Williams, an addiction psychiatrist, remains an essential tool in delivering impactful education, as well as a continuity of communication between the consumers attending the centers and the CHOICES team. The full curriculum is accessible [here](#).

CHOICES Impact from July 2024 – Present

During the 2024-2025 grant year (July 2024 to present), CHOICES reports the following metrics, which will increase by approximately 20-25% by the end of the grant period:

81 in-person and virtual visits to mental health treatment providers across New Jersey. (As of March 25, 2025)

Engagement with 1,088 consumers who smoke, providing education and motivation for tobacco dependence treatment. (As of

March 25, 2025)

Two newsletters published and distributed to over 1,500 consumers and mental health agencies, reinforcing the importance of tobacco treatment.

Additional Programs Provided with the CHOICES Educational Site Visit and Carbon Monoxide Monitoring and Feedback for 2024-2025: St Clare's Inpatient Unit, Broadway House, Booker BH, Donald Mays CWC, Camden CWC, Princeton House, Ancora Psychiatric Hospital, Essecare, SERV Annual Conference, UBHC Cherry Hill, Options, Up Your Alley, Broadway House, Greystone, Main Hospital, West Bergen Mental Healthcare, Future Dreams, Bergen County Wellness Center, Jewish Family Services of Atlantic and Cape May Counties, Greystone Wellness, Catholic Charities East Windsor, Mt Carmel Guild Cranford, and Mt Carmel Guild Newark.

Historical Achievements and Milestones

Since its inception in 2005, CHOICES has built an impressive legacy:

2,098 community visits conducted, reaching over 61,935 individuals with mental illness who smoke.

13,490 individuals received individualized feedback sessions, including carbon monoxide monitoring and personalized discussions about the health and financial impact of smoking.

Looking Ahead

As CHOICES celebrates its 20th anniversary, it reflects on past achievements while planning for future growth. Program focus continues to include tobacco education, cannabis education, including structured healthy living groups will ensure continued relevance and effectiveness. The enthusiasm and engagement of CTAs have been instrumental in inspiring participants and fostering hope that positive behavior change is possible.

With ongoing dedication, CHOICES remains committed to supporting individuals with mental illness in achieving better health outcomes and promoting a tobacco-free future. The program's sustained impact highlights the power of peer-led initiatives in driving meaningful change within the mental health community.

Children's System of Care (CSOC)

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

Clinically appropriate and accessible

Individualized and delivered through a continuum of services and/or supports, both formal and informal, based on the unique strengths and needs of each youth and his or her family/ caregivers

Provided in the most appropriate and natural setting required to meet the needs of the youth and his or her family/caregivers

Family-guided, with families engaged as active participants at all levels of planning, organization, and service delivery

Community-based, coordinated, and integrated with the focus of having services, decision-making responsibility, and management operational at a community level

Protective of the rights of youth and their family/caregivers and

Collaborative across child-serving systems, including child protection, juvenile justice, and other system partners who are responsible for providing services and supports to the statutory populations.

Adolescent Substance Use Recovery Initiative

The Adolescent Substance Use Recovery Initiative aims to enhance access to treatment services for New Jersey adolescents aged 13 to 17 with co-occurring substance use and mental health disorders. The program provides outpatient and intensive outpatient services, emphasizing integrated care to address both substance use and mental health needs comprehensively. It prioritizes early intervention and family involvement to prevent serious injury and support recovery, utilizing evidence-based practices like Cognitive Behavioral Therapy and Motivational Interviewing. The initiative also includes non-clinical services such as case management, psychoeducation, and transportation, ensuring a holistic approach to treatment.

The In-Home Recovery Program

The In-Home Recovery Program, modeled after the Yale Child Study Center's Family Based Recovery Program in Connecticut, provides intensive in-home treatment for parents with substance use disorders, parenting support for children under the age of 72 months, and case management. In 2019, the Nicholson Foundation provided funding to implement and support the first year of the program in Ocean County. In 2020, the New Jersey Department of Children and Families (NJDCF) assumed this responsibility. In 2024, DCF also funded a second site in Camden County. With financial support from NJDCF, Montclair State University provides ongoing training, consultation, and technical assistance to both sites and Rutgers University evaluates the program.

Peer Recovery Support Staff Services

Peer Recovery Support Staff (PRSS) Services are a component of the Division of Child Protection and Permanency's Child Protection Substance Abuse Initiative (CPSAI). The Peer Recovery Support Staff establishes a one-on-one relationship with the parent/caregiver and encourages, motivates, and supports a peer who is seeking to establish or strengthen his or her recovery. They also assist the parent/caregiver to engage in treatment or reenter the community after residential treatment and to develop skills and access resources needed to initiate and maintain recovery by offering the benefit of shared life experiences and providing support. PRSS Services include Peer Mentoring/Coaching to assist the parent/caregiver access formal treatment services and other professional and non-professional services, resources in the community that can help meet his or her individual needs, set recovery goals, develop recovery action plans, and solve problems related to health, wellness, recovery, and recovery supports, including safe and sober housing, building or re-establishing supportive relationships, managing crises, and learning relapse prevention skills. PRSS Services also include Recovery Consultation, Education, and Advocacy including attending treatment team meetings, family team meetings, staying in communication with counselors and supervisors, facilitating discharge planning in collaboration with treatment team, educating family, community and other supportive individuals about recovery and recovery management, and documenting information as required by program policies and procedures.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations.

DMHAS has been long invested in providing recovery support to individuals challenged by issues with substance use. Recovery support and recovery-oriented systems of care help people with mental and substance use disorders manage their conditions successfully. Recovery Support Services (RSS) are non-clinical services that assist families of, and individuals with, a substance use disorder (with or without a co-occurring MH issue). They include social supports, linkage to and coordination among a full range of service providers that facilitate recovery and wellness for an improved quality of life. Services are flexible and may be provided prior to, during, and after treatment. They may be delivered by peers, professionals, faith-based and community-based groups, and others. They are key components of the state's behavioral health system,

Peer support services include the coordination of personal, family, and community resources to achieve the best possible quality of life for every client entering the substance use early intervention, treatment or recovery system. The chronic nature of addiction requires recovery support to promote sustained periods of wellness to continuously decrease the need for additional acute care. Acute care substance use treatment without other recovery supports is often not sufficient in helping individuals to maintain long-term recovery. Recognizing that treatment for substance use disorders does not end upon discharge, a continuum of care recovery plan, including personal, family and community resources, needs to be established. The plan ranges from low level contact such as bi-weekly telephone conversations to high level contact such as coaching, depending on support needed.

The Table 10b on Recovery Supports funded by SUPTRS is only a fraction of all the work we have done in this arena. Below is a list of 30 recovery initiatives that NJ has supported with either state, block grant or discretionary grant funding. These are described in detail below.

SUD Peer Recovery Workforce

- SUD Peer Credentials
- SUD Peer Guidelines and Supervision
- Peer Training

- Peer Recovery Support Summit
- Peer Roster
- Recovery Data Platform

Advocacy

- Citizens Advisory Council
- Coalition for Addiction Recovery Support

Self-Help Groups

Transportation

- Transportation Reimbursement and Invoicing Program (TRIP)

SUD Peer Recovery Programs

- Opioid Overdose Recovery Program (OORP)
- Support Teams for Addiction Recovery (STAR)
- Maternal Wraparound Program (MWRAP)

Recovery Community Organization (RCO)

- Regional Recovery Centers
- Community Peer Recovery Centers (CPRC)
- Grassroots Recovery Organizations and Centers
- Other Recovery Organizations

Family Support Centers (FSC)

Collegiate Recovery Programs

Telephone Recovery Support (TRS)

Intensive Recovery Treatment Support (IRTS)

Peers in Residential Treatment Programs

Recovery Support Care Management (RSCM)

Recovery Management Check-Up (RMC)

County Innovation

Housing

- Group Homes for Persons in Recovery (Oxford House)
- MATI Intensive Supportive Housing (ISH)
- Women's Intensive Supportive Housing (WISH)
- OUD Supportive Housing
- Sober Housing

SUD Peer Recovery Workforce

A key to successful recovery programs is the involvement of peers. Over the last several years, the DMHAS has made significant efforts to increase the SUD peer workforce. Recovery Staff were hired for the Opioid Overdose Recovery Program (OORP), Support Team for Addiction Recovery (STAR), Telephone Recovery Support (TRS) and Intensive Recovery and Treatment Support (IRTS) programs, where they now play a vital role. They are employed in our two large Recovery Centers and all our smaller Community Peer Recovery Centers. They provide recovery support for our various SUD housing programs. While there is currently a gap in the provision of peer services in residential settings, DMHAS has issued an RFP and made awards to employ peers in residential settings. A current goal for DMHAS is to expand the SUD workforce and the wealth of experience peers can bring to the SUD continuum of care.

Recovery support and recovery-oriented systems of care help people with mental and substance use disorders manage their conditions successfully. Peer support services include the coordination of personal, family, and community resources to achieve the best possible quality of life for every client entering the substance use early intervention and treatment system. The chronic nature of addiction requires recovery support to promote sustained periods of wellness to continuously decrease the need for additional acute care. Acute care substance use treatment without other recovery supports is often not sufficient in helping individuals to maintain long-term recovery. Recognizing that treatment for substance use disorders does not end upon discharge,

a continuum of care recovery plan, including personal, family and community resources, is established. The plan ranges from low level contact such as quarterly telephone conversations to high level contact such as coaching, depending on support needed.

Peer-based recovery support is defined as a process of giving and receiving nonprofessional, nonclinical assistance to engage, educate, and support the client to make the necessary changes to live a self-directed life. In New Jersey, recovery support services are provided by certified peer recovery staff with lived experience who have been successful in the recovery process in order to support others experiencing similar situations. DMHAS views peers as an integral partner in our system of care as recovery support services expand the capacity of formal and informal treatment and recovery pathways. Peers are an essential component of programs, including residential, therapeutic community, outpatient, emergency department deployment, justice-involved programs, family, and community recovery centers. Through shared understanding, respect, and mutual empowerment, certified peer recovery staff strengthen an individual's motivation to change by initiating the recovery process to decrease the likelihood of a return to substance use.

Peer workers assist recoverees with accessing External and Internal Recovery Capital, and Family and/or Social Recovery Capital. External Recovery Capital includes, but is not limited to, financial assets, health insurance, safe and recovery-conducive shelter, clothing, food, and access to transportation. Internal Recovery Capital includes, but is not limited to, values, knowledge, educational/vocational skills and credentials, self-awareness, self-esteem, self-efficacy, hopefulness/optimism, perception of one's past/present/future, sense of wholeness and healing. Family and/or Social Recovery Capital includes, but is not limited to, intimate relationships, family and kinship relationships (defined here non-traditionally, i.e., family of choice), and social relationships that are supportive of recovery efforts. Recovery staff encourage families (biological, nuclear or self-chosen) to become willing to participate in their loved one's treatment and recovery. The presence of others in recovery within the family and social network can help access sober outlets for sobriety-based fellowship/leisure and relational connections to conventional institutions (school, workplace, church, and other mainstream community organizations).

According to a report from the University of California San Francisco (UCSF), while peer providers have traditionally worked as volunteers, changes in mental health and SUD treatment and recognition of the importance of long-term recovery support, have led to a professionalization of this role with formalized training and certification, and the potential for paid employment. In recent years, the peer support services (PSS) workforce has evolved to become an essential part of mental health and addiction treatment, family support, and primary care services (Chapman, S., Blash, L., and Chan, K., *The Peer Provider Workforce in Behavioral Health: A Landscape Analysis*. San Francisco, CA, UCSF Health Workforce Research Center on Long-Term Care, 2015.)

Bassuk et al conducted a systematic review of the evidence on the effectiveness of peer support services for people in recovery from alcohol and drug addiction, which resulted in nine studies meeting the criteria for review. Despite methodological limitations found in the studies, the body of evidence suggested beneficial effects on participants (Bassuk, E., Hanson J., Greene, R., Richard, M., Laudet, A. Peer-delivered recovery support services for addictions in the United States: a systematic review. *Journal of Substance Abuse Treatment*. 2016; 63:1–9). In another systematic review, Reif et al evaluated peer support services for individuals with substance use disorders resulting in ten studies that met the review criteria. The studies demonstrated increased treatment retention, improved relationships with treatment providers and social supports, increased satisfaction, and decreased relapse rates (Reif, S., Braude, L., Lyman, D. R., Dougherty, R., Daniels, A., Ghose, S., Salim, O., & Delphin-Rittmon, M. (2014). Peer recovery support for individuals with substance use disorders: Assessing the evidence. *Psychiatric Services*, 65(7), 853–861).

A literature review by Tracy and Wallace found ten studies that met their minimum criteria, including randomized controlled trials or pre-/post-data studies, adult participants, group format, substance use-related, and US-conducted studies published in 1999 or later. Studies demonstrated associated benefits in the following areas: 1) substance use, 2) treatment engagement, 3) human immunodeficiency virus/hepatitis C virus risk behaviors, and 4) secondary substance-related behaviors such as craving and self-efficacy. Peer support groups included in addiction treatment show much promise in potentially decreasing substance use, improving engagement, decreasing HIV/HCV risk behaviors, and improving substance-related outcomes (Tracy K, Wallace SP. Benefits of peer support groups in the treatment of addiction. *Substance Abuse and Rehabilitation*, 2016 Sep 29;7:143-154).

Another review by the Peer Recovery Center of Excellence states that because of the knowledge gained through lived experience of addiction and recovery, and training received, Peer Support Workers (PSWs) are uniquely positioned to provide four key types of social support often missing from the addiction and recovery field: emotional, informational, instrumental and affiliation. Emotional support is perhaps the most readily understood, as it is central to the peer role; peers offer empathy, encouragement, and care to the peers with whom they work. In providing informational support, PSWs share knowledge and information about the recovery process and often provide skills training related to achieving and maintaining a life in recovery. Instrumental support is a tangible form of support, providing concrete assistance to accomplish tasks, such as providing transportation. Through affiliational support, peer staff help connect individuals to the greater recovery community, wrapping them in a supportive (Peer recovery support: evolving roles and settings: a literature review, March 2021.)

SAMHSA defines peer support services (PSS) as assistance that is delivered by a person in recovery from serious mental illnesses (SMI), substance use, or co-occurring mental and substance use conditions, before, during, and after treatment to facilitate a recipient's long-term recovery in the community (Chinman, G., Dougherty, D., Ghose, S., and Delphin-Rittmon, 2014). The goal of these services is to assist with the development of strategies to promote coping, problem-solving, and self-management of a person's behavioral health condition. This is accomplished by the peer support staff drawing upon his/her own lived experiences and empathy to help others by promoting hope, developing skills and insights, fostering treatment engagement, accessing

community supports, and building a satisfying life. Through the Recovery Community Services Program (RCSP), the Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment (SAMHSA/CSAT) funds grant projects across the country to develop and deliver these services. The peer recovery support services developed by the RCSP projects help people become and stay engaged in the recovery process and decrease the likelihood of relapse. Because they are designed and delivered by peers who have been successful in the recovery process, they embody a powerful message of hope, as well as a wealth of experiential knowledge. The services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking to achieve or sustain recovery.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), Peer Recovery Support Services (PRSS) workers have been successful in the recovery process by helping others that are experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process, thereby decreasing the likelihood of relapse. PRSS services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process.

Recovery support services encompass SAMHSA's guiding principles of recovery and include four major dimensions that support a life in recovery: health, home, purpose, and community. Peer workers assist individuals with developing a recovery plan that enables them to identify goals for achieving wellness. Peer workers also help the clients they work with to facilitate resilience and manage setbacks or other stressful events that may precipitate a return to substance use. New Jersey's recovery support services are designed to span all stages of recovery – from initiation/stabilization through recovery maintenance and the enhancement of quality of life in long-term recovery.

Based on guidance from SAMHSA and numerous research studies, the DMHAS SUD Peer Recovery Staff provides non-clinical assistance and recovery supports services and works with individuals to assist with issues that often occur concurrently with a substance use disorder, such as homelessness, legal issues, employment, education, transportation, need for social services, health care, child welfare involvement, child care, health insurance, etc. The Recovery Staff provides services according to a recovery based philosophy of care and supports the individuals' continuing stability, recovery and wellness as they move through the recovery continuum and support recovery planning by linking individuals to resources and appropriate services in the community, identifying factors that impact wellness and recovery, providing assistance in the managing of crisis situations, and modeling strategies on how to manage addiction successfully.

Basic requirements for a DMHAS SUD Recovery Staff are at minimum a high school diploma or equivalency; associate's degree or above preferred. Duties include providing recovery support and peer coaching to program participants. The Recovery Staff is required to attend a three (3) day DMHAS mandated training that delineates peer role functions, competencies, responsibilities and includes an orientation to DMHAS' multiple treatment and recovery initiatives. If not already credentialed, it is expected that the Recovery Staff will work towards attaining a Certified Peer Recovery Staff (CPRS) or National Certified Peer Recovery Support Staff (NCPRSS) credential by attending free training offered by NJPN. The Recovery Staff must have two (2) years of experience in the guiding principles of recovery that assist individuals to improve their health and wellness, live a self-directed life, and reach their full potential. The Recovery Staff are expected to work with individuals to support and strengthen their capacity to engage in their personal recovery. The competencies and role of the Recovery Staff shall include, but are not limited to the following:

- In collaboration with the individual, develop a recovery plan which should include services that identifies goals with measurable objectives, assesses strengths, can be used to work towards those goals, identifies impediments that can inhibit goal attainment, and monitors the progress made attaining those goals;
- Educate the individuals on how to navigate treatment, social service and recovery support systems;
- Provide recovery support services based on the individual's preference and his/her assessed needs;
- Support the individuals as they move through the stages of change to encourage them in their recovery;
- Assist the individuals with accessing recovery support services in the community;
- Work collaboratively with the case manager to ensure the individual engages in services and transitions to the next level of care when indicated;
- Be a positive role model by sharing experiential knowledge, hope, and skills;
- Maintain relationships with the individual in order to assist him/her in the treatment engagement and retention process;
- Reinforce, guide, and reassure the individual that recovery is possible, and is built on multiple strengths, coping abilities, and the resources of each individual;
- Assist the individual with gaining skills and resources needed to initiate and maintain recovery and maintain compliance with MAT if it is part of their treatment;
- Assist in establishing and sustaining a social and physical environment supportive of recovery;
- Enhance identification and participation in the recovery community;
- Advocate for appropriate and effective community treatment and recovery;
- Empower individuals to make self-determined and self-directed choices about their recovery pathway;
- Provide support with face-to-face sessions and/or telephone support based on the individual's personal choice; and
- Help individuals maintain healthy community, family and social functioning.

Other examples of peer services include recovery mentoring/coaching, recovery connecting, recovery consultation, peer support groups, and telephone recovery support.

Under the supervision of a licensed clinical professional, Certified Peer Recovery Staff (CPRS) or National Certified Peer Recovery Support Staff (NCPRSS) provide non-clinical assistance and support throughout all stages of the SUD recovery and rehabilitation process. Peer recovery support services are intended to provide individually based direction, support, and encouragement for individuals in need of substance use disorder treatment.

The Division supports the role of peers through several individual and family-based initiatives. These programs, such as the Opioid Overdose Recovery Program, Maternal Wraparound Program, Support Teams for Addiction Recovery, Family Support Centers, Recovery Centers Community Peer Recovery Centers, and prison-based Intensive Recovery Treatment Support, are described as follows. Newly added programs included the placement of peers in residential treatment programs, the Recovery Management Check-In, and the SUD FFS Recovery Care Management initiative.

SUD Peer Credentials

The DMHAS has also worked to develop two peer credentials, the Certified Peer Recovery Staff (CPRS) and National Peer Recovery Support Staff (NPRSS) and has worked with Medicaid to reimburse OORP services in Emergency Rooms and SUD peer services in outpatient. However, there is currently a gap in the provision of peer services in residential settings that DMHAS is seeking to improve. These services are not eligible for reimbursement by Medicaid. Utilizing Supplemental and ARPA funding, DMHAS issued RFPs to continue to expand the SUD peer workforce in residential settings and the wealth of experience peers can bring to those settings.

SUD Peer Guidelines and Supervision

Additionally, DMHAS recognizes the importance of peer supervision and protection. The PAC Peer Recovery Support Services (PRSS) Committee developed Guidelines for Best Practices: Peer Recovery Services which were published June 2023 to help ensure that peer recovery support services are provided using best practices based in research and experiences in various settings. The PRSS Committee acknowledges that this report is the beginning of the development of necessary standards for peer recovery support services in New Jersey. The guidelines have been worked on for the past several years during the expansion of this evolving field. It is designed to bring practical processes, strategies and tools to peers, their supervisors, administrators, and others committed to initiating and sustaining best practices in the peer recovery support services field and the supporting work environments.

Following the publication of the Guidelines for Best Practices in Peer Recovery Services document by the Professional Advisory Committee's (PAC) Peer Best Practices Committee, a need was identified for more specific guidance around the integration of peers in residential and outpatient treatment centers. Several New Jersey treatment programs anecdotally report that they have—quite successfully—integrated peers into their service array, preliminarily seeing positive results in patient outcomes. However, these programs remain the exception and not the norm, despite funding made available through DMHAS for peers in residential settings and Medicaid reimbursement for peer services in outpatient settings.

This Addendum: Peers in Residential and Outpatient Treatment Settings addresses the following concerns and challenges that treatment providers may be facing in incorporating peer services into their programs:

- Lack of clarity around the peer role and how it differs from other roles, such as behavioral health techs and counseling interns
- Difficulty recruiting and retaining qualified and experienced peers
- Insufficient institutional knowledge and capacity to supervise peers

Peer Training

DMHAS supports the advancement of peers by offering training and professional development activities that increase and enhance the peer workforce. All peers working in DMHAS initiatives attend a 3-day Ethics training. The curriculum includes self-reflection, self-disclosure, MOUD, motivational interviewing, outreach, and engagement techniques. In addition, peers attend the 5-day Connecticut Community for Addiction Recovery (CCAR) which leads to peer certification.

DMHAS supports two pathways to peer certification. The International Reciprocity and Credentialing Consortium (IC&RC) NJ affiliate, the Addiction Professionals Certification Board, issues the Certified Peer Recovery Staff (CPRS) and NAADAC/NCC AP, the Association for Addiction Professionals, issues the National Certified Peer Recovery Support Staff (NCPRS). To ensure DMHAS recovery programs have adequate staffing levels, DMHAS provides scholarships for training, certification, and testing fees. To date more than 1550 peers have been trained through the Division's Addiction Training and Workforce Development initiative.

In addition to the basic core training, our training partner, the New Jersey Prevention Network (NJPN), has developed other training modules for peers. NJPN is planning to develop a more advanced curriculum. NJPN is also working on a series of trainings that will lead to certification, such as, working in emergency rooms, treatment agencies, etc.

Peer Recovery Support Summit

Annually the New Jersey Prevention Network (NJPN), a partner of DMHAS in collaboration with DMHAS, holds a Peer Recovery Support Summit. The last summit entitled, Stronger Together: Shared Learning and Building a Unified Future was held on September 25, 2024. This was NJPN's 8th summit and equipped attendees with strategies in providing recovery support services

across the continuum of care, best practices that are relevant to the addiction/recovery field, and opioid use disorders.

Peer Roster

DMHAS maintains a Peer Recovery Roster system designed to capture key demographic and workforce data from staff working in DMHAS-funded recovery programs. Program staff are required to complete an online Qualtrics survey, entering details such as their role, agency, supervisor, education level, certification status, credentialing, and training history.

As of July 2025, information has been collected from 687 Peer Recovery Staff. This data allows DMHAS to accurately track the size and makeup of the peer workforce, monitor trends, and assess both program and workforce development needs. In partnership with DMHAS, NJPN has developed customized dashboard reports for each funded initiative, providing a visual summary of key metrics such as certification progress, completed training, and current employment status.

Recovery Data Platform

The Division of Mental Health and Addiction Services (DMHAS) continues to utilize the Recovery Data Platform (RDP) as its centralized system for collecting and analyzing peer recovery support service data. Originally launched in 2020, RDP is a secure, HIPAA-compliant, cloud-based platform developed in collaboration with Faces & Voices of Recovery and RecoveryTrek. It is specifically designed to document peer-delivered services provided to individuals impacted by substance use disorders (SUDs) and now stands as one of the most comprehensive peer recovery data systems in New Jersey. In 2024, RDP recorded services for more than 15,000 participants, more than doubling the number from the prior year and reflecting growing adoption across DMHAS-funded initiatives.

RDP enables peer service providers to capture a wide range of data, including recovery coaching sessions, telephone recovery support calls, recovery-related activities and events, referrals, and participant demographics. The platform also facilitates real-time tracking and scheduling, allowing organizations to monitor participant engagement and service delivery across programs. To measure the effectiveness of these services, RDP uses scientifically validated tools administered at regular intervals. The Cravings Rating Scale (CRS) showed that participants experienced an average 25.4% decrease in cravings, while the Outcome Rating Scale (ORS) reflected an 18.3% improvement in self-reported well-being, relationships, and life satisfaction. Additionally, the Brief Addiction Recovery Capital (BARC-10) tool revealed a 10.8% increase in recovery capital, a key indicator of long-term recovery stability.

In 2024, peer recovery coaches delivered nearly 14,000 coaching sessions, providing over 540,000 minutes of direct support, with an average session lasting 38 minutes. More than 39,000 telephone recovery support calls were made, and over half of those resulted in successful participant engagement, averaging 11.3 minutes per call. Providers also logged more than 5,200 recovery activities, including support groups, educational workshops, and sober social events, marking a 53% increase from the previous year. Participants in the RDP system represented all 21 counties in New Jersey, with the highest numbers coming from Union, Bergen, and Sussex counties.

Looking ahead, the RDP is poised for continued expansion, with new organizations joining and existing participants deepening their use of the platform. With the number of participant records expected to surpass 20,000 in 2025, RDP remains a critical tool for tracking outcomes, demonstrating the effectiveness of peer services, and supporting a data-informed recovery infrastructure across New Jersey.

Advocacy

Citizens Advisory Council (CAC)

The Citizens Advisory Council (CAC) is composed of representatives from DMHAS-funded Community Peer Recovery Centers (CPRCs), which provide support and services for individuals facing substance use challenges. CAC members meet regularly with DMHAS leadership, including staff from the Office of Community Services and the Office of Advocacy and Peer Services.

These meetings foster communication, collaboration, and mutual support among persons who oversee the day-to-day operations of the CPRCs. They offer a platform for sharing updates on center activities, community needs, innovative practices, and both the successes and challenges experienced in delivering services.

The primary goals of the CAC meetings are to build a strong sense of community among those who oversee the day-to-day operations of the CPRCs, establish a professional support network, and maintain open lines of communication with DMHAS, particularly the Office of Advocacy and Peer Services. DMHAS staff provide updates on division-wide initiatives and receive direct feedback from persons who function as CPRC direct-care staff, while Advocacy and Peer Services staff contribute valuable insights from their lived experience with recovery and navigating substance use disorder (SUD) services.

Moving forward, CAC will collaborate more closely with the Statewide Consumer Advisory Committee (SCAC), which represents Community Wellness Centers. This partnership aims to better coordinate services and support for individuals in the community with co-occurring mental health and substance use needs.

The New Jersey Coalition for Addiction Recovery Support (NJ-CARS) is a statewide organization that provides a platform to celebrate the hope of recovery, promote the value of individuals with lived experience, and to incorporate and strengthen recovery support services across the continuum of care for substance use disorders throughout New Jersey. NJ-CARS Advisory Committee is a broad group of experienced recovery support practitioners and providers from New Jersey comprised of 75% peers at minimum. CARS offers the opportunity for members to be part of a statewide voice for recovery. For organizations, it offers the opportunity to contribute to the development and expansion of recovery support services in New Jersey and an opportunity to coordinate the training of the peer workforce. The organization is currently funded through SAMHSA's Building Communities of Recovery (BCOR) grant.

Self-Help Groups

Support for involvement of recovering persons in self-help groups such as Alcoholics Anonymous and Narcotics Anonymous is also routinely provided as part of recovery planning, beginning in treatment and continuing upon discharge. Recently, providers have included evidence-based approaches like SMART Recovery. Additionally, several providers in New Jersey have developed All-Recovery groups, which are open to anyone who is living with an addictive disorder. The meetings are attended by persons in recovery, and those seeking recovery, as well as their friends and loved ones.

Transportation

Transportation Reimbursement and Invoicing Program (TRIP)

According to Bellamy et al. (2016), unreliable access to transportation was the most frequently documented and reported non-medical impediment to clients seeking substance abuse and mental health outpatient services. Transportation impediments manifest themselves in several ways: a lack of independent car ownership, high cost of public transportation, travel distance, travel time, parking fees, a lack of public transportation, distance from agency to a bus stop, and cost of ride-sharing services (Locatelli et al., 2017). Without adequate and affordable transportation options, clients are unable to begin vital treatment nor consistently attend and complete treatment, resulting in suboptimal outcomes. NJ's 2018 Household Survey of Drug Use and Health indicated that of the clients surveyed who indicated they wanted treatment, transportation was an impediment for 39% of the participants.

Transportation is a key recovery support. A reliable means of transportation is needed so clients can get to prevention, recovery and treatment support programs. As a result of this gap, DMHAS has developed a new program called the Transportation Reimbursement and Invoicing Program (TRIP). This will enable transportation to treatment for individuals who do not have Medicaid, as well as enable transportation to and from non-healthcare facilities such as Community Peer Recovery Centers or prevention programs. TRIP is intended and designed to eliminate transportation impediments and facilitate access to substance use disorder Treatment, Prevention and Recovery Support Services (RSS). Currently, SUPTRS Block Grant COVID-19 Supplemental and ARPA funds are being utilized. Funding of \$1,000,000 was set aside for this project.

Critical partners are the County and Alcohol Drug Directors (CADADs), our various recovery support programs such as the Opioid Overdose Recovery Program (OORP), Support Team for Addiction Recovery (STAR), Community Peer Recovery Centers (CPRC), Intensive Recovery and Treatment Support (IRTS), Maternal Wrap Around Program (MWRAP), prevention and SUD treatment providers.

SUD Peer Recovery Programs

Opioid Overdose Recovery Program (OORP)

The Division of Mental Health and Addiction Services (DMHAS) supports the role of peers through several recovery support initiatives. These programs assist individuals with opioid use disorders or those who are at risk of an opioid overdose through supportive services, case management, education, resources, and advocacy for families and individuals. The Opioid Overdose Recovery Program (OORP), which is in all 21 counties, provides support services to individuals reversed from opioid overdoses treated at hospital emergency departments. Peers working in OORP programs meet with individuals at bedside where they share their stories of hope and recovery. These peers continue to follow the patient for eight weeks after discharge and are instrumental in engaging individuals in the emergency department and beyond and letting them know that they are not alone and that recovery is possible by whatever pathway they choose.

OORPs operate in 56 of 75 (75%) hospital emergency departments throughout New Jersey. Fourteen OORPs are operating in all (100%) of the hospital emergency departments in their respective counties.

Since its implementation on January 1, 2016, NJ's OORPs have cumulatively served 26,593 individuals who were reversed from an opioid overdose and were taken to a participating hospital emergency department. Eleven percent of individuals cumulatively served (3,032 of 26,593) were initially referred to withdrawal management and ten percent (2,641) of individuals cumulatively served were initially referred to substance use disorder treatment. An additional 11,421 (43%) individuals sought recovery support services. Common recovery supports included referrals to self-help, transportation supports, mental health and medical services and housing support, including sober living.

In 2018, the scope of core OORP activities was expanded by 16 of the 21 OORPs. The OORP expansion sites increased core services

to include new sets of activities, including services beyond the emergency department in other areas within the hospital as well as services outside the hospital within the community for persons with an opioid or substance use disorder. OORP expansion within hospitals serves emergency department patients who suffered an opioid overdose but who were not administered naloxone as well as hospital in-patients with an identified primary or secondary OUD or SUD who are being treated for any condition in other hospital units. As with core OORP, OORP expansion provides eight weeks of patient follow-up. OORP expansion within the community includes funding additional peers to perform community outreach for persons with an OUD and/or SUD at shelters and neighborhood fairs. Through expansion, partnerships with prosecutors, sheriffs and other law enforcement personnel, healthcare providers, treatment providers and community programs were established. Since its introduction, OORP expansion services have been provided to over 43,000 persons.

Support Teams for Addiction Recovery (STAR)

STAR program provides case management and recovery support services for individuals with opioid use disorders (OUD). The STAR initiative is comprised of one team, each consisting of a program supervisor, two case managers and two recovery staff. The team is required to maintain a caseload of 40 individuals. STAR case managers work with individuals to assist with issues that often occur concurrently with an OUD, such as homelessness, legal issues, employment, education, transportation, need for social services, health care, child welfare involvement, childcare, health insurance, etc. The STAR recovery staff provide non-clinical assistance and recovery support services. The overall goal of STAR is to help maintain individuals with an OUD in the Recovery Zone, help decrease the risk of recurring episodes of opioid related problems and prevent future overdose.

The STR grant funded the initial STAR program in 10 counties. SOR grant and SOR supplemental grant funds enabled DMHAS to provide STAR services in all NJ's 21 counties.

In 2019, the ten STARs serving the counties with the greatest need (determined by number of overdoses, naloxone administrations, and rates of incarceration for opioid-related offences) received funds to develop an additional team to serve individuals with Opioid Use Disorder who are released from county or municipal jails. STAR programs used the funds to cover costs of hiring an additional case manager and recovery staff for the new team. Services provided are similar to those offered the original STAR teams, but with modifications to provide more effective services to this population

STAR tracks client outcomes through two surveys: the GPRA and the STAR survey. Results cited below come from the STAR survey administered at intake vs the STAR survey administered 6 months post intake. All results are based on proportion of individuals who answered to these questions and completed their surveys between January 1st, 2021 to December 31st, 2022.

The STAR program reported a decline in drug usage among its clients at the 6-month follow up vs intake. For the primary substance of choice, either a stimulant or an opioid, the proportion of clients who reported that they had no relapse in the last 3 months increased 26.5% at the 6-month follow-up compared to the intake survey. For overall abstinence from all substances (including alcohol and tobacco), STAR reported an increase of 5.4% in the proportion of clients who reported no overdose in the past 3 months. Finally, the proportion of individuals who attended self-help programs in the last month increased 15.5% at the 6-month post intake vs the intake. In summation, the STAR program was associated with a significant increase in those did not use their primary substance, a smaller increase in the proportion of individuals who were abstinent from all substances and was associated with improved participation in program to maintain abstinence.

Decreased drug usage is not the only improvement found in STAR clients. STAR also reported notable improvements in stability of client's living situation, which helps in maintaining abstinence from drugs. While housing is not a service directly funded from the SOR contract, our providers successfully formed links with Non-Governmental Organizations (NGOs) and government that provide housing. Our follow ups reported an increase of 5.5% of clients who have stable housing. To further illustrate this, in the most recent quarter (3rd quarter of federal fiscal year 2025), our providers were able to place and allow 82 STAR clients to move into stable housing. We were also very successful in increasing the proportion of individuals who reported being either employed, volunteering, and/or enrolled in educational/vocational programs by 71.9%. Our programs also worked help clients apply for health insurance such as Medicaid and our 6-month follow-up survey reported a 5% increase in the proportion of individuals who had health insurance. Finally, in the overall measure of financial stability; the proportion of individuals who agreed with the statement that they had enough money to meet their needs increased 11.4%.

Clients also reported improvements in Quality of Life and satisfaction with their health at 6 months into the STAR program. On the measurement of Quality of Life, the client's average reported quality of life had jumped 12.5% between the intake vs 6 months. On satisfaction with health, STAR saw a 11.3% increase in the average.

Maternal Wraparound Program

The Maternal Wraparound Program (M-WRAP) is a program that provides intensive case management and recovery support services for pregnant women with substance use disorder. Pregnant women are eligible for services through M-WRAP 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. Recovery Support Staff provide non-clinical assistance and recovery supports while maintaining follow-up with the women and their infants. Block Grant funding supports seven (7) M-WRAP regions statewide with each region serving 60 pregnant women. The overall goal with the M-WRAP is to provide services through comprehensive care coordination implemented within the five major timeframes when intervention in the life of the

substance exposed infants (SEI) can decrease prenatal substance exposure: pre-pregnancy, prenatal, birth, neonatal and early childhood. M-WRAP providers are required to develop Plans of Safe Care. The M-WRAP model is intended to promote maternal health, improve birth outcomes for women, their infants and families, and decrease the risks and adverse consequences of prenatal substance exposure.

Recovery Community Organization (RCO)

Regional Recovery Centers

From 2008 to 2019 there were only two state funded centers, one in the northern region of the state, Eva's Village in Paterson, and one location in the southern region of the state, Living Proof in Voorhees. Recovery support is an essential part of the continuum of care since substance use dependence (SUD) is a chronic biologically based disease of the brain and as such requires a system of care designed to treat a chronic condition rather than an acute illness. With other chronic conditions, e.g., diabetes, hypertension, heart disease, that are characterized by periods of wellness and acute episodes of care, the care system and intervention are designed to manage the illness in order to promote sustained periods of wellness and eliminate or minimize the need for acute care. Similarly, the SUD treatment system had to adapt to support the process of sustained recovery. The New Jersey Recovery Centers have been effective with many individuals seeking recovery.

DMHAS' plan was to expand the continuum of care to include an array of services that support individuals in their recovery from addiction. Recognizing the need to support individuals in their pathway to recovery, a Recovery Center is a place where individuals who have completed or left treatment, or who have never entered formal treatment, can find a nurturing and empowering environment in which they can learn new skills and develop a social network. A Recovery Center helps prevent relapse and provides support for sustained recovery within the community. Services are provided by peers who serve as positive role models.

During CY 2022, there were 84,437 discharges from substance use treatment in New Jersey. Of these, 24,555 or 29%, quit or dropped out of treatment. While ALL clients can benefit from recovery support services, those clients who did not complete treatment may find recovery support beneficial and a gateway back into treatment and/or sustained recovery. It is clear that there are significant numbers of people who could benefit from ongoing recovery programs. While these figures are drawn from those who enter the formal treatment system, there is a group of people of unknown size who have never accessed formal treatment who could also benefit from recovery services. This will also be an opportunity for those for whom access to treatment is not possible or delayed due to insufficient capacity within the system. The DMHAS Recovery Centers offer training, social, educational and recreational opportunities. There are classes focused on wellness, nutrition and illness management, including classes on self-care, stress management, financial management, literacy education, job, and parenting skills. Housing assistance (e.g., finding apartments and roommates) is provided, and telephone support is available to Recovery Center participants. It is expected that this peer-delivered service will result in improved social functioning, decreased substance abuse and an improved quality of life, including more social connectedness.

For SFY 2022, the two NJ State funded Regional Recovery Centers (Eva's Village and Living Proof Recovery Center of Voorhees) provided peer support services to 2,394 individuals.

Community Peer Recovery Centers (CPRC)

Funding was issued in FY 2019 to FY 2025 through multiple Request for Proposals (RFP) to expand and develop Community Peer Recovery Centers (CPRC) where individuals can access peer support, information about substance use disorder treatment, recovery support services, and information about other community resources in a supportive substance free environment.

DMHAS initially awarded three providers \$100,000 each for start-up small-scale Recovery Centers to provide peer-to-peer recovery support services to prevent recurrent of substance use and promote sustained recovery. NJ DMHAS has now accomplished its goal of having at least one Community Peer Recovery Center (CPRC) in each of New Jersey's twenty-one counties with SOR funding of \$100,000 each to help start up new or enhance recovery support services within the community. In 2024, DMHAS issued an RFP to expand the CPRC in FY25 by utilizing \$100,000 SOR funding and \$275,000 Opioid Recovery and Remediation Funding for all CPRCs. All of the CPRCs were required to reapply for the funding and all but two of the original CPRCs were rewarded a CPRC Contract to provide CPRCs with an expansion of hours, staff and services to all 21 counties.

All activities and peer support recovery services through the CPRCs are led and driven by "peers", individuals who have experienced addiction and recovery, either directly or indirectly as a family member or friend. CPRC programming focuses on different aspects of the four dimensions to support a healthy life (health, home, purpose, and community). The overall goal of the CPRC is to provide a safe place for recovering individuals to gather in support of one another and experience recovery-oriented living in a community setting. The CPRC is also a place where those in recovery can have the opportunity to give back to their community thereby fostering senses of empowerment and independence. With limited funding, CPRCs were able to respond to the challenges of the COVID epidemic, by finding creative ways to keep individuals engaged with their centers via virtual, hybrid, as well as traditional in-person Services. They are further challenged now by the continued and expanding need for community peer recovery support services to individuals exposed to all aspects of substance use; including keeping up with current SUD trends of use, treatment, medication assisted recovery, as well as the needs to assist individuals with transportation, and recovery support housing.

Many of the 25,019 unduplicated individuals in FY24 took advantage of the wide range of services that the 21 CPRC's offered,

which equated to 46,321 duplicated individuals being served during this SOR funding period. It is expected that going forward from FY25 that all of these numbers will increase due to the expanded funding. The CPRCs continue to be among the most accessible resources in NJ, that are rooted in empowering people in recovery to be agents of change in the communities that they serve. The CPRCs serve as a vital hub for the recovery community providing peer coaching, mutual support meetings, telephone recovery, social events and activities, wellness activities, and linkages to all supportive services needed by the recoveree.

Major CPRC accomplishments include:

- Recovery Housing: 659 individuals
 - Recovery Coaching or Peer Coaching: 3,381 individuals
 - Employment Support: 447 individuals
 - Multiple Recovery Support Services: 15,142 individuals
- Other Specific Recovery Support Services received:
- Basic Needs-Food, Clothing, Emergency Shelter: 712 individuals
 - Case Management/Individual Services Coordination: 7,190 individuals
 - Community Resources: 6,574 individuals
 - Historical Issues: 1,516 individuals
 - Educational Support: 596 individuals
 - Life Skills: 842 individuals
 - Naloxone distribution: 3,938 individuals
 - Outreach: 3,051 individuals
 - Parenting/Childcare Resources: 984 individuals
 - Recovery Support: 14,000 individuals
 - Relapse Prevention: 2,064 individuals
 - Self-Help and Recovery Support Groups: 10,724 individuals
 - Social/Recreational: 5,214 individuals
 - Spiritual and Faith based: 498 individuals
 - Substance Abuse Education: 2,663 individuals
 - Transportation: 1263 individuals
 - Treatment/care support/system navigation: 6,079 individuals
 - Wellness activities: 661 individuals

Additional CPRC accomplishments include:

- Number of group recovery support meetings held (virtual): 1,618
- Number of group recovery support meetings held (in-person): 4,487
- Number of group recovery support meetings held (hybrid): 705
- Number of individual meetings held (virtual): 532
- Number of individual meetings held (in-person): 6249
- Number of phone contacts (successful): 7421
- Number of text or email contacts: 9,181
- Number of community activities (virtual): 41
- Number of community activities (in-person): 1,166
- Number of community activities (hybrid): 41
- Number of referrals to services made: 10,515
- Number of mailings: 560
- Other Interactions/Outreach: 134

Every county in NJ is different and unique; the compilation of accomplishments below shows that all 21 CPRCs support of all pathways to recovery within their community and efforts of increasing Recovery Capital.

Recovery Center Advisory Boards. "The Advisory Board continues to work on strategies to boost participation at the center. Initiatives include expanding outreach, forming new partnerships with community organizations, launching new programs, and advocating for resources. Each board member has a designated role, including managing communication efforts, coordinating events, and overseeing partnerships." – Union County CPRC

Mutual Support Group Meetings. All Recovery Meetings, SMART Recovery, Narcotics Anonymous, Alcohol Anonymous, Crystal Meth Anonymous, particular needs Support Groups, The Recovery Bible Meeting, Refuge Recovery, Veteran Support Groups, Canines for Recovery, First Responders Support Group, Works Meetings, Health and Wellness Group, Mental Health support groups, Smoking Cessation, and Active Parenting groups.

"Our recovery support meetings remain a cornerstone of our community, offering a wide range of options to meet a variety of needs. These initiatives and groups reflect our dedication to fostering a vibrant, and supportive environment for everyone on their recovery journey." – Mercer County CPRC

Wide Range of Activities and Social Events. Game Nights, Recovery Movie night, Bonfires on the farm, Cirque Risqué, Talent

Shows, Arts And Crafts, Mindfulness Nature Walk, Recovery Hikes, Y12SR Yoga, Origami workshops, Book Clubs, Soul Collage, Cards for Caring, Sound Medication & Healing, Birdhouse construction and painting, Shamanic Healing, Hummingbird Gardens, Horseback riding, Bowling, Spring Fling Dinner, Annual Summer picnic, Art Fridays, Recovery BBQ, Community Block Party, Friendsgiving, Halloween Party, Coffee and Conversation, Pizza Positivity, Holiday Positivity, and Patient Positivity.

"The Wellness and Relaxation Event was widely publicized, drawing in a total of 20 enthusiastic participants who actively engaged in various activities aimed at promoting relaxation, self-care, and overall wellbeing. It was heartwarming to witness the positive impact the event had on everyone who attended." ~Mercer County

Community Awareness. Meet and Greet Open House, "Giving Back Tree" event, Volunteer Celebration Event, Recovery Day of Service International Overdose Awareness Events, Weekly Farmer's Market Outreach, Annual Recovery Day, and Social Media presence on Facebook and Instagram to share resources, decrease stigma and inform the public through the means they communicate most frequently.

"We held a very successful Monthly Breakfast in our CPRC with community partners, law enforcement, volunteers, and participants." ~ Morris County

Naloxone Training and Distribution. One small scall CPRC was able to distribute 439 Narcan kits, train over 100 residents in its use, and distributed 300+ fentanyl test strip kits.

Peer Workforce Development and Educational Workshops. Financial Literacy Class, Re-Entry Relapse Prevention Tools and Life Skills, Nutrition and Wellness, as well as connect members with educational and employment support, including NJ Re-Entry, DVR, One-Stop Career Centers, Consumer Connections through the Mental Health Association in NJ, as well as job fairs, job finding apps, resume writing support in the center, and job opportunities that come through the network.

"Our CPRC has allowed CCAR/ Ethics training participants to volunteer with the recovery center to earn the 500 internship hours needed for certification. This has allowed interns to get direct contact with participants through motivational interviewing, telephone recovery support, outreach, co-facilitating mutual support meetings, and event planning. " ~Middlesex County CPRC

Collaboration with Local Family Support Groups. "We formed a strong partnership with the Family Support Center to exchange resources and expertise for better supporting individuals and families affected by addiction" – Union County.

During FFY 2024 there were 2,846 intake surveys. There were more male (62.0%) than female (38.0%) participants. Of CPRC participants that completed the survey (n=2846), 31.1% (n=107) utilized MOUD. Of this group, 55.67% (n=41) utilized Methadone, 30.97% (n=40) buprenorphine, and 9.69% (n=10) Vivitrol, and 3.66% Other. Since all CPRCs will be using the Recovery Data Platform (RDP) going forward that demographics will be more robust in the future.

Grassroots Recovery Organizations and Centers

The Recovery Movement is well established in New Jersey. In terms of social media, there are numerous NJ Recovery Support pages on Facebook, Instagram and Twitter – ranging from parent-to-parent support groups to groups advocating for more treatment and recovery options for those suffering from a substance use disorder. At the community level, New Jersey has seen tremendous efforts in advocacy and recovery support. The New Jersey affiliate of the National Center for Advocacy and Recovery for Behavioral Health (NCAAR-BH – formerly NCADD-New Jersey) developed a "Recovery Advocates" program with graduates being divided into regional teams across the state. These Advocacy Leaders are trained on how to provide testimony to the New Jersey Assembly as well to develop regional events to educate the community about recovery and decrease stigma regarding addiction.

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

All of these centers train their peer recovery staff and volunteers using the Connecticut Community for Addiction Recovery (CCAR) curriculum. Once they meet the required education and service hours, peers can take the examination and earn the NJ specific Certified Peer Recovery Staff credential or the National Certified Peer Recovery Support Staff credential offered by NAADAC.

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).

Family Support Centers (FSC)

Three regional Family Support Centers (FSC) continue to be funded through SOR funding to provide peer to peer family support services to families in each region whose loved ones suffer mainly from an opioid use and/or stimulant use disorder. FSCs were the first formal family support service in the New Jersey's Substance Use Disorder continuum of care that offered direct family support, education, resources and advocacy in a safe and non-stigmatizing environment. Each regional center is staffed with Family Support Coordinators with lived experiences who are trained in the Community Reinforcement and Family Training (CRAFT) Model which teaches families self-protection along with non-confrontational skills to help empower their loved one to seek treatment. The CRAFT Model which was developed and researched by Robert J. Meyers, PhD. CRAFT is a non-confrontational intervention and skills-based program designed to impact families in multiple areas of their lives, including self-care, pleasurable activities, problem solving, and goal setting. CRAFT addresses their loved one's resistance to change, in addition to teaching families behavioral and motivational strategies for interacting with their loved one.

CRAFT training is provided by DMHAS to all FSC Coordinators. The three major goals of CRAFT that the Family Support Center Coordinators work with families on are:

- Decrease a loved one's substance use
- Influence a loved one to seek substance use treatment and recovery
- Improve the functioning of family members by making positive life changes

Through brief CRAFT model supportive sessions, the FSC Coordinator assist family members with examining their interactions with the substance-using person, improving their communication strategies, and decreasing emotional stress, support to parents, build hope and provide a sense of optimism, teach positive communication skills, be able to engage in role-plays with parents to rehearse positive communication skills, conduct supportive or psycho-education groups, develop wellness plans, share stories of hope and recovery, connect family members to each other, and advocate for family members' health and safety.

The FSC Coordinator helps each family member develop and work on their own Individualized Wellness Recovery Plan. The overall goal of the FSC Coordinator is to provide compassionate support to empower family members to have a better quality of life, improve their psychological health, decrease levels of stress, feel less isolated, and gain skills needed to cope with their loved one's use. Families who receive FSC services also receive Naloxone Training and Kits to assist their loved ones at risk of opioid overdose.

In 2021, each regional FSC expanded due to the increased numbers of referrals coming from OORPs, STARs, ReachNJ, Connect4Recovery Call Center, Division of Children and Families, and Families, Probation, and Treatment Providers to assist family members of loved ones with an OUD/stimulant use disorder, and some families without. Each FSC Region now provides family support services for at least 150 families in their region.

In addition to providing its families with Naloxone trainings, kits, and medication assisted resources and treatment, Regional FSCs also provide ongoing peer individual support, education, and coaching to families on an ongoing basis. The FSC's individual services and support to families constitute the most utilized form of service that the program offers.

As a result of the COVID-19 pandemic, several adaptations to FSCs continue to be made to accommodate the individualized needs of the families and staff members. The hybrid work model has become the new standard for each FSC. Since the objective of all peer work is to "meet people where they are," the FSCs respected the participants' wishes and continued with hybrid and virtual alternatives for individual and group sessions as well.

FSCs continued to run weekly virtual CRAFT-based Family Support Groups for enrolled FSC clients. Groups such as Helping Through Understanding; Understanding Substance Use; Strategies for Improving Communication; Strengthening Healthy Alternatives; Offering Information and Making Requests; Conversations Suggesting Treatment continue to be a success as evident by the fact that they are well attended and that families continue to provide positive feedback.

FSCs also offer families, various partners, and the community, educational workshops designated as "The Support Series" that also consist of CRAFT Strategies (topics include: Engagement Strategies, the Dichotomy of Control, Communication Skills, Boundary Setting, Enabling vs. Helping, Behavioral Reinforcement, Self-Care, The Stages of Change, Motivational Interviewing, Acceptance and Commitment Techniques, Unilateral Approach to Change, etc.). Monthly Self-Care events are also made available to help FSC family members; events include Floral Design Workshop, Crafting Hope, Self-Care Soiree, Pizza and Painting, Outdoor Paint Party, Spring Flower Arranging, Weekly Yoga for Recovery, Overbooked Book Club, and Tending Our Inner Self Book Club. The FSC also engages in community outreach events, meeting in-person with partners and providers, and meeting in-person with families at the agency and within the community. The FSC also continues to engage families remotely telephonically or virtually through the Telehealth platform.

In FY 2024, the Regional Family Support Centers provided support to 289 families who had a family member with a verified opioid and/or stimulant use disorder. FSCs also provided family support to 165 additional family members who could not verify the substance their loved one was using. These additional family members still received family support from the FSC, however are counted separately and not included in the FSC Outcome Data which only focused on opioid and/or stimulant use families.

FY 2024 FSC Outcome Data was collected from the opioid/stimulant use families who received services from the three regional Family Support Centers (FSC). Some of these families completed an intake during the time frame while others began service prior to and continue to receive services. Outcome data for opioid/stimulant use families is collected through the FSC survey. The FSC enrollment survey is self-administered by family members within two weeks of their first contact with the program and a follow-up survey is completed approximately six months later. Data are from family members who received services from program inception through June 30, 2022.

Most (82%) family members were female and 65.2% were parents of their loved one with OUD. The highest percentage (58.9%) of loved ones of family members were aged 14-34 and the majority (73.5%) were male (n=296). Please note that not all families who were served completed an intake survey.

Updated outcome data are not available, so the most up-to-date data are included below. Family members' areas of concern regarding their loved ones are also collected. The area of concern most frequently cited as the main concern was mental health, accounting for 52.88% (n=55). Following mental health, the chief concerns cited were medical health at 19.23%, interpersonal and family relationships at 13.92% and educational progress at 1.92%.

The SOS assesses the impact of loved one's substance use on family members across the eight domains shown below. Items asked how often family members experienced a total of 54 difficulties as a result of a loved one's abuse of alcohol or drugs. On a scale ranging from 1 (never) to 5 (almost always), mean values were highest on the emotional (M = 3.12) and relationship (M = 2.55) domains. Impacts on the legal (M = 1.00) and physical violence (M = 1.01) domains were lowest.

In addition, the Central FSC Region used the FSC Recovery Data Platform (RDP) Pilot to collect data. This pilot dramatically improved the monthly reporting process, supported the hybrid work model, eliminated paper files and offered opportunities to track outcomes for the Central Region FSC. The owner of the platform, Faces and Voices of Recovery, agreed with the recommendation to identify one specific CRAFT strategies for each family interaction. The Central Region FSC is very excited about this data collection because no one is tracking the individual CRAFT strategies. This is a recent upgrade and a small sample, so more data needs to be collected. Practicing self-care was identified as the most commonly used strategy and this was addressed by the introduction of the self-care events. This is an example of the output that will help the FSC in planning future programming:

Self-Care Strategy Number of Interactions

Self-care 385

Problem Solving 108

Positive communication strategies 64

Getting a loved one to accept help 43

Understanding a loved one's triggers to use substances 38

Understanding readiness for change 24

Setting health boundaries 14

Collegiate Recovery Programs

DMHAS provides funding to five state institutions of higher education. The funding enables them to offer students in recovery from a substance use disorder (SUD), students at-risk of developing a SUD, and students not in recovery who choose not to use alcohol and drugs, a supportive community (including housing) that promotes physical, psychological, social, and spiritual health. By providing this support, it is easier for a student who is in recovery to thrive in the college setting and work toward his/her/their academic goals.

The colleges/universities are Rutgers University New Brunswick and Newark campuses, The College of New Jersey, Rowan University and Richard Stockton University. During SFY 2024:

- o 1458 students received individual and/or group recovery support services
- o 65 students resided in recovery housing
- o in excess of 18,000 students participated in campus-wide or large-scale
- o substance-free activities/events
- o 94% reported (past 30-day) abstinence from substance use
- o 70% reported being employed
- o 100% of students reported satisfactory academic standing
- o 100% of students reported no criminal justice involvement
- o 100% of students reported stable housing (on or off campus)
- o 100% of students reported satisfaction with the services they receive through the collegiate recovery program

- o 100% reported social connectedness with peers, family, friends and/or coworkers
- o 60% of students reported need for mental health resources, all of whom were either engaged with a lead counselor or were linked to a community mental health program.

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. Through June 2025, 2,387 individuals have been served by TRS. Additional information about TRS services is provided below.

- Total phone calls outgoing: 33,975
- Total phone calls incoming: 12,616 calls
- Average length outgoing: 5 minutes 53 seconds
- Average length incoming: 9 minutes 21 seconds

Intensive Recovery Treatment Support

Since 2017, DMHAS has worked with the Department of Corrections to provide Intensive Recovery Treatment Supports (IRTS) post-release services to a cohort of eligible offenders (n=200) with Opioid Use Disorder that receive MAT prior to release from prison, and to another cohort of non-MAT eligible offenders (n=400) both pre- and post-release into the community.

In October 2020, NJ Governor Phil Murphy signed legislation for decreasing sentences and early release of certain NJ state prison inmates incarcerated for non-violent offences. The law was effective in early November 2020. Through January 2021, almost 3,000 inmates were released. Approximately 800 of these individuals had an OUD diagnosis and 364 enrolled in the IRTS program. Two additional IRTS teams were developed to serve them.

IRTS links eligible offenders to recovery services necessary to support wellness and successful community re-integration. It helps offenders address issues such as health/wellness, treatment adherence, employment, housing, and opportunities and skills to enhance the individual's ability to participate in meaningful life activities. There are five IRTS teams providing services for up to six months prior to release and up to 12 months post release. To date, 5,792 inmates have been referred to the program.

In a subsample of IRTS (N = 334), the percentage who reported being housed increased from 74% in the first month after release to 84.7% in the fifth month, while the percentage who reported employment increased from 27% to 73%. The self-reported percentage using MOUD decreased modestly over this period but remained relatively high at 63.4% after five months. Self-reported alcohol and drug use increased over this time but remained below 30%. Among participants, on a monthly basis, 0.8% and 2.4% of active participants in the community experienced overdose or return to prison.

The following table provides a description of IRTS participants as of 6/30/2024.

Characteristic %

Sex

Female 9.6

Male 90.3

Age

18-24 6.6

25-34 35.9

35-44 31.7

45-54 17.6

55+ 8.2

MAT use among participants with OUD, January 2020 – May 2024

Month N with OUD On MAT Month N with OUD On MAT

Jan 2020 172 66.9% Apr 2022 100 63.0%

Feb 2020 149 64.4% May 2022 90 68.9%

Mar 2020 149 67.8% Jun 2022 65 67.7%

Apr 2020 143 70.6% Jul 2022 60 68.3%

May 2020 175 68.6% Aug 2022 59 64.4%

Jun 2020 161 69.6% Sep 2022 50 68.0%

Jul 2020 155 68.4% Oct 2022 51 64.7%

Aug 2020 143 67.8% Nov 2022 51 68.6%

Sep 2020 139 68.3% Dec 2022 54 64.8%

Oct 2020 116 65.5% Jan 2023 45 55.6%

Nov 2020 155 63.9% Feb 2023 50 64.0%

Dec 2020 158 62.7% Mar 2023 42 54.8%
 Jan 2021 144 65.3% Apr 2023 53 62.3%
 Feb 2021 155 64.5% May 2023 51 56.9%
 Mar 2021 115 70.4% Jun 2023 46 56.5%
 Apr 2021 68 69.1% Jul 2023 46 60.9%
 May 2021 106 74.5% Aug 2023 43 58.1%
 Jun 2021 132 66.7% Sep 2023 41 58.5%
 Jul 2021 116 65.5% Oct 2023 67 56.7%
 Aug 2021 90 67.8% Nov 2023 79 51.9%
 Sep 2021 108 69.4% Dec 2023 85 51.8%
 Oct 2021 105 64.8% Jan 2024 86 52.3%
 Nov 2021 79 77.2% Feb 2024 81 56.8%
 Dec 2021 72 73.6% Mar 2024 78 57.7%
 Jan 2022 68 69.1% Apr 2024 81 60.5%
 Feb 2022 79 73.4% May 2024 72 58.3%
 Mar 2022 108 66.7% Average 95 64.5%

Note: N represents the number of participants with documented OUD diagnosis who completed monthly reports for the month. Data entry may be incomplete for most recent months.

Peers in Residential Treatment Programs

Over the last several years, DMHAS has made significant efforts to increase the SUD peer workforce. Peer support services have positively impacted and provided assistance to persons in recovery from serious mental illness, substance use or co-occurring mental and substance use conditions before, during and after treatment. As a means to close the gap in the provision of peer services in residential settings, DMHAS issued an RFP in March 2023 to expand the peer workforce to include peer services in inpatient withdrawal management, short-term and long-term residential and halfway house settings. In June 2023, eight providers were awarded a contract for a total of 26 peers. In the following year DMHAS expanded this service to add an additional provider as well as fund an additional 26 peers. The successful bidders hired peers who assist with issues that often occur concurrently with SUD, such as homelessness, legal issues, employment, childcare, etc. In addition to linking individuals with the appropriate community resources, peers also encourage individuals to remain in treatment as recommended in the treatment plan and modeling strategies on how to manage addiction successfully.

Recovery Support Care Management (RSCM)

RSCM was established and effective on March 7, 2023 and is a behavioral health service intended to support consumers who have a SUD with complex physical and/or psychosocial needs. RSCM provides direct and comprehensive assistance to consumers to ensure access to the necessary treatment, rehabilitative and recovery services with the intent of decreasing psychiatric and addiction symptoms, connect consumers with services, improve transitions between levels of care, implement strategies to address their unique needs, decrease opioid related deaths and sustain recovery in the community while supporting the consumers' continued stability and recovery throughout the continuum of care. This service is available as an enhancement in all levels of care. This service may be provided face-to-face or via a telehealth platform. Since Medicaid offers Care Management in outpatient, RSCM is excluded from reimbursement for consumers admitted into Ambulatory LOCs in Recovery Care Efficiency (RCE). As of March 31, 2025, there were 4,615 unduplicated clients who received this service.

RSCM activities are categorized into separate initiatives:

- Driving Under the Influence Initiative (DUII): DUII supports the treatment of financially indigent residents of New Jersey who have been convicted or recently arrested for a Driving Under the Influence (DUI) charge. Individuals must be clinically assessed and determined to be in need of substance abuse treatment services and meet financial eligibility requirements in order to access the DUII funding. Financially indigent intoxicated drivers can receive the appropriate level and duration of treatment warranted, thus the incidence of recidivism among intoxicated drivers and ultimately creating safer highways.
- New Jersey Statewide Initiative (NJSI): NJSI funds ambulatory and residential levels of care including Outpatient, Intensive Outpatient, Short Term Residential (STR), Halfway House, and Long Term Residential (LTR) and enhancement services. Ambulatory levels of care and Halfway House Services are State funded; STR and LTR services are funded through Federal Block grant dollars. Eligible consumers are New Jersey residents who have income up to 350% of the FPL and have been determined to be in need of SUD treatment in the levels of care offered in this initiative.
- Substance Abuse Prevention and Treatment Initiative (SAPTI): On July 1, 2016 the contracted methadone outpatient, intensive outpatient and residential services reimbursed by Substance Abuse Prevention and Treatment (SAPT) Federal Block Grant (BG) funds were transitioned to Fee for Service. Inpatient Withdrawal Management was added to this initiative on April 11, 2017, supported by State dollars.
- State Parole Board (SPB): The SPB is designed to provide substance abusing inmates and parolees with the opportunity to receive structured, community-based substance abuse treatment that introduces intensive therapy for behavioral and psychological problems related to addiction. This funding is a combination of direct appropriations to DMHAS and funds transferred from the Department of Corrections (DOC) and State Parole Board (SPB) to support an FFS network of licensed community-based substance

abuse treatment programs. For SPB, these funds support a similar FFS network which offers the full continuum of care including long term and short-term residential care, halfway house, partial care, detoxification, intensive outpatient, and outpatient treatment for SPB parolees. If you are interested in substance abuse treatment and believe you may qualify for services through this initiative, please contact your parole or corrections officer.

- South Jersey Initiative: South Jersey Initiative. This state funded fee-for-service initiative for young adults (ages 18-24) from eight counties (Ocean, Atlantic, Burlington, Camden, Gloucester, Cape May, Salem and Cumberland). SFY23, the SJI eligibility criteria was expanded to include young adults ages 25 to 30 years old. The criteria change provides the opportunity to reach more young adults over the age of 24, and those who age out from their parents' insurance coverage who are in need of substance use disorder treatment (SUD). The SJI provides a continuum of care that includes methadone maintenance, detoxification, residential, halfway house, and outpatient treatment services.

Recovery Management Check-Up

Recovery Management Check-up (RMC) is a statewide service for discharged clients to support independent living and success with recovery and provide more methods of outreach to clients. This includes virtual face-to-face visits, text messaging, chat features, and the opportunity for actual in person contacts. Monthly contact forms the core of RMC, which aims to identify and alleviate client problems before they derail recovery. Problems are addressed using motivational interviewing techniques or connecting clients to appropriate community resources or treatment if needed, including medication assisted treatment (MAT). The conceptual framework of RMC is to treat addiction as a chronic disease, with long-term management to minimize the number of acute episodes of substance use disorder and with prompt treatment when episodes occur to prevent them from becoming more severe and consequential. RMC is a program designed to provide local recovery support services in the following three regions of the state.

- 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.

Key goals of the RMC are a) provide a regionalized, innovative recovery program to individuals recovering from SUD in all 21 counties of New Jersey; b) provide and coordinate integrated person-centered recovery support services to persons in recovery; c) identify, improve, and sustain the recovery capital for persons or individuals recovering from SUD. The overall purpose of RMC is to ensure optimal success for persons in recovery. To this end, the program employs four dimensions of recovery; health, home, purpose, and community. RMC seeks to meet participants wherever they are in their individual recovery journey by honoring their choice, voice, and agency.

Through concerted efforts, collaborations and team technical supports, RMC was enhanced to gain buy-in and to become institutionalized as an integral process in the recovery community in the state. To achieve this, the program launched the RMC Referral website and e-referral kiosk at <https://fvrlhub.org/rmc-nj-cars/>, as an effective tool to facilitate referrals to the appropriate regions based on the participant's county of residence. Available indicators show that RMC had consolidated and registered progress across the three regions of the state. Data below will highlight the quantitative value of progress made in RMC from onset to present.

From the beginning of the program to March 2025, for all three regions, a total of 14,032 outreach attempts were made by certified peer support staff. 3,987 of those were successful contacts. On average, 584 attempts were made, with 166 succeeding, per month. The program's output was on an upwards trajectory, and the last 6 months of the program were its most productive. In that time, the program expanded to 1,030 outreach attempts per month, with 272 successes. The program was able to serve 1,503 unique participants. RMC was able to serve as a connective program, making 2,692 referrals to other both SUD and non-SUD -related programs

County Innovation

Recovery Support services were developed in all 21 NJ counties, utilizing State Opioid Response (SOR) funding. A description of these programs follows.

Atlantic \$126,059- 2 programs

Innovative Recovery Support Services: \$66,059

AIM provides support, encouragement, and empathy to a vulnerable population associated with those living with substance use disorder. Furthermore, AIM proposes to provide 200 individuals within the community with transportation, linkage to treatment facilities, assistance with sober living, and provide individuals with basic needs such as toiletries, food, and clothing. The level of service and cost proposed by AIM are within reason and a contract is warranted. AIM proposes to provide Recovery Support Services to 1000 individuals: \$50/client with follow-up \$50; Recovery House funding at \$175/week for 3 weeks; Assistance with 12-Step-Facilitation at \$50 x 3 events; Necessity support at \$50 x 2; Transportation costs up to \$750 (contingent on actual costs); Outreach \$200/event; Blessing Bags \$200/event, and Admin costs including insurance, etc.

John Brooks Recovery Center: \$60,000

The agency will assume to re-open/continue operating a Recovery Center that would provide innovative services to the recovering community, with an emphasis being placed on providing services to affected persons of the opioid epidemic and family members of affected persons of opioid overdose deaths. This would include John Brooks Recovery Center (JBRC) which submitted a proposal for \$60,000 to provide a wide array of recovery support services to all people in recovery with a substance use disorder. JBRC operates two Recovery Community Centers with the ability to service approximately 550 unduplicated individuals. Cost for individual peer to peer services, navigation, coaching, follow-up, education/prevention, and service connections (housing, employment, tobacco dependence) is \$16.00/15 minute unit of service. Cost for group peer to peer services, workshops, support

groups, education, prevention, and health/wellness is \$4.00/each individual/group. The Recovery Center is located close to public transportation and will utilize both professional and volunteer staff to function daily.

Burlington \$134,615

Resource Recovery Center

The one-time award for the Resource Center is to provide an environment 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.

The Resource Center will include an array of services that support individuals in their recovery from substance use and misuse. In summary, this funding will:

- Strengthen the linkage between treatment and recovery;
- Increase support for sustained recovery within the community;
- Offer resources to individuals seeking information on substance use disorder and behavioral treatment. Resources will include accessing treatment information through NJ Connect, private insurance, DMHAS Interim Managing Entity (IME) Addictions Access Center, Family Support Centers, Support Team for Addiction Recovery (STAR), Medication Assisted Treatment (MAT) options,
- Help prevent recurrence of substance use;
- Inform individuals about Naloxone training and where one can obtain a kit;
- Provide recovery resources;
- Provide a trauma informed community where individuals can achieve a full and satisfying life free of trauma and its consequences; and
- Provide a center for community-based leadership to grow and develop.

The coordinator is to be a person in Recovery and trained as a Certified Peer Recovery Staff. An Oversight Team will be developed to guide the programming and running of the resource room. This team will include County A/D Director, Peers in Recovery, Providers, Burlington County Prosecutors Office (BCPO), etc. The coordinator will be responsible for the daily operations and oversight of the Resource Room (i.e., startup activities, growth, stabilization, and continued innovation). He/she will report to the A/D Director. The BCPO is providing a Certified Peer Recovery Staff (CPRS)/Recovery Coach training run by City of Angels. It will be free to Burlington County residents and occur sometime in March. The BCPO, through its Operation Helping Hands Program, has offered to provide CPRS for July and August. The County will use funds to pay the CPRS the other months for the first year. A CPRS pool will be created to staff the recovery center with the coordinator. The County plans to have at least two people working the recovery room when it is open, so no one is there alone in case of emergency.

Camden \$190,039

Program: Joseph's House

Location: 555 Atlantic Ave, Camden, NJ 08104 which is an 88-bed shelter in Camden City. The shelter is co-ed

Program: Volunteers of America – Delaware Valley, Anna Sample Complex

Location: 408-416 Line Street, Camden, NJ 08103. 93-bed Transitional Housing program serves single women and families.

Since April 2020, Camden County was funded by the National Association of County & City Health Officials (NACCHO) to provide a Peer Recovery Staff (CPRS/HRS) who are required to work 'in-person' at two homeless shelters under the direction or co-direction of the shelter and or substance use licensed treatment facility. For 2023/2024, Maryville, Inc., a SUD treatment provider who will supply the CPRS and coordinate the data.

The shelter administrative team/s will determine and provide the required hours based upon the number of overdoses in the area. Also considered is when the shelter guests are available. That means working during the day, evening and on weekends. The hired licensed entity selected to provide the CPRS service must enter into a Memorandum of Understanding (MOU) with the homeless shelter(s) post award, subject to the approval and acceptance by the County, to determine the hours of operation. They must have mutual agreement of all operational terms, including provision of replacement staff in the event the assigned CPRS/HRS is unavailable.

Therefore, the CPRS/HRS is required to be co-supervised by the SUD treatment agency and shelter administrator. The CPRS/HRS cannot perform any activities on behalf of the SUD treatment agency, shelter or county not defined or approved by the shelter or county. The CPRS/HRS offers an opportunity to share the experience of lived experience, however, referrals will be made in accordance with the most evidenced based practices. The CPRS/HRS must be fully knowledgeable about multiple pathways to recovery and SUD treatment. Individuals with 'opiate use disorders' (OUD) must be referred to the most evidenced based treatment. The shelters may bill \$1,004.00 per month for the provision of a desk and supervision. The CPRS provider may bill \$35,000.00 per CPRS plus up to 25% for fringe (\$8,750.00). The cost of CPRS cell phones, a lease of a vehicle, incidental travel costs for the patients, cell phones and tablets for the CPRS will be covered. CPRS must come from an agency that has direct capacity to an inpatient admission center. The County will cover the cost of an afterhours line with an inpatient treatment agency to allow for greater access to treatment for its residents. CPRS are provided instruction about multiple pathways to prevention services. When shelter guests are not ready for treatment, they are encouraged to take advantage of multiple pathways to prevention services. The County will directly with its multiple pathways to prevention center to assist in the education about that topic. The County will also work with its shelters to increase their understanding of the value of multiple pathways to prevention.

Program: Regan Center

Location: 508 Lakeland Road Gloucester Township, NJ 08012 (856) 549-0590

The Regan Center is a 23-bed facility comprised of a 15-bed emergency shelter program and 8 bed medical respite program for homeless adult men.

There are 2 CPRS full time. To complement this program, the County funded 1 CPRS with lawsuit remediation funds – to provide CPRS services for the other 3 shelters in the county. Burlington and Gloucester Counties refer all homeless individuals to Camden County's shelters.

Cape May \$35,751

This program will use funding to establish a recovery center in the county which will serve as the hub of many recovery programs that currently operate out of churches and other general areas. It will be peer driven and peer delivered and serve people currently in recovery and are dedicated to maintaining a sustainable path in recovery. Recovery staff will be present to develop a recovery plan for those in attendance and assist with Medicaid applications. Support groups for at risk populations such as pregnant and new mothers and families (CRAFT) will be scheduled, education regarding treatment and MAT will be available, fellowship groups including 12 step and all recovery will be welcomed. Agencies will bring support programs on a routine basis such as work readiness, nutrition, job search, entitlements, etc. The Center will operate from 10 to 6 daily and allow for meetings after hours. It is expected that 300 people will participate and 100 will develop a recovery plan and will be linked to resources, including MAT. Thirty percent of those who develop a recovery plan will remain in recovery three months.

Gloucester \$111,151

This program is a collaboration between Gloucester County and Center for Family Services, operating on the campus of Rowan College of South Jersey. The program will provide the following:

- Expand Substance Abuse Family Recovery Support Program. Opening additional satellite locations in Gloucester County to provide better access to residents. Areas of particular interest would include the eastern part of Gloucester County (Monroe Twp., Franklin Twp., Clayton) and the southwest riverside communities (Paulsboro, Greenwich, Logan).
- Provide transportation to and from withdrawal management and treatment services. A subcontracted agency would provide transportation on an as-needed basis for Gloucester County residents.
- Additional Supports for sober living residents. Currently, Gloucester County funds a limited number of residents entering into sober living by paying their move-in fee and first 2 weeks rent. Funding is also made available in cases of hardship. Additional support is needed to provide daily living essentials, such as toiletries and food.
- Enhance Collaborations with community service organizations. Gloucester County will look to expand partnerships to increase access to, and education on, Medication Assisted Treatment, Narcan, SBIRT Intervention, Peer Recovery Support, Family Support, Sober Living, and other programs/services, at various locations throughout county.

Hudson \$203,963

The Hudson County Innovation Program will provide the following services.

- Supporting Treatment for Addiction, Recovery and Success (STARS) Program - Mobile outreach van to offer Info, Naloxone training and support services.
- STARS support materials
- Youth recovery support group (Ages 13 - 17)
- Young adults' recovery support group (Ages 18 - 24)
- 6 Recovery events
- Youth sober activities
- Outreach/ education to prescribers

Hunterdon \$35,708

The Hope One Vehicle in Hunterdon County will educate those addicted to heroin and other opioids about the dangers of ongoing use, as well as give resources to get help. It will provide transportation at the end of each shift to MAT services as well as to the County's screener for services to assist those who express interest in getting services. The County will also provide funds for taxi service back or provide linkages to the local Link service. Transportation has long been an impediment that has prevented many from being able to consider getting to treatment. Hope One will work with the Social Services Department to assist consumers to be able to sign up for benefits, assisting them in being able to gain access for needed services, as well as housing and food needs. MOU's will be set up with mental health agencies, as well as the local health department, so that consumers can have referrals for services. Rapid testing HIV will be offered, as well as education on safe injection, abscesses, and Hepatitis C. Peer Staff will be invited on Hope One as another way to reach out to consumers who may be using substances and as a means to educate and assist those who want to get treatment understand their options.

Mercer \$140,490

The overall goal of the implementation of a medication assisted treatment (MAT) Coordinator is to improve the availability and accessibility of an array of appropriate MAT, for people who have substance use disorders (SUD), those with opioid use disorder (OUD). The concept of a county MAT coordinator will help with promoting treatment services, consistent with DMHAS' message regarding this evidence-based practice. This position will help individuals and their families navigate the array of treatment providers in order to connect to MAT, for those individuals who are not yet eligible for other programmatic support. The MAT coordinator would have the full support of the Mercer County Department of Human Services to educate all areas of Human Services, such as aging providers, disability providers, criminal justice, youth, mental health, and the housing and homelessness system. For example, the MAT coordinator could provide education to the Coordinated Entry and Assessment System (CEASe-Homelessness system) with direct linkages to MAT. This position can support the consistent message that MAT can help individuals. This coordinator will also accompany the CEASe system outreach team on their mobile van to help promote treatment services in order to help the unsheltered homeless population of people.

Middlesex \$264,916

The innovative MORE (Middlesex Outreach for Recovery) project will meet people wherever they are – whether in homes, parks, trailer parks, soup kitchens, food pantries, abandoned buildings and houses of worship. MORE is envisioned as a space where engagement and relationship building begin. MORE will offer water, non-perishable snacks, blankets, Naloxone, and Fentanyl and Xylazine test strips, resource information and linkages, to establish trust and to empower people to begin addressing the

complex issues at the heart of their personal challenges. Outreach will allow MORE to educate individuals and the larger community about available services, including evidence-based MAT. MORE will provide health and wellness promotion, preventative education and clinical services to statutory populations throughout Middlesex County. With a holistic, person-centered approach, MORE will:

- Decrease Opioid use
- Connect individuals diagnosed with opioid use disorders to medication-assisted treatment
- Support individuals on a path to recovery

Meeting people in the MORE will provide a greater amount of privacy, safety and resources than is possible through outreach activities conducted by staff on the streets, which is essential to determine eligibility for diagnostic and medical services.

Monmouth \$226,366

Monmouth County is utilizing the innovative grant award to fund a mobile recovery unit (not a vehicle per se, but a group of partnering agencies). The unit will go to statutory communities on a regular schedule throughout the period of the contract. The mobile recovery unit will outreach to the identified community and educate the community on substance use disorder (SUD), particularly opioid use disorder (OUD), and provide information on the resources available. Certified peer recovery staff from partnering agencies will work to engage with individuals struggling with addiction and build a relationship in the identified communities. Simultaneously, they will have treatment agencies partner to offer a free half hour consultation with a licensed clinician via phone. This option will be open to an individual contemplating treatment OR to the family member of a loved one with SUD. They can remain anonymous if they wish. If it is a person with SUD, the clinician will use the opportunity to engage, educate and discuss what their options may be for treatment and what treatment looks like with a particular focus on Medication Assisted Treatment (MAT) options. If the person decides at the end of the consultation, they'd like to seek treatment, they will be referred into the Monmouth County Care Management Collaborative and be assigned to an agency that will link them to treatment and continue to provide ongoing care management and support. If they do not want to seek treatment at that time, they can opt-in for a follow up "check-in" phone call from the clinician. Additionally, if the peer recovery staff engages with someone in the community who does not want the consultation but does express interest in treatment, the recovery staff can refer them directly to the Care Management Collaborative to be assigned.

The goal of the mobile recovery unit is to reach communities through boots on the ground efforts providing education and information/access to available resources utilizing certified peer recovery staff to engage individuals at high risk of overdose who may not otherwise be seeking treatment and linking them to life saving medication assisted treatment and other treatment options. Additionally, the mobile recovery unit will work to engage families to provide information, support, and resources that will assist them in managing the impact of their loved one's addiction. It is expected that through these local statutory efforts, Monmouth County will increase the number of residents with OUD on MAT and/or linked to a treatment program.

Morris \$151,505

Morris County has implemented a Successful Transition and Re-Entry (STAR) program model for Pre-Trial Division. The Addictions case manager provides up to 1 year of community engagement and linkage to services and recovery staff available 24 hours for those involved in Pre-Trial services.

Ocean \$229,936

The Ocean County Innovation programming will provide the following services.

- Post-Narcan Case Management - social worker conduct post-Narcan interviews with police depts.,
- Recovery events
- Enhance recovery support programs w/ services aimed at emotional self-management,
- First month rent for those in need of Oxford House or Sober Living placement,
- Planning grant for Recovery High School,
- Transportation study of those provided w/ transportation and telephone case management vs control group of those who did not
- Training for 24 elementary school teachers on "Footprints for Life (EBP) for 2nd and 3rd graders

Passaic \$167,627

The Passaic County Mobile Recovery Unit Program is a mobile access unit (to be named at a later date) that will be used to engage individuals in the community. The provider will host the mobile access van in upper and lower Passaic County in areas determined to be locations of concern and need as it relates to opioid use and opioid addiction. Services provided will include immediate information and resources, training on opioid overdose prevention and multiple pathways to prevention, multiple pathways to prevention kits, and support services to those in need of substance use support and treatment. In an effort to engage individuals in a friendly and supportive manner, the mobile access unit will provide food, beverages, multiple pathways to prevention kits as well as information.

The primary goal of the program is to ensure those in need of services and support for substance use receives the appropriate resources and assistance directly linked to services as needed. The program also aims to decrease rates of substance use, lessen crimes related to substance use, prevent opioid overdoses and overdose deaths, develop a rapport with those affected by addiction, and educate individuals on multiple pathways to prevention methods. Initially, the van will be deployed in the community for two days per week for up to 4 hours each deployment.

Salem \$24,795

The program will support individuals in recovery by offering opportunities for exploring new activities on a regular basis both in and outside of Salem County. Very often, those new to recovery are focused on trying to regain life's balance and do not have the financial stability to pay for activities that will allow for them to discover new hobbies. Also, there are few opportunities for recovery supportive environments and those leading a substance abuse free lifestyle are seeking others on the same path. With

limited sources of entertainment in Salem County, this is a gap that needs to be filled to support the recovery community. These opportunities would include a sober, substance abuse free environment and growing the individual's network of acquaintances. This will encourage healthy relationships with others in recovery from opioid use disorder. A certified recovery coach will be on site and have the tools to meet each person where they are in their recovery. This recovery coach can also connect event attendees to community resources and help them with wellness planning. Fellowship activities will be held on a monthly basis throughout Salem County. These monthly events will be 3 hours in length and take place at various times of day, depending on the activity. Some of these events may include cooking classes, practicing yoga or tai chi, bowling, art classes, hiking, or attending a play or live music event. These monthly activities will be open to anyone in the recovery community that is looking for free activities and ways to meet others on their journey to long term recovery.

Somerset \$94,967

The innovation program will support the recovery of Somerset County pregnant/parenting women with an opioid use disorder (OUD). It will provide Somerset County pregnant/parenting women with an OUD linkage to recovery support services identified by DMHAS and SAMHSA as the following: employment assistance; peer to peer services; sober living housing; transportation; child care assistance; education/training assistance; family counseling and education; medical or dental services; and groups such as relapse prevention, coping/life skills, parenting skills, AA or NA, sponsorship and faith-based groups.

Also, the program will provide evidenced-based family programs such as parent-child interaction therapy, multisystem therapy, multi-dimensional family therapy, or functional family therapy that increase the parent-child bond, strengthen families and keep families resilient, assist families integrate school involvement in child's social, emotional and academic success and decrease substance use and help families recover as a whole family.

Union \$170,574

Trinitas Regional Medical Center will provide wraparound services to connect Union County residents living with, or who have a history of, an opioid use disorder (OUD), addiction to stimulants, or co-occurring disorders to resources that support recovery. Family members of individuals affected by OUD and/or addiction to stimulants are also eligible to receive wraparound services.

Warren \$36,675

Warren provides a community program to provide Narcan trainings to community professionals and lay people. The program also provides education on addiction and treatment and recovery in schools, such as educational sessions for parents and loved ones.

Housing

Group Homes for Persons in Recovery (Oxford House)

Funding is provided to Oxford Houses to provide administrative and programmatic oversight of the statewide network of peer-led group recovery homes in New Jersey. The Oxford House model offers recovery-oriented living as a choice in a person's continuum of care. Recovery is an individualized process for individuals with substance use disorders. As of March 2023, New Jersey has approximately 146 Oxford Houses (107 male houses, 31 women houses, and 8 women with children houses); total beds are 1,164 with 858 male and 306 female beds. The Revolving Loan Fund is administered by Oxford House annually to establish new homes, with additional funding from the State and DMHAS treatment contracts. This funding supports Oxford House, Inc. outreach staff to establish homes exclusive for statutory populations such as women with children.

Federal funding for the State Opioid Response (SOR) allowed for expansion of the Oxford House contract for three full-time Outreach staff employed by Oxford House, Inc. to establish 10 new homes per year. DMHAS expanded the Oxford House contract in State Fiscal Year 2022 with SA Block Grant Funds for two additional full-time Outreach staff employed by Oxford House, Inc., and to support separate start-up funds to cover additional costs associated with the development and opening of houses for at risk populations. The populations include the following: women with children and men with children, individuals re-entering from incarceration and individuals with a history of opioid use who are at high risk for an overdose death.

In response to the opioid overdose epidemic, and its effects related to Oxford House, DMHAS requires Oxford House outreach staff to conduct annual trainings (overdose specific) for the 14 Oxford House Chapters throughout the state. Trainings are provided at the Oxford House annual state workshop. Each home is required to maintain Naloxone kits on site. Oxford House has seen an increase in members applying for membership with opioid use disorder (OUD). This increase supports the need for Naloxone training and information on access to Medical Assisted Recovery (MAR) options. The New Jersey outreach team continues to educate members on MAR and the importance of being an active member of their recovery community. Oxford House shall make every effort to accept individuals prescribed Medication Assisted Treatment (MAT) as well as other legitimately prescribed medications. Oxford Houses are responsible for providing lockboxes to each woman for medication storage, and residents in Oxford Houses are responsible for their individual medication lockboxes.

The DMHAS Program Manager and Oxford House, Inc. communicate on a regular basis and updates are provided regarding the current housing market or other challenges facing individuals seeking sober living in the midst of a pandemic. Oxford House, Inc. is part of the continued efforts to provide evidence-based recovery housing amidst a global pandemic. COVID-19 in New Jersey presented significant challenges for rental properties that Oxford House utilizes. The housing market is still causing impediments to finding affordable houses to be used as new Oxford Houses. In addition, the average cost to rent homes the size needed to be used as Oxford Houses has dramatically increased in 2022. These challenges have caused the team to struggle to find houses in some regions of the state where the rental amounts are much higher. The Oxford House outreach team continues to be vigilant in exploring all possible ways of identifying new locations. The team is focused on maintaining the current network of Oxford Houses while simultaneously finding new and replacement Oxford Houses.

Oxford House utilized online platforms for workshops during the pandemic to provide the following: expand overdose reversal and prevention trainings to houses with statewide partners; help residents to schedule COVID-19 vaccines; virtual platforms to assist residents with recovery meetings; accessing unemployment benefits; helping residents regain and maintain financial stability through the pandemic; establish virtual/teleworking; helping residents with Oxford House operations; provide updates on CDC, New Jersey and Oxford House, Inc. guidelines. Oxford House maintained ongoing communication with treatment

providers and other state systems regarding vacancies.

Oxford House reports that in SFY23 they began to see progress with the slowing spread of COVID19 infections, and the implications that came with it. Outreach staff, alums, and Oxford House members could visit each other in houses and hold face-to-face chapter and state meetings. These meetings have been a long-standing and stabilizing part of the Oxford House Model. MATI Intensive Supportive Housing (ISH)

The SSA has two supportive housing programs and incorporated into its Medication Assisted Treatment Initiative (MATI). These two contracts combined provide for a total of 63 supportive 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 and is funded at \$903,104.

Women's Intensive Supportive Housing (WISH)

The SSA developed a Women's Intensive Supportive Housing (WISH) Program funded at \$386,029. This program provides permanent supportive housing for pregnant and/or parenting women with a co-existing substance use disorder and mental illness who are homeless or at risk of homelessness and being discharged from a licensed long-term residential substance abuse treatment and/or halfway house facility. An RFP was developed and released in January 2015. The RFP was for the development of a WISH team to provide case management and supportive housing services for 10 women and their children. A contract was awarded in 2015 to a licensed treatment provider in women's specific treatment, offers a continuum of care, and has a longstanding history of providing supportive housing and has demonstrated success in managing permanent supportive housing programs.

ODU Supportive Housing

DMHAS awarded contracts in 2019 to provide individualized case management and supportive services to up to 200 individuals with an OUD, on average, up to 8 hours per month, billable in 15 units, based on individual needs. These services will assist individuals in seeking and connecting with behavioral health and or physical healthcare needs. DMHAS provides 175 rental subsidies, up to the fair market rate (FMR) for supportive housing. One-time funding will be available to consumers for security deposits, utility start-up costs and furnishings. Contracts were awarded four agencies to serve individuals in five counties: Atlantic, Burlington, Camden, Mercer and Monmouth. Since the awarding of the OUD contracts, the number of referrals has reached approximately 250 referrals with a total of 114 subsidies currently occupied, and an additional 24 in housing search phase. The turnover of the OUD vouchers is approximately 10%, with consumers surrendering the subsidies. The onset of the COVID-19 Pandemic has resulted in the full payment of rent for some of the OUD consumers since they lost employment.

Sober Housing

Contracts were awarded in 2019 for three pilot recovery-based housing residences (a minimum of five individuals in each residence), one in each region (North, Central and South), for individuals with an OUD who are homeless or at risk of homelessness. Individuals are in, or recently discharged, from treatment and are seeking a drug free, sober and supportive living environment, with access and linkage to sober community resources. Individualized case management and recovery-based housing services is provided for 15 individuals (a minimum of five individuals in each region) who have been identified as needing a safe, healthy, peer-lead, recovery-oriented environment. The housing provided must be licensed as a Class F, Cooperative Sober Living Residence (NJAC § 5:27). Accordingly, individuals are responsible for providing their own food and taking care of their own laundry. Treatment and counseling may not be provided in the residence; however, non-clinical recovery support services may be provided at the site and the agency may require, at its discretion, drug or alcohol testing of residents. (NJAC § 5:27-2.1). Although increased funded sober housing slots are needed, the pilots are thriving and continue to benefit those individuals seeking a stable sober environment.

5. Does the state have any activities that it would like to highlight?

Transportation is a key recovery support. A reliable means of transportation is needed so clients can get to prevention, recovery and treatment support programs. As a result of this gap, DMHAS has developed a new program called the Transportation Reimbursement and Invoicing Program (TRIP). Without adequate and affordable transportation options, clients are unable to begin vital treatment nor consistently attend and complete treatment, resulting in suboptimal outcomes. This will enable transportation to treatment for individuals who do not have Medicaid, or for trips Medicaid does not cover, as well as enable transportation to and from non-healthcare facilities such as Community Peer Recovery Centers or prevention programs. TRIP is intended and designed to eliminate transportation impediments and facilitate access to substance use disorder treatment, prevention and recovery support services (RSS). Currently, SUPTRS Block Grant COVID-19 Supplemental and ARPA funds are being utilized. Funding of \$1,000,000 was set aside for this project. It will then transition to SOR funding.

The Division of Mental Health and Addiction Services (DMHAS) recognizes the importance of peer supervision and protection. The PAC Peer Recovery Support Services (PRSS) Committee developed Guidelines for Best Practices: Peer Recovery Services which were published June 2023 to help ensure that peer recovery support services are provided using best practices based in research and experiences in various settings. The PRSS Committee acknowledges that this report is the beginning of the development of necessary standards for peer recovery support services in New Jersey. The guidelines have been worked on for the past several years during the expansion of this evolving field. It is designed to bring practical processes, strategies and tools to peers, their supervisors, administrators, and others committed to initiating and sustaining best practices in the peer recovery support services field and the supporting work environments.

As part of the DMHAS Opioid Housing Subsidy Initiative, individuals in the program are also provided peer services through a

Certified Recovery Peer Staff (CPRS). The CPRS works with individuals with an OUD by connecting them to needed services and entitlements, and assisting them with apartment searching. Up to six (6) hours of peer services provided by a CPRS per month are reimbursed through Medicaid for individuals who are enrolled in FamilyCare (NJ's Medicaid program). For the services provided by peers who are not certified and for individuals who are not enrolled in FamilyCare, reimbursement is through State funds while the consumer seeks FamilyCare and the peer is in training to receive certification. Peer services may be billed to Medicaid once an individual is enrolled in FamilyCare and services are provided by a certified peer.

DMHAS has worked with the Division of Medical Assistance and Health Services (DMAHS) to develop a bundled reimbursement rate for the Opioid Overdose Recovery Program (OORP). The rate has been approved by CMS. NJ Medicaid provides reimbursement for peers working in independent clinics which includes outpatient substance use agencies.

The Division of Mental Health and Addiction Services (DMHAS) continues to utilize the Recovery Data Platform (RDP) as its centralized system for collecting and analyzing peer recovery support service data. Originally launched in 2020, RDP is a secure, HIPAA-compliant, cloud-based platform developed in collaboration with Faces & Voices of Recovery and RecoveryTrek. It is specifically designed to document peer-delivered services provided to individuals impacted by substance use disorders (SUDs) and now stands as one of the most comprehensive peer recovery data systems in New Jersey. In 2024, RDP recorded services for more than 15,000 participants, more than doubling the number from the prior year and reflecting growing adoption across DMHAS-funded initiatives.

6. Please indicate areas of technical assistance needs related to this section.

Continued expansion of Medicaid reimbursement for SUD Peer Services. Currently there is no reimbursement for peers working in withdrawal management or any residential treatment.

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Footnotes:

10. Recovery – Required

1. Does the state support recovery through any of the following:

- a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?
☒ Yes ☐ No
- b) Required peer accreditation or certification?
☒ Yes ☐ No
- c) Use block grant funding of recovery support services?
☒ Yes ☐ No
- d) Involvement of people with lived experience /peers/family members in planning, implementation, or evaluation of the impact of the state's behavioral health 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.

Recovery Support Services are non-clinical services that assist families of, and individuals with, a mental illness (with or without a co-occurring SUD). They include social supports, linkage to and coordination among a full range of service providers that facilitate recovery and wellness for an improved quality of life. Services are flexible and may be provided prior to, during, and after treatment. They may be delivered by peers, professionals, faith-based and community-based groups, and others; they are key components of the state's behavioral health system, and include Community Support Services (CSS), Supported Employment, Supported Education, Family Support Services, trainings, and Peer Staff.

Community Support Services (CSS) provide rehabilitation and supports to individuals living in the community; various levels of staff in CSS help individuals attain their individualized recovery goals in **social, employment, educational and housing domains**, so they achieve independent living and community integration. CSS also helps to administer State-funded rental subsidies and tenancy support services (housing search assistance, utility set up, financial budgeting, etc.), that help individuals live in the community and sustain community tenure. Staff

also assist and support efforts to secure available financial assistance (food stamps, utility discounts), navigate public transportation, linkage to legal assistance, access and use of primary medical care, etc.

Supported Employment is provided statewide and allows individuals to obtain and sustain integrated employment in jobs of their choosing within their skill set.

Supported Education is designed to help individuals pursue their individual educational goals by helping them gain access to education and training opportunities and maintain their student status until they can complete basic education, remedial education, General Educational Development (GED), technical programs, college, and graduate school.

Intensive Family Support Services (IFSS) provides support, education, and advocacy for families with a member who has a mental illness. Services include multi-family support groups, family advocacy services, educational conferences, and referrals and linkages to other resources.

DMHAS also supports statewide training in evidence-based practices that support recovery, such as on **illness management and recovery (IMR)**, and it also supports a center of excellence that offers training on **recovery-oriented cognitive therapy**.

Mental health peer staff have front line roles in many treatment settings and help individuals to set and develop recovery skills and as well as in make connections to treatment and resources. Peer staff have a major role in mental health crisis programs, where they serve on mobile crisis outreach teams and in screening/crisis centers. Peer support services are a required component of the state's certified community behavioral health clinics, as well as in other outpatient services, and peers supported housing and in various community settings, ensuring a person-centered approach and addressing individuals' recovery needs. DMHAS also established peer-operated organizations that provide a range of recovery supports, including a peer warm line, peer wellness (drop in) centers, respite housing, and a peer-to-peer program that assists individuals with cessation of tobacco use.

DMHAS also supports peer led trainings to help individuals achieve peer certification, training in the development of psychiatric advance directives, and training on wellness coaching, supervision, and whole health wellness.

For a complete description of peer recovery supports and services, please see the attachment entitled, "NJ DMHAS Peer Recovery Supports"

Behavioral Health Planning Council and Citizens Advisory Board

The NJ Behavioral Health Planning Council (NJ BHPC) / NJ Mental Health Citizens Advisory Board (CAB) is a unified body of volunteer advocates drawn from all parts of New Jersey's system of behavioral health care. Incorporating the interests of adult and youth mental health, substance use prevention, and treatment, the members of the council include consumers, family members,

provider agency staff, stakeholders, representatives from state and county government and the general public.

The core functions of the NJ BHPC/CAB are: 1. the Review of the Block Grant, 2. System Advocacy, and 3. System Monitoring. The BHPC/CAB receives updates on the development of the CMHSBG & SUPTRS applications and Implementation Reports several times a year. In addition, the BHPC/CAB composes a key “Gaps in Services” Section of this application and are invited to read and share feedback on the block grant materials via WebBGAS. Systems Advocacy is conducted and advanced by this group in the course of their monthly open public meetings where members, guests (and the general public) are encouraged to share their experiences with the state-funded system of care, and have direct, candid discussions with the State Mental Health Planner of the SMHA. The Planning Council/CAB monitors New Jersey’s behavioral health care system vis-a-vis receiving formal reports/presentations from a wide range of system partners (e.g. units within the SMHA, portions of state government that impact the system of care, provider agencies and stakeholder organizations). The sum of these, and related activities puts the NJ BHPC / CAB in a central role in New Jersey’s overall system of behavioral health care.

Division of Mental Health and Addiction Services (DMHAS)

Peer Services

Division of Mental Health and Addiction Services (DMHAS) Office of Advocacy and Peer Services (formally Consumer Affairs); has direct oversight of most peer-operated services delivered in the New Jersey community. This Peer run office is supervised by the Division’s Office of the Medical Director.

The office employs two individuals with lived expertise within the office. One peer, who has been part of DMHAS since 2011 serves as the manager of the office and as the Division’s Mental Health Ombudsman. The managers purview includes the Community and Hospital based Wellness Centers, the Peer Respite program, CHOICES (Smoking Cessation), Peer training for mental health, Peer operated Warmline, NJ Mental Health Cares information line. The other lived expertise person has been with the Division for one year and is in a full-time role. She has been a tremendous addition to the Office of Advocacy and Peer Services and has made great connections with the peer workforce across New Jersey.

DMHAS works in tandem with people having lived experience, family members, providers and other stakeholders, to promote recovery and wellness for persons managing a mental illness, substance use challenge or co-occurring issues, through a sequence of prevention, early intervention, treatment and recovery services provided by a well-trained and skilled workforce.

State-wide Consumer Advisory Committee (SCAC) meets virtually on a quarterly basis. Virtual meetings are facilitated by the Office of Advocacy and Peer Services personnel. SCAC membership consists of the 22 Community Wellness Center peer managers, three hospital-based Wellness Center peer managers. These meetings generally include a presence by DMHAS executive leadership, including the DMHAS Medical Director and the Division’s Deputy Assistant

Commissioner. There is also attendance by Office of Community Services Regional staff.

DMHAS shares recent updates with the attendees and answers individual questions. The Community Wellness Center peer managers are asked to share updates about their centers and discuss needs of the community members they serve. Topics include individual accomplishments, community challenges, concerns and ideas, and participants are comfortable asking questions and learning innovative skills from their fellow Peers.

The SCAC members have provided the Division of Mental Health and Addiction Services with feedback that they find the quarterly meetings helpful, but they would like some of the meetings to be in person. The Division benefits from hearing from these front-line service providers to better understand the communities needs and discuss any short-comings.

In 2024, DMHAS rebid the Community Wellness Centers (CWCs) and added funding dollars to provide more competitive salaries for the Center's Peer workforce, to enhance programing and expand community outreach. Many centers have added marketing strategies and provide a vast variety of community outreach. There have also been many centers adding additional satellite sites. These services take trained staff members into their communities to work with individuals who may not get to the centers or that don't know about the services offered at the Wellness Centers. Each Community Wellness Center is expected to be open at minimum 25 hours at the primary location. Those hours of operation must include two nights and one weekend day. In SFY 2024, the Wellness Centers served 31,291 individuals and 33,364 individuals in SFY 2025.

As the world has moved beyond the pandemic, DMHAS has made certain all centers are returning to in person activities, as well as still providing some virtual recovery groups to their participants who had gotten used to the virtual model. These hybrid centers allow more participants to engage in activities offered. The centers are an essential part of their individual community. Many operate in the structure of a "home" with living rooms, kitchens, game rooms, libraries, rooms with exercise equipment and craft rooms, to name a few. They are a place where participants can engage in social interactions, by sitting in a cozy welcoming space and having conversations with each other. They can eat together and build the ties of a family environment.

Wellness Centers provide a space that is non-stigmatizing and always works to be respectful of one another's similarities and understanding of each other's differences. Members can play a game of pool or air hockey, as well as chess or board games. The centers offer wellness and recovery groups and other group activities such as healthy cooking classes or arts and crafts. Outside trips are taken regularly to places like the grocery store, food pantries or Walmart. Staff from the centers also go into the communities and bring wellness-related activities with them, as well as marketing items to introduce people who have lived experience or have family members with mental health or co-occurring needs to available services and other resource opportunities. They visit other types of Human Services centers, Veteran's centers, libraries and churches and will sometimes hold scheduled wellness-focused groups or similar activities at these locations.

The peer staff represented within DMHAS Office of Advocacy and Peer Services make frequent visits across the State to better support the varieties of activities that people sharing their lived experience provide to the Community. It is also an opportunity to share the impact of peer work and engage to support each other. Site visits have included both Community-based and Hospital

based Wellness Centers, 988 call centers, Peer Warmline centers and Mobile Community Outreach Team (MCORT) work sites. As new centers (provider agencies) have opened their doors, the Office of Advocacy and Peer Services staff have attended these Grand Opening events. It has brought joy and support to work in a collaborative manner and for the community service providers to be aware that their services are appreciated and supported by the Division of Mental Health and Addiction Services.

Currently, DMHAS Office of Advocacy and Peer Services is working on a plan to have a state-wide, yearly, in person SCAC meeting that would allow the peer Wellness Center managers engage and network face-to-face. The Whole Health Learning Community Initiative, funded by DMHAS, has already started this multi-agency engagement across the Wellness Centers. The initiative has created an environment of comradery and built wonderful collaborations between providers. Plans are being made to invite the peer managers of the Substance Use Recovery Centers to come together with the Office of Advocacy and Peer Services staff and share their lived experience to initiate quarterly meetings for Substance Use peer programs.

A long-term objective of this office is to allow both groups of peer managers to gather collectively and meet their counterparts who operate DMHAS Substance Use Recovery Centers and Community Wellness Centers. This will build an environment that could potentially create seamless transitions from one service center to the other, for participants in need of Community-based services from either or both operating community service center.

RFP Reviews. As part of the internal DMHAS Request for Proposal review process, DMHAS includes staff members with lived-experience to sit on all of the reconciliation committees to review and score any proposals that are submitted by an agency. Peers use the value of lived experience, as recipients of mental health services and/or co-occurring services, to bring their unique perspective to the review meetings. The awareness that peers bring to the review teams has impacted other staff's viewpoints when scoring proposals, creating an understanding that leads to open discussion, which may impact scoring decisions and final awards. The Division has included Peers in the review process for over fourteen years.

Community members with lived experience and family members of persons receiving services, also participate in the RFP process, in the capacity of paid consultants. These community members review proposals and provide a written and oral summary of each proposal to the RFP Team Lead. The representatives are compensated for their input. The Team Lead's discuss each review with the community member, and responses are shared with the DMHAS internal review committee before each proposal is scored. The perspective of the community members is shared and considered, as part of the overall process.

DMHAS Mental Health Ombudsman is a DMHAS staff person with lived experience. The Ombudsman responds to callers who use the Division of Mental Health and Addiction Services (DMHAS) Ombudsman Line, which is a non-crisis line, that is monitored Monday through Friday from 9:00 am to 5:00 pm. The line accepts recorded messages 24/7. It is important for the Ombudsman to develop trust with the caller to allow the caller to feel comfortable being open and honest about their call. For this, the Ombudsman must possess learned engagement strategies which they use to work with the caller. The Ombudsman begins the conversation by letting the caller know it is the formal complaint line for DMHAS services. A process is in place to resolve

most issues in a swift, confidential and effective manner.

This role requires outstanding communication and interpersonal skills, knowledge of resources of other professionals, problem solving skills and the ability to be empathetic. The DMHAS Ombudsman role is filled by a Peer with lived Mental Health service experience, who is also a family member of a person(s) who has received Mental Health and co-occurring services.

DMHAS Secret Shopper Initiative, at the Assistant Commissioner's directive, Consumer Affairs introduced the DMHAS Secret Shopper Program. The purpose of this project was to generate feedback about how our provider agencies are responding to calls made by persons who pose as clients. The program has provided the Division with valuable information about the experience when calling a provider, the availability of appointments and challenges clients may face when trying to access services.

The Program currently has two community-based callers. One with mental health lived experience and one who has co-occurring challenges. The participants divide the phone calls between MH agencies and SUD agencies. Each participant is issued a state cellular phone to use when making calls to providers. This is important because they are asked to leave a message for a call back when they reach an answering machine. Each participant also receives a state email account connected to the Division's network. The Secret Shopper sends a synopsis of each call to the Initiative Supervisor at the end of each month. A total requirement of 15 outreach calls per month are expected per participant. In past periods the expectations were greater and it was found to be an overwhelming demand on individuals making calls. They are paid by the state as consultants for their services.

The feedback from such calls to agencies is tracked and monitored. In the past the agencies received a letter detailing the Shopper's experience. There is a plan to once again alert provider agencies of the outcome of each of these calls. The initiative has no intention to create blame for a problematic call. The Secret Shopper Initiative has been used to enhance services and to make systemic awareness of a DMHAS expectation to demonstrate respect, knowledge and to offer support an individual seeking services for any behavioral health related condition.

Some issues identified by the Secret Shoppers have included:

- Calls being answered by an answering machine rather than speaking to a live person.
- Long wait times to get an appointment for emergent issues.
- Having to call another number to make an appointment.

An outcome of this initiative, was a pro-active group of providers met with DMHAS Executive Leadership to resolve some of the concerns expressed to DMHAS. One of these concerns was the regular use of answering machines and calls not being returned in a timely manner or not returned at all. The agencies didn't like this practice either, however, the providers communicated that they could no longer afford the cost of having a receptionist available to take calls.

Both groups brainstormed and some resolutions were discussed and implemented. The agencies stated that using an answering machine was necessary due to staffing and funding constraints. The

DMHAS Medical Director then put forth a change to state regulations that stipulated, if a recording system was in use, any voice messages left on any agency system, must be outreached within 24 hours of regular business hours.

Some more issues identified by the Secret Shoppers included:

Answering systems were malfunctioning or went to random unmonitored mailboxes.

Agencies went out of business or merged and the directory numbers were no longer valid.

Legacy Treatment Services

Legacy Treatment Services operates Crosswinds, a peer-run mental health crisis respite center in Toms River, NJ. This program provides crisis respite services for 7-14 days for adults who need a supportive residential environment to work towards wellness and recovery and avoid psychiatric re-hospitalization. The program has several peers on staff who work with consumers to develop WRAPs and PADs and run peer support groups. Consumers have access to staff on a 24/7 basis to receive needed supports, while working to be linked with essential services, such as housing, financial assistance, physical health care and mental health care. The program also has peers in substance use recovery on staff who can assist consumers who have both mental health and substance use concerns work towards their own recovery. The success of the program is such that consumers have graduated from the program and worked to obtain peer certificates to come back as volunteers or employees in Crosswinds.

Legacy also operates several programs that have peer staff available to provide support. Kairos House, a similar residential program to Crosswinds, also employs peer workers on staff to provide support. Crisis programs include 988 Mobile Crisis Outreach Response Teams, in which a certified peer is part of a response team for in-person community crisis outreach. The Screening and Crisis Intervention Program (SCIP) employs peers to provide support for in-person outreach, emergent case management, and follow-up supports to those experiencing psychiatric crisis. Involuntary Outpatient Commitment programs employ peer case managers who use their own story of wellness and recovery to connect with consumers who are court-ordered to outpatient mental health treatment.

Community Support Services has peers on staff specifically to work with individuals developing WRAP plans and Psychiatric Advance Directives. Lastly, the Outpatient department has peers on staff to provide individual peer to peer sessions to those who receive therapy and medication management.

Consumer Parent Support Network

The purpose of the Consumer Parent Support Network is to support parents with a diagnosis of a mental illness in their parenting efforts and to promote the healthy functioning within their families.

The Consumer Parent Support Network uses traditional case management, combines it with support groups, education and advocacy, using mentors. Each program participant has the opportunity to select from a variety of support services that can strengthen their role as a parent. Our Parent Support Staff assists with needed referrals and case management. Our Parent Advocates are both parents and people with lived experience. They can help a person negotiate the challenges of parenting by acting as a mentor, sounding board and source of encouragement.

Statewide Mobile Crisis Outreach Support Teams (MCORTS)

The Peer Support Staff employed in the Mobile Crisis Outreach Response Team (MCORT) provide evidence-based crisis services, to an individual identified by 988 Lifeline center staff, as experiencing a mental health or substance use disorder crisis in the community and is agreeable to outreach. The person in the community experiencing a crisis can get non-clinical support from MCORT. The MCORT teams employ peers who offer support beyond the resolution of any immediate crisis. The peer team member can follow up with the person, making connections to social services and other services that increase access to needed supports. When appropriate there is collaboration with family members, friends or loved ones to assist and support individuals in crisis.

Statewide Peer to Peer Support Warmline

MHANJ's Peer to Peer Support Line is a peer-operated warm line that offers emotional support, hope, encouragement and resources to callers. Peer to peer Support line is staffed by people with lived experience with mental health challenges who provide supportive communication with callers who share mental health challenges. The warmline provides Intention Peer Support, a model developed by Shery Mead, to individuals with mental health difficulties, in lieu of using more traditional emergency psychiatric services. All Peer Line staff receive training and have monthly team meetings to discuss caller issues and receive additional support.

Mental Health Association of Essex and Morris

Mental Health Association (MHA E&M) embeds Peer Led services throughout several programs within the agency as it recognizes the importance of the ability to connect with the individuals served through shared life experience.

The Forensic Peer Support Staff provides off-site and in-home, hands-on support to mental health individuals playing a role in supporting these individuals from start to finish. Peer support helps individuals transition out of the justice system and build stability in their mental health and everyday lives, increasing socialization and successful reintegration into the community. Peer Support Staff offer guidance, encouragement, and advocacy to keep participants engaged and connected to needed resources. The Peer Support Staff co-facilitate peer groups which help individual receiving services develop coping skills and navigate the ups and downs of recovery. Sharing the lived experience of navigating mental health challenges and a similar history, provides participants with motivation, builds trust, and creates an ability to relate to one another.

Peers with lived experience are employed at the Community Wellness Centers to provide

appropriate services. They partner with community providers for available services and coordinate resource events at the Community Wellness Centers. Lived experience professionals share life experiences, provide engagement and promote skill-building services, creating a collaborative and caring relationship, that focuses on strengths-based, person-centered services. Additionally, the lived experience professionals provide support in recovery planning through evidenced-based practices, such as Motivational Interviewing, and through advocacy. Lived Experience Professionals are equipped to assist with managing crisis, de-escalation, and promoting the integration of physical and mental health wellness which nurtures growth and development.

Peer-operated wellness centers are community-based organizations run by individuals with lived experiences of mental health or substance use challenges. These centers provide various interventions aimed at supporting recovery, wellness, and empowerment. Some common interventions include:

1. Peer Support Groups: - Facilitated by trained peers, these groups offer mutual support and shared experiences to help individuals manage their mental health or substance use challenges.
2. One-on-One Peer Support: - Personalized support sessions where peers offer guidance, encouragement, and resources based on their own recovery journeys.
3. Wellness and Recovery Education: - Workshops and classes focused on topics like stress management, coping skills, nutrition, exercise, mindfulness, and other wellness strategies.
4. Resource Navigation: - Assistance in connecting with community resources, such as housing, employment, healthcare, and social services.
5. Social and Recreational Activities- Organized events and activities to promote social interaction, decrease isolation, and build a sense of community.
6. Advocacy and Empowerment - Training and support for individuals to advocate for their own needs and rights, as well as to participate in broader advocacy efforts for systemic change.
7. Skill-Building Workshops: - Training sessions on practical skills such as financial management, job readiness, communication, and problem-solving.
8. Holistic Health Services: - Access to complementary therapies like yoga, meditation, art therapy, and other holistic practices that support overall well-being.
9. Outreach and Community Engagement: - Efforts to reach statutory populations and raise awareness about mental health and wellness within the broader community.

These interventions are designed to create a supportive environment where individuals can share experiences, gain new skills, and build a network of supportive relationships, all of which are crucial for sustaining long-term recovery and wellness.

Catholic Charities of Greater Trenton

Riverbank Community Wellness Center

Since its inception in 1997, the Riverbank Community Wellness Center (RCWC) has been at the forefront of the Community Wellness Center initiative, significantly impacting the lives of individuals dealing with mental health and co-occurring issues.

A key aspect of the RCWC is its peer-led model, which involves staff members who have first-hand experience with mental health and substance use challenges. The center offers a wide range of life skills, training and educational programs that focus on self-care, and help decrease isolation. RCWC empowers its members to lead healthier and more balanced lives. Monthly groups are tailored to address the specific needs of individuals, including those with mental health concerns, co-occurring challenges like, substance use, chronic medical issues, aging, and individuals experiencing homelessness.

Positioned as a central resource hub, the RCWC is dedicated to helping individuals navigate the complexities of mental health services and co-occurring challenges. A team of trained peer counselors is available to assist members in accessing vital resources, such as housing assistance, SNAP benefits, health insurance, tax preparation aid, and vocational support. Additionally, the center collaborates with the South Jersey Food Bank, collecting 300 pounds of food every two months, which includes fresh produce and nutritious items for community meals that are served three times a week. There is also a food pantry available to members and the public at any time for those in need.

In late 2024, the RCWC was awarded a new contract from DMHAS, which facilitated an expansion of services. As a result, the center has extended its operating hours at our Burlington location to five days a week, in addition to providing services one night a week at two satellite sites, one in Browns Mills and one in Maple Shade. Furthermore, the acquisition of a 15-passenger van enables transportation for up to 40 members to and from various center activities, enhancing accessibility for those in the community.

The RCWC is pleased to report that for FY 2024-25, as of March 24, 2025, it has welcomed nearly 150 consumers, providing 813 self-help activities and 428 wellness and recovery activities to them.

Riverbank Transportation & Roads to Recovery

Since 2001, the peer operated Riverbank Transportation program (RBT) has been offering transportation to individuals with mental health challenges who aspire to pursue employment or education but face difficulties accessing public transportation. Recognizing that transportation often poses a significant obstacle to achieving vocational goals, RBT serves as a reliable and cost-effective alternative to rideshare options, playing an essential role in promoting independence. The program averages 75 rides per month and charges \$2.00 per trip.

Roads to Recovery (RTR) is another peer-run transportation initiative that provides rides for participants of community recovery groups like Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Gamblers Anonymous (GA). This service caters to co-occurring peers, located within a ten-mile radius of Westampton and is offered at no cost. In 2024, RTR facilitated nearly 100 rides for those engaged in their recovery efforts. However, due to financial constraints and staffing shortages, the RTR program has been temporarily put on hold until further notice.

Both RBT and RTR are peer-operated programs employing three part-time drivers along with one

dispatcher, which allows them to achieve their own recovery objectives. Additionally, it is important to note that all bi-annual satisfaction surveys conducted among RBT and RTR consumers indicate complete satisfaction with the services provided.

Center for Family Services

Better Future Community Wellness Center (BFCWC) is a peer-operated wellness center providing support, connection and recreation for adults with mental health issues who seek community, friends, social outlets, and relaxation. It provides a warm and welcoming environment where individuals access needed community-based social services, receive peer support, and are informed about mental health, substance use disorder, and co-occurring issues in a supportive environment. No individual is denied full access to or participation in services or activities. This safe and non-restrictive environment provides participants from all backgrounds with a sense of hope and allows them to come together to engage in peer-to-peer support and be offered social, educational and recreational opportunities.

Better Future Community Wellness Center provides members with meaningful activities to decrease co-occurring substance use and mental health issues in a place where they will feel accepted and valued. It is equipped with trained, compassionate staff and community-based resources in a safe environment, consumers receive welcoming, non-institutional services from peers with similar experiences who overcame their debilitating issues. Social connection influences an individual's educational attainment, workplace satisfaction, economic prosperity, and overall feelings of well-being and life fulfillment. Social isolation and loneliness have repeatedly been linked to negative physical and mental health outcomes across studies nationwide. Risk factors associated with social isolation include living in rural and/or urban areas where resources are limited, having a chronic physical or mental illness, and lack of transportation, among others. BFCWC's goal is to reach all individuals and offer non-restrictive, peer support for consumers with long-term physical and mental health conditions in various locations to significantly improve their quality of life, social functioning, and knowledge, skills and confidence to manage their health and physical functioning.

The BFCWC is a vital community-based initiative aimed at empowering adults who are recipients of mental health services to take control of their well-being, foster resilience, and support one another on their journey to recovery. It is operated by peers who have experience with mental health challenges and provide one-on-one or group support to program participants. The center offers regular workshops and educational sessions covering a variety of topics such as stress management, emotional regulation, mindfulness, and self-care. There are also organized social events, group outings, and recreational activities that foster a sense of community and provide opportunities for social interaction and recreation. The center holds various support groups facilitated by peers that focus on specific mental health conditions or common challenges, providing a space for sharing and mutual support. This program plays a significant role in decreasing stigma, fostering recovery, and promoting well-being for all participants.

The Mental Health Association in New Jersey; Peer Services

Atlantic Community Wellness Center (Originally called ICE: Individuals Concerted in Effort) has over four decades of experience in providing people access to meaningful activities in a place

where individuals are accepted and valued. MHA staff have an intimate understanding of the value of social connections which contribute to members' health, feeling of safety, prosperity, and ability to be resilient. ACWC became the first center to adapt to the need within the community and offer "center without walls" concept and modality of services which allowed greater access to people living throughout the county. The ACWC provides four core services, peer support activities, wellness recovery classes, training/education workshops, and community engagement. Peer support activities include supportive counseling, information/referral/linkages, end-to-end application & paperwork assistance, system navigation, promoting coping skills/selfcare, boundary/limit setting, and others. Wellness Recovery Classes include topics such as healthy behaviors: physical activity & nutrition, health literacy of use of substances (e.g., tobacco, alcohol, drugs, caffeine, sugar), social isolation/supports (community connections), healthy relationships/belonging, and mental health: stress, anxiety, depression management/emotions, grief/trauma, self-esteem/motivation/self-care, and recovery. Training and education workshops focus on unmet needs (food/ housing/utility instability, financial resource strains, employment, and education). ACWC is an integral partner in providing training to first responders to produce better outcomes for our residents in crisis providing peer delivered training and perspective.

Ocean County Community Wellness Center; Journey to Wellness (JTW), provides a holistic approach to mental wellness, offering free peer support and wellness services to individuals looking to enhance their mental health, well-being, and self-care. Through structured support groups, wellness coaching, skill-building workshops, and socialization activities, JTW fosters resilience, self-advocacy, and personal growth in a non-clinical, stigma-free environment. Staffed by individuals with lived experience of mental health and/or co-occurring challenges, JTW fosters a community of understanding and empathy, allowing participants to connect with others who have similar journeys. Peer support staff serve as mentors and advocates, guiding participants in navigating their recovery paths while providing encouragement and motivation. Utilizing recovery-oriented, person-centered, trauma informed, and responsive approaches, JTW creates a safe space where individuals can openly discuss their struggles and triumphs without fear of stigma, empowering community members to take charge of their mental health, build resilience, and develop a sense of belonging, ultimately contributing to a healthier and more connected community. JTW's mobile wellness unit, "Wellness on Wheels" (WOW Van) offers curbside wellness and support throughout Ocean County, truly embodying "meeting a person where they are at" in all ways possible, by providing access to information, referrals, wellness & support out in the community. By meeting people where they are, the WOW Van breaks down impediments and ensures that individuals who may not otherwise seek support can connect with peer staff in a safe, non-judgmental environment. The WOW Van is deployed throughout the week and whenever needed, including scheduled community events and outreach efforts.

Ocean County Community Peer Recovery Center; ROADS Recovery Center Recovery, Opportunities, Acceptance, Dignity, and Support (R.O.A.D.S.) offers a supportive space where individuals are accepted and valued, regardless of stage, phase, or recovery pathway. ROADS provides appropriate, participant-centered support encouraging individuals to be in the driver's seat of their own recovery. ROADS is designed to offer support, help prevent recurrence of SUD, and promote sustained recovery from substance use and co-occurring disorders by being recovery-orientated, person-centered, trauma-informed, and focused on peer support. ROADS offers

services that address the members' recovery, wellbeing, and unmet needs. ROADS follows SAMHSA's Recovery Oriented System of Care Principles & focuses services food, housing, utilities, transportation, finance, substance use, mental health, & co-occurring, education/employment, isolation/connections, healthy behavior, etc.. ROADS also offers a community-driven approach, having strong partnerships across Ocean County to connect individuals with additional recovery resources.

United by Wellness (UBW) was designed and built by MHANJ Peer Leadership Team to expand access to peer-to-peer support on a virtual platform for peers across New Jersey and beyond. Peer staff, interns and volunteers working with MHANJ's wellness centers, Individuals Concerted in Effort (ICE), and Journey to Wellness (JTW) combined resources along with other MHANJ to create a virtual wellness center that was launched in 2022. UBW currently provides free access to over 50 support groups weekly, which are offered 7 days a week to over 1800 current active members. A comprehensive array of groups offer support, wellness, spiritual, education, socialization, training, community meetings for both mental health and co-occurring individuals in recovery. UBW has recently expanded to partner with a Center for Independent Living to engage those with disabilities dealing with behavioral health challenges.

The Peer Recovery Warmline (PRW) has been an integral part of NJ peer services since 2009. The warmline is fully staffed and supervised by experienced peer staff who provide support, education, advocacy and "personal peer to peer support". Utilizing WRAP (Wellness Recovery Action Planning) and IPS (Intentional Peer Support) models, the team operates 7 days a week, and volunteers to work holidays. Each year over 40,000 calls are answered. The PRW offers an optional text/chat component that provides daily text messages of support throughout the day and week. This provides another level of support and connection. PRW operates as part of the MHANJ Call Center that has multiple behavioral health lines – that provides easy access warm transfers to information and referral- through NJ Mental Health Cares- that also provides the PRW with a vast database of community recovery support services to share with peer warmline callers. In 2022 MHANJ became an anchor of the NJ 998 Lifeline network- leading and advocating for peers to play a major role in crisis response. As a result, peers have been hired on 988 and facilitate easy warm transfers to PRW for 988 crisis callers. MHANJ continues to expand the role of peers in the operation of the call center – with many peers integrated across all service lines in partnerships with strong support, supervision, and clinical backup- proving their value to NJ's crisis response network.

Building a strong peer workforce has been the goal of MHANJ's Consumer Connections since it was founded in 1997. Consumer Connections has been training peers to work in paid positions within New Jersey's mental health system for over 25 years. Over time, the program has evolved into a comprehensive workforce development initiative, supporting the growth of the Certified Recovery Support Practitioner (CRSP) credential, New Jersey's only mental health peer certification recognized by Medicaid. Consumer Connections continues to strengthen the peer workforce by providing all required CRSP training, including the 84-hour Core Training and WRAP Seminar I, offering scholarships for credentialing fees, and assisting peers throughout the credentialing process. Additionally, the program serves as a liaison to the state certification board, offers career counseling and vocational services to programming alumni, and delivers a full range of technical assistance and training to peer employers in mental health and co-occurring services

within the adult system of care. Recognizing the importance of co-occurring capacity in the peer workforce, Consumer Connections is committed to expanding expertise in this area. To that end, the program provides Core Training graduates with access to the Certified Peer Recovery Staff (CPRS) training, which leads to New Jersey's substance use disorder (SUD) peer credential. Consumer Connections has secured additional funding through ARPA federal dollars to expand programming in 2025. This funding has enabled the program to increase the number of Core Trainings from three to five, WRAP Seminar I workshops from six to ten, and CPRS trainings from one to three. Additionally, this expansion has allowed the program to hire two additional full-time peer trainers, further strengthening training capacity. Funding to support CRSP credentialing scholarships has significantly increased the number of credentialed individuals in New Jersey, more than doubling the total within just one year. With continued funding and strong policy leadership, MHANJ has established a solid foundation to meet the evolving needs of New Jersey's peer workforce and to drive sustainable growth in the field. However, a significant challenge is that ARPA funding is a one-time allocation that will end in September 2025. It is already clear that there is sufficient demand to continue operating at this expanded capacity, but without sustained funding, it is uncertain how the program will be able to maintain its staffing levels and training capabilities beyond the third quarter of 2025.

The Whole Health Learning Collaborative: NJ Peer Connections is a program of the Mental Health Association in New Jersey, that is funded and designed to assist and support the 20+ Division funded Community Wellness Centers (CWC) in the state of New Jersey. This program unifies and unites all NJ CWCs for the cause of Whole Health Care by prioritizing the eight dimensions of wellness in all centers and the services provided to the community in which they serve. Whole Health is based on SAMHSA's 8 Dimensions of Wellness, which promotes mental health care is more than just psychological but covers many different aspects of life (social, spiritual, emotional, intellectual, vocational, financial, and physical health). In WHLC's 1st year of programming, WHLC assisted each CWC create wellness-based goals to implement whole health initiatives in their centers. All centers were given in-person and virtual technical assistance, a liaison for feedback with the Division, and communal support and education through regionalized events across the state. Each CWC was awarded Wellness Dollars to fund these initiatives and given an opportunity to share their successes and best implementation practices at the programs ended statewide event.

The regionalized events, offered in the North, Central, and Southern parts of the state, offered great educational and networking opportunities for all CWCs helping to create a network of support cross organizationally and statewide for the staff of the Wellness Centers. Educational workshops included: PADS, Choices, Recovery-Based Solutions, Creative Minds, Peer Advocacy, WRAP, Resource Sharing, and more. Due to its success, the Whole Health initiative was funded through ARPA (until March 2025) with funding to sustain the momentum and collaborative efforts of the centers and focus and prioritize the integration of the four newly awarded CWCs. This round of funding allowed for on-going in-person and virtual technical assistance to the newly awarded centers and other CWCs who needed assistance integrating their newly established goals and priorities resulting from the new CWC contracts. It also allowed for an additional two in-person regional events welcoming in the new Community Wellness Centers to the statewide community and in an effort to help each center reach its full potential. This program enhanced the CWCs by allowing them the opportunity to learn, network, and advocate for each other to better the people

they serve. It can only be hoped this initiative can continue in some way in the future as this tie between all the CWCs is long overdue and extremely necessary in the success of the CWCs.

Collaborative Support Programs of New Jersey (CSPNJ)

Hospital-based Wellness Centers

CSPNJ's Hospital Wellness Centers at Greystone, Ancora, and Trenton Psychiatric Hospitals serve as essential, recovery-focused spaces led by individuals with lived experience. These centers provide peer support, wellness activities aligned with the 8 Dimensions of Wellness, and advocacy opportunities through The Coalition of Mental Health Consumer Organization (COMHCO) and the NJ Behavioral Health Planning Council. Programs such as the Hearing Voices Network, skill-building workshops, and the Hospital Cell Phone Project empower individuals to navigate their recovery journey with greater autonomy. We receive an average of 10 referrals to the Hospital Cell Phone Project (HCPP) monthly, effectively engaging and enrolling more than four-fifths of those interested. Additionally, CSPNJ's Program Aide roles and Unit Wellness Providers strengthen transition planning by participating in Life Management and Community Integration Meetings, offering advocacy in treatment team discussions, and expanding peer support sessions for those facing complex discharge challenges. Through structured wellness activities, peer support calls, and Health & Well-Being Surveys, CSPNJ ensures individuals receive personalized, continuous support that fosters a successful transition from hospitalization to independent living.

Recognizing the critical role of stable housing in recovery, CSPNJ has partnered with Ancora State Psychiatric Hospital to launch the Community Housing Options Tour, an innovative initiative that enhances discharge planning by connecting hospital staff and individuals served with real-world housing solutions. This program introduces participants, including supported housing providers, wellness center staff, and individuals preparing for discharge, to various housing models such as Residential Health Care Facilities, boarding homes, and independent supported housing. By improving understanding of recovery-oriented housing that emphasizes safe re-entry into the community, this initiative strengthens collaboration between hospital discharge teams and community-based providers. As a result, there has been a marked increase in proactive engagement in discharge planning, leading to more successful transitions. Given the measurable success at Ancora, CSPNJ is expanding this initiative to Trenton Psychiatric Hospital, with plans underway to bring it to Greystone Park Psychiatric Hospital.

Looking ahead, CSPNJ is dedicated to scaling and strengthening its hospital wellness centers with innovative programming designed to enhance recovery outcomes and community reintegration. Planned initiatives include the relaunch of virtual Community Wellness Center groups, an employment pilot program incorporating Indeed job search training, and the expansion of Program Aide roles at Trenton Psychiatric Hospital. To foster engagement across centers, CSPNJ will introduce a statewide basketball tournament, expand Peer Gatherings featuring CSPNJ Wellness Institute workshops, and provide Peer Certification training for staff pursuing CPRS and CRSP credentials. To recognize member achievements, CSPNJ will implement a Certificate of

Achievement program for vocational and wellness milestones. Additionally, contingent on funding, CSPNJ will organize community integration trips and conference opportunities, further reinforcing the organization's commitment to holistic recovery. With sustained investment, CSPNJ's hospital wellness centers will continue to serve as transformational spaces that empower individuals, decrease hospital recidivism, and build a bridge to lasting independence.

Wellness Respite Services

Respite is a safe, peer-run alternative to an inpatient psychiatric hospitalization and our services are at no cost to guests. Our Wellness Respite House is staffed 24 hours a day, 7 days a week by people who are trained and experienced in supporting others to transform a crisis into an opportunity for enhancing personal wellness and recovery. During the final quarter of the 2024 calendar year, all three of our respite houses averaged occupancy rates of over 98%.

The mission of our Wellness Respite Services is to provide an alternative to hospitalization which instills a sense of hope, empowerment, and self-determination in people experiencing emotional distress and fosters recovery and wellness to pursue valued life roles and personal goals. Each Respite House is a clean, safe, supportive, tranquil and non-judgmental environment in a residential community.

We offer intensive peer support and involvement in wellness activities to help guests to restore balance, and plan for adjustments when they return to their home, their associated valued roles, and their community activities. Guests meet with staff for one hour every day to learn coping skills for their wellness goals. Guests can stay at the house for a maximum of 10 days. If there is a waiting list or if a guest chooses to remain at home, we can provide wellness planning and intensive phone contact and outreach in the community for up to 10 days. After completing a Respite House stay or Intensive Outreach, all guests are offered up to 30 days of continued support through a follow up wellness plan and phone contact and outreach in the community for up to 30 days. Respite staff have developed a robust and intentional marketing plan designed to raise awareness among potential guests, families, service providers, and key community partners. Beyond traditional outreach, staff take an active and engaged role in the community, consistently promoting the lifesaving and life-changing support that Wellness Respite offers. For example, in 2025, Respite staff presented at the Whole Health event, sharing insights about Wellness Respite's mission, services, and impact on the lives of those seeking alternatives to hospitalization. Thus, as of March 2025, we have supported over 3,950 guest stays. Lastly, despite limited capacity (15 beds), the impact is profound: 84.38% of Respite guests avoided hospitalization during their stay. And 91.62% felt valued and respected by peer staff; while 95.48% reported improved ability to manage their emotional and practical needs.

Community Wellness Centers

The Community Wellness Centers (CWC's) at CSPNJ provide a welcoming and supportive environment where individuals can access a range of peer-operated services to support their journey toward wellness. These centers are dedicated to fostering a sense of belonging and empowerment through personalized peer support, wellness activities, and community engagement. Whether in-person or virtual, peer mentors and support staff offer compassionate guidance, ensuring that every visitor has access to encouragement, advocacy, and resources that align with

their unique needs. By centering services around the eight dimensions of wellness emotional, physical, social, intellectual, occupational, environmental, financial, and spiritual CWC promotes holistic well-being that extends beyond traditional healthcare models to over 16,000 unique members across our 15 locations.

The comprehensive services offered at CWC's go beyond immediate wellness support by addressing essential life needs. Through wellness groups, substance use support, and advocacy connections, members and visitors receive structured guidance tailored to their specific challenges. Linkages to crisis intervention, housing, healthcare services, and community resources ensure that individuals have a strong support network during difficult times. The centers also assist with obtaining identification, applying for mainstream benefits, and navigating the complexities of services. These offerings create a foundation for self-sufficiency and stability, allowing individuals to regain control over their lives while feeling supported by a compassionate community.

What sets CWC's apart is the quality of care and dedication embedded in peer-operated services. Every interaction is rooted in lived experience, empathy, and a deep understanding of the challenges individuals face. Peer mentors not only provide resources but also foster meaningful connections that encourage self-advocacy and resilience. By emphasizing the uniqueness of each member's journey and integrating the eight dimensions of wellness into all services, CWC's ensures that every person who walks through its doors receives individualized, respectful, and comprehensive support. This person-centered approach makes the Community Wellness Centers a vital resource for those seeking to improve their well-being and transform their lives.

COMHCO

COMHCO continues to lead innovative and high-impact peer advocacy efforts across New Jersey, demonstrating the power of lived experience in shaping policy and service delivery. Over the past year, we have expanded engagement through monthly virtual membership meetings, providing real-time updates on critical issues such as Medicaid waivers, the integration of behavioral health services, and the expansion of involuntary commitment laws. Notably, we saw a significant increase in participation from individuals currently residing in state psychiatric hospitals, reflecting the success of our outreach and the growing demand for peer-led advocacy. Our quarterly leadership meetings have also strengthened peer involvement in county mental health boards and state and national stakeholder groups, ensuring that individuals directly affected by policies have a seat at the table. A cornerstone of our work is the Annual Statewide Conference, which in 2024 brought together over 300 participants to engage in workshops on legal advocacy, voting rights, psychiatric advanced directives, and cross-disability advocacy. This event has become a vital platform for educating and empowering peers while fostering community connections. In preparation for our 2025 conference, we have implemented membership pulse surveys to ensure programming aligns with the needs and priorities of our community. In tandem with this, we have expanded our coalition to reach young adults, individuals with co-occurring substance use challenges, and communities throughout the state. These efforts are reinforced by our structural growth, with updates to our by-laws establishing a 13-person board with regional representation, ensuring leadership and input from all areas of the state.

In September 2024, COMHCO partnered with the National Disability Rights Network to host screenings of *Accessing Democracy* by Jack Rosen at the CSPNJ Annual Fall Fest and at local

community wellness centers. This powerful film was part of a broader effort to promote civic engagement. During the same month, we collaborated with the REV UP campaign to increase voter registration and education, emphasizing bi-partisan voter education and accessibility for individuals with disabilities.

As part of our continued commitment to peer engagement, we will also be holding two statewide town halls to gather feedback from peers, as recommended during our monthly membership meetings. These town halls will serve as open forums for individuals to share their experiences and shape advocacy priorities. In addition, we will conduct workshops focused on telling your story and coalition building, equipping peers with tools to effectively share lived experiences and strengthen collaborative efforts across the state.

Looking ahead to the 2026–2027 funding period, COMHCO is committed to sustaining and expanding these initiatives to further elevate the voice and impact of peer advocacy. Our focus will be on strengthening our infrastructure, increasing accessibility to advocacy opportunities, and continuing to challenge policies that diminished individuals with behavioral health conditions. SAMHSA funding will be critical in supporting these efforts, allowing us to enhance virtual engagement, develop new leadership pipelines, and expand peer-led initiatives that promote recovery. By investing in peer- driven solutions, we can continue to drive systemic change and improve outcomes for individuals navigating behavioral health challenges in New Jersey.

Certification training for staff pursuing CPRS and CRSP credentials. To recognize member achievements, CSPNJ will implement a Certificate of Achievement program for vocational and wellness milestones. Additionally, contingent on funding, CSPNJ will organize community integration trips and conference opportunities, further reinforcing the organization’s commitment to holistic recovery. With sustained investment, CSPNJ’s hospital wellness centers will continue to serve as transformational spaces that empower individuals, decrease hospital recidivism, and build a bridge to lasting independence.

Prevention Resources

The Community Wellness Center (CWC) in Hunterdon provides individualized peer services focused on holistic well-being and personal empowerment. Each guest meets with a Peer Advocate to develop a personalized “wellness plan,” setting goals and tracking progress across the Eight Dimensions of Wellness—physical, emotional, occupational, spiritual, financial, mental, environmental, and intellectual well-being. This tailored approach ensures that each person receives support that meets their specific needs while fostering personal growth and self-sufficiency.

Beyond individual plans, the CWC emphasizes a strong sense of community, where guests actively contribute by cooking for one another, offering support, and sharing resources. This community of mutual aid promotes dignity and pride while creating a welcoming, home-like atmosphere rather than a traditional service facility. The center operates six days a week, offering activities such as yoga, meditation, journaling, nutrition classes, and recreational programs.

Adding to the sense of community, the CWC offers Peer-led programming and services at several

satellite locations; wellness classes at the Fisherman’s Mark food bank in Lambertville, yoga and meditation at the Hunterdon County libraries, as well as wellness programming offered to the residents of Veterans Haven North, in Glen Gardner. The CWC also distributes food both on site and in the “Little Free Food Pantries” located throughout the town in conjunction with the Flemington Food Pantry.

All programs and services are provided by a Peer, or an individual with lived experience in mental health.

CHOICES & LAHL 2024-2025 DMHAS Report

Introduction

CHOICES (Consumers Helping Others Improve their Condition by Ending Smoking) is an innovative peer outreach program dedicated to addressing tobacco use among individuals with mental illness in New Jersey. For two decades, CHOICES has been at the forefront of delivering education, resources, and motivation to smokers with mental illness. The program employs trained mental health peer counselors, known as Consumer Tobacco Advocates (CTAs), who work tirelessly to support smokers in their journey toward a healthier lifestyle. The program was originally conceptualized to use peer counselors to reach out to smokers with serious mental illness living in the community. This approach was an advantage in reaching individuals who might not be motivated to talk to a health care provider.

Program	Achievements
Entering its 20th year, CHOICES has continued to evolve its approach to tobacco education and intervention. While the program maintains its core mission of providing educational presentations to consumers in mental health treatment across all levels of care, the 2024-2025 grant year has seen a significant expansion. This year, CHOICES introduced Learning About Healthy Living (LAHL) Groups at four Community Wellness Centers, enhancing peer-led support and education. The centers include; Moving Forward CWC (New Brunswick), CARE Center (Neptune), Riverbank CWC (Burlington), Freedom Trail CWC (Somerville). These biweekly groups meet for 12 sessions and provide structured education, linkage to tobacco treatment resources, referrals, and continued peer support. The LAHL curriculum, developed by CHOICES founder and medical director Dr. Jill Williams, an addiction psychiatrist, remains an essential tool in delivering impactful education, as well as a continuity of communication between the consumers attending the centers and the CHOICES team. The full curriculum is accessible here .	

CHOICES	Impact	from	July	2024	–	Present
During the 2024-2025 grant year (July 2024 to present), CHOICES reports the following metrics, which will increase by approximately 20-25% by the end of the grant period:						

81 in-person and virtual visits to mental health treatment providers across New Jersey. (As of March 25, 2025)

Engagement with 1,088 consumers who smoke, providing education and motivation for tobacco dependence treatment. (As of March 25, 2025)

Two newsletters published and distributed to over 1,500 consumers and mental health agencies,

reinforcing the importance of tobacco treatment.

Additional Programs Provided with the CHOICES Educational Site Visit and Carbon Monoxide Monitoring and Feedback for 2024-2025: St Clare's Inpatient Unit, Broadway House, Booker BH, Donald Mays CWC, Camden CWC, Princeton House, Ancora Psychiatric Hospital, Essecare, SERV Annual Conference, UBHC Cherry Hill, Options, Up Your Alley, Broadway House, Greystone, Main Hospital, West Bergen Mental Healthcare, Future Dreams, Bergen County Wellness Center, Jewish Family Services of Atlantic and Cape May Counties, Greystone Wellness, Catholic Charities East Windsor, Mt Carmel Guild Cranford, and Mt Carmel Guild Newark.

Historical Achievements and Milestones
Since its inception in 2005, CHOICES has built an impressive legacy:

2,098 community visits conducted, reaching over 61,935 individuals with mental illness who smoke.

13,490 individuals received individualized feedback sessions, including carbon monoxide monitoring and personalized discussions about the health and financial impact of smoking.

Looking Ahead
As CHOICES celebrates its 20th anniversary, it reflects on past achievements while planning for future growth. Program focus continues to include tobacco education, cannabis education, including structured healthy living groups will ensure continued relevance and effectiveness. The enthusiasm and engagement of CTAs have been instrumental in inspiring participants and fostering hope that positive behavior change is possible.

With ongoing dedication, CHOICES remains committed to supporting individuals with mental illness in achieving better health outcomes and promoting a tobacco-free future. The program's sustained impact highlights the power of peer-led initiatives in driving meaningful change within the mental health community.

Children's System of Care (CSOC)

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

- a. Clinically appropriate and accessible
- b. Individualized and delivered through a continuum of services and/or supports, both formal and informal, based on the unique strengths and needs of each youth and his or her family/caregivers
- c. Provided in the most appropriate and natural setting required to meet the needs of the youth and his or her family/caregivers
- d. Family-guided, with families engaged as active participants at all levels of planning, organization, and service delivery
- e. Community-based, coordinated, and integrated with the focus of having services, decision-making responsibility, and management operational at a community level
- f. Protective of the rights of youth and their family/caregivers and
- g. Collaborative across child-serving systems, including child protection, juvenile justice, and

other system partners who are responsible for providing services and supports to the statutory populations.

Adolescent Substance Use Recovery Initiative

The Adolescent Substance Use Recovery Initiative aims to enhance access to treatment services for New Jersey adolescents aged 13 to 17 with co-occurring substance use and mental health disorders. The program provides outpatient and intensive outpatient services, emphasizing integrated care to address both substance use and mental health needs comprehensively. It prioritizes early intervention and family involvement to prevent serious injury and support recovery, utilizing evidence-based practices like Cognitive Behavioral Therapy and Motivational Interviewing. The initiative also includes non-clinical services such as case management, psychoeducation, and transportation, ensuring a holistic approach to treatment.

The In-Home Recovery Program

The In-Home Recovery Program, modeled after the Yale Child Study Center's Family Based Recovery Program in Connecticut, provides intensive in-home treatment for parents with substance use disorders, parenting support for children under the age of 72 months, and case management. In 2019, the Nicholson Foundation provided funding to implement and support the first year of the program in Ocean County. In 2020, the New Jersey Department of Children and Families (NJDCF) assumed this responsibility. In 2024, DCF also funded a second site in Camden County. With financial support from NJDCF, Montclair State University provides ongoing training, consultation, and technical assistance to both sites and Rutgers University evaluates the program.

Peer Recovery Support Staff Services

Peer Recovery Support Staff (PRSS) Services are a component of the Division of Child Protection and Permanency's Child Protection Substance Abuse Initiative (CPSAI). The Peer Recovery Support Staff establishes a one-on-one relationship with the parent/caregiver and encourages, motivates, and supports a peer who is seeking to establish or strengthen his or her recovery. They also assist the parent/caregiver to engage in treatment or reenter the community after residential treatment and to develop skills and access resources needed to initiate and maintain recovery by offering the benefit of shared life experiences and providing support. PRSS Services include Peer Mentoring/Coaching to assist the parent/caregiver access formal treatment services and other professional and non-professional services, resources in the community that can help meet his or her individual needs, set recovery goals, develop recovery action plans, and solve problems related to health, wellness, recovery, and recovery supports, including safe and sober housing, building or re-establishing supportive relationships, managing crises, and learning relapse prevention skills. PRSS Services also include Recovery Consultation, Education, and Advocacy including attending treatment team meetings, family team meetings, staying in communication with counselors and

supervisors, facilitating discharge planning in collaboration with treatment team, educating family, community and other supportive individuals about recovery and recovery management, and documenting information as required by program policies and procedures.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations.

DMHAS has been long invested in providing recovery support to individuals challenged by issues with substance use. Recovery support and recovery-oriented systems of care help people with mental and substance use disorders manage their conditions successfully. Recovery Support Services (RSS) are non-clinical services that assist families of, and individuals with, a substance use disorder (with or without a co-occurring MH issue). They include social supports, linkage to and coordination among a full range of service providers that facilitate recovery and wellness for an improved quality of life. Services are flexible and may be provided prior to, during, and after treatment. They may be delivered by peers, professionals, faith-based and community-based groups, and others. They are key components of the state's behavioral health system,

Peer support services include the coordination of personal, family, and community resources to achieve the best possible quality of life for every client entering the substance use early intervention, treatment or recovery system. The chronic nature of addiction requires recovery support to promote sustained periods of wellness to continuously decrease the need for additional acute care. Acute care substance use treatment without other recovery supports is often not sufficient in helping individuals to maintain long-term recovery. Recognizing that treatment for substance use disorders does not end upon discharge, a continuum of care recovery plan, including personal, family and community resources, needs to be established. The plan ranges from low level contact such as bi-weekly telephone conversations to high level contact such as coaching, depending on support needed.

The Table 10b on Recovery Supports funded by SUPTRS is only a fraction of all the work we have done in this arena. Below is a list of 30 recovery initiatives that NJ has supported with either state, block grant or discretionary grant funding. These are described in detail below.

SUD Peer Recovery Workforce

- SUD Peer Credentials
- SUD Peer Guidelines and Supervision
- Peer Training
- Peer Recovery Support Summit
- Peer Roster
- Recovery Data Platform

Advocacy

- Citizens Advisory Council
- Coalition for Addiction Recovery Support

Self-Help Groups

Transportation

- Transportation Reimbursement and Invoicing Program (TRIP)

SUD Peer Recovery Programs

- Opioid Overdose Recovery Program (OORP)
- Support Teams for Addiction Recovery (STAR)
- Maternal Wraparound Program (MWRAP)

Recovery Community Organization (RCO)

- Regional Recovery Centers
- Community Peer Recovery Centers (CPRC)
- Grassroots Recovery Organizations and Centers
- Other Recovery Organizations

Family Support Centers (FSC)

Collegiate Recovery Programs

Telephone Recovery Support (TRS)

Intensive Recovery Treatment Support (IRTS)

Peers in Residential Treatment Programs

Recovery Support Care Management (RSCM)

Recovery Management Check-Up (RMC)

County Innovation

Housing

- Group Homes for Persons in Recovery (Oxford House)
- MATI Intensive Supportive Housing (ISH)
- Women's Intensive Supportive Housing (WISH)
- OUD Supportive Housing
- Sober Housing

SUD Peer Recovery Workforce

A key to successful recovery programs is the involvement of peers. Over the last several years, the DMHAS has made significant efforts to increase the SUD peer workforce. Recovery Staff were

hired for the Opioid Overdose Recovery Program (OORP), Support Team for Addiction Recovery (STAR), Telephone Recovery Support (TRS) and Intensive Recovery and Treatment Support (IRTS) programs, where they now play a vital role. They are employed in our two large Recovery Centers and all our smaller Community Peer Recovery Centers. They provide recovery support for our various SUD housing programs. While there is currently a gap in the provision of peer services in residential settings, DMHAS has issued an RFP and made awards to employ peers in residential settings. A current goal for DMHAS is to expand the SUD workforce and the wealth of experience peers can bring to the SUD continuum of care.

Recovery support and recovery-oriented systems of care help people with mental and substance use disorders manage their conditions successfully. Peer support services include the coordination of personal, family, and community resources to achieve the best possible quality of life for every client entering the substance use early intervention and treatment system. The chronic nature of addiction requires recovery support to promote sustained periods of wellness to continuously decrease the need for additional acute care. Acute care substance use treatment without other recovery supports is often not sufficient in helping individuals to maintain long-term recovery. Recognizing that treatment for substance use disorders does not end upon discharge, a continuum of care recovery plan, including personal, family and community resources, is established. The plan ranges from low level contact such as quarterly telephone conversations to high level contact such as coaching, depending on support needed.

Peer-based recovery support is defined as a process of giving and receiving nonprofessional, nonclinical assistance to engage, educate, and support the client to make the necessary changes to live a self-directed life. In New Jersey, recovery support services are provided by certified peer recovery staff with lived experience who have been successful in the recovery process in order to support others experiencing similar situations. DMHAS views peers as an integral partner in our system of care as recovery support services expand the capacity of formal and informal treatment and recovery pathways. Peers are an essential component of programs, including residential, therapeutic community, outpatient, emergency department deployment, justice-involved programs, family, and community recovery centers. Through shared understanding, respect, and mutual empowerment, certified peer recovery staff strengthen an individual's motivation to change by initiating the recovery process to decrease the likelihood of a return to substance use.

Peer workers assist recoverees with accessing External and Internal Recovery Capital, and Family and/or Social Recovery Capital. External Recovery Capital includes, but is not limited to, financial assets, health insurance, safe and recovery-conducive shelter, clothing, food, and access to transportation. Internal Recovery Capital includes, but is not limited to, values, knowledge, educational/vocational skills and credentials, self-awareness, self-esteem, self-efficacy, hopefulness/optimism, perception of one's past/present/future, sense of wholeness and healing. Family and/or Social Recovery Capital includes, but is not limited to, intimate relationships, family and kinship relationships (defined here non-traditionally, i.e., family of choice), and social relationships that are supportive of recovery efforts. Recovery staff encourage families (biological, nuclear or self-chosen) to become willing to participate in their loved one's treatment and recovery. The presence of others in recovery within the family and social network can help access sober outlets for sobriety-based fellowship/leisure and relational connections to conventional institutions

(school, workplace, church, and other mainstream community organizations).

According to a report from the University of California San Francisco (UCSF), while peer providers have traditionally worked as volunteers, changes in mental health and SUD treatment and recognition of the importance of long-term recovery support, have led to a professionalization of this role with formalized training and certification, and the potential for paid employment. In recent years, the peer support services (PSS) workforce has evolved to become an essential part of mental health and addiction treatment, family support, and primary care services (Chapman, S., Blash, L., and Chan, K., *The Peer Provider Workforce in Behavioral Health: A Landscape Analysis*. San Francisco, CA, UCSF Health Workforce Research Center on Long-Term Care, 2015.)

Bassuk et al conducted a systematic review of the evidence on the effectiveness of peer support services for people in recovery from alcohol and drug addiction, which resulted in nine studies meeting the criteria for review. Despite methodological limitations found in the studies, the body of evidence suggested beneficial effects on participants (Bassuk, E., Hanson J., Greene, R., Richard, M., Laudet, A. Peer-delivered recovery support services for addictions in the United States: a systematic review. *Journal of Substance Abuse Treatment*. 2016; 63:1–9). In another systematic review, Reif et al evaluated peer support services for individuals with substance use disorders resulting in ten studies that met the review criteria. The studies demonstrated increased treatment retention, improved relationships with treatment providers and social supports, increased satisfaction, and decreased relapse rates (Reif, S., Braude, L., Lyman, D. R., Dougherty, R., Daniels, A., Ghose, S., Salim, O., & Delphin-Rittmon, M. (2014). Peer recovery support for individuals with substance use disorders: Assessing the evidence. *Psychiatric Services*, 65(7), 853–861).

A literature review by Tracy and Wallace found ten studies that met their minimum criteria, including randomized controlled trials or pre-/post-data studies, adult participants, group format, substance use-related, and US-conducted studies published in 1999 or later. Studies demonstrated associated benefits in the following areas: 1) substance use, 2) treatment engagement, 3) human immunodeficiency virus/hepatitis C virus risk behaviors, and 4) secondary substance-related behaviors such as craving and self-efficacy. Peer support groups included in addiction treatment show much promise in potentially decreasing substance use, improving engagement, decreasing HIV/HCV risk behaviors, and improving substance-related outcomes (Tracy K, Wallace SP. Benefits of peer support groups in the treatment of addiction. *Substance Abuse and Rehabilitation*, 2016 Sep 29;7:143-154).

Another review by the Peer Recovery Center of Excellence states that because of the knowledge gained through lived experience of addiction and recovery, and training received, Peer Support Workers (PSWs) are uniquely positioned to provide four key types of social support often missing from the addiction and recovery field: emotional, informational, instrumental and affiliation. Emotional support is perhaps the most readily understood, as it is central to the peer role; peers offer empathy, encouragement, and care to the peers with whom they work. In providing informational support, PSWs share knowledge and information about the recovery process and often provide skills training related to achieving and maintaining a life in recovery. Instrumental

support is a tangible form of support, providing concrete assistance to accomplish tasks, such as providing transportation. Through affiliational support, peer staff help connect individuals to the greater recovery community, wrapping them in a supportive (Peer recovery support: evolving roles and settings: a literature review, March 2021.)

SAMHSA defines peer support services (PSS) as assistance that is delivered by a person in recovery from serious mental illnesses (SMI), substance use, or co-occurring mental and substance use conditions, before, during, and after treatment to facilitate a recipient's long-term recovery in the community (Chinman, G., Dougherty, D., Ghose, S., and Delphin-Rittmon, 2014). The goal of these services is to assist with the development of strategies to promote coping, problem-solving, and self-management of a person's behavioral health condition. This is accomplished by the peer support staff drawing upon his/her own lived experiences and empathy to help others by promoting hope, developing skills and insights, fostering treatment engagement, accessing community supports, and building a satisfying life. Through the Recovery Community Services Program (RCSP), the Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment (SAMHSA/CSAT) funds grant projects across the country to develop and deliver these services. The peer recovery support services developed by the RCSP projects help people become and stay engaged in the recovery process and decrease the likelihood of relapse. Because they are designed and delivered by peers who have been successful in the recovery process, they embody a powerful message of hope, as well as a wealth of experiential knowledge. The services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking to achieve or sustain recovery.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), Peer Recovery Support Services (PRSS) workers have been successful in the recovery process by helping others that are experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process, thereby decreasing the likelihood of relapse. PRSS services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process.

Recovery support services encompass SAMHSA's guiding principles of recovery and include four major dimensions that support a life in recovery: health, home, purpose, and community. Peer workers assist individuals with developing a recovery plan that enables them to identify goals for achieving wellness. Peer workers also help the clients they work with to facilitate resilience and manage setbacks or other stressful events that may precipitate a return to substance use. New Jersey's recovery support services are designed to span all stages of recovery – from initiation/stabilization through recovery maintenance and the enhancement of quality of life in long-term recovery.

Basic on guidance from SAMHSA and numerous research studies, the DMHAS SUD Peer Recovery Staff provides non-clinical assistance and recovery supports services and works with individuals to assist with issues that often occur concurrently with a substance use disorder, such as homelessness, legal issues, employment, education, transportation, need for social services, health care, child welfare involvement, child care, health insurance, etc. The Recovery Staff

provides services according to a recovery based philosophy of care and supports the individuals' continuing stability, recovery and wellness as they move through the recovery continuum and support recovery planning by linking individuals to resources and appropriate services in the community, identifying factors that impact wellness and recovery, providing assistance in the managing of crisis situations, and modeling strategies on how to manage addiction successfully.

Basic requirements for a DMHAS SUD Recovery Staff are at minimum a high school diploma or equivalency; associate's degree or above preferred. Duties include providing recovery support and peer coaching to program participants. The Recovery Staff is required to attend a three (3) day DMHAS mandated training that delineates peer role functions, competencies, responsibilities and includes an orientation to DMHAS' multiple treatment and recovery initiatives. If not already credentialed, it is expected that the Recovery Staff will work towards attaining a Certified Peer Recovery Staff (CPRS) or National Certified Peer Recovery Support Staff (NCPRSS) credential by attending free training offered by NJPN. The Recovery Staff must have two (2) years of experience in the guiding principles of recovery that assist individuals to improve their health and wellness, live a self-directed life, and reach their full potential. The Recovery Staff are expected to work with individuals to support and strengthen their capacity to engage in their personal recovery. The competencies and role of the Recovery Staff shall include, but are not limited to the following:

- In collaboration with the individual, develop a recovery plan which should include services that identifies goals with measurable objectives, assesses strengths, can be used to work towards those goals, identifies impediments that can inhibit goal attainment, and monitors the progress made attaining those goals;
- Educate the individuals on how to navigate treatment, social service and recovery support systems;
- Provide recovery support services based on the individual's preference and his/her assessed needs;
- Support the individuals as they move through the stages of change to encourage them in their recovery;
- Assist the individuals with accessing recovery support services in the community;
- Work collaboratively with the case manager to ensure the individual engages in services and transitions to the next level of care when indicated;
- Be a positive role model by sharing experiential knowledge, hope, and skills;
- Maintain relationships with the individual in order to assist him/her in the treatment engagement and retention process;
- Reinforce, guide, and reassure the individual that recovery is possible, and is built on multiple strengths, coping abilities, and the resources of each individual;
- Assist the individual with gaining skills and resources needed to initiate and maintain recovery and maintain compliance with MAT if it is part of their treatment;
- Assist in establishing and sustaining a social and physical environment supportive of recovery;
- Enhance identification and participation in the recovery community;
- Advocate for appropriate and effective community treatment and recovery;

- Empower individuals to make self-determined and self-directed choices about their recovery pathway;
- Provide support with face-to-face sessions and/or telephone support based on the individual's personal choice; and
- Help individuals maintain healthy community, family and social functioning.

Other examples of peer services include recovery mentoring/coaching, recovery connecting, recovery consultation, peer support groups, and telephone recovery support.

Under the supervision of a licensed clinical professional, Certified Peer Recovery Staff (CPRS) or National Certified Peer Recovery Support Staff (NCPRSS) provide non-clinical assistance and support throughout all stages of the SUD recovery and rehabilitation process. Peer recovery support services are intended to provide individually based direction, support, and encouragement for individuals in need of substance use disorder treatment.

The Division supports the role of peers through several individual and family-based initiatives. These programs, such as the Opioid Overdose Recovery Program, Maternal Wraparound Program, Support Teams for Addiction Recovery, Family Support Centers, Recovery Centers Community Peer Recovery Centers, and prison-based Intensive Recovery Treatment Support, are described as follows. Newly added programs included the placement of peers in residential treatment programs, the Recovery Management Check-In, and the SUD FFS Recovery Care Management initiative.

SUD Peer Credentials

The DMHAS has also worked to develop two peer credentials, the Certified Peer Recovery Staff (CPRS) and National Peer Recovery Support Staff (NPRSS) and has worked with Medicaid to reimburse OORP services in Emergency Rooms and SUD peer services in outpatient. However, there is currently a gap in the provision of peer services in residential settings that DMHAS is seeking to improve. These services are not eligible for reimbursement by Medicaid. Utilizing Supplemental and ARPA funding, DMHAS issued RFPs to continue to expand the SUD peer workforce in residential settings and the wealth of experience peers can bring to those settings.

SUD Peer Guidelines and Supervision

Additionally, DMHAS recognizes the importance of peer supervision and protection. The PAC Peer Recovery Support Services (PRSS) Committee developed *Guidelines for Best Practices: Peer Recovery Services* which were published June 2023 to help ensure that peer recovery support services are provided using best practices based in research and experiences in various settings. The PRSS Committee acknowledges that this report is the beginning of the development of necessary standards for peer recovery support services in New Jersey. The guidelines have been worked on for the past several years during the expansion of this evolving field. It is designed to bring practical processes, strategies and tools to peers, their supervisors, administrators, and others committed to initiating and sustaining best practices in the peer recovery support services field and the supporting work environments.

Following the publication of the *Guidelines for Best Practices in Peer Recovery Services* document

by the Professional Advisory Committee's (PAC) Peer Best Practices Committee, a need was identified for more specific guidance around the integration of peers in residential and outpatient treatment centers. Several New Jersey treatment programs anecdotally report that they have—quite successfully—integrated peers into their service array, preliminarily seeing positive results in patient outcomes. However, these programs remain the exception and not the norm, despite funding made available through DMHAS for peers in residential settings and Medicaid reimbursement for peer services in outpatient settings.

This *Addendum: Peers in Residential and Outpatient Treatment Settings* addresses the following concerns and challenges that treatment providers may be facing in incorporating peer services into their programs:

- Lack of clarity around the peer role and how it differs from other roles, such as behavioral health techs and counseling interns
- Difficulty recruiting and retaining qualified and experienced peers
- Insufficient institutional knowledge and capacity to supervise peers

Peer Training

DMHAS supports the advancement of peers by offering training and professional development activities that increase and enhance the peer workforce. All peers working in DMHAS initiatives attend a 3-day Ethics training. The curriculum includes self-reflection, self-disclosure, MOUD, motivational interviewing, outreach, and engagement techniques. In addition, peers attend the 5-day Connecticut Community for Addiction Recovery (CCAR) which leads to peer certification.

DMHAS supports two pathways to peer certification. The International Reciprocity and Credentialing Consortium (IC&RC) NJ affiliate, the Addiction Professionals Certification Board, issues the Certified Peer Recovery Staff (CPRS) and NAADAC/NCC AP, the Association for Addiction Professionals, issues the National Certified Peer Recovery Support Staff (NCPRS). To ensure DMHAS recovery programs have adequate staffing levels, DMHAS provides scholarships for training, certification, and testing fees. To date more than 1550 peers have been trained through the Division's Addiction Training and Workforce Development initiative.

In addition to the basic core training, our training partner, the New Jersey Prevention Network (NJPN), has developed other training modules for peers. NJPN is planning to develop a more advanced curriculum. NJPN is also working on a series of trainings that will lead to certification, such as, working in emergency rooms, treatment agencies, etc.

Peer Recovery Support Summit

Annually the New Jersey Prevention Network (NJPN), a partner of DMHAS in collaboration with DMHAS, holds a Peer Recovery Support Summit. The last summit entitled, Stronger Together: Shared Learning and Building a Unified Future was held on September 25, 2024. This was NJPN's 8th summit and equipped attendees with strategies in providing recovery support services across the continuum of care, best practices that are relevant to the addiction/recovery field, and opioid

use disorders.

Peer Roster

DMHAS maintains a Peer Recovery Roster system designed to capture key demographic and workforce data from staff working in DMHAS-funded recovery programs. Program staff are required to complete an online Qualtrics survey, entering details such as their role, agency, supervisor, education level, certification status, credentialing, and training history.

As of July 2025, information has been collected from 687 Peer Recovery Staff. This data allows DMHAS to accurately track the size and makeup of the peer workforce, monitor trends, and assess both program and workforce development needs. In partnership with DMHAS, NJPN has developed customized dashboard reports for each funded initiative, providing a visual summary of key metrics such as certification progress, completed training, and current employment status.

Recovery Data Platform

The Division of Mental Health and Addiction Services (DMHAS) continues to utilize the Recovery Data Platform (RDP) as its centralized system for collecting and analyzing peer recovery support service data. Originally launched in 2020, RDP is a secure, HIPAA-compliant, cloud-based platform developed in collaboration with Faces & Voices of Recovery and RecoveryTrek. It is specifically designed to document peer-delivered services provided to individuals impacted by substance use disorders (SUDs) and now stands as one of the most comprehensive peer recovery data systems in New Jersey. In 2024, RDP recorded services for more than 15,000 participants, more than doubling the number from the prior year and reflecting growing adoption across DMHAS-funded initiatives.

RDP enables peer service providers to capture a wide range of data, including recovery coaching sessions, telephone recovery support calls, recovery-related activities and events, referrals, and participant demographics. The platform also facilitates real-time tracking and scheduling, allowing organizations to monitor participant engagement and service delivery across programs. To measure the effectiveness of these services, RDP uses scientifically validated tools administered at regular intervals. The Cravings Rating Scale (CRS) showed that participants experienced an average 25.4% decrease in cravings, while the Outcome Rating Scale (ORS) reflected an 18.3% improvement in self-reported well-being, relationships, and life satisfaction. Additionally, the Brief Addiction Recovery Capital (BARC-10) tool revealed a 10.8% increase in recovery capital, a key indicator of long-term recovery stability.

In 2024, peer recovery coaches delivered nearly 14,000 coaching sessions, providing over 540,000 minutes of direct support, with an average session lasting 38 minutes. More than 39,000 telephone recovery support calls were made, and over half of those resulted in successful participant engagement, averaging 11.3 minutes per call. Providers also logged more than 5,200 recovery activities, including support groups, educational workshops, and sober social events, marking a 53% increase from the previous year. Participants in the RDP system represented all 21 counties in New Jersey, with the highest numbers coming from Union, Bergen, and Sussex counties.

Looking ahead, the RDP is poised for continued expansion, with new organizations joining and existing participants deepening their use of the platform. With the number of participant records expected to surpass 20,000 in 2025, RDP remains a critical tool for tracking outcomes, demonstrating the effectiveness of peer services, and supporting a data-informed recovery infrastructure across New Jersey.

Advocacy

Citizens Advisory Council (CAC)

The Citizens Advisory Council (CAC) is composed of representatives from DMHAS-funded Community Peer Recovery Centers (CPRCs), which provide support and services for individuals facing substance use challenges. CAC members meet regularly with DMHAS leadership, including staff from the Office of Community Services and the Office of Advocacy and Peer Services.

These meetings foster communication, collaboration, and mutual support among persons who oversee the day-to-day operations of the CPRCs. They offer a platform for sharing updates on center activities, community needs, innovative practices, and both the successes and challenges experienced in delivering services.

The primary goals of the CAC meetings are to build a strong sense of community among those who oversee the day-to-day operations of the CPRCs, establish a professional support network, and maintain open lines of communication with DMHAS, particularly the Office of Advocacy and Peer Services. DMHAS staff provide updates on division-wide initiatives and receive direct feedback from persons who function as CPRC direct-care staff, while Advocacy and Peer Services staff contribute valuable insights from their lived experience with recovery and navigating substance use disorder (SUD) services.

Moving forward, CAC will collaborate more closely with the Statewide Consumer Advisory Committee (SCAC), which represents Community Wellness Centers. This partnership aims to better coordinate services and support for individuals in the community with co-occurring mental health and substance use needs.

Coalition for Addiction Recovery Support

The New Jersey Coalition for Addiction Recovery Support (NJ-CARS) is a statewide organization that provides a platform to celebrate the hope of recovery, promote the value of individuals with lived experience, and to incorporate and strengthen recovery support services across the continuum of care for substance use disorders throughout New Jersey.

NJ-CARS Advisory committee is a broad group of experienced recovery support practitioners and providers from New Jersey comprised of 75% peers at minimum. CARS offers the opportunity for members to be part of a statewide voice for recovery. For organizations, it offers the opportunity to contribute to the development and expansion of recovery support services in New

Jersey and an opportunity to coordinate the training of the peer workforce. The organization is currently funded through SAMHSA's Building Communities of Recovery (BCOR) grant.

Self-Help Groups

Support for involvement of recovering persons in self-help groups such as Alcoholics Anonymous and Narcotics Anonymous is also routinely provided as part of recovery planning, beginning in treatment and continuing upon discharge. Recently, providers have included evidence-based approaches like SMART Recovery. Additionally, several providers in New Jersey have developed All-Recovery groups, which are open to anyone who is living with an addictive disorder. The meetings are attended by persons in recovery, and those seeking recovery, as well as their friends and loved ones.

Transportation

Transportation Reimbursement and Invoicing Program (TRIP)

According to Bellamy et al. (2016), unreliable access to transportation was the most frequently documented and reported non-medical impediment to clients seeking substance abuse and mental health outpatient services. Transportation impediments manifest themselves in several ways: a lack of independent car ownership, high cost of public transportation, travel distance, travel time, parking fees, a lack of public transportation, distance from agency to a bus stop, and cost of ride-sharing services (Locatelli et al., 2017). Without adequate and affordable transportation options, clients are unable to begin vital treatment nor consistently attend and complete treatment, resulting in suboptimal outcomes. NJ's 2018 Household Survey of Drug Use and Health indicated that of the clients surveyed who indicated they wanted treatment, transportation was an impediment for 39% of the participants.

Transportation is a key recovery support. A reliable means of transportation is needed so clients can get to prevention, recovery and treatment support programs. As a result of this gap, DMHAS has developed a new program called the Transportation Reimbursement and Invoicing Program (TRIP). This will enable transportation to treatment for individuals who do not have Medicaid, as well as enable transportation to and from non-healthcare facilities such as Community Peer Recovery Centers or prevention programs. TRIP is intended and designed to eliminate transportation impediments and facilitate access to substance use disorder Treatment, Prevention and Recovery Support Services (RSS). Currently, SUPTRS Block Grant COVID-19 Supplemental and ARPA funds are being utilized. Funding of \$1,000,000 was set aside for this project.

Critical partners are the County and Alcohol Drug Directors (CADADs), our various recovery support programs such as the Opioid Overdose Recovery Program (OORP), Support Team for Addiction Recovery (STAR), Community Peer Recovery Centers (CPRC), Intensive Recovery and Treatment Support (IRTS), Maternal Wrap Around Program (MWRAP), prevention and SUD treatment providers.

SUD Peer Recovery Programs

Opioid Overdose Recovery Program (OORP)

The Division of Mental Health and Addiction Services (DMHAS) supports the role of peers through several recovery support initiatives. These programs assist individuals with opioid use disorders or those who are at risk of an opioid overdose through supportive services, case management, education, resources, and advocacy for families and individuals. The Opioid Overdose Recovery Program (OORP), which is in all 21 counties, provides support services to individuals reversed from opioid overdoses treated at hospital emergency departments. Peers working in OORP programs meet with individuals at bedside where they share their stories of hope and recovery. These peers continue to follow the patient for eight weeks after discharge and are instrumental in engaging individuals in the emergency department and beyond and letting them know that they are not alone and that recovery is possible by whatever pathway they choose.

OORPs operate in 56 of 75 (75%) hospital emergency departments throughout New Jersey. Fourteen OORPs are operating in all (100%) of the hospital emergency departments in their respective counties.

Since its implementation on January 1, 2016, NJ's OORPs have cumulatively served 26,593 individuals who were reversed from an opioid overdose and were taken to a participating hospital emergency department. Eleven percent of individuals cumulatively served (3,032 of 26,593) were initially referred to withdrawal management and ten percent (2,641) of individuals cumulatively served were initially referred to substance use disorder treatment. An additional 11,421 (43%) individuals sought recovery support services. Common recovery supports included referrals to self-help, transportation supports, mental health and medical services and housing support, including sober living.

In 2018, the scope of core OORP activities was expanded by 16 of the 21 OORPs. The OORP expansion sites increased core services to include new sets of activities, including services beyond the emergency department in other areas within the hospital as well as services outside the hospital within the community for persons with an opioid or substance use disorder. OORP expansion within hospitals serves emergency department patients who suffered an opioid overdose but who were not administered naloxone as well as hospital in-patients with an identified primary or secondary OUD or SUD who are being treated for any condition in other hospital units. As with core OORP, OORP expansion provides eight weeks of patient follow-up. OORP expansion within the community includes funding additional peers to perform community outreach for persons with an OUD and/or SUD at shelters and neighborhood fairs. Through expansion, partnerships with prosecutors, sheriffs and other law enforcement personnel, healthcare providers, treatment providers and community programs were established. Since its introduction, OORP expansion services have been provided to over 43,000 persons.

Support Teams for Addiction Recovery (STAR)

STAR program provides case management and recovery support services for individuals with opioid use disorders (OUD). The STAR initiative is comprised of one team, each consisting of a program supervisor, two case managers and two recovery staff. The team is required to maintain

a caseload of 40 individuals. STAR case managers work with individuals to assist with issues that often occur concurrently with an OUD, such as homelessness, legal issues, employment, education, transportation, need for social services, health care, child welfare involvement, childcare, health insurance, etc. The STAR recovery staff provide non-clinical assistance and recovery support services. The overall goal of STAR is to help maintain individuals with an OUD in the Recovery Zone, help decrease the risk of recurring episodes of opioid related problems and prevent future overdose.

The STR grant funded the initial STAR program in 10 counties. SOR grant and SOR supplemental grant funds enabled DMHAS to provide STAR services in all NJ's 21 counties.

In 2019, the ten STARs serving the counties with the greatest need (determined by number of overdoses, naloxone administrations, and rates of incarceration for opioid-related offences) received funds to develop an additional team to serve individuals with Opioid Use Disorder who are released from county or municipal jails. STAR programs used the funds to cover costs of hiring an additional case manager and recovery staff for the new team. Services provided are similar to those offered the original STAR teams, but with modifications to provide more effective services to this population

STAR tracks client outcomes through two surveys: the GPRA and the STAR survey. Results cited below come from the STAR survey administered at intake vs the STAR survey administered 6 months post intake. All results are based on proportion of individuals who answered to these questions and completed their surveys between January 1st, 2021 to December 31st, 2022.

The STAR program reported a decline in drug usage among its clients at the 6-month follow up vs intake. For the primary substance of choice, either a stimulant or an opioid, the proportion of clients who reported that they had no relapse in the last 3 months increased 26.5% at the 6-month follow-up compared to the intake survey. For overall abstinence from all substances (including alcohol and tobacco), STAR reported an increase of 5.4% in the proportion of clients who reported no overdose in the past 3 months. Finally, the proportion of individuals who attended self-help programs in the last month increased 15.5% at the 6-month post intake vs the intake. In summation, the STAR program was associated with a significant increase in those did not use their primary substance, a smaller increase in the proportion of individuals who were abstinent from all substances and was associated with improved participation in program to maintain abstinence.

Decreased drug usage is not the only improvement found in STAR clients. STAR also reported notable improvements in stability of client's living situation, which helps in maintaining abstinence from drugs. While housing is not a service directly funded from the SOR contract, our providers successfully formed links with Non-Governmental Organizations (NGOs) and government that provide housing. Our follow ups reported an increase of 5.5% of clients who have stable housing. To further illustrate this, in the most recent quarter (3rd quarter of federal fiscal year 2025), our providers were able to place and allow 82 STAR clients to move into stable housing. We were also very successful in increasing the proportion of individuals who reported being either employed, volunteering, and/or enrolled in educational/vocational programs by 71.9%. Our programs also worked help clients apply for health insurance such as Medicaid and

our 6-month follow-up survey reported a 5% increase in the proportion of individuals who had health insurance. Finally, in the overall measure of financial stability; the proportion of individuals who agreed with the statement that they had enough money to meet their needs increased 11.4%.

Clients also reported improvements in Quality of Life and satisfaction with their health at 6 months into the STAR program. On the measurement of Quality of Life, the client's average reported quality of life had jumped 12.5% between the intake vs 6 months. On satisfaction with health, STAR saw a 11.3% increase in the average.

Maternal Wraparound Program

The Maternal Wraparound Program (M-WRAP) is a program that provides intensive case management and recovery support services for pregnant women with substance use disorder. Pregnant women are eligible for services through M-WRAP 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. Recovery Support Staff provide non-clinical assistance and recovery supports while maintaining follow-up with the women and their infants. Block Grant funding supports seven (7) M-WRAP regions statewide with each region serving 60 pregnant women. The overall goal with the M-WRAP is to provide services through comprehensive care coordination implemented within the five major timeframes when intervention in the life of the substance exposed infants (SEI) can decrease prenatal substance exposure: pre-pregnancy, prenatal, birth, neonatal and early childhood. M-WRAP providers are required to develop Plans of Safe Care. The M-WRAP model is intended to promote maternal health, improve birth outcomes for women, their infants and families, and decrease the risks and adverse consequences of prenatal substance exposure.

Recovery Community Organization (RCO)

Regional Recovery Centers

From 2008 to 2019 there were only two state funded centers, one in the northern region of the state, Eva's Village in Paterson, and one location in the southern region of the state, Living Proof in Voorhees. Recovery support is an essential part of the continuum of care since substance use dependence (SUD) is a chronic biologically based disease of the brain and as such requires a system of care designed to treat a chronic condition rather than an acute illness. With other chronic conditions, e.g., diabetes, hypertension, heart disease, that are characterized by periods of wellness and acute episodes of care, the care system and intervention are designed to manage the illness in order to promote sustained periods of wellness and eliminate or minimize the need for acute care. Similarly, the SUD treatment system had to adapt to support the process of sustained recovery. The New Jersey Recovery Centers have been effective with many individuals seeking recovery.

DMHAS' plan was to expand the continuum of care to include an array of services that support individuals in their recovery from addiction. Recognizing the need to support individuals in their pathway to recovery, a Recovery Center is a place where individuals who have completed or left treatment, or who have never entered formal treatment, can find a nurturing and empowering environment in which they can learn new skills and develop a social network. A Recovery Center

helps prevent relapse and provides support for sustained recovery within the community. Services are provided by peers who serve as positive role models.

During CY 2022, there were 84,437 discharges from substance use treatment in New Jersey. Of these, 24,555 or 29%, quit or dropped out of treatment. While ALL clients can benefit from recovery support services, those clients who did not complete treatment may find recovery support beneficial and a gateway back into treatment and/or sustained recovery. It is clear that there are significant numbers of people who could benefit from ongoing recovery programs. While these figures are drawn from those who enter the formal treatment system, there is a group of people of unknown size who have never accessed formal treatment who could also benefit from recovery services. This will also be an opportunity for those for whom access to treatment is not possible or delayed due to insufficient capacity within the system. The DMHAS Recovery Centers offer training, social, educational and recreational opportunities. There are classes focused on wellness, nutrition and illness management, including classes on self-care, stress management, financial management, literacy education, job, and parenting skills. Housing assistance (e.g., finding apartments and roommates) is provided, and telephone support is available to Recovery Center participants. It is expected that this peer-delivered service will result in improved social functioning, decreased substance abuse and an improved quality of life, including more social connectedness.

For SFY 2022, the two NJ State funded Regional Recovery Centers (Eva's Village and Living Proof Recovery Center of Voorhees) provided peer support services to 2,394 individuals.

Community Peer Recovery Centers (CPRC)

Funding was issued in FY 2019 to FY 2025 through multiple Request for Proposals (RFP) to expand and develop Community Peer Recovery Centers (CPRC) where individuals can access peer support, information about substance use disorder treatment, recovery support services, and information about other community resources in a supportive substance free environment.

DMHAS initially awarded three providers \$100,000 each for start-up small-scale Recovery Centers to provide peer-to-peer recovery support services to prevent recurrent of substance use and promote sustained recovery. NJ DMHAS has now accomplished its goal of having at least one Community Peer Recovery Center (CPRC) in each of New Jersey's twenty-one counties with SOR funding of \$100,000 each to help start up new or enhance recovery support services within the community. In 2024, DMHAS issued an RFP to expand the CPRC in FY25 by utilizing \$100,000 SOR funding and \$275,000 Opioid Recovery and Remediation Funding for all CPRCs. All of the CPRCs were required to reapply for the funding and all but two of the original CPRCs were rewarded a CPRC Contract to provide CPRCs with an expansion of hours, staff and services to all 21 counties.

All activities and peer support recovery services through the CPRCs are led and driven by "peers", individuals who have experienced addiction and recovery, either directly or indirectly as a family member or friend. CPRC programming focuses on different aspects of the four dimensions to support a healthy life (health, home, purpose, and community). The overall goal of the CPRC is to provide a safe place for recovering individuals to gather in support of one another and experience

recovery-oriented living in a community setting. The CPRC is also a place where those in recovery can have the opportunity to give back to their community thereby fostering senses of empowerment and independence. With limited funding, CPRCs were able to respond to the challenges of the COVID epidemic, by finding creative ways to keep individuals engaged with their centers via virtual, hybrid, as well as traditional in-person Services. They are further challenged now by the continued and expanding need for community peer recovery support services to individuals exposed to all aspects of substance use; including keeping up with current SUD trends of use, treatment, medication assisted recovery, as well as the needs to assist individuals with transportation, and recovery support housing.

Many of the 25,019 unduplicated individuals in FY24 took advantage of the wide range of services that the 21 CPRC's offered, which equated to 46,321 duplicated individuals being served during this SOR funding period. It is expected that going forward from FY25 that all of these numbers will increase due to the expanded funding. The CPRCs continue to be among the most accessible resources in NJ, that are rooted in empowering people in recovery to be agents of change in the communities that they serve. The CPRCs serve as a vital hub for the recovery community providing peer coaching, mutual support meetings, telephone recovery, social events and activities, wellness activities, and linkages to all supportive services needed by the recoveree.

Major CPRC accomplishments include:

- Recovery Housing: 659 individuals
- Recovery Coaching or Peer Coaching: 3,381 individuals
- Employment Support: 447 individuals
- Multiple Recovery Support Services: 15,142 individuals

Other Specific Recovery Support Services received:

- Basic Needs-Food, Clothing, Emergency Shelter: 712 individuals
- Case Management/Individual Services Coordination: 7,190 individuals
- Community Resources: 6,574 individuals
- Historical Issues: 1,516 individuals
- Educational Support: 596 individuals
- Life Skills: 842 individuals
- Naloxone distribution: 3,938 individuals
- Outreach: 3,051 individuals
- Parenting/Childcare Resources: 984 individuals
- Recovery Support: 14,000 individuals
- Relapse Prevention: 2,064 individuals
- Self-Help and Recovery Support Groups: 10,724 individuals
- Social/Recreational: 5,214 individuals
- Spiritual and Faith based: 498 individuals
- Substance Abuse Education: 2,663 individuals
- Transportation: 1263 individuals
- Treatment/care support/system navigation: 6,079 individuals
- Wellness activities: 661 individuals

Additional CPRC accomplishments include:

- Number of group recovery support meetings held (virtual): 1,618
- Number of group recovery support meetings held (in-person): 4,487
- Number of group recovery support meetings held (hybrid): 705
- Number of individual meetings held (virtual): 532
- Number of individual meetings held (in-person): 6249
- Number of phone contacts (successful): 7421
- Number of text or email contacts: 9,181
- Number of community activities (virtual): 41
- Number of community activities (in-person): 1,166
- Number of community activities (hybrid): 41
- Number of referrals to services made: 10,515
- Number of mailings: 560
- Other Interactions/Outreach: 134

Every county in NJ is different and unique; the compilation of accomplishments below shows that all 21 CPRCs support of all pathways to recovery within their community and efforts of increasing Recovery Capital.

Recovery Center Advisory Boards. “The Advisory Board continues to work on strategies to boost participation at the center. Initiatives include expanding outreach, forming new partnerships with community organizations, launching new programs, and advocating for resources. Each board member has a designated role, including managing communication efforts, coordinating events, and overseeing partnerships.” – Union County CPRC

Mutual Support Group Meetings. All Recovery Meetings, SMART Recovery, Narcotics Anonymous, Alcohol Anonymous, Crystal Meth Anonymous, particular needs Support Groups, The Recovery Bible Meeting, Refuge Recovery, Veteran Support Groups, Canines for Recovery, First Responders Support Group, Works Meetings, Health and Wellness Group, Mental Health support groups, Smoking Cessation, and Active Parenting groups.

“Our recovery support meetings remain a cornerstone of our community, offering a wide range of options to meet a variety of needs. These initiatives and groups reflect our dedication to fostering a vibrant, and supportive environment for everyone on their recovery journey.” – Mercer County CPRC

Wide Range of Activities and Social Events. Game Nights, Recovery Movie night, Bonfires on the farm, Cirque Risqué, Talent Shows, Arts And Crafts, Mindfulness Nature Walk, Recovery Hikes, Y12SR Yoga, Origami workshops, Book Clubs, Soul Collage, Cards for Caring, Sound Medication & Healing, Birdhouse construction and painting, Shamanic Healing, Hummingbird Gardens, Horseback riding, Bowling, Spring Fling Dinner, Annual Summer picnic, Art Fridays, Recovery BBQ, Community Block Party, Friendsgiving, Halloween Party, Coffee and Conversation, Pizza Positivity, Holiday Positivity, and Patient Positivity.

“The Wellness and Relaxation Event was widely publicized, drawing in a total of 20 enthusiastic participants who actively engaged in various activities aimed at promoting relaxation, self-care, and overall wellbeing. It was heartwarming to witness the positive impact the event had on everyone who attended.” ~Mercer County

Community Awareness. Meet and Greet Open House, “Giving Back Tree” event, Volunteer Celebration Event, Recovery Day of Service International Overdose Awareness Events, Weekly Farmer’s Market Outreach, Annual Recovery Day, and Social Media presence on Facebook and Instagram to share resources, decrease stigma and inform the public through the means they communicate most frequently.

“We held a very successful Monthly Breakfast in our CPRC with community partners, law enforcement, volunteers, and participants.” ~ Morris County

Naloxone Training and Distribution. One small scall CPRC was able to distribute 439 Narcan kits, train over 100 residents in its use, and distributed 300+ fentanyl test strip kits.

Peer Workforce Development and Educational Workshops. Financial Literacy Class, Re-Entry Relapse Prevention Tools and Life Skills, Nutrition and Wellness, as well as connect members with educational and employment support, including NJ Re-Entry, DVR, One-Stop Career Centers, Consumer Connections through the Mental Health Association in NJ, as well as job fairs, job finding apps, resume writing support in the center, and job opportunities that come through the network.

“Our CPRC has allowed CCAR/ Ethics training participants to volunteer with the recovery center to earn the 500 internship hours needed for certification. This has allowed interns to get direct contact with participants through motivational interviewing, telephone recovery support, outreach, co-facilitating mutual support meetings, and event planning.” ~Middlesex County CPRC

Collaboration with Local Family Support Groups. *“We formed a strong partnership with the Family Support Center to exchange resources and expertise for better supporting individuals and families affected by addiction” – Union County.*

During FFY 2024 there were 2,846 intake surveys. There were more male (62.0%) than female (38.0%) participants. Of CPRC participants that completed the survey (n=2846), 31.1% (n=107) utilized MOUD. Of this group, 55.67% (n=41) utilized Methadone, 30.97% (n=40) buprenorphine, and 9.69% (n=10) Vivitrol, and 3.66% Other. Since all CPRCs will be using the Recovery Data Platform (RDP) going forward that demographics will be more robust in the future.

Grassroots Recovery Organizations and Centers

The Recovery Movement is well established in New Jersey. In terms of social media, there are numerous NJ Recovery Support pages on Facebook, Instagram and Twitter – ranging from parent-to-parent support groups to groups advocating for more treatment and recovery options for those suffering from a substance use disorder. At the community level, New Jersey has seen tremendous efforts in advocacy and recovery support. The New Jersey affiliate of the National Center for

Advocacy and Recovery for Behavioral Health (NCAAR-BH – formerly NCADD-New Jersey) developed a “Recovery Advocates” program with graduates being divided into regional teams across the state. These Advocacy Leaders are trained on how to provide testimony to the New Jersey Assembly as well to develop regional events to educate the community about recovery and decrease stigma regarding addiction.

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

All of these centers train their peer recovery staff and volunteers using the Connecticut Community for Addiction Recovery (CCAR) curriculum. Once they meet the required education and service hours, peers can take the examination and earn the NJ specific Certified Peer Recovery Staff credential or the National Certified Peer Recovery Support Staff credential offered by NAADAC.

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).

Family Support Centers (FSC)

Three regional Family Support Centers (FSC) continue to be funded through SOR funding to provide peer to peer family support services to families in each region whose loved ones suffer mainly from an opioid use and/or stimulant use disorder. FSCs were the first formal family support service in the New Jersey's Substance Use Disorder continuum of care that offered direct family

support, education, resources and advocacy in a safe and non-stigmatizing environment. Each regional center is staffed with Family Support Coordinators with lived experiences who are trained in the Community Reinforcement and Family Training (CRAFT) Model which teaches families self-protection along with non-confrontational skills to help empower their loved one to seek treatment. The CRAFT Model which was developed and researched by Robert J. Meyers, PhD. CRAFT is a non-confrontational intervention and skills-based program designed to impact families in multiple areas of their lives, including self-care, pleasurable activities, problem solving, and goal setting. CRAFT addresses their loved one's resistance to change, in addition to teaching families behavioral and motivational strategies for interacting with their loved one.

CRAFT training is provided by DMHAS to all FSC Coordinators. The three major goals of CRAFT that the Family Support Center Coordinators work with families on are:

- Decrease a loved one's substance use
- Influence a loved one to seek substance use treatment and recovery
- Improve the functioning of family members by making positive life changes

Through brief CRAFT model supportive sessions, the FSC Coordinator assist family members with examining their interactions with the substance-using person, improving their communication strategies, and decreasing emotional stress, support to parents, build hope and provide a sense of optimism, teach positive communication skills, be able to engage in role-plays with parents to rehearse positive communication skills, conduct supportive or psycho-education groups, develop wellness plans, share stories of hope and recovery, connect family members to each other, and advocate for family members' health and safety.

The FSC Coordinator helps each family member develop and work on their own Individualized Wellness Recovery Plan. The overall goal of the FSC Coordinator is to provide compassionate support to empower family members to have a better quality of life, improve their psychological health, decrease levels of stress, feel less isolated, and gain skills needed to cope with their loved one's use. Families who receive FSC services also receive Naloxone Training and Kits to assist their loved ones at risk of opioid overdose.

In 2021, each regional FSC expanded due to the increased numbers of referrals coming from OORPs, STARS, ReachNJ, Connect4Recovery Call Center, Division of Children and Families, and Families, Probation, and Treatment Providers to assist family members of loved ones with an *OUD/stimulant use disorder, and some families without*. Each FSC Region now provides family support services for at least 150 families in their region.

In addition to providing its families with Naloxone trainings, kits, and medication assisted resources and treatment, Regional FSCs also provide ongoing peer individual support, education, and coaching to families on an ongoing basis. The FSC's individual services and support to families constitute the most utilized form of service that the program offers.

As a result of the COVID-19 pandemic, several adaptations to FSCs continue to be made to accommodate the individualized needs of the families and staff members. The hybrid work model

has become the new standard for each FSC. Since the objective of all peer work is to “meet people where they are,” the FSCs respected the participants’ wishes and continued with hybrid and virtual alternatives for individual and group sessions as well.

FSCs continued to run weekly virtual CRAFT-based Family Support Groups for enrolled FSC clients. Groups such as Helping Through Understanding; Understanding Substance Use; Strategies for Improving Communication; Strengthening Healthy Alternatives; Offering Information and Making Requests; Conversations Suggesting Treatment continue to be a success as evident by the fact that they are well attended and that families continue to provide positive feedback.

FSCs also offer families, various partners, and the community, educational workshops designated as “The Support Series” that also consist of CRAFT Strategies (topics include: Engagement Strategies, the Dichotomy of Control, Communication Skills, Boundary Setting, Enabling vs. Helping, Behavioral Reinforcement, Self-Care, The Stages of Change, Motivational Interviewing, Acceptance and Commitment Techniques, Unilateral Approach to Change, etc.). Monthly Self-Care events are also made available to help FSC family members; events include Floral Design Workshop, Crafting Hope, Self-Care Soiree, Pizza and Painting, Outdoor Paint Party, Spring Flower Arranging, Weekly Yoga for Recovery, Overbooked Book Club, and Tending Our Inner Self Book Club. The FSC also engages in community outreach events, meeting in-person with partners and providers, and meeting in-person with families at the agency and within the community. The FSC also continues to engage families remotely telephonically or virtually through the Telehealth platform.

In FY 2024, the Regional Family Support Centers provided support to 289 families who had a family member with a verified opioid and/or stimulant use disorder. FSCs also provided family support to 165 additional family members who could not verify the substance their loved one was using. These additional family members still received family support from the FSC, however are counted separately and not included in the FSC Outcome Data which only focused on opioid and/or stimulant use families.

FY 2024 FSC Outcome Data was collected from the opioid/stimulant use families who received services from the three regional Family Support Centers (FSC). Some of these families completed an intake during the time frame while others began service prior to and continue to receive services. Outcome data for opioid/stimulant use families is collected through the FSC survey. The FSC enrollment survey is self-administered by family members within two weeks of their first contact with the program and a follow-up survey is completed approximately six months later. Data are from family members who received services from program inception through June 30, 2022.

Most (82%) family members were female and 65.2% were parents of their loved one with OUD. The highest percentage (58.9%) of loved ones of family members were aged 14-34 and the majority (73.5%) were male (n=296). Please note that not all families who were served completed an intake survey.

Updated outcome data are not available, so the most up-to-date data are included below. Family members’ areas of concern regarding their loved ones are also collected. The area of concern most

frequently cited as the main concern was mental health, accounting for 52.88% (n=55). Following mental health, the chief concerns cited were medical health at 19.23%, interpersonal and family relationships at 13.92% and educational progress at 1.92%.

The SOS assesses the impact of loved one's substance use on family members across the eight domains shown below. Items asked how often family members experienced a total of 54 difficulties as a result of a loved one's abuse of alcohol or drugs. On a scale ranging from 1 (never) to 5 (almost always), mean values were highest on the emotional (M = 3.12) and relationship (M = 2.55) domains. Impacts on the legal (M = 1.00) and physical violence (M = 1.01) domains were lowest.

In addition, the Central FSC Region used the FSC Recovery Data Platform (RDP) Pilot to collect data. This pilot dramatically improved the monthly reporting process, supported the hybrid work model, eliminated paper files and offered opportunities to track outcomes for the Central Region FSC. The owner of the platform, Faces and Voices of Recovery, agreed with the recommendation to identify one specific CRAFT strategies for each family interaction. The Central Region FSC is very excited about this data collection because no one is tracking the individual CRAFT strategies. This is a recent upgrade and a small sample, so more data needs to be collected. Practicing self-care was identified as the most commonly used strategy and this was addressed by the introduction of the self-care events. This is an example of the output that will help the FSC in planning future programming:

<u>Self-Care Strategy</u>	<u>Number of Interactions</u>
Self-care	385
Problem Solving	108
Positive communication strategies	64
Getting a loved one to accept help	43
Understanding a loved one's triggers to use substances	38
Understanding readiness for change	24
Setting health boundaries	14

Collegiate Recovery Programs

DMHAS provides funding to five state institutions of higher education. The funding enables them to offer students in recovery from a substance use disorder (SUD), students at-risk of developing a SUD, and students not in recovery who choose not to use alcohol and drugs, a supportive community (including housing) that promotes physical, psychological, social, and spiritual health. By providing this support, it is easier for a student who is in recovery to thrive in the college setting and work toward his/her/their academic goals.

The colleges/universities are Rutgers University New Brunswick and Newark campuses, The College of New Jersey, Rowan University and Richard Stockton University. During SFY 2024:

- o 1458 students received individual and/or group recovery support services
- o 65 students resided in recovery housing

- o in excess of 18,000 students participated in campus-wide or large-scale
- o substance-free activities/events
- o 94% reported (past 30-day) abstinence from substance use
- o 70% reported being employed
- o 100% of students reported satisfactory academic standing
- o 100% of students reported no criminal justice involvement
- o 100% of students reported stable housing (on or off campus)
- o 100% of students reported satisfaction with the services they receive through the collegiate recovery program
- o 100% reported social connectedness with peers, family, friends and/or coworkers
- o 60% of students reported need for mental health resources, all of whom were either engaged with a lead counselor or were linked to a community mental health program.

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. Through June 2025, 2,387 individuals have been served by TRS. Additional information about TRS services is provided below.

- Total phone calls outgoing: 33,975
- Total phone calls incoming: 12,616 calls
- Average length outgoing: 5 minutes 53 seconds
- Average length incoming: 9 minutes 21 seconds

Intensive Recovery Treatment Support

Since 2017, DMHAS has worked with the Department of Corrections to provide Intensive Recovery Treatment Supports (IRTS) post-release services to a cohort of eligible offenders (n=200) with Opioid Use Disorder that receive MAT prior to release from prison, and to another cohort of non-MAT eligible offenders (n=400) both pre- and post-release into the community.

In October 2020, NJ Governor Phil Murphy signed legislation for decreasing sentences and early release of certain NJ state prison inmates incarcerated for non-violent offences. The law was effective in early November 2020. Through January 2021, almost 3,000 inmates were released. Approximately 800 of these individuals had an OUD diagnosis and 364 enrolled in the IRTS program. Two additional IRTS teams were developed to serve them.

IRTS links eligible offenders to recovery services necessary to support wellness and successful

community re-integration. It helps offenders address issues such as health/wellness, treatment adherence, employment, housing, and opportunities and skills to enhance the individual's ability to participate in meaningful life activities. There are five IRTS teams providing services for up to six months prior to release and up to 12 months post release. To date, 5,792 inmates have been referred to the program.

In a subsample of IRTS (N = 334), the percentage who reported being housed increased from 74% in the first month after release to 84.7% in the fifth month, while the percentage who reported employment increased from 27% to 73%. The self-reported percentage using MOUD decreased modestly over this period but remained relatively high at 63.4% after five months. Self-reported alcohol and drug use increased over this time but remained below 30%. Among participants, on a monthly basis, 0.8% and 2.4% of active participants in the community experienced overdose or return to prison.

The following table provides a description of IRTS participants as of 6/30/2024.

Characteristic	%
Sex	
Female	9.6
Male	90.3
Age	
18-24	6.6
25-34	35.9
35-44	31.7
45-54	17.6
55+	8.2

MAT use among participants with OUD, January 2020 – May 2024

Month	N with OUD	On MAT	Month	N with OUD	On MAT
Jan 2020	172	66.9%	Apr 2022	100	63.0%
Feb 2020	149	64.4%	May 2022	90	68.9%
Mar 2020	149	67.8%	Jun 2022	65	67.7%
Apr 2020	143	70.6%	Jul 2022	60	68.3%
May 2020	175	68.6%	Aug 2022	59	64.4%
Jun 2020	161	69.6%	Sep 2022	50	68.0%
Jul 2020	155	68.4%	Oct 2022	51	64.7%
Aug 2020	143	67.8%	Nov 2022	51	68.6%

Sep 2020	139	68.3%
Oct 2020	116	65.5%
Nov 2020	155	63.9%
Dec 2020	158	62.7%
Jan 2021	144	65.3%
Feb 2021	155	64.5%
Mar 2021	115	70.4%
Apr 2021	68	69.1%
May 2021	106	74.5%
Jun 2021	132	66.7%
Jul 2021	116	65.5%
Aug 2021	90	67.8%
Sep 2021	108	69.4%
Oct 2021	105	64.8%
Nov 2021	79	77.2%
Dec 2021	72	73.6%
Jan 2022	68	69.1%
Feb 2022	79	73.4%
Mar 2022	108	66.7%

Dec 2022	54	64.8%
Jan 2023	45	55.6%
Feb 2023	50	64.0%
Mar 2023	42	54.8%
Apr 2023	53	62.3%
May 2023	51	56.9%
Jun 2023	46	56.5%
Jul 2023	46	60.9%
Aug 2023	43	58.1%
Sep 2023	41	58.5%
Oct 2023	67	56.7%
Nov 2023	79	51.9%
Dec 2023	85	51.8%
Jan 2024	86	52.3%
Feb 2024	81	56.8%
Mar 2024	78	57.7%
Apr 2024	81	60.5%
May 2024	72	58.3%
Average	95	64.5%

Note: N represents the number of participants with documented OUD diagnosis who completed monthly reports for the month. Data entry may be incomplete for most recent months.

Peers in Residential Treatment Programs

Over the last several years, DMHAS has made significant efforts to increase the SUD peer workforce. Peer support services have positively impacted and provided assistance to persons in recovery from serious mental illness, substance use or co-occurring mental and substance use conditions before, during and after treatment. As a means to close the gap in the provision of peer services in residential settings, DMHAS issued an RFP in March 2023 to expand the peer workforce to include peer services in inpatient withdrawal management, short-term and long-term residential and halfway house settings. In June 2023, eight providers were awarded a contract for a total of 26 peers. In the following year DMHAS expanded this service to add an additional

provider as well as fund an additional 26 peers. The successful bidders hired peers who assist with issues that often occur concurrently with SUD, such as homelessness, legal issues, employment, childcare, etc. In addition to linking individuals with the appropriate community resources, peers also encourage individuals to remain in treatment as recommended in the treatment plan and modeling strategies on how to manage addiction successfully.

Recovery Support Care Management (RSCM)

RSCM was established and effective on March 7, 2023 and is a behavioral health service intended to support consumers who have a SUD with complex physical and/or psychosocial needs. RSCM provides direct and comprehensive assistance to consumers to ensure access to the necessary treatment, rehabilitative and recovery services with the intent of decreasing psychiatric and addiction symptoms, connect consumers with services, improve transitions between levels of care, implement strategies to address their unique needs, decrease opioid related deaths and sustain recovery in the community while supporting the consumers' continued stability and recovery throughout the continuum of care. This service is available as an enhancement in all levels of care. This service may be provided face-to-face or via a telehealth platform. Since Medicaid offers Care Management in outpatient, RSCM is excluded from reimbursement for consumers admitted into Ambulatory LOCs in Recovery Care Efficiency (RCE). As of March 31, 2025, there were 4,615 unduplicated clients who received this service.

RSCM activities are categorized into separate initiatives:

- **Driving Under the Influence Initiative (DUII):** DUII supports the treatment of financially indigent residents of New Jersey who have been convicted or recently arrested for a Driving Under the Influence (DUI) charge. Individuals must be clinically assessed and determined to be in need of substance abuse treatment services and meet financial eligibility requirements in order to access the DUII funding. Financially indigent intoxicated drivers can receive the appropriate level and duration of treatment warranted, thus the incidence of recidivism among intoxicated drivers and ultimately creating safer highways.
- **New Jersey Statewide Initiative (NJSI):** NJSI funds ambulatory and residential levels of care including Outpatient, Intensive Outpatient, Short Term Residential (STR), Halfway House, and Long Term Residential (LTR) and enhancement services. Ambulatory levels of care and Halfway House Services are State funded; STR and LTR services are funded through Federal Block grant dollars. Eligible consumers are New Jersey residents who have income up to 350% of the FPL and have been determined to be in need of SUD treatment in the levels of care offered in this initiative.
- **Substance Abuse Prevention and Treatment Initiative (SAPTI):** On July 1, 2016 the contracted methadone outpatient, intensive outpatient and residential services reimbursed by Substance Abuse Prevention and Treatment (SAPT) Federal Block Grant (BG) funds were transitioned to Fee for Service. Inpatient Withdrawal Management was added to this initiative on April 11, 2017, supported by State dollars.
- **State Parole Board (SPB):** The SPB is designed to provide substance abusing inmates and parolees with the opportunity to receive structured, community-based substance abuse

treatment that introduces intensive therapy for behavioral and psychological problems related to addiction. This funding is a combination of direct appropriations to DMHAS and funds transferred from the Department of Corrections (DOC) and State Parole Board (SPB) to support an FFS network of licensed community-based substance abuse treatment programs. For SPB, these funds support a similar FFS network which offers the full continuum of care including long term and short-term residential care, halfway house, partial care, detoxification, intensive outpatient, and outpatient treatment for SPB parolees. If you are interested in substance abuse treatment and believe you may qualify for services through this initiative, please contact your parole or corrections officer.

- **South Jersey Initiative:** South Jersey Initiative. This state funded fee-for-service initiative for young adults (ages 18-24) from eight counties (Ocean, Atlantic, Burlington, Camden, Gloucester, Cape May, Salem and Cumberland). SFY23, the SJI eligibility criteria was expanded to include young adults ages 25 to 30 years old. The criteria change provides the opportunity to reach more young adults over the age of 24, and those who age out from their parents' insurance coverage who are in need of substance use disorder treatment (SUD). The SJI provides a continuum of care that includes methadone maintenance, detoxification, residential, halfway house, and outpatient treatment services.

Recovery Management Check-Up

Recovery Management Check-up (RMC) is a statewide service for discharged clients to support independent living and success with recovery and provide more methods of outreach to clients. This includes virtual face-to-face visits, text messaging, chat features, and the opportunity for actual in person contacts. Monthly contact forms the core of RMC, which aims to identify and alleviate client problems before they derail recovery. Problems are addressed using motivational interviewing techniques or connecting clients to appropriate community resources or treatment if needed, including medication assisted treatment (MAT). The conceptual framework of RMC is to treat addiction as a chronic disease, with long-term management to minimize the number of acute episodes of substance use disorder and with prompt treatment when episodes occur to prevent them from becoming more severe and consequential. RMC is a program designed to provide local recovery support services in the following three regions of the state.

- 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.

Key goals of the RMC are a) provide a regionalized, innovative recovery program to individuals recovering from SUD in all 21 counties of New Jersey; b) provide and coordinate integrated person-centered recovery support services to persons in recovery; c) identify, improve, and sustain the recovery capital for persons or individuals recovering from SUD. The overall purpose of RMC is to ensure optimal success for persons in recovery. To this end, the program employs four dimensions of recovery; health, home, purpose, and community. RMC seeks to meet participants wherever they are in their individual recovery journey by honoring their choice, voice, and agency.

Through concerted efforts, collaborations and team technical supports, RMC was enhanced to gain

buy-in and to become institutionalized as an integral process in the recovery community in the state. To achieve this, the program launched the RMC Referral website and e-referral kiosk at <https://fvrhub.org/rmc-nj-cars/>, as an effective tool to facilitate referrals to the appropriate regions based on the participant's county of residence. Available indicators show that RMC had consolidated and registered progress across the three regions of the state. Data below will highlight the quantitative value of progress made in RMC from onset to present.

From the beginning of the program to March 2025, for all three regions, a total of 14,032 outreach attempts were made by certified peer support staff. 3,987 of those were successful contacts. On average, 584 attempts were made, with 166 succeeding, per month. The program's output was on an upwards trajectory, and the last 6 months of the program were its most productive. In that time, the program expanded to 1,030 outreach attempts per month, with 272 successes. The program was able to serve 1,503 unique participants. RMC was able to serve as a connective program, making 2,692 referrals to other both SUD and non-SUD-related programs

County Innovation

Recovery Support services were developed in all 21 NJ counties, utilizing State Opioid Response (SOR) funding. A description of these programs follows.

Atlantic \$126,059- 2 programs

Innovative Recovery Support Services: \$66,059

AIM provides support, encouragement, and empathy to a vulnerable population associated with those living with substance use disorder. Furthermore, AIM proposes to provide 200 individuals within the community with transportation, linkage to treatment facilities, assistance with sober living, and provide individuals with basic needs such as toiletries, food, and clothing. The level of service and cost proposed by AIM are within reason and a contract is warranted. AIM proposes to provide Recovery Support Services to 1000 individuals: \$50/client with follow-up \$50; Recovery House funding at \$175/week for 3 weeks; Assistance with 12-Step-Facilitation at \$50 x 3 events; Necessity support at \$50 x 2; Transportation costs up to \$750 (contingent on actual costs); Outreach \$200/event; Blessing Bags \$200/event, and Admin costs including insurance, etc.

John Brooks Recovery Center: \$60,000

The agency will assume to re-open/continue operating a Recovery Center that would provide innovative services to the recovering community, with an emphasis being placed on providing services to affected persons of the opioid epidemic and family members of affected persons of opioid overdose deaths. This would include John Brooks Recovery Center (JBRC) which submitted a proposal for \$60,000 to provide a wide array of recovery support services to all people in recovery with a substance use disorder. JBRC operates two Recovery Community Centers with the ability to service approximately 550 unduplicated individuals. Cost for individual peer to peer services, navigation, coaching, follow-up, education/prevention, and service connections (housing, employment, tobacco dependence) is \$16.00/15 minute unit of service. Cost for group peer to peer services, workshops, support groups, education, prevention, and health/wellness is \$4.00/each individual/group. The Recovery Center is located close to public transportation and will utilize

both professional and volunteer staff to function daily.

Burlington \$134,615

Resource Recovery Center

The one-time award for the Resource Center is to provide an environment 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.

The Resource Center will include an array of services that support individuals in their recovery from substance use and misuse. In summary, this funding will:

- Strengthen the linkage between treatment and recovery;
- Increase support for sustained recovery within the community;
- Offer resources to individuals seeking information on substance use disorder and behavioral treatment. Resources will include accessing treatment information through NJ Connect, private insurance, DMHAS Interim Managing Entity (IME) Addictions Access Center, Family Support Centers, Support Team for Addiction Recovery (STAR), Medication Assisted Treatment (MAT) options,
- Help prevent recurrence of substance use;
- Inform individuals about Naloxone training and where one can obtain a kit;
- Provide recovery resources;
- Provide a trauma informed community where individuals can achieve a full and satisfying life free of trauma and its consequences; and
- Provide a center for community-based leadership to grow and develop.

The coordinator is to be a person in Recovery and trained as a Certified Peer Recovery Staff. An Oversight Team will be developed to guide the programming and running of the resource room. This team will include County A/D Director, Peers in Recovery, Providers, Burlington County Prosecutors Office (BCPO), etc. The coordinator will be responsible for the daily operations and oversight of the Resource Room (i.e., startup activities, growth, stabilization, and continued innovation). He/she will report to the A/D Director. The BCPO is providing a Certified Peer Recovery Staff (CPRS)/Recovery Coach training run by City of Angels. It will be free to Burlington County residents and occur sometime in March. The BCPO, through its Operation Helping Hands Program, has offered to provide CPRS for July and August. The County will use funds to pay the CPRS the other months for the first year. A CPRS pool will be created to staff the recovery center with the coordinator. The County plans to have at least two people working the recovery room when it is open, so no one is there alone in case of emergency.

Camden \$190,039

Program: Joseph's House

Location: 555 Atlantic Ave, Camden, NJ 08104 which is an 88-bed shelter in Camden City. The shelter is co-ed

Program: Volunteers of America – Delaware Valley, Anna Sample Complex

Location: 408-416 Line Street, Camden, NJ 08103. 93-bed Transitional Housing program serves single women and families.

Since April 2020, Camden County was funded by the National Association of County & City Health Officials (NACCHO) to provide a Peer Recovery Staff (CPRS/HRS) who are required to work ‘in-person’ at two homeless shelters under the direction or co-direction of the shelter and or substance use licensed treatment facility. For 2023/2024, Maryville, Inc., a SUD treatment provider who will supply the CPRS and coordinate the data.

The shelter administrative team/s will determine and provide the required hours based upon the number of overdoses in the area. Also considered is when the shelter guests are available. That means working during the day, evening and on weekends. The hired licensed entity selected to provide the CPRS service must enter into a Memorandum of Understanding (MOU) with the homeless shelter(s) post award, subject to the approval and acceptance by the County, to determine the hours of operation. They must have mutual agreement of all operational terms, including provision of replacement staff in the event the assigned CPRS/HRS is unavailable.

Therefore, the CPRS/HRS is required to be co-supervised by the SUD treatment agency and shelter administrator. The CPRS/HRS cannot perform any activities on behalf of the SUD treatment agency, shelter or county not defined or approved by the shelter or county. The CPRS/HRS offers an opportunity to share the experience of lived experience, however, referrals will be made in accordance with the most evidenced based practices. The CPRS/HRS must be fully knowledgeable about multiple pathways to recovery and SUD treatment. Individuals with ‘opiate use disorders’ (OUD) must be referred to the most evidenced based treatment. The shelters may bill \$1,004.00 per month for the provision of a desk and supervision. The CPRS provider may bill \$35,000.00 per CPRS plus up to 25% for fringe (\$8,750.00). The cost of CPRS cell phones, a lease of a vehicle, incidental travel costs for the patients, cell phones and tablets for the CPRS will be covered. CPRS must come from an agency that has direct capacity to an inpatient admission center. The County will cover the cost of an afterhours line with an inpatient treatment agency to allow for greater access to treatment for its residents. CPRS are provided instruction about multiple pathways to prevention services. When shelter guests are not ready for treatment, they are encouraged to take advantage of multiple pathways to prevention services. The County will directly with its multiple pathways to prevention center to assist in the education about that topic. The County will also work with its shelters to increase their understanding of the value of multiple pathways to prevention.

Program: Regan Center

Location: 508 Lakeland Road Gloucester Township, NJ 08012 (856) 549-0590

The Regan Center is a 23-bed facility comprised of a 15-bed emergency shelter program and 8 bed medical respite program for homeless adult men.

There are 2 CPRS full time. To complement this program, the County funded 1 CPRS with lawsuit remediation funds – to provide CPRS services for the other 3 shelters in the county. Burlington and Gloucester Counties refer all homeless individuals to Camden County’s shelters.

Cape May \$35,751

This program will use funding to establish a recovery center in the county which will serve as the hub of many recovery programs that currently operate out of churches and other general areas. It will be peer driven and peer delivered and serve people currently in recovery and are dedicated to maintaining a sustainable path in recovery. Recovery staff will be present to develop a recovery plan for those in attendance and assist with Medicaid applications. Support groups for at risk populations such as pregnant and new mothers and families (CRAFT) will be scheduled, education regarding treatment and MAT will be available, fellowship groups including 12 step and all recovery will be welcomed. Agencies will bring support programs on a routine basis such as work readiness, nutrition, job search, entitlements, etc. The Center will operate from 10 to 6 daily and allow for meetings after hours. It is expected that 300 people will participate and 100 will develop a recovery plan and will be linked to resources, including MAT. Thirty percent of those who develop a recovery plan will remain in recovery three months.

Gloucester \$111,151

This program is a collaboration between Gloucester County and Center for Family Services, operating on the campus of Rowan College of South Jersey. The program will provide the following:

- Expand Substance Abuse Family Recovery Support Program. Opening additional satellite locations in Gloucester County to provide better access to residents. Areas of particular interest would include the eastern part of Gloucester County (Monroe Twp., Franklin Twp., Clayton) and the southwest riverside communities (Paulsboro, Greenwich, Logan).
- Provide transportation to and from withdrawal management and treatment services. A subcontracted agency would provide transportation on an as-needed basis for Gloucester County residents.
- Additional Supports for sober living residents. Currently, Gloucester County funds a limited number of residents entering into sober living by paying their move-in fee and first 2 weeks rent. Funding is also made available in cases of hardship. Additional support is needed to provide daily living essentials, such as toiletries and food.
- Enhance Collaborations with community service organizations. Gloucester County will look to expand partnerships to increase access to, and education on, Medication Assisted Treatment, Narcan, SBIRT Intervention, Peer Recovery Support, Family Support, Sober Living, and other programs/services, at various locations throughout county.

Hudson \$203,963

The Hudson County Innovation Program will provide the following services.

- Supporting Treatment for Addiction, Recovery and Success (STARS) Program - Mobile outreach van to offer Info, Naloxone training and support services.

- STARS support materials
- Youth recovery support group (Ages 13 - 17)
- Young adults' recovery support group (Ages 18 - 24)
- 6 Recovery events
- Youth sober activities
- Outreach/ education to prescribers

Hunterdon \$35,708

The Hope One Vehicle in Hunterdon County will educate those addicted to heroin and other opioids about the dangers of ongoing use, as well as give resources to get help. It will provide transportation at the end of each shift to MAT services as well as to the County's screener for services to assist those who express interest in getting services. The County will also provide funds for taxi service back or provide linkages to the local Link service. Transportation has long been an impediment that has prevented many from being able to consider getting to treatment. Hope One will work with the Social Services Department to assist consumers to be able to sign up for benefits, assisting them in being able to gain access for needed services, as well as housing and food needs. MOU's will be set up with mental health agencies, as well as the local health department, so that consumers can have referrals for services. Rapid testing HIV will be offered, as well as education on safe injection, abscesses, and Hepatitis C. Peer Staff will be invited on Hope One as another way to reach out to consumers who may be using substances and as a means to educate and assist those who want to get treatment understand their options.

Mercer \$140,490

The overall goal of the implementation of a medication assisted treatment (MAT) Coordinator is to improve the availability and accessibility of an array of appropriate MAT, for people who have substance use disorders (SUD), those with opioid use disorder (OUD). The concept of a county MAT coordinator will help with promoting treatment services, consistent with DMHAS' message regarding this evidence-based practice. This position will help individuals and their families navigate the array of treatment providers in order to connect to MAT, for those individuals who are not yet eligible for other programmatic support. The MAT coordinator would have the full support of the Mercer County Department of Human Services to educate all areas of Human Services, such as aging providers, disability providers, criminal justice, youth, mental health, and the housing and homelessness system. For example, the MAT coordinator could provide education to the Coordinated Entry and Assessment System (CEASe- Homelessness system) with direct linkages to MAT. This position can support the consistent message that MAT can help individuals. This coordinator will also accompany the CEASe system outreach team on their mobile van to help promote treatment services in order to help the unsheltered homeless population of people.

Middlesex \$264,916

The innovative MORE (Middlesex Outreach for Recovery) project will meet people wherever they are – whether in homes, parks, trailer parks, soup kitchens, food pantries, abandoned buildings and

houses of worship. MORE is envisioned as a space where engagement and relationship building begin. MORE will offer water, non-perishable snacks, blankets, Naloxone, and Fentanyl and Xylazine test strips, resource information and linkages, to establish trust and to empower people to begin addressing the complex issues at the heart of their personal challenges. Outreach will allow MORE to educate individuals and the larger community about available services, including evidence-based MAT. MORE will provide health and wellness promotion, preventative education and clinical services to statutory populations throughout Middlesex County. With a holistic, person-centered approach, MORE will:

- Decrease Opioid use
- Connect individuals diagnosed with opioid use disorders to medication-assisted treatment
- Support individuals on a path to recovery

Meeting people in the MORE will provide a greater amount of privacy, safety and resources than is possible through outreach activities conducted by staff on the streets, which is essential to determine eligibility for diagnostic and medical services.

Monmouth \$226,366

Monmouth County is utilizing the innovative grant award to fund a mobile recovery unit (not a vehicle per se, but a group of partnering agencies). The unit will go to statutory communities on a regular schedule throughout the period of the contract. The mobile recovery unit will outreach to the identified community and educate the community on substance use disorder (SUD), particularly opioid use disorder (OUD), and provide information on the resources available. Certified peer recovery staff from partnering agencies will work to engage with individuals struggling with addiction and build a relationship in the identified communities. Simultaneously, they will have treatment agencies partner to offer a free half hour consultation with a licensed clinician via phone. This option will be open to an individual contemplating treatment OR to the family member of a loved one with SUD. They can remain anonymous if they wish. If it is a person with SUD, the clinician will use the opportunity to engage, educate and discuss what their options may be for treatment and what treatment looks like with a particular focus on Medication Assisted Treatment (MAT) options. If the person decides at the end of the consultation, they'd like to seek treatment, they will be referred into the Monmouth County Care Management Collaborative and be assigned to an agency that will link them to treatment and continue to provide ongoing care management and support. If they do not want to seek treatment at that time, they can opt-in for a follow up "check-in" phone call from the clinician. Additionally, if the peer recovery staff engages with someone in the community who does not want the consultation but does express interest in treatment, the recovery staff can refer them directly to the Care Management Collaborative to be assigned.

The goal of the mobile recovery unit is to reach communities through boots on the ground efforts providing education and information/access to available resources utilizing certified peer recovery staff to engage individuals at high risk of overdose who may not otherwise be seeking treatment and linking them to life saving medication assisted treatment and other treatment options. Additionally, the mobile recovery unit will work to engage families to provide information,

support, and resources that will assist them in managing the impact of their loved one's addiction. It is expected that through these local statutory efforts, Monmouth County will increase the number of residents with OUD on MAT and/or linked to a treatment program.

Morris \$151,505

Morris County has implemented a Successful Transition and Re-Entry (STAR) program model for Pre-Trial Division. The Addictions case manager provides up to 1 year of community engagement and linkage to services and recovery staff available 24 hours for those involved in Pre-Trial services.

Ocean \$229,936

The Ocean County Innovation programming will provide the following services.

- Post-Narcan Case Management - social worker conduct post-Narcan interviews with police depts.,
- Recovery events
- Enhance recovery support programs w/ services aimed at emotional self-management,
- First month rent for those in need of Oxford House or Sober Living placement,
- Planning grant for Recovery High School,
- Transportation study of those provided w/ transportation and telephone case management vs control group of those who did not
- Training for 24 elementary school teachers on "Footprints for Life (EBP) for 2nd and 3rd graders

Passaic \$167,627

The Passaic County Mobile Recovery Unit Program is a mobile access unit (to be named at a later date) that will be used to engage individuals in the community. The provider will host the mobile access van in upper and lower Passaic County in areas determined to be locations of concern and need as it relates to opioid use and opioid addiction. Services provided will include immediate information and resources, training on opioid overdose prevention and multiple pathways to prevention, multiple pathways to prevention kits, and support services to those in need of substance use support and treatment. In an effort to engage individuals in a friendly and supportive manner, the mobile access unit will provide food, beverages, multiple pathways to prevention kits as well as information.

The primary goal of the program is to ensure those in need of services and support for substance use receives the appropriate resources and assistance directly linked to services as needed. The program also aims to decrease rates of substance use, lessen crimes related to substance use, prevent opioid overdoses and overdose deaths, develop a rapport with those affected by addiction, and educate individuals on multiple pathways to prevention methods. Initially, the van will be deployed in the community for two days per week for up to 4 hours each deployment.

Salem \$24,795

The program will support individuals in recovery by offering opportunities for exploring new activities on a regular basis both in and outside of Salem County. Very often, those new to recovery are focused on trying to regain life's balance and do not have the financial stability to pay for activities that will allow for them to discover new hobbies. Also, there are few opportunities for recovery supportive environments and those leading a substance abuse free lifestyle are seeking others on the same path. With limited sources of entertainment in Salem County, this is a gap that needs to be filled to support the recovery community. These opportunities would include a sober, substance abuse free environment and growing the individual's network of acquaintances. This will encourage healthy relationships with others in recovery from opioid use disorder. A certified recovery coach will be on site and have the tools to meet each person where they are in their recovery. This recovery coach can also connect event attendees to community resources and help them with wellness planning. Fellowship activities will be held on a monthly basis throughout Salem County. These monthly events will be 3 hours in length and take place at various times of day, depending on the activity. Some of these events may include cooking classes, practicing yoga or tai chi, bowling, art classes, hiking, or attending a play or live music event. These monthly activities will be open to anyone in the recovery community that is looking for free activities and ways to meet others on their journey to long term recovery.

Somerset \$94,967

The innovation program will support the recovery of Somerset County pregnant/parenting women with an opioid use disorder (OUD). It will provide Somerset County pregnant/parenting women with an OUD linkage to recovery support services identified by DMHAS and SAMHSA as the following: employment assistance; peer to peer services; sober living housing; transportation; child care assistance; education/training assistance; family counseling and education; medical or dental services; and groups such as relapse prevention, coping/life skills, parenting skills, AA or NA, sponsorship and faith-based groups.

Also, the program will provide evidenced-based family programs such as parent-child interaction therapy, multisystem therapy, multi-dimensional family therapy, or functional family therapy that increase the parent-child bond, strengthen families and keep families resilient, assist families integrate school involvement in child's social, emotional and academic success and decrease substance use and help families recover as a whole family.

Union \$170,574

Trinitas Regional Medical Center will provide wraparound services to connect Union County residents living with, or who have a history of, an opioid use disorder (OUD), addiction to stimulants, or co-occurring disorders to resources that support recovery. Family members of individuals affected by OUD and/or addiction to stimulants are also eligible to receive wraparound services.

Warren \$36,675

Warren provides a community program to provide Narcan trainings to community professionals and lay people. The program also provides education on addiction and treatment and recovery in

schools, such as educational sessions for parents and loved ones.

Housing

Group Homes for Persons in Recovery (Oxford House)

Funding is provided to Oxford Houses to provide administrative and programmatic oversight of the statewide network of peer-led group recovery homes in New Jersey. The Oxford House model offers recovery-oriented living as a choice in a person's continuum of care. Recovery is an individualized process for individuals with substance use disorders. As of March 2023, New Jersey has approximately 146 Oxford Houses (107 male houses, 31 women houses, and 8 women with children houses); total beds are 1,164 with 858 male and 306 female beds. The Revolving Loan Fund is administered by Oxford House annually to establish new homes, with additional funding from the State and DMHAS treatment contracts. This funding supports Oxford House, Inc. outreach staff to establish homes exclusive for statutory populations such as women with children.

Federal funding for the State Opioid Response (SOR) allowed for expansion of the Oxford House contract for three full-time Outreach staff employed by Oxford House, Inc. to establish 10 new homes per year. DMHAS expanded the Oxford House contract in State Fiscal Year 2022 with SA Block Grant Funds for two additional full-time Outreach staff employed by Oxford House, Inc., and to support separate start-up funds to cover additional costs associated with the development and opening of houses for at risk populations. The populations include the following: women with children and men with children, individuals re-entering from incarceration and individuals with a history of opioid use who are at high risk for an overdose death.

In response to the opioid overdose epidemic, and its effects related to Oxford House, DMHAS requires Oxford House outreach staff to conduct annual trainings (overdose specific) for the 14 Oxford House Chapters throughout the state. Trainings are provided at the Oxford House annual state workshop. Each home is required to maintain Naloxone kits on site. Oxford House has seen an increase in members applying for membership with opioid use disorder (OUD). This increase supports the need for Naloxone training and information on access to Medical Assisted Recovery (MAR) options. The New Jersey outreach team continues to educate members on MAR and the importance of being an active member of their recovery community. Oxford House shall make every effort to accept individuals prescribed Medication Assisted Treatment (MAT) as well as other legitimately prescribed medications. Oxford Houses are responsible for providing lockboxes to each woman for medication storage, and residents in Oxford Houses are responsible for their individual medication lockboxes.

The DMHAS Program Manager and Oxford House, Inc. communicate on a regular basis and updates are provided regarding the current housing market or other challenges facing individuals seeking sober living in the midst of a pandemic. Oxford House, Inc. is part of the continued efforts to provide evidence-based recovery housing amidst a global pandemic. COVID-19 in New Jersey presented significant challenges for rental properties that Oxford House utilizes. The housing market is still causing impediments to finding affordable houses to be used as new Oxford Houses. In addition, the average cost to rent homes the size needed to be used as Oxford Houses has dramatically increased in 2022. These challenges have caused the team to struggle to find houses

in some regions of the state where the rental amounts are much higher. The Oxford House outreach team continues to be vigilant in exploring all possible ways of identifying new locations. The team is focused on maintaining the current network of Oxford Houses while simultaneously finding new and replacement Oxford Houses.

Oxford House utilized online platforms for workshops during the pandemic to provide the following: expand overdose reversal and prevention trainings to houses with statewide partners; help residents to schedule COVID-19 vaccines; virtual platforms to assist residents with recovery meetings; accessing unemployment benefits; helping residents regain and maintain financial stability through the pandemic; establish virtual/teleworking; helping residents with Oxford House operations; provide updates on CDC, New Jersey and Oxford House, Inc. guidelines. Oxford House maintained ongoing communication with treatment providers and other state systems regarding vacancies.

Oxford House reports that in SFY23 they began to see progress with the slowing spread of COVID19 infections, and the implications that came with it. Outreach staff, alums, and Oxford House members could visit each other in houses and hold face-to-face chapter and state meetings. These meetings have been a long-standing and stabilizing part of the Oxford House Model.

MATI Intensive Supportive Housing (ISH)

The SSA has two supportive housing programs and incorporated into its Medication Assisted Treatment Initiative (MATI). These two contracts combined provide for a total of 63 supportive 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 and is funded at \$903,104.

Women's Intensive Supportive Housing (WISH)

The SSA developed a Women's Intensive Supportive Housing (WISH) Program funded at \$386,029. This program provides permanent supportive housing for pregnant and/or parenting women with a co-existing substance use disorder and mental illness who are homeless or at risk of homelessness and being discharged from a licensed long-term residential substance abuse treatment and/or halfway house facility. An RFP was developed and released in January 2015. The RFP was for the development of a WISH team to provide case management and supportive housing services for 10 women and their children. A contract was awarded in 2015 to a licensed treatment provider in women's specific treatment, offers a continuum of care, and has a longstanding history of providing supportive housing and has demonstrated success in managing permanent supportive housing programs.

ODU Supportive Housing

DMHAS awarded contracts in 2019 to provide individualized case management and supportive services to up to 200 individuals with an OUD, on average, up to 8 hours per month, billable in 15 units, based on individual needs. These services will assist individuals in seeking and connecting with behavioral health and or physical healthcare needs. DMHAS provides 175 rental subsidies, up to the fair market rate (FMR) for supportive housing. One-time funding will be available to

consumers for security deposits, utility start-up costs and furnishings. Contracts were awarded four agencies to serve individuals in five counties: Atlantic, Burlington, Camden, Mercer and Monmouth. Since the awarding of the OUD contracts, the number of referrals has reached approximately 250 referrals with a total of 114 subsidies currently occupied, and an additional 24 in housing search phase. The turnover of the OUD vouchers is approximately 10%, with consumers surrendering the subsidies. The onset of the COVID-19 Pandemic has resulted in the full payment of rent for some of the OUD consumers since they lost employment.

Sober Housing

Contracts were awarded in 2019 for three pilot recovery-based housing residences (a minimum of five individuals in each residence), one in each region (North, Central and South), for individuals with an OUD who are homeless or at risk of homelessness. Individuals are in, or recently discharged, from treatment and are seeking a drug free, sober and supportive living environment, with access and linkage to sober community resources. Individualized case management and recovery-based housing services is provided for 15 individuals (a minimum of five individuals in each region) who have been identified as needing a safe, healthy, peer-lead, recovery-oriented environment. The housing provided must be licensed as a Class F, Cooperative Sober Living Residence (NJAC § 5:27). Accordingly, individuals are responsible for providing their own food and taking care of their own laundry. Treatment and counseling may not be provided in the residence; however, non-clinical recovery support services may be provided at the site and the agency may require, at its discretion, drug or alcohol testing of residents. (NJAC § 5:27-2.1). Although increased funded sober housing slots are needed, the pilots are thriving and continue to benefit those individuals seeking a stable sober environment.

5. Does the state have any activities that it would like to highlight?

- Transportation is a key recovery support. A reliable means of transportation is needed so clients can get to prevention, recovery and treatment support programs. As a result of this gap, DMHAS has developed a new program called the Transportation Reimbursement and Invoicing Program (TRIP). Without adequate and affordable transportation options, clients are unable to begin vital treatment nor consistently attend and complete treatment, resulting in suboptimal outcomes. This will enable transportation to treatment for individuals who do not have Medicaid, or for trips Medicaid does not cover, as well as enable transportation to and from non-healthcare facilities such as Community Peer Recovery Centers or prevention programs. TRIP is intended and designed to eliminate transportation impediments and facilitate access to substance use disorder treatment, prevention and recovery support services (RSS). Currently, SUPTRS Block Grant COVID-19 Supplemental and ARPA funds are being utilized. Funding of \$1,000,000 was set aside for this project. It will then transition to SOR funding.

- The Division of Mental Health and Addiction Services (DMHAS) recognizes the importance of peer supervision and protection. The PAC Peer Recovery Support Services (PRSS) Committee developed *Guidelines for Best Practices: Peer Recovery Services* which were published June 2023 to help ensure that peer recovery support services are provided using best practices based in research and experiences in various settings. The PRSS Committee

acknowledges that this report is the beginning of the development of necessary standards for peer recovery support services in New Jersey. The guidelines have been worked on for the past several years during the expansion of this evolving field. It is designed to bring practical processes, strategies and tools to peers, their supervisors, administrators, and others committed to initiating and sustaining best practices in the peer recovery support services field and the supporting work environments.

- As part of the DMHAS Opioid Housing Subsidy Initiative, individuals in the program are also provided peer services through a Certified Recovery Peer Staff (CPRS). The CPRS works with individuals with an OUD by connecting them to needed services and entitlements, and assisting them with apartment searching. Up to six (6) hours of peer services provided by a CPRS per month are reimbursed through Medicaid for individuals who are enrolled in FamilyCare (NJ's Medicaid program). For the services provided by peers who are not certified and for individuals who are not enrolled in FamilyCare, reimbursement is through State funds while the consumer seeks FamilyCare and the peer is in training to receive certification. Peer services may be billed to Medicaid once an individual is enrolled in FamilyCare and services are provided by a certified peer.
- DMHAS has worked with the Division of Medical Assistance and Health Services (DMAHS) to develop a bundled reimbursement rate for the Opioid Overdose Recovery Program (OORP). The rate has been approved by CMS. NJ Medicaid provides reimbursement for peers working in independent clinics which includes outpatient substance use agencies.
- The Division of Mental Health and Addiction Services (DMHAS) continues to utilize the Recovery Data Platform (RDP) as its centralized system for collecting and analyzing peer recovery support service data. Originally launched in 2020, RDP is a secure, HIPAA-compliant, cloud-based platform developed in collaboration with Faces & Voices of Recovery and RecoveryTrek. It is specifically designed to document peer-delivered services provided to individuals impacted by substance use disorders (SUDs) and now stands as one of the most comprehensive peer recovery data systems in New Jersey. In 2024, RDP recorded services for more than 15,000 participants, more than doubling the number from the prior year and reflecting growing adoption across DMHAS-funded initiatives.

6. Please indicate areas of technical assistance needs related to this section.

Continued expansion of Medicaid reimbursement for SUD Peer Services. Currently there is no reimbursement for peers working in withdrawal management or any residential treatment.

Environmental Factors and Plan

11. Children and Adolescents M/SUD Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health disorder and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.^[1] Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.^[2] For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.^[3]

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started using substances the age of 18. Of people who started using substances before the age of 18, one in four will develop a substance use disorder compared to one in 25 who started using substances after age 21.^[4]

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance use, 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, states are encouraged to designate a point person for children to assist schools in assuring identified children relate to available prevention services and interventions, mental health and/or substance use screening, treatment, and recovery support services.

Since 1993, the federally funded Children's Mental Health Initiative (CMHI) has been used as an approach to build the system of care model 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, states have also received planning and implementation grants for adolescent and transition age youth SUD and MH treatment and infrastructure development. This work has included a focus on formal partnership development across child serving systems and policy change related to 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 functioning of children, youth and young adults in home, school, and community settings. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult, and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.^[5]

According to data from the 2017 Report to Congress on systems of care, services reach many children and youth typically underserved by the mental health system.

1. improve emotional and behavioral outcomes for children and youth.
2. enhance family outcomes, such as decreased caregiver stress.
3. decrease suicidal ideation and gestures.
4. expand the availability of effective supports and services; and
5. save money by reducing costs in high-cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

The expectation is that states will build on the well-documented, effective system of care approach. 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:

1. 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);
2. supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education

and employment); and

3. residential services (e.g., therapeutic foster care, crisis stabilization services, and inpatient medical withdrawal management).

^[1]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

^[2]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

^[3]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

^[4]The National Center on Addiction and Substance use disorder at Columbia University. (June, 2011). Adolescent Substance use disorder: America's #1 Public Health Problem.

^[5]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM>

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

- a) The recovery of children and youth with SED? ☒ Yes ☐ No
- b) The resilience of children and youth with SED? ☒ Yes ☐ No
- c) The recovery of children and youth with SUD? ☒ Yes ☐ No
- d) The resilience of children and youth with SUD? ☒ Yes ☐ No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

- a) Child welfare? ☒ Yes ☐ No
- b) Health care? ☒ Yes ☐ No
- c) Juvenile justice? ☒ Yes ☐ No
- d) Education? ☒ Yes ☐ No

3. Does the state monitor its progress and effectiveness, around:

- a) Service utilization? ☒ Yes ☐ No
- b) Costs? ☒ Yes ☐ No
- c) Outcomes for children and youth services? ☒ Yes ☐ No

4. Does the state provide training in evidence-based:

- a) Substance use prevention, SUD treatment and recovery services for children/adolescents, and their families? ☒ Yes ☐ No
- b) Mental health treatment and recovery services for children/adolescents and their families? ☒ Yes ☐ No

5. Does the state have plans for transitioning children and youth receiving services:

- a) to the adult M/SUD system? ☒ Yes ☐ No
- b) for youth in foster care? ☒ Yes ☐ No
- c) Is the child serving system connected with the Early Serious Mental Illness (ESMI) services? ☒ Yes ☐ No
- d) Is the state providing trauma informed care? ☒ Yes ☐ No

6. Describe how the state provides integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The Division of Mental Health and Addiction Services (DMHAS) funds five Coordinated Specialty Care Community Integration

Programs (CSC CI) for individuals with First Episode Psychosis (FEP) and Affective Psychosis. These programs offer services to individuals aged 15-35 in the CSC program and 15 and older in the Community Integration (step-down program).

DMHAS has a Memorandum of Agreement (MOA) with the Department of Children and Families (DCF), Division of Child Protection and Permanency (DCP&P) to transfer funding annually in the amount of approximately \$1,401,000. This funding is for the Substance Abuse Initiative for Substance Abusing Women (SISAW) for enhanced treatment services (screening, assessment and treatment planning) for women with children under the supervision of DCP&P. The funding supports eighteen (18) long term residential treatment beds at Straight and Narrow, and forty-one (41) intensive outpatient treatment slots for Essex and Monmouth County residents.

The DCF provides DCF-CP&P staff with training on substance use prevention, treatment, and recovery, including the Substance Use Disorder Fellowship: A NJ Child Welfare Certification Program, as well as training for system partners who work with children and families. CSOC is presently working with NASHP to improve transition planning.

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

Clinically appropriate and accessible

Individualized and delivered through a continuum of services and/or supports, both formal and informal, based on the unique strengths and needs of each youth and his or her family/ caregivers

Provided in the least restrictive, most natural setting appropriate to meet the needs of the youth and his or her family/caregivers

Family-guided, with families engaged as active participants at all levels of planning, organization, and service delivery

Community-based, coordinated, and integrated with the focus of having services, decision-making responsibility, and management operational at a community level

Protective of the rights of youth and their family/caregivers and

Collaborative across child-serving systems, including child protection, juvenile justice, and other system partners who are responsible for providing services and supports to the statutory requirements.

CSOC served 63,665 unique youth in CY 2024 through a complement of needs-driven supports and services within a system of care approach: family driven, youth-guided, strengths-based, individualized care. The primary goals of CSOC are to ensure youth receive quality care in the most appropriate, community-based setting whenever possible to maintain connections to family and communities for sustainable relationships and planning. CSOC also has a continuum of out-of-home treatment settings of varying degrees of intensity of service accessible based on youths' individual needs.

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

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

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.

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

Services are funded with state dollars as well as by federal match through Medicaid state plan amendments (Title XIX and Title XXI).

CSOC also receives funding and/or federal match through the NJ FamilyCare Comprehensive Demonstration (1115 Waiver). The most recent Waiver renewal was approved by the Centers for Medicare and Medicaid Services (CMS) on March 30, 2023 through June 30, 2028. More information about the Children's Support Services Program is available at Department of Human Services | 1115 NJ FamilyCare Demonstration Renewal Request.

Services are provided based on clinical criteria.

Service provision based on clinical criteria is authorized by PerformCare, the Contracted System Administrator (CSA)/Administrative Services Organization (ASO), which provides the administrative services to the system of care.

Care Management Organization (CMO)

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

Child Family Team (CFT)-Wraparound Approach

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

Behavioral Health Homes

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

Family Support Organizations (FSOs)

FSOs are nonprofit organizations run by family members of youth with emotional, behavioral, developmental, and/or substance use challenges that have lived experience in supporting youth in addressing their needs. FSOs provide advocacy, education, and

support through an array of supports and services including individual family-to-family peer support for youth with moderate and high needs, support groups and workshops, community outreach and education, telephonic support, and local level advocacy to help them navigate the System of Care, school system, CP&P, and the legal system, and to listen and provide moral support. In addition to caregiver supports, FSO Youth Partnerships (YPs), led by a young-adult Youth Coach, help youth to engage with other youth with mental, emotional, and behavioral health needs. Through support groups, social activities, and leadership development, youth and young adults ages 13-21 find their voice to affect change in their own lives and the lives of others. Each YP participates in monthly community activities to challenge stigma and strengthen other youth in their communities, and each year, youth leaders across the state develop and facilitate an annual youth conference.

Mobile Response and Stabilization Services (MRSS)

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

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

Intensive In-Community/Behavioral Assistance (IIC/BA) services are short term, intensive, community-based therapeutic interventions, rather than clinic or office-based, that are needs-driven, youth and family guided, and accessible. IIC/BA are aimed at engaging youth and families in a therapeutic process to decrease 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 decrease acute symptomatology, enhance strengths, and transition youth and families to more traditional, i.e. clinic/office-based services, as soon as possible.

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

The Children's System of Care supports the integration and utilization of evidence based practices throughout our service continuum. Evidence based practices include Cognitive Behavioral Therapy (CBT), Multisystemic Therapy (MST), Functional Family Therapy (FFT), Wraparound approach, Trauma Focused Cognitive Behavioral Therapy (TF CBT), Six Core Strategies and the Attachment, Regulation and Competency Framework. Additional information on EBPs available through CSOC is located in another document (C12 – Trauma).

Youth Outpatient Services

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

Partial Care/Partial Hospitalization

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

Children's InterAgency Coordinating Council (CIACC)

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

Evaluating the local county policies to understand and minimize the impact of local barriers to serving youth with behavioral and emotional health needs, substance use, and/or intellectual and developmental disabilities in their community.

Identifying local strategies and mechanisms to promote the integration and coordination of county, State, or other resources serving youth with behavioral and emotional health needs, substance use, and/or intellectual or development disabilities.

Assessing local systems needs using information received from DCF, the Contracted System Administrator (CSA), any child-serving agency identified by DCF, and other bodies to make recommendations regarding service and resource development priorities.

Identifying and informing DCF/CSOC regarding gaps and barriers to local service effectiveness.

Providing input to State, regional, and county entities regarding system performance and service need.

In collaboration with the Department of Education, DCF recommended the creation of an "Educational Partnership" in every county in NJ. These partnerships use the County Inter-Agency Coordinating Councils to build a better working partnership between the DCF system of care and the local education system. This initiative has many goals, but one simple goal is to have at least one person in every school in NJ formally trained on the DCF service delivery system. This will help to facilitate a more

preventative response to behavioral health challenges. Efforts to achieve this goal continue. DCF believes bringing systems together through the Educational Partnership will improve coordination in the service delivery process.

Out-of-Home (OOH) Treatment Services

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

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

Behavioral Health Out of Home Treatment Services

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

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

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

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

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

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

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

SSH IDD - 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 fully 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.

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 acceptance in family life and community. Challenging behaviors may be unusual responses to sensory experiences and recurring trauma, thus manifesting challenging behaviors that include, but are not limited to, inappropriate/rule violations, noncompliance, self-injurious behaviors, and destructive, aggressive, and/or assaultive behaviors that require medical attention.

Crisis Stabilization and Assessment Program - CSAP IDD provides 24-hour care in a highly structured, community-based treatment setting with professional competencies and capabilities to stabilize youth with I/DD ages 6 to 20 years old (males/females) that are in crisis and unable to be safely supported in their current living situation. The primary goal upon stabilization is transitioning the youth to the community with wraparound services and supports, whenever possible. CSAP provides comprehensive diagnostic assessments that result in the identification of proper in-home services and supports that can meet the youth's habilitative and behavioral health needs upon transition.

Substance Use (SU) Treatment

The Children's System of Care offers an array of substance use treatment services for youth and young adults, including withdrawal management, outpatient/intensive outpatient services, short term out-of-home treatment, and residential treatment services for youth with co-occurring substance use needs and significant behavioral health needs.

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

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

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

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

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

Types of substance use treatment services offered through CSOC

Outpatient (Level I) – consists of less than 6 hours of service per week for adolescents including individual, family, and group therapy/counseling, including co-occurring services.

Intensive Outpatient (Level 2.1) – consists of more than 6 hours per week of day treatment for adolescents including individual, family, and group therapy/counseling, including co-occurring services.

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, comprehensive, 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.

Supports and Services for Youth with Developmental Disabilities

DD Eligibility

The Children's System of Care (CSOC) is responsible for determining eligibility for Developmental Disability (DD) services for children under age 18. Families apply for DD eligibility through the CSOC established process. The CMOs and MRSS agencies work with family members enrolled with them to apply for DD eligibility determinations. The Division of Developmental Disabilities (DDD) continues to determine DD eligibility for individuals aged 18 and over, and the CSOC provides services to those youth until age 21. DDD and CSOC collaborate through an established protocol to provide a seamless transition to adult services once the youth turns 21.

Intensive In-Home: IIH Supports

While traditional therapies are typically provided at the health care provider's office location, Intensive In-Home (IIH) services are provided in the youth's home or at another location in the community, which makes sense to both the family needs and the goals

of the service. IIH covers a variety of services geared to assist youth with challenging behaviors that may impact their ability to remain at home.

Clinical and therapeutic interventions (IIH Clinical)- These services are rehabilitative, focused on the restoration of a youth's functional level after an acute episode or decline in functioning related to mental illness or a significant life stressor.

Behavioral-Applied Behavior Analysis (IIH Behavioral-ABA)- A set of habilitation services, designed to decrease dangerous behaviors while assisting youth in acquiring and retaining self-help, communication, and adaptive skills. Services focus on helping youth learn these skills while working with and training the youth's parent or caregiver to implement a behavior plan.

Individual Support Services (ISS)- ISS provides skill development for activities of daily living, including self-care tasks that enable an individual to live independently in the community.

Family Support Services for Children with Intellectual/Developmental Disabilities

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

Respite means "break" or "relief." Respite services are intended to provide temporary relief for the primary caregiver from the demands of caring for an individual with disabilities during the times when the caregiver would normally be available to provide care. The service relieves family members from care responsibilities on a temporary basis for short periods of time. There are several different settings for respite, including home-based, agency after-school, overnight stays, and weekend recreation. Please note that respite services are dependent upon funding and provider availability.

Assistive Technology is designed to increase the functional skills of a youth with a developmental disability and enhance their ability to live successfully in the community. An assistive device is an item to increase, maintain, or improve functional capabilities of the youth, and is not solely therapeutic. Vehicle and home (environmental) modifications are also included in this category. It must be an item not covered by medical insurance and cannot be used to restrain the youth.

Educational Advocacy is a service provided to youth and their families when the youth needs in-depth help with education-related needs.

Summer Camp offers limited financial support for eligible youth to attend summer camp. Youth can attend a qualified camp through CSOC. Funding for One-to-One Aide services may also be available for youth deemed eligible.

Youth Justice

Decreasing the Number of Youth Justice Commitments

The Children's System of Care (CSOC) is fully accessible to youth involved with the youth 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 a decrease of the number of county detention centers from seventeen to six. In the past few years, there has been an increase utilization of Bio-Psychosocial (BPS) evaluations by the youth justice system. These assessments ensure all youth that are need of mental or behavioral health services have the opportunity to receive them.

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

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

Medicaid

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

CSOC Representation on the New Jersey Council for Youth Justice Improvement

Youth Justice processes are discussed by the sub-committees of the Council. Formal recommendations are presented to the full Council by the individual sub-committees.

DCF Cooperative Relationships with the Youth Justice Commission (YJC)

Since December 2004, the Department has maintained a Memorandum of Understanding with the YJC that outlines a distinct process by which youth in the YJC 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 YJC facility. Representation from both CP&P and CSOC participate in the YJC and Annie E. Casey Foundation driven Juvenile Detention Alternative Initiative (JDAI) in order to collaborate on developing alternatives to detention and to decrease the number of youth going into detention. Both systems participate in each other's planning and case review processes.

The Youth Justice Commission is responsible for operating state services and sanctions for youth and for developing a statewide plan for the effective provision of youth 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 YJC established the State/Community Partnership Grant Program. These Partnership Grants provide funding to each county for services to decrease 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 (SCRC)

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

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

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

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

CSOC maintains a "Protocol for Supervision of Juvenile Probationers Court-ordered to Attend and Complete a DCSOC Out-of-Home Treatment Program." This protocol was approved in 2018 by NJ Juvenile Probation Managers, NJ Conference of Chief Probation Officers, CSOC Representative for Juvenile Programs, NJ Juvenile Committee of Family Presiding Judges, and the NJ Conference of Family Presiding Judges. Subsequent protocols were developed that address communication and collaboration for youth in either a residential treatment program or a substance use treatment program.

CSOC Training and Technical Assistance

CSOC offers a broad array of training and technical assistance to system partners through contracts with several entities including Rutgers University Behavioral Health Care, The Boggs Center on Disability and Human Development, and Autism New Jersey.

DCF/CSOC funds the Technical Assistance Center through University Behavioral Health Care - Rutgers, the State University, to provide training statewide. CSOC, through the UMDNJ Training contract, offers training to all Children's System of Care Providers free of charge.

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

The Contracted System Administrator (CSA)

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

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

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

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

Providing a Call Center with 24-hour/7-day intake and customer service capability.

Providing a web-based application/interface with the CSA's Management Information System (MIS).

Managing care, including utilization management, outlier management (including authorization of services), and care coordination; if youth are involved with a Care Management Organization, the CSA reviews service requests based on the youth's comprehensive plan of care which is developed by the Child/Family Team (CFT).

Coordinating access to services for all youth, including facilitating access to services for youth involved with the Division of Child Protection and Permanency (CP&P).

Coordinating Third Party Liability and medical coverages.

Intellectual/Developmental Disability (IDD) eligibility determinations for youth up to age 18.

Coordinating a transition to adult services for youth.

Providing quality and outcomes management, and system measurement that supports CSOC's goal to promote best practices and aiding the State in assuring compliance with State and federal guidelines.

Providing training and training materials.

Providing support for provider network development.

Completing annual audit reviews.

To support these administrative services, the CSA created and routinely maintains an MIS called CYBER (Child and Youth Behavioral Electronic Record) that is backed by strong, clinical guidance and fosters flexibility, system integration, comprehensive information management, and production of management reports that support business decisions.

Youth Suicide Prevention Resources

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

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

The Traumatic Loss Coalitions for Youth Program (TLC) at Rutgers-University Behavioral HealthCare is an interactive, statewide network that seeks to decrease suicide attempts, deaths by suicide, and to promote recovery of persons affected by suicide by offering collaboration and support to professionals working with school-age youth and direct crisis response services to staff and youth at youth-serving organizations following a traumatic event. The TLC offers county, regional, and statewide conferences, training, consultation, on-site traumatic loss response, and technical assistance. Since its inception, the TLC has trained thousands of individuals throughout the state with the purpose of saving lives and promoting post trauma healing and resiliency for the youth of New Jersey.? In state fiscal year 2024, the TLC launched the HOPES Program to help others process the experience of a suicide loss.? Adapted from the LOSS Team model, HOPES provides support and hope to families bereaved by the suicide loss of a child (21 and under); empowering survivors so they can thrive and lead meaningful lives. ?The TLC website can be accessed at <http://ubhc.rutgers.edu/tlc/>

Project Connect

In November 2020, the Garrett Lee Smith Youth Suicide Prevention Grant was awarded to the New Jersey Department of Health (NJDOH) from the Substance Abuse and Mental Health Services Administration (SAMHSA). This federal grant was awarded to implement NJDOH's Readiness to Stand United Against Youth Suicide (R2S Challenge). The Department of Children and Families (DCF) is collaborating with the DOH on a portion of the grant. This collaboration is to assist New Jersey hospitals to effectively

connect youth to services following suicide attempts. DCF developed Project Connect to increase engagement in community mental health services after hospital discharge, decrease unnecessary Emergency Department utilization through connection to appropriate community services, and improve safety and well-being for youth and families.? Through the innovative role of the Regional Care Coordinator (RCC), Project Connect works in partnership with hospitals to enhance discharge planning for youth with suicide ideation and/or attempts. After youth are medically stabilized, screened, and determined to be safe for discharge, hospital staff will engage in a warm transfer process to connect families to PerformCare and community resources. ?Hospital staff also obtain consent to connect the family to the RCC who will make contact with the caregiver post-discharge to provide the youth and family with follow up support and ensure linkage and engagement with community behavioral health services.

2NDFLOOR Youth Helpline

Accredited by the American Association of Suicidology, 2NDFLOOR is a confidential call/text helpline and message board platform serving youth and young adults. Youth who contact the 2NDFLOOR are assisted with their daily life challenges by professional staff and trained volunteers.? The 2NDFLOOR launched a mobile application in 2024 that allows youth to anonymously connect to their services via the app.? The app allows call, chat, and message board and has additional features such as resources, polls, and emojis.? The launch of the app significantly increased utilization of the message board and clicks to resources.? The website can be accessed at <http://www.2ndfloor.org/>

Additional Suicide Prevention/Crisis Resources

Dialing 988 will connect you with the Suicide & Crisis Prevention Lifeline, which provides 24/7 free confidential support to anyone in emotional distress or suicidal crisis. Calls, texts, or chats to 988 will connect you with a trained counselor who will listen, understand, and provide support and access to resources to address your immediate needs as well as your ongoing care.? Additional ?????????? information is available at: www.njheline.com

New Jersey Youth Suicide Prevention Advisory Council

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

7. Does the state have any activities related to this section that you would like to highlight?

See text above

8. Please indicate areas of technical assistance needs related to this section.

None

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

12. Suicide Prevention – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death nationally, with over 49,000 people dying by suicide in 2022 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance use, painful losses, exposure to violence, economic and financial insecurity, and social isolation. Mental illness and substance use are possible factors in 90 percent of deaths by suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, M/SUD agencies are urged to lead in ways that are suitable to this growing area of concern. M/SUD agencies are encouraged to 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 since the FY2024-2025 Plan was submitted? ☒ Yes ☐ No

2. Describe activities intended to reduce incidents of suicide in your state.

In spring 2019, DMHAS created a full-time position within the Medical Director's Office at DMHAS to lead and coordinate general suicide-related matters and specifically to develop a strategic plan, promote a statewide Zero Suicide approach, and lead other statewide activities. Funding specific to suicide prevention has also been included in the DHS budget, and this funding has been authorized in every year since 2019. In addition to supporting the statewide Zero Suicide Academy training, the funding also supports initiatives by the Rutgers Gun Violence Research Center to address lethal means, an annual suicide prevention conference, and related activities. In 2025, DMHAS changed the coordination and oversight of the suicide prevention activities to share the coordination between the 988/acute care services unit and the medical director unit, and the full-time position was eliminated.

The state reviews and monitors unusual events including suicide deaths and incidents involving clients receiving care in licensed agencies. Mental Health and Substance Use Disorder providers contracted and/or licensed by the Department of Human Services are required to report Unusual Incidents regarding individuals they serve. State Psychiatric Hospitals are also required to report Unusual Incident Reporting Management System (UIRMS) data regarding individuals they serve, but the facilities report to the Department of Health's Division of Behavioral Health Services (DBHS), not to DHS/DMHAS. Both reporting systems require reporting of serious suicide attempts and deaths. DMHAS requires providers to intensely analyze each of these events to assess opportunities for improvement in their systems and processes.

DOH/DBHS revised Administrative Bulletin # 3:41: Screening, Assessment, Management, and Treatment of Suicidal and Non-Suicidal Self-Directed Violence that requires all NJ Psychiatric Hospitals to screen and/or assess all patients admitted to and discharged from state psychiatric hospitals. In addition, the Bulletin delineates the administration of evidence-based screening and assessment tools at various points of care to keep all patients safe during their hospital stay and mandates suicide specific treatments for patients identified with moderate or high suicide risk. Treatment modalities include Safety Planning and Cognitive-Behavioral Therapy for Suicide Prevention (CBT-SP). DMHAS assisted with the aforementioned training, which was held on August 14, 2019.

DMHAS has a Suicide Prevention Advisory Committee that assists with planning round suicide prevention and treatment /recovery services. Data on suicide deaths, self-injury, and suicide attempts; the NJ Violence Death Reporting System (VDRS), Department of Health is New Jersey's detailed and timely surveillance system of all violent fatalities, and this is reviewed, along with NJ data from other systems that capture non-fatal suicide attempts of individuals who received treatment through Emergency Department visits and inpatient hospitalizations. Data show that New Jersey has the lowest suicide death rate of any state in the nation in recent years, although this does not mean that efforts will not continue to address the need, including concerns about rising rates of attempts in female adolescents and older adults.

With this information, the New Jersey Department of Human Services (DHS) continues to offer an annual Suicide Prevention Conference to reflect new data, resources, and information available for the public. The conferences have attracted over 1,400 attendees from all walks of life in 2024. A variety of topics including 988, Veterans, and Gun Violence were addressed. Several break-out sessions based on practice gaps and major issues in the public mental health system, as well as being tailored to specific interests and areas of concern. This year's Suicide Prevention Conference is tentatively planned to be held on September 10, 2025 and will be virtual.

DMHAS has also developed brochures that raise awareness and educate the public about suicide prevention. Podcasts used to train primary care physicians on suicide prevention and on how to address the clinical needs of their at-risk patients had been developed with the partnership of the New Jersey Academy of Family Physicians, and these podcasts are still available on its website.

Since early 2021, DMHAS has participated in the VA/SAMHSA Governor's Challenge to Prevent Suicide Among Service Members, Veterans, and Their Families (SMVF). Military service members are faced with many challenges, including depression and suicidality: veterans die by suicide at a rate 15 times higher than other adults, and a major factor for both is their being more likely to own or have access to a firearm. This challenge expands into core areas consisting of screening, identifying, connecting, and assessing for lethal means for SMVF. DMHAS continues to be an active participant, however, and has related sponsored training and offered the services of the Rutgers GVRG to assist with the initiative.

As a participant in the Governor's Challenge for SMVF, the DMHAS Medical Director is chairing one of the of the three priority areas that will be addressed by the initiative. This area is lethal means and firearm safety, which will be addressed with the collaboration of the Rutgers-GVRG. By ongoing training and discussions on lethal means and safe firearm storage in many public forums, DMHAS has supported efforts of the GVRG to provide of an online map of firearm storage options statewide, to train the faith community and other community members in raising public awareness of the issues. DMHAS plans to support a GVRG initiative to introduce The Armory Project (TAP) in the veteran community via the Governor's Challenge, as well as statewide in this fiscal year. The TAP is an effective approach to prevent firearm suicides by facilitating safe, voluntary, out-of-home firearm storage with trusted firearms dealers and other vetted partners in local communities.

While the Plan for the Governor's Challenge, New Jersey has not updated its strategic plan for suicide prevention for several years. Discussion have been held with DCF to see if the two Departments (e.g., DHS and DCF) could do a joint plan strategic plan combining efforts for children, youth and adults, but this has not been decided.

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Additional Suicide Prevention/Crisis Resources

The SMHA now funds four (4) centers that together provide in-state response to calls, chats and texts through the 988 Suicide and Crisis Lifeline. The 988 Lifeline is a national hotline offering one-on-one support for mental health, suicide and substance-use related problems for anyone 24/7. Together, the New Jersey 988 Lifeline centers respond to calls 24 hours a day, every day of the year from individuals who are seeking assistance or information for themselves, friends or relatives that may be at risk of suicide and in need of services. In Calendar Year 2024, NJ 988 Lifeline centers received a total of 84,406 incoming calls of which they answered 67,503. To further promote the Lifeline throughout New Jersey, the SMHA has translated and printed brochures in ten (10) of the most commonly used languages (besides English and Spanish) in N.J. for distribution.

The SMHA continues to fund the NJ Hopeline, a suicide prevention call line operated by Rutgers University Behavioral Health Care (R-UBHC) which has been operational since 2013. In SFY24, the Hopeline received a total of 26,619 incoming calls. R-UBHC is also one (1) of NJ's four (4) 988 Lifeline centers. The SMHA has been in the process of sunsetting the NJ Hopeline in order to further promote and expand the 988 Suicide and Crisis Lifeline in NJ. While the Hopeline number remains operational, marketing for the Hopeline has ended and callers are being encouraged to dial 988 instead.

3. Have you incorporated any strategies supportive of the Zero Suicide Initiative? ☒ Yes ☐ No
4. Do you have any initiatives focused on improving care transitions for patients with suicidal ideation being discharged from inpatient units or emergency departments? ☒ Yes ☐ No

If yes, please describe how barriers are eliminated.

Revision Request 11/3/25:

Yes, part of the Zero Suicide approach focuses on improving care transitions for individuals who are suicidal being discharged after receiving treatment following suicidal ideation and/or an attempt. In the Zero Suicide model, in order to ensure effective care transitions for at-risk individuals, follow-up care and supports are provided after a stay in ED or a psychiatric hospitalization. Follow-up care and support can be in the form of post-discharge telephone calls, providing family support and education, linkages to appointments and warm handoffs to outpatient providers. Ideally, patients with the highest suicide risk will have a safety plan involving the individuals' family, caregivers, and other supports. However, the barriers to accomplishing successful transition are numerous. Many outpatient programs have wait times for client appointments, although those leaving psychiatric hospitals are typically given priority. While some providers are not aware of the problems with transition or their role in addressing these, nearly all of the barriers exist because of patient and environmental factors, which can include a client's lack of housing, transportation, or of even of having a telephone or way to be contacted. Individuals who are either unhoused or who do not have any social supports, while having complex treatment needs, present a particular need, especially since they may also be reluctant to continue needed mental health treatment.

The state is also trying to support the needs of these individuals by providing access to housing and when needed means of transportation. Peer specialists have been available in many EDs to positively connect with these patients to support their discharges, and individuals needing support post-discharge or at other times when needed. Individuals can attend a peer-run community recovery center located throughout the state. New Jersey is also building services with peer specialists to expand this role in crisis settings, such as in crisis stabilization centers, where they will remain in contact with clients for up to eight weeks post-discharge. The state has many resources that can help make the connection with outpatient providers, which is often a role for agency case managers who serve as boundary spanners in this role. One outpatient program, the certified community behavioral health clinic (CCBHC), provides care coordination to every client, and the CCBHC also does not require significant wait times for appointments and can offer same day referrals or walk-in appointments when needed. Additionally, CCBHCs receive Admission, Transfer and Discharge (ADT) notices from Health Information Exchanges (HIEs) for individuals they serve; this enables follow-up by the CCBHC in real time. For demonstration CCBHCs, SAMSHA required data on the performance related to CCBHC follow up with a consumer after 1) an emergency department visit and 2) an after discharge from an acute care hospital. Although the CCBHC demonstration has concluded, NJ requires CCBHCs to continue to report on these metrics. While not yet in regulation, the practice of safe transitions in accordance with the Zero Suicide approach is being promoted statewide through regular trainings and in meetings with behavioral health providers. As many individuals also have more contact with their primary care providers, the state is developing connections with primary care providers and physician organizations to make them aware of the needs of individuals at risk of suicide and the resources available to assist them.

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Original submission 9/1/25:

Yes, our partnership with EDC was a two-year investment, starting with the implementation of Zero Suicide within our Care Management and Family Support organizations as well as a handful of our out of home treatment programs. Year 2 expanded to include Mobile Response and Stabilization Service organizations (MRSS) and additional out of home treatment providers. Providers identified an internal Zero Suicide team within their agency, that included senior management with decision making ability to support the importance of leadership in organizational change.

Provider agencies:

- Completed a Self-Study before the start of the 2-day Academy
- Attended a 1.5-hour Pre-Academy
- Attended a 2-day Academy
- Participated in monthly 90-minute webinars hosted by EDC with CSOC support with work assignments in between that will focus on the seven elements of Zero Suicide: Lead (implementation team, OSS, lived experience), Train (workforce readiness and support), Identify (universal screening and assessment using evidence-based tools), Engage (create clinical care pathway, collaborative care), Treat (specifically and directly provide/coordinate direct treatment for suicidality), Transition (safe care transitions) and Improve (ensure improved care and better outcomes).

Providers currently continue to work locally in Zero Suicide while meeting quarterly as a group to continue, share and sustain Zero Suicide work.

A barrier identified through this work was a need to improve care transitions for youth being discharged after receiving treatment following suicidal ideation and/or an attempt but were unaware of or engaged with a local Care Management Organizations designed to provide intensive care management services to youth with moderate to high level needs. In response, the Department of Children (DCF) launched Project Connect in partnership with the Department of Health to assist New Jersey hospitals to effectively connect youth to services following suicide attempts. DCF developed Project Connect to increase engagement in community mental health services after hospital discharge, reduce unnecessary acute care utilization through connection to appropriate community services, and improve safety and well-being for youth and families. Through the innovative role of the Regional Care Coordinator (RCC), Project Connect works in partnership with identified hospitals to enhance discharge planning for youth who experienced a psychiatric emergency. After youth are medically stabilized, screened, and determined to be safe for discharge, hospital staff will engage in a warm transfer process to connect families to PerformCare, CSOC contracted service administrator, and community resources. Hospital staff are also be coached on how to obtain consent to connect the family to the RCC who will then outreach the caregiver post-discharge to provide the youth and family with follow up support and ensure linkage and engagement with community behavioral health services.

5. Have you begun any prioritized or statewide initiatives since the FFY 2024 - 2025 plan was submitted?

☒ Yes ☐ No

If so, please describe the population of focus?

Revision Request 11/3/25:

While all individuals who are at-risk of suicide are candidates for DMHAS services, the focus of most of the state's crisis and outpatient services are individuals with serious mental illness and/or substance use disorders. Priority is also given to certain higher-risk groups, including youth and young adults, veterans and service members, peripartum women, older males, and those in rural areas. Many of these at-risk individuals come through crisis and screening programs, but the advent of 988 and mobile crisis outreach services means that they will be seen in community services and diverted from needing to go to the ED or to be evaluated for psychiatric hospitalization.

Screening and Screening Outreach Programs are located within each of New Jersey's 21 counties. These programs are available to individuals in emotional crisis who require immediate attention and cannot wait for a regular appointment. Screening and

screening services are typically located in a general hospital and available 24-hours a day, seven-days a week. An individual may walk in without an appointment, or be brought to the screening center by a parent, friend, spouse, law enforcement officials, mental health worker, or any other concerned individual. If the person in crisis is unable or unwilling to come to the Center, a screening outreach team may be sent to the person.

For information about adult mental health services, visit the Division of Mental Health and Addiction Services' website at <http://www.state.nj.us/humanservices/divisions/dmhas/>.

The National Suicide Prevention Lifeline transitioned to 988 in July 2022 and is now the 988 Suicide and Crisis Lifeline. The 988 Lifeline continues to provide free and confidential emotional support to people in suicidal crisis, mental health and/or substance use crisis, or emotional distress. The 988 Lifeline is available to individuals who are seeking information or assistance for themselves, friends or relatives and can be reached 24 hours a day, every day of the year via call, text and chat.

Calls are received from anyone of any age and are answered by a peer, a trained volunteer, or a clinical staff member. To establish a "no wrong door" philosophy for 988, NJ DMHAS has been working closely with multiple agencies in New Jersey's system of acute care and crisis response. Agencies include the Department of Children and Families' (DCF) Children's System of Care (CSOC)/PerformCare (serving children and adolescents), ReachNJ (substance use treatment resources and referrals), the Department of Human Services' Division of Developmental Disabilities (DDD), and NJ211. NJ DMHAS has established warm transfers between 988 and these partner agencies. These transfers are used after an initial assessment determines specialists on other call lines could be helpful to the individual in crisis. If a caller is assessed as being at imminent risk of suicide, the caller can be referred to the appropriate local higher-level of care (Psychiatric Emergency Service, Early Intervention Support Services, etc.) or 9-1-1 can be contacted for emergency rescue.

The SMHA now funds four 988 Suicide and Crisis Lifeline contact centers that operate in New Jersey. The NJ Suicide Prevention Hopeline, operated by Rutgers University Behavioral Health Care since 2013, is transitioning calls, chats and texts to the 988 Lifeline system. In SFY23 (July 1, 2022 – June 30, 2023) the 988 Lifeline centers in NJ received approximately 57,000 incoming calls. In SFY24, NJ 988 centers received approximately 75,600 incoming calls.

In response to firearm access increasing the risk for suicide among all household members DMHAS has partnered with the Rutgers University School of Public Health's Gun Violence Research Center (GVRC) to address suicide by firearms and to promote safe firearm storage. The GVRC has produced a number of webinars for DMHAS on firearms and suicide, and has participated in the Governor's Challenge and presented at the Annual DMHAS Suicide Prevention Conference. and on an educational podcast for healthcare providers. The GVRC has developed a freely available online gun storage map of locations across New Jersey willing to consider temporary and legal storage of personal firearms, and plan to disseminate the map broadly and to examine the experiences of participating sites in the months following the development and dissemination of the map. Most recently, they have networked with clergy, barbershops and hairdressers and provide lethal means training in their communities on the need for safe storage of firearms.

A statewide Zero Suicide approach in collaboration with the Zero Suicide Institute was launched in 2019 And they provided two or three Zero Suicide Academics annually through 2024. Participating agencies sent teams of staff to virtual trainings, and this was followed by the staffs' participation in Community of Practice sessions with the Educational Development Corporation (EDC) to aid in the implementation of the approach within their agencies.

The Children's System of Care supported Zero Suicide Academics with the EDC, as well. as well. In 2025, DMHAS shifted from having annual Zero Suicide Academy trainings with the EDC; instead, the state university, Rutgers, will be providing the Zero Suicide training. This will allow added flexibility and the allow trainees to develop a greater understanding of and connection with state-specific suicide prevention efforts, including 988 and crisis services.

Zero Suicide is a Transformational Framework for Health and Behavioral Health Care Systems. The foundational belief of Zero Suicide is that suicide deaths for individuals under the care of health and behavioral health systems are preventable. For systems dedicated to improving patient safety, Zero Suicide presents an aspirational challenge and practical framework for system-wide transformation toward safer suicide care. The Zero Suicide Institute (ZSI) at the EDC provides expertise, customized consultation, and training for health and behavioral health care systems and providers, state agencies, tribal governments, health plans, and others as they launch evidence-based practices for suicide prevention, adopt continuous quality improvement efforts, and implement the Zero Suicide framework for safer suicide care.

As a result of working to implement the Zero Suicide Framework, our partners have created and updated policies regarding suicide prevention, attempts, and protocols and some have engaged in agency-wide staff training, policy consultation, workforce readiness surveys, and piloted screening projects that regularly assess a youth's potential for suicidal thoughts or ideations, and, if identified, guide the youth onto a pathway that will build their resilience and coping skills, reducing risk and helping them to thrive. Some of our partners have also included individuals with living experience on their Zero Suicide teams.

In November 2020, the Garrett Lee Smith Youth Suicide Prevention Grant was awarded to the New Jersey Department of Health (NJDOH) from the Substance Abuse and Mental Health Services Administration (SAMHSA). This federal grant was awarded to

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

Original submission 9/1/25:

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6. Please indicate areas of technical assistance needs related to this section.

DMHAS would like to receive technical assistance in relation to website development and the use of social media.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

13. Support of State Partners – Required for MHBG & SUPTRS BG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnerships that SMHAs and SSAs have or will develop with other health, social services, community-based organizations, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The State Medicaid Authority agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations.
- The state 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 prioritize risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of M/SUD, 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 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 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.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults with M/SUD.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and co-occurring M/SUD.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state, and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- Enhancing the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states is crucial to optimal outcomes. In many respects, successful implementation is dependent on leadership and

collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? ☒ Yes ☐ No
2. Has your state identified the need to develop new partnerships that you did not have in place? ☒ Yes ☐ No

If yes, with whom?

Division of Mental Health and Addiction Services (DMHAS) New Partnerships

SSA New Partnerships

Data Leadership Team (DLT) for Childhood Preventing Adverse Childhood Experiences (ACEs)

DMHAS joined the DLT in 2024 along with the Center for Health Care Strategies, and Departments of Education, Health, Children and Families and Medicaid to better capture both adverse and positive childhood experiences in the state and ensure that the data is useful and actionable.

Healthy New Jersey 2030

The New Jersey Department of Health (NJDOH) is in the development phase of the Healthy New Jersey 2030 (HNJ2030) State Health Improvement Plan to promote, strengthen, and evaluate the State's efforts to improve the health and well-being of all people, and advance health access, statewide health assessment and health improvement plan. DMHAS was a member of the Healthy New Jersey (HNJ) Action Teams between 2022-2023 and will be participating in the re-convened HNJ Advisory Council to evaluate and prioritize the strategies that were proposed. The teams have been reorganized based on the 2025 SHIP Priority Areas: Access to Quality Care, Healthy Communities, and Healthy Living. DMHAS will serve on the Healthy Living Action Team.

Responsible Gaming Task Force

On June 14, 2024, Governor Phil Murphy signed Executive Order No. 360, which established a Responsible Gaming Task Force to provide advice and offer recommendations for government actions to support Responsible Gaming (RG) and to address Problem Gambling (PG) in New Jersey. The Task Force is composed of seven members with the Attorney General serving as Chair. The Office of the Attorney General ("OAG") supervises the divisions, offices, and commissions within the Department of Law and Public Safety ("LPS"). The New Jersey Division of Consumer Affairs ("DCA"), a division of LPS, regulates and certifies operators to offer permitted fantasy sports activities. DCA also provides investigative and operational support to the Legalized Games of Chance Control Commission ("LGCCC"). LGCCC licenses and regulates bingos, raffles, and amusement games. In addition, DCA, through its professional licensing boards, licenses and regulates mental health professionals who treat gambling disorders. The New Jersey Division of Gaming Enforcement ("DGE"), also a division of LPS, is responsible for licensing and regulating land-based casino gambling, internet gaming, and retail and mobile sports wagering. The New Jersey Racing Commission ("NJRC") is the division of LPS that regulates the sport of horse racing and the pari-mutuel wagering that takes place on horse races. From the Department of Treasury, the Division of the State Lottery sells lottery tickets through its retail vendors and online through lottery couriers. The New Jersey Casino Control Commission ("CCC") is an independent commission, "in" but not "of" the Department of Treasury, which licenses casinos and certain casino employees. The Department of Human Services ("DHS") through its Division of Mental Health and Addiction Services ("DMHAS") plans and funds an array of mental health and addiction programs, including prevention, early intervention, treatment, and recovery support services. DMHAS oversees RG funding, now provided by the casino gaming and racing industries, for compulsive gambling treatment, education, and prevention programs.

Since its creation in June 2024, the Task Force has met with numerous stakeholders to explore different areas to strengthen RG in New Jersey. The Task Force recommends actions that are designed to increase prevention and education efforts throughout New Jersey. These recommendations include providing RG education beginning in elementary school; requiring identified underage gamers to complete educational programs; and providing state-funded RG resources more uniformly available across multiple forms of gaming.

Alcohol Policy Academy

DMHAS provided a letter of commitment to indicate New Jersey's desire to participate in the State and Community Policy Academy on Building Capacity to Address Alcohol Use and Alcohol Use Disorder: Breaking Down Silos and Fostering Collaboration with support from SAMHSA. NJ expressed its intent to participate in the required activities to improve alcohol policies, practices, and programs across the continuum of care.

Specifically, New Jersey hopes to improve its system of care for individuals with problem alcohol use and alcohol use disorder (AUD). This includes the promotion of evidence-based treatment services, with an emphasis on the provision of medication for alcohol use disorder (MAUD) in our treatment network. Another goal is to increase utilization and acceptance of established evidence-based prevention interventions and of early intervention and preventative services, placing an emphasis on individuals aged 55 and older and on young females. Additionally, we hope to increase knowledge and understanding of the risks associated with AUD, including its occasional use, which includes an increased risk of cancer, and hope to equip medical and healthcare providers with evidence-based tools to address alcohol related issues. Working with the state Department of Health, and with our medical and primary care partners, we want to promote a policy of universal screening for alcohol and substance misuse in primary care settings and emergency rooms throughout the state as well as increase the use of multiple pathways to prevention and MAUD. The six-member NJ team consisted of representatives from DMHAS, a DMHAS Consultant, the Director of the Office of Opioid Response in the Department of Health and the Director of the Southern New Jersey Center of Excellence for Medication Assisted Treatment at Cooper University Healthcare.

Naloxone Saturation Policy Academy

SAMHSA, in collaboration with the Association of State and Territorial Health Officials (ASTHO) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD), sponsored a 2024 Naloxone Saturation Policy Academy which was open to 10 states. DMHAS was a successful applicant and participated in the academy with a state team of six attending the in-person meeting in April.

It allowed state teams the opportunity to continue to build on evidence-based and innovative strategies to expand access to naloxone and other opioid overdose reversal medications across their communities and high-risk populations. The agenda included successful state models and evidence-based and innovative strategies to expand access to naloxone and other opioid overdose reversal medications across settings and high-risk populations. In addition, the agenda focused on topics most requested by states, such as funding considerations to reach populations in need, using data to inform saturation efforts, and partnerships across governmental agencies and non-governmental organizations. The NJ State six-member team consisted of representatives from: DMHAS, Director of the Office of Opioid Response and Policy in the Department of Health, a Senior Policy Advisor from the Department of Human Services, the NJ Jersey State Police.

Partnership with the Division of Medical Assistance and Health Services (DMAHS) for Integration of Behavioral Health

DMHAS has been an active partner with NJ's State Medicaid Agency, DMAHS as they implement the state's 1115 Waiver. Specifically, NJ is partnering with Medicaid to implement the Integration of Medicaid Behavioral Health Care Services into NJ's five Managed Care Organizations (MCO). Phase I of this Integration was implemented in January 2025. During that phase of the Integration, ambulatory SUD and MH treatment services were integrated into the MCO management. Phase II is expected no earlier than January 2026 and will include MH and SUD residential services and Opioid Treatment Program services.

The process includes multiple opportunity for stakeholder review and recommendations as well as multiple trainings, online manuals and assistance and an ongoing email for providers to use to report problems or complaints about the process.

Partnerships for Success

Needs assessments conducted during the initial year of PFS project funding showed that access to tobacco and vaping products are a significant issue in the high-need communities that are served by the county-based prevention coalitions. Therefore, DMHAS submitted a Change of Scope request to focus its efforts on this issue of concern.

DMHAS reviewed the needs assessments conducted by PFS sub-grantees (14 county-based prevention coalitions). The assessments provided insight regarding the use/misuse of alcohol, marijuana, and tobacco among populations in the counties served by the coalitions. Based on our review, DMHAS requested and was approved for a change of scope by SAMHSA. A more efficacious utilization of funds from the 2023 PFS award is to focus on environmental strategies involving tobacco retailers. Data demonstrated the need to serve youth 12-25, schools, and colleges.

With regard to retailers, the TASE violation rate was consistently around 10% until 2023 when it dramatically increased to 26%. The rate remained over 20% for FY 24/25. Efforts will serve this group.

Tobacco Free for a Healthy NJ is working with NJ Youth through the Youth Tobacco Action Groups - a prevention and cessation program for youth 13-18. Each county in NJ has a county youth tobacco action group. These groups are working to decrease youth tobacco use and initiation. PFS coalitions collaborate with the Youth Tobacco Action Groups in their counties.

Office of Population Health

The New Jersey Department of Health (NJDOH) is in the development phase of the Healthy New Jersey 2030 (HNJ2030) State Health Improvement Plan to promote, strengthen, and evaluate the State's efforts to improve the health and well-being of all people and advance health access. The Office oversees the statewide health assessment and health improvement plan. DMHAS was a member of the Healthy New Jersey (HNJ) Action Teams between 2022-2023 and will be participating in the re-convened the HNJ Advisory Council to evaluate and prioritize the strategies that were proposed. The teams have been reorganized based on the 2025 SHIP Priority Areas: Access to Quality Care, Healthy Communities, and Healthy Living. DMHAS will serve on the Healthy Living Action Team.

Division of Disaster Preparedness, Resiliency and Emergency Medical Services (DPREMS).

DMHAS has been collaborating with DPREMS for years. DMHAS works with this Division's Office of Data Analytics, Resources, and Infrastructure to receive information on EMS transports of individuals who were reversed from an overdose with naloxone to emergency departments. This allows DMHAS to better monitor the performance of our OORP programs that provide recovery support to these individuals at the specific hospitals where they are located. The OORP program is in 75% of NJ Acute care hospitals.

DOH Office of Women's Health (OWH).

DMHAS has formed a new partnership with the DOH Office of Women's Health. The Office for Women's Health (OWH) is dedicated to protecting and strengthening women's health in New Jersey by fostering healthy families and communities. OWH promotes, evidence-based healthcare services with a focus on accessibility, innovation, and integration to empower women to live long, healthy, and autonomous lives. The New Jersey Maternal Data Center aims to assure data regarding maternal health and related outcomes are transparent to policy makers, consumers, and relevant stakeholders in New Jersey, through dissemination of data visualizations focused on the maternal health ecosystem.

In partnership with the OWH and the Department of Human Services (DHS) Division of Mental Health and Addiction Services (DMHAS), this project aims to develop a comprehensive spatial analysis and mapping initiative focused on substance use disorder (SUD) among the maternal health population. Utilizing data from the Maternal Data Center and matched hospital discharge and birth certificate records, the project will map treatment access points, including Maternal Wrap-Around (MWRAP), Intensive Outpatient Treatment for Substance Exposed Infants (IOT-SEI), and Medication-Assisted Treatment (MAT) programs, alongside key maternal and infant health outcomes. This visualization will identify geographic gaps in treatment and prevention services, particularly in the critical postpartum period, to support interventions and improve maternal and infant health outcomes.

The project will involve mapping NJ women who gave birth with a SUD diagnosis and DMHAS' various women's programs. The goal is to determine where more women's programs may be needed.

Department of Labor.

The New Jersey Department of Labor and Workforce Development (NJDOLE) Pathways to Recovery Initiative launched in 2019 connects residents impacted by the opioid crisis to employment and offers supportive services in job readiness, skill building and obtaining industry recognized credentials. NJDOLE announced in March 2025 the availability of an additional \$5 million in grant funding for organizations to offer training, employment, and retention services for individuals in recovery. Eligible applicants—including nonprofits, for-profits, government entities, and higher education institutions connected to mental health or opioid treatment centers—can receive up to \$1 million over 24 months starting June 1, 2025. Since its inception, the program has expanded statewide, forged over 1,550 employer partnerships, and supported more than 4,150 participants.

NJ Higher Education Student Assistance Authority

In June of 2024, the Department collaborated with the Department of Children and Families and Higher Education Student Assistance Authority to launch the Home and Community Based Services (HCBS) Provider Loan Redemption Program. The program provided eligible workers with up to \$50,000 in loan relief in exchange for one year of service at an approved HCBS location and is funded with \$17.5m in funding from the American Rescue Plan Act.

Eligible professions included psychiatrists, social workers, registered nurses, alcohol and drug counselors, marriage and family therapists, and numerous other HCBS positions providing healthcare, behavioral health, and social services to individuals with medical needs, mental health conditions, and disabilities.

448 individuals enrolled in the loan redemption program, selected from over 1,000 applicants, with the largest groups of participants being registered nurses, licensed social workers, DCF care managers, and licensed professional and associate counselors.

Law and Public Safety.

The Office of Alternative and Community Responses (OACR) within the Department of Law and Public Safety (LPS) strives to, among other things, incorporate public health strategies into public safety responses to the opioid and addiction crises. The Opioid Policy and Response Bureau (OPRB) within OACR provides funding for Operation Helping Hands (OHH), which supports programs in which law enforcement officers play an active role in identifying individuals with substance use disorders (SUD) and together with community partners serve as an entry point to treatment and/or recovery support services. DMHAS and the Office of Alternative and Community Response (OACR) are meeting concerning naloxone distribution and better coordination of services with the goal of continued sustainability. Another goal is to better align where naloxone is distributed and where actual overdoses are occurring.

SMHA New Partnerships

Administrative Office of the Courts (AOC)

In 2019, a Mental Health Advisory Committee was formed, co-chaired by the Chief Justice and DHS Commissioner and recommended the development of mental health pilot programs for individuals with suspected serious mental illness and criminal charges. From this, DMHAS and Administrative Office of the Courts (AOC) recognized the need for a multidisciplinary concerted effort in identifying individuals with a mental illness quickly, sharing information efficiently, and coordinating efforts with the appropriate entities. Currently, there are five counties with mental health pilot programs with the goal of connecting individuals to mental health and other services that address needs. With the exception of one county, these services were procured through a competitive bid process administered by DMHAS in 2022. Programs were underway in 2023 and throughout the implementation, DMHAS has maintained ongoing collaboration with the AOC along with county judges, prosecutors and the public defender's office.

ARRIVE Together

ARRIVE Together is an initiative out of the Attorney General's Office in partnership with DMHAS' contracted providers that has been in effect since 2021 and expanded in 2023 to all 21 NJ counties. ARRIVE Together is a program that pairs law enforcement officers with mental health professionals to respond to behavioral health crises. The goal is to provide immediate support, de-escalate situations, and connect individuals in crisis with appropriate mental health services. This collaborative approach aims to improve outcomes for those experiencing mental health crises and enhance the safety of both the individuals in crisis and the responding officers. DMHAS continues to partner with the Attorney General's Office of Alternative Community Response throughout the implementation of this key initiative.

Children's System of Care (CSOC)

New Partnerships

Project Connect

In November 2020, the Garrett Lee Smith Youth Suicide Prevention Grant was awarded to the New Jersey Department of Health (NJDOH) from the Substance Abuse and Mental Health Services Administration (SAMHSA). This federal grant was awarded to implement NJDOH's Readiness to Stand United Against Youth Suicide (R2S Challenge). The Department of Children and Families (DCF) is collaborating with the DOH on a portion of the grant. This collaboration is to assist New Jersey hospitals to effectively connect youth to services following suicide attempts. As a result of this initiative and partnership, DCF developed Project Connect in 2023 to increase engagement in community mental health services after hospital discharge, decrease unnecessary Emergency Department utilization through connection to appropriate community services, and improve safety and well-being for youth and families. Through the innovative role of the Regional Care Coordinator (RCC), Project Connect works in partnership with identified hospitals to enhance discharge planning for youth with suicide ideation and/or attempts. After youth are medically stabilized, screened, and determined to be safe for discharge, hospital staff will engage in a warm transfer process to connect families to PerformCare and community resources. Hospital staff are also coached on how to obtain consent to connect the family to the RCC who will make contact with the caregiver post-discharge to provide the youth and family with follow up support and ensure linkage and engagement with community behavioral health services.

Assertive Community Treatment (ACT)

The CSOC awarded the Youth Assertive Community Treatment (Youth ACT) pilot to Legacy Treatment Services, which began service delivery in Cape May and Atlantic Counties in July 2024. Youth ACT uses evidence-based and promising practices to provide flexible, comprehensive, in-home treatment, rehabilitation, and support services to youth ages 5 to 20 who are likely to experience psychiatric crises, and their families. Youth ACT is designed to serve a total of 40 youth and young adults at any given time. Service goals include stabilizing youth so they may remain in their home, decreasing the likelihood of inpatient psychiatric hospitalization and residential placement, and preventing youth from further decompensation and presentation at emergency rooms, psychiatric screening centers, and psychiatric inpatient units.

Two multi-disciplinary treatment teams (one in each county) are comprised of licensed therapists and psychiatric experts, supported by a team of other professionals, including those with lived experience as a family member, and provide services tailored to each youth and family based on an assessment of the youth and family system.

Services are provided using evidence-based and best practices, including Motivational Interviewing, Cognitive Behavioral Therapy, Strengths-Based Approaches, Dialectical Behavior Therapy, and Stages of Change.

Children's Crisis Intervention Services (CCIS) IDD Qualified Project (IDD-Q)

CSOC was awarded a 2024 NASMHPD Technology Transfer Initiative 8 month grant to develop and implement training and technical assistance to increase the capacity of the NJ subsidized child and adolescent psychiatric inpatient units to effectively treat youth with intellectual and developmental disabilities. Each of the three pilot units (Trinitas, Inspira and Rutgers UBHC) received funds to purchase recommended items for individualized resource toolkits to support learned interventions and to ensure youth with Intellectual and Developmental Disabilities on their units receive quality care, resources, and support.

In addition, and a vital part of this grant, caregivers/stakeholders with lived experience, provided valuable feedback regarding their experience, providing suggestions for trainings and advising on the initiative through regular stakeholder meetings. For their participation, these stakeholders received a stipend at the end of the initiative.

In FY26, the IDD Q project is expanding to three addition CCIS units (Hoboken, St. Claire's and Carrier Clinic).

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)

Certified Community Behavioral Health Clinics

The state continues to work in partnership with our sister division, the Division of Medical Assistance and Health Services (DMAHS) on a number of initiatives that will promote services and enhance the Medicaid behavioral health benefit. Recent examples, with assistance from DMHAS, DMAHS has included Substance Use Disorder Case Management and Peer Services in the Medicaid benefit package.

The Division of Mental Health and Addiction Services (DMHAS) was selected to be one of the eight Certified Community Behavioral Health Clinic (CCBHC) demonstration states. This project is a collaboration between the Department of Human Services' Division of Medical Assistance and Health Services (DMAHS) and DMHAS and the Department of Children and Families (DCF). There are seven behavioral health providers dually licensed in mental health and substance abuse participating as CCBHCs. The Federal Demonstration was extended to September 30, 2025, and the state partners are currently DMHAS, DMAHS and DCF are working collaboratively to develop a Medicaid State Plan Amendment which would include the CCBHC service in the Medicaid State Plan.

Behavioral Health Homes (BHH)

DMHAS has explored several models of integration. Health Homes is a Medicaid State Plan option that provides an opportunity to build a person-centered system of care that achieves improved outcomes and better services and value for the NJ Medicaid program. New Jersey maintains the original BHH services developed through Medicaid State Plan Amendments.

In a partnership with the Division of Medical Assistance and Health Services (Medicaid) and the Department of Children and Families, DMHAS launched health homes in select counties in July of 2014, Atlantic, Bergen and Mercer.

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Promoting Integration of Primary Behavioral Health Care (PIPBHC)

In August 2024 New Jersey was awarded a SAMHSA Promoting Integration of Primary Behavioral Health Care Collaborative Care Mod (CoCM) grant. This is a five-year grant that will offer universal behavioral health, screening assessment, intervention and referral at three primary care clinics in Essex and Union County. There are two adult and one children's clinic in the program.

In Depth Technical Assistance (IDTA) Neonatal Abstinence Syndrome and Substance Exposed Infants (NAS SEI)

As a SAMHSA Prescription Drug Abuse Policy Academy State, in 2014, NJ applied for a unique technical assistance opportunity through the SAMHSA supported NCSACW to address the multi-faceted problems of NAS and SEI. NJ DHS/DMHAS as the lead State agency, partnered with the Department of Children and Families (DCF) and Department of Health (DOH), and submitted a successful application (no funding attached). The IDTA goal was to develop uniform policies/guidelines that address the entire spectrum of NAS and SEI from pre-pregnancy, prevention, early intervention, assessment and treatment, postpartum and early

childhood. The IDTA provided technical assistance to NJ to strengthen collaboration and linkages across multiple systems such as addictions treatment, child welfare, and medical communities to improve services for pregnant women with opioid and other substance use disorders and outcomes for their babies. The Core Team included over 60 individuals representing multiple State Departments and Divisions, community stakeholders, treatment providers, and the medical community. Three goals were established: (1) Increase perinatal SEI screening at multiple intervention points; (2) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women screening positive on the 4P's Plus get connected for a comprehensive assessment by establishing formal warm-handoffs and other safety net measures; and (3) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women delivering SEIs and their babies and any other eligible children, receive early support services for which they are eligible. Workgroups were formed. New Jersey was recently awarded technical assistance through the National Center on Substance Abuse and Child Welfare's (NCSACW) 2023 Policy Academy: Advancing Collaborative Practice and Policy: Promoting Healthy Development and Family Recovery for Infants, Children, Parents, and Caregivers Affected by Prenatal Substance Exposure. The Department of Health is the lead State Department and NJ Policy Academy State representatives include the Departments of Children and Families, Human Services, and the Governor's Office. The DMHAS Women's Treatment Coordinator represents the Department of Human Services. The overall goal is to increase awareness of pregnant women and SUD, through increased education and maximizing messaging through the perinatal work force, increase awareness and access to treatment, Plans of Safe Care, and improving screenings in hospitals and healthcare providers.

Housing

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

In January 2019, the Department of Human Services/ DMHAS launched a partnership with the Department of Community Affairs (DCA) to administer housing subsidies to consumers receiving services from DMHAS. DCA/SHC is responsible for the following tasks on behalf of the Division: Housing Search Assistance, Landlord Recruitment, Housing Inspections, Subsidy Processing, Rental Subsidy Administration, and Tenant/Landlord Inquiry Resolutions. The goal of this partnership is to increase community-based living and enhance community tenure for consumers recently recovering from and/or at-risk for homelessness and/or placement in inpatient psychiatric settings.

Division of Developmental Disabilities

DMHAS' Office of Planning, Research, Evaluation, Prevention, and Olmstead (OPREPO) partners with DMHAS' Division of Developmental Disabilities (DDD) and the Department of Health's (DOH) State Psychiatric Hospitals on the discharge planning of individuals diagnosed with a serious mental illness and a co-occurring developmental disability (DD/MI). DDD Transitional Case Managers (TCMs) are stationed at each respective state hospital and focus on the referrals of DD/MI patients to community placements and collaborate with the OPREPO and state psychiatric hospital staff to address and ameliorate any discharge impediments that may be present. Joint DMHAS, DDD and State Hospital meetings occur at each hospital on a monthly basis to discuss discharge planning of DD/MI individuals and address systems issues. On a bi-weekly basis, administrative level meetings are scheduled between DDD and DMHAS to discuss issues that require a higher-level review.

Division of Medical Assistance and Health Services

DMHAS' Office of Planning, Research, Evaluation, Prevention, and Olmstead (OPREPO) staff partners with Department of Health's (DOH) State Psychiatric Hospitals and the DMAHS Office of Managed Care to facilitate state hospital discharges of individuals who are in need of Managed Long Term Support Services (MLTSS) or Medicaid state plan services such as nursing supports or personal care assistance. Coordinating these services allows for an alternative to nursing home placement; with additional supports individuals can be placed in the community residential settings or age in place in their own homes.

DMHAS' Office of Planning, Research, Evaluation, Prevention, and Olmstead (OPREPO), continues to focus its efforts on improving community integration for individuals in the state psychiatric hospital receiving services. The Department of Health operates three adult psychiatric hospitals and one adult forensic hospital that serve individuals with severe mental illness who are in need of intensive, inpatient care and treatment. OPREPO works collaboratively with the Division of Behavioral Health Services to facilitate community placement referrals for individuals in the state hospitals.

Centralized Admission – OPREPO has increased its scope from primary implementation, monitoring and facilitation of discharges for individuals at the state psychiatric hospitals to overseeing diversion to the state psychiatric hospitals. OPREPO has worked collaboratively with the Department of Health's Centralized Admissions within the state psychiatric hospitals on a process for providing diversionary activities for individuals that do not meet criteria for commitment to the state hospitals and are in need of less restrictive community settings. Olmstead staff assist in securing additional supports needed for individuals to remain in the most in the most integrated setting possible within their required level of care addressing their individualized needs. This collaboration allows for decreased hospital admissions and census as well as enhanced community re-integration of persons receiving services.

DMHAS Olmstead unit has provided a series of trainings for the state hospitals and Community Support Services providers, addressing level of care opportunities that are available in the community for individuals in need of mental health, substance use disorders, or co-occurring services. OPREPO and DBHS data and information technology staff have also been meeting to streamline data reporting, validate data and existing reports and queries, as well as establish data definitions for data fields and parameters for reports.

Integration of Behavioral Health into Managed Care Organizations

DMHAS has been an active partner with NJ's State Medicaid Agency, DMAHS as they implement the state's 1115 Waiver. Specifically, NJ is partnering with Medicaid to implement the Integration of Medicaid Behavioral Health Care Services into NJ's five Managed Care Organizations (MCO). Phase I of this Integration was implemented in January 2025. During that phase of the Integration, ambulatory SUD and MH treatment services were integrated into the MCO management. Phase II is expected no earlier than January 2026 and will include MH and SUD residential services and Opioid Treatment Program services.

The process includes multiple opportunity for stakeholder review and recommendations as well as multiple trainings, online manuals and assistance and an ongoing email for providers to use to report problems or complaints about the process.

Children's System of Care (CSOC)

Juvenile Justice

Decreasing the Number of Youth Justice Commitments

The Children's System of Care (CSOC) is fully accessible to youth involved with the youth 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 decrease of the number of county detention centers from seventeen to six. In the past few years, there has been an increase utilization of Bio-Psychosocial (BPS) evaluations by the youth justice system. These assessments ensure all youth that are need of mental or behavioral health services have the opportunity to receive them.

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

Medicaid

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

CSOC Representation on the New Jersey Council for Youth Justice Improvement

Reentry processes are discussed by the sub-committees of the Council. Formal recommendations are presented to the full Council by the individual sub-committees.

DCF Cooperative Relationships with the Youth Justice Commission (YJC)

Since December 2004, the Department has maintained a Memorandum of Understanding with the YJC that outlines a distinct process by which youth in the YJC 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 YJC facility. Representation from both CP&P and CSOC participate in the YJC and Annie E. Casey Foundation driven Juvenile Detention Alternative Initiative (JDAI) in order to collaborate on developing alternatives to detention and to decrease the number of youth going into detention. Both systems participate in each other's planning and case review processes.

The Youth Justice Commission is responsible for operating state services and sanctions for youth and for developing a statewide plan for the effective provision of youth 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 YJC established the State/Community Partnership Grant Program. These Partnership Grants provide funding to each county for services to decrease 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 (SCRC)

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

representatives from CP&P, Office of Adolescent Services, Children's System of Care, the YJC, Juvenile Parole and Transitional Services (JP&TS), Pre-Release Teams, Regional Court Liaisons/designees, the YJC Child Study Teams, YJC community residential homes, and representatives from the New Jersey Training School at Jamesburg (NJTS), Juvenile Medium Security Facility (JMSF), and the Juvenile Female Secure Care and Intake Facility (Hayes Unit) Social Services Departments.

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

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

CSOC maintains a "Protocol for Supervision of Juvenile Probationers Court-ordered to Attend and Complete a DCSOC Out-of-Home Treatment Program." This protocol was approved in 2018 by NJ Juvenile Probation Managers, NJ Conference of Chief Probation Officers, CSOC Representative for Programs, NJ Juvenile Committee of Family Presiding Judges, and the NJ Conference of Family Presiding Judges. Subsequent protocols were developed that address communication and collaboration for youth in either a residential treatment program or a substance use treatment program.

CSOC Training and Technical Assistance

CSOC offers a broad array of training and technical assistance to system partners through contracts with several entities including Rutgers University Behavioral Health Care, The Boggs Center on Disability and Human Development, and Autism New Jersey.

DCF/CSOC funds the Technical Assistance Center through University Behavioral Health Care - Rutgers, the State University, to provide training statewide. CSOC, through the UMDNJ Training contract, offers training to all Children's System of Care Providers free of charge.

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

Children's InterAgency Coordinating Council (CIACC)

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

and emotional health needs, substance use, and/or intellectual and developmental disabilities in their community.

Identifying local strategies and mechanisms to promote the integration and coordination of county, State, or other resources serving youth with behavioral and emotional health needs, substance use, and/or intellectual or development disabilities.

Assessing local systems needs using information received from DCF, the Contracted System Administrator (CSA), any child-serving agency identified by DCF, and other bodies to make recommendations regarding service and resource development priorities.

Identifying and informing DCF/CSOC regarding gaps and impediments to local service effectiveness.

Providing input to State, regional, and county entities regarding system performance and service need.

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

Educational Services

Educational Stability for Homeless Youth

The McKinney-Vento Act defines homeless children as "individuals who lack a fixed, regular, and adequate nighttime residence." This includes youth residing in out of home (OOH)/State facilities. The Department of Corrections, the DCF, the DHS, and the JJC are required to provide educational programs to students in State facilities ages five through 20 and for students with disabilities ages three through 21 who do not hold a high school diploma. Students must be able to receive high school credit.

In general State agencies are required to: provide a program comparable to the Sp. Education student's current individualized education program (IEP), and implement the current IEP or develop a new IEP; develop an individualized program plan (IPP), within 30 calendar days, for each general education student, in consultation with the student's parent, school district of residence, and a team of professionals with knowledge of the student's educational, behavioral, emotional, social, and health needs to identify appropriate instructional and support services; discuss the IPP with the student and make a reasonable effort to obtain parental consent for an initial IPP, including written notice; and, review and revise the IPP at any time during the student's enrollment, as needed, or on an annual basis if the student remains enrolled in the State facility educational program, in consultation with the school district of residence.

Attendance in educational programs is compulsory for all students, except for a student age 16 or above who may explicitly waive this right. For a student between the ages 16 and 18, a waiver is not effective unless accompanied by consent from a student's parent or guardian. A waiver may be revoked at any time by the former student. The actual number of days a student with a disability must attend the educational program shall be determined by the student's IEP.

Each State agency shall ensure all students with a disability in the agency's State facilities are provided a free and appropriate public education as set forth under the Individuals with Disabilities Education Act, 20 U.S.C. §§1400 et seq., and shall provide Sp. Education and related services as stipulated in the individualized education program (IEP) in accordance with the rules governing Sp. 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

On October 7, 2008, the federal government signed into law the Fostering Connections to Success and Increasing Adoptions Act (P.L. 110-351). This act required all states to arrange for children and youth in foster care to remain in their "school of origin" to ensure educational stability unless it is determined to be in a child's best interest to go to the new district where the Resource Family Home is located. New Jersey responded to this charge by passing the Education Stability Law on September 9, 2010, which established a system that supports the act. The DCF, Department of Education (DOE) and Office of the Child Advocate (OCA) worked together to implement this law. For children, changing schools can affect their ability to thrive academically, socially, behaviorally and psychologically. This is especially true for children in resource family homes. For these children – who often suffer the lingering effects of abuse or neglect and the trauma of being removed from their homes and families – school can often be the most stable part of their lives.

Work continues to fully implement the requirements of coordination between the DCF and the local school districts. To support the continued progress "Improving the Educational Outcomes of Children in Out-of-Home Placements: An Interagency Guidance Manual" is available on the DCF website at

<https://www.nj.gov/dcf/families/educational/stability/GuidanceManual.pdf>

The guidance manual includes a model memorandum of agreement (MOA) and provides specific actions to reach the indicator and goals in the MOA.

Youth Suicide Prevention Resources

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

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

The Traumatic Loss Coalitions for Youth Program (TLC) at Rutgers-University Behavioral HealthCare is an interactive, statewide network that seeks to decrease suicide attempts, deaths by suicide, and to promote recovery of persons affected by suicide by offering collaboration and support to professionals working with school-age youth and direct crisis response services to staff and youth at youth-serving organizations following a traumatic event. The TLC offers county, regional, and statewide conferences, training, consultation, on-site traumatic loss response, and technical assistance. Since its inception, the TLC has trained thousands of individuals throughout the state with the purpose of saving lives and promoting post trauma healing and resiliency for the youth of New Jersey. In state fiscal year 2024, the TLC launched the HOPES Program to help others process the experience of a suicide loss. Adapted from the LOSS Team model, HOPES provides support and hope to families bereaved by the suicide loss of a child (21 and under); empowering survivors so they can thrive and lead meaningful lives. The TLC website can be accessed at <http://ubhc.rutgers.edu/tlc/>

Project Connect

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

2NDFLOOR Youth Helpline

Accredited by the American Association of Suicidology, 2NDFLOOR is a confidential call/text helpline and message board platform serving youth and young adults. Youth who contact the 2NDFLOOR are assisted with their daily life challenges by professional staff and trained volunteers. The 2NDFLOOR launched a mobile application in 2024 that allows youth to anonymously connect to their services via the app. The app allows call, chat, and message board and has additional features such as resources, polls, and emojis. The launch of the app significantly increased utilization of the message board and clicks to resources. The website can be accessed at <http://www.2ndfloor.org/>

Additional Suicide Prevention/Crisis Resources

Dialing 988 will connect you with the Suicide & Crisis Prevention Lifeline, which provides 24/7 free confidential support to anyone in emotional distress or suicidal crisis. Calls, texts, or chats to 988 will connect you with a trained counselor who will listen, understand, and provide support and access to resources to address your immediate needs as well as your ongoing care. Additional information is available at: www.njheline.com

New Jersey Youth Suicide Prevention Advisory Council

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

Zero Suicide

The Children's System of Care was granted the opportunity to work with the Educational Development Center (EDC) on Zero Suicide. Zero Suicide is a Transformational Framework for Health and Behavioral Health Care Systems. The foundational belief of Zero Suicide is that suicide deaths for individuals under the care of health and behavioral health systems are preventable. For systems dedicated to improving patient safety, Zero Suicide presents an aspirational challenge and practical framework for system-wide transformation toward safer suicide care. The Zero Suicide Institute at EDC (ZSI) provides expertise, customized consultation, and training for health and behavioral health care systems and providers, state agencies, tribal governments, health plans, and

others as they launch evidence-based practices for suicide prevention, adopt continuous quality improvement efforts, and implement the Zero Suicide framework for safer suicide care. The Zero Suicide EDC website is zerosuicide.edc.org

Our partnership with EDC is a two-year investment, that started with the implementation of Zero Suicide within our Care Management and Family Support Organizations as well as some of our out of home treatment programs. Year 2 looks to include teams from additional OOH organizations as well as the organizations that oversee our Mobile Response Stabilization Services.

As a result of working with the EDC to implement the Zero Suicide Framework, our partners have created and updated policies regarding suicide prevention, attempts, and protocols and some have engaged in agency-wide staff training, policy consultation, workforce readiness surveys, and piloted screening projects that regularly assess a youth's potential for suicidal thoughts or ideations, and, if identified, guide the youth onto a pathway that will build their resilience and coping skills, decrease risk and helping them to thrive. Some of our partners have also included individuals with living experience on their Zero Suicide teams.

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

On September 30, 2018, SAMHSA awarded a 4-year grant to the Children's System of Care to address youth and young adults at clinical high risk for psychosis. CSOC worked in partnership with DMHAS to develop the NJ-PROMISE program, which provides outreach and intervention for youth and young adults up to age 25, who may be experiencing prodromal symptoms of psychosis. In 2022, CSOC was awarded a second 4-year grant from SAMHSA to continue delivering this important treatment in New Jersey.

NJ PROMISE provides intervention to approximately 60 youth and young adults across three regions annually. Through extensive outreach, coordinated care, the use of evidence-based, evidence-informed, best, and promising practices, as well as the expertise of a team of professionals, participants and their families will have the tools necessary to lead productive lives in their homes and communities.

The project's measurable goals are to:

Decrease the percentage of youth/young adults at clinical high risk for psychosis who develop psychotic disorder

Decrease the duration of untreated psychosis, for those who develop psychotic disorder

Support youth and young adults at clinical high risk for psychosis to improve functioning in work/ school.

Support youth and young adults at clinical high risk for psychosis to improve social functioning.

Division of Child Protection and Permanency

The Division of Child Protection and Permanency (CP&P) is New Jersey's child protection and child welfare agency within the New Jersey Department of Children and Families (DCF). Its mission is to ensure the safety, permanency, and well-being of children and support families. CP&P is responsible for investigating allegations of child abuse and neglect and, if necessary, arranging for the child's protection and the family's treatment. The Child Abuse Hotline (State Central Registry) receives reports of child abuse and neglect 24-hours a day, 7-days a week. Reports requiring a field response are forwarded to the CP&P Local Office who investigates.

Clinical Consultants report to CP&P Area Offices and serve as liaisons, joined from the wraparound perspective, that translate system of care principles and values into case practice and planning and assist in the coordination of behavioral health services for youth involved in the child welfare system. The Care Management Organization (CMO) Clinical Consultant is a jointly owned and administered position between the CMO and CP&P. Clinical Consultants translate clinical information into user-friendly language to identify mental health concerns regarding youth involved in the child welfare system and propose interventions to address underlying issues. Clinical Consultants serve as an advocate for youth in permanency and discharge planning, speaking on a clinical level with the Contracted Systems Administrator (CSA), PerformCare, and provider agencies and facilitating communication between care management entities. Clinical Consultants are required to be master's level clinician's licensed by the New Jersey Board of Marriage and Family Therapists or Board of Social Work Examiners.

Office of Adolescent Services (OAS)

The New Jersey Department of Children and Families' (DCF) Office of Adolescent Services (OAS) supports adolescents' transition to adulthood, achieve economic self-sufficiency and interdependence, and engage in healthy lifestyles by:

Ensuring services provided through DCF are coordinated, effective, meet best practice standards, are youth-driven, and adapt to the needs of families and communities,

Developing linkages with other service providers to create a 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 approach,

Assist youth to develop protective and positive attributes and decrease 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 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>

DCF Division of Family and Community Partnerships (FCP)

DCF's Family and Community Partnerships' (FCP) promotes the health, well-being and personal safety of New Jersey's children and families. It works with parents, caregivers, organizations, and communities to ensure an effective network of proven support services, public education, and community advocacy to prevent maltreatment.

The Office of Early Childhood Services is responsible for the planning, development, implementation and evaluation of prevention services for families and caregivers of children from pregnancy/birth to kindergarten. OECS provides oversight and technical support to ensure evidence-based practice, ongoing quality improvement, and positive impacts for participants of funded programs. OECS works in close collaboration with local, state and national partners to ensure integration of maternal, parent, infant and early childhood services to promote family health and well-being, and prevent child neglect and abuse.

Family and Community Partnerships' Office of Early Childhood Services (OECS) works across state government and with state and local advocates to ensure child abuse and neglect prevention services and supports reach families before a child is born. Early childhood services are available up to a child's sixth birthday.

Programs include:

Connecting NJ

New Jersey's network of service hubs dedicated to providing essential services that help families, and care for children, primarily from pregnancy to age five. Connecting NJ agencies, partners and support systems offer access to information and referrals to local wellness services, including healthcare for mothers and children, early education programs, domestic violence support, addiction treatment, financial assistance, home visiting programs, behavioral health services, and more. For more information: <https://nj.gov/connectingnj/>

Help Me Grow

Help Me Grow (HMG) promotes infant and child health, development, and well-being; early learning and school readiness; and helps to prevent child neglect and abuse. HMG works with partners to improve the quality and availability of services at the state and local level, and eliminate variations in outcomes through early childhood systems integration.

Home Visitation

The Home Visitation Initiative seeks to improve the physical and emotional well-being of infants, children, and their families by providing community-based education and in-home support to parents.

Project LAUNCH (Linking Actions for Unmet Needs in Children's Health)

With the support of the Substance Abuse and Mental Health Services Administration and the New Jersey Department of Children and Families, Project LAUNCH links and enhances efforts to improve the overall wellness of young children in Essex County.

School-Linked Services

The Office of School-Linked Services (OSLS) contracts with private non-profit organizations and school districts to provide prevention and support services for youth in New Jersey's elementary, middle, and high schools. OSLS's programs aim to implement prevention and intervention programs that are comprehensive and multifaceted and build on the strengths of young people so they can achieve their educational and life goals.

School Based Youth Services Program

The School Based Youth Services Program (SBYSP) is located in host schools and coordinate with existing resources in the community. All youth are eligible to participate and services are provided before, during, and after school. SBYSP services include: mental health counseling; employment counseling; substance abuse education/prevention; preventive health awareness including pregnancy prevention; primary medical linkages; learning support; healthy youth development; recreation; and information/referral.

Prevention of Juvenile Delinquency

Prevention of Juvenile Delinquency (PJD) is located in host schools to enhance services and collaborate with SBYSP. All youth enrolled in the host school where they display behaviors that can or have caused them to become involved in the juvenile justice system are eligible to participate. PJD services complement the SBYSP and focus specifically juvenile delinquency prevention strategies and self-regulation skills to prevent juvenile delinquent behaviors that can impede the student's achievement of their education and life goals. PJD services include case management and counseling services; collaboration with local law enforcement, state and school and community-based agencies, dropout prevention, life and coping skills.

Adolescent Pregnancy Prevention Initiative

Adolescent Pregnancy Prevention Initiative (APPI) is located in host schools to enhance services and collaborate with SBYSP where available. All youth enrolled in the host school where they display behaviors that could lead to an unplanned pregnancy are eligible to participate. Youth involved in the program will gain increased pregnancy prevention skills to support the achievement of their education and life goals. APPI services complement the SBYSP program, where available, and focus specifically on pregnancy prevention skills and knowledge to support the student's ability to achieve their education and life goals. APPI services include: case management and counseling services; education and awareness groups; linkages to available services and resources; and collaboration with school personnel.

Family Friendly Centers

Family Friendly Centers (FFC) is located in host schools to enhance afterschool programming in elementary and middle schools. FFCs provide constructive academic, recreational, and social enrichment activities to students and their families. All FFC programs emphasize positive youth development, encourage parental participation, and seek to establish partnerships with school and community stakeholders to meet the unique needs of youth and their families.

Parent Linking Program

Parent Linking Program (PLP) is located in host high schools to enhance services and to collaborate with SBYSP. For expecting and parenting teen mothers and fathers, PLP works to minimize and eliminate impediments to earning a high school diploma. This is accomplished through the development and implementation of programs that strengthen pregnant and parenting teen's ability and access to complete their education (secondary and postsecondary); improve child and maternal health outcomes; improve pregnancy spacing and decrease the likelihood of repeat teen pregnancies; increase parenting skills for mothers, fathers, and families; strengthen positive young father involvement and co-parenting relationships, as appropriate, decrease intimate partner violence; and raise awareness of available resources.

New Jersey Child Assault Prevention

New Jersey Child Assault Prevention programs operate in every county, providing educational awareness training and implementing strategies to handle and/or prevent child assault/neglect to children in grades pre-school through twelve, their parents/guardians as well as educators.

Newark School Based Health Center

Newark School Based Health Center provides primary medical, dental, and behavioral health care services to students and families

(up to age 21). Centers are located in several Newark schools and services are available to members of the school's surrounding community.

Additional State and Local Partnerships?

Children's System of Care Planning

The Children's System of Care (CSOC) has previously reported on the collaboration with the Center for Health Care Strategies (CHCS) and Casey Family Programs through which a task force of sixteen stakeholders was convened to participate in building a behavioral and physical health integration model. Additional information on the task force, including meeting agendas and summaries can be found posted on the DCF website. Release of the report and recommendation from this task force was delayed due to the onset of the COVID-19 pandemic but are now also posted with the meeting agendas and summaries here: [DCF | Children's System of Care Stakeholder Task Force \(nj.gov\)](#). In August 2021, a final stakeholder advisory group was held. During this session, CSOC presented on the progress made toward the previously identified priorities, as well as provided an outline for initiatives in fiscal year 2022. Shortly thereafter, CHCS convened an internal meeting with CSOC leadership to focus on reviewing and committing to identified program initiatives organized under the three main priorities which continue as CSOC's priority areas of focus:

Building capacity for integrated health;

Increasing the availability of evidence-based and best practice interventions and services; and

Improving access to CSOC services and supports, as well as including the priority of Service Excellence.

CSOC continues to partner around the following initiatives which have current cycles and updated program plans: the Infant and Early Childhood Mental Health (IECMH) Initiative, the Garrett Lee Smith (GLS) Suicide Prevention Grant, and the Developing Resiliency with Engaging Approaches to Maximize Success (DREAMS) Initiative, to implement the Nurtured Heart Approach in 50 school districts.

1. IECMH has identified three major objectives: staff development, community collaboration & increased support for families. CSOC has launched training as well as a guidance manual to support MRSS staff in working with youth birth to aged 5. Additionally, in partnership with Montclair State University, a consultation line as well as a resource navigator site has been made available to partners for this area of practice. Leadership level trainings and annual symposium have been instituted and the fifth cohort of clinicians is currently beginning training in best practice to support this population address their needs.

2. The GLS grant was awarded to the New Jersey Department of Health (DOH) in November of 2020 from the Substance Abuse and Mental Health Services Administration (SAMHSA). This federal grant was awarded to implement NJDOH's Readiness to Stand United Against Youth Suicide (R2S Challenge). The Department of Children and Families (DCF) is collaborating with the DOH on a portion of the grant. This collaboration is to assist New Jersey hospitals to effectively connect youth to services following suicide attempts. DCF developed Project Connect to increase engagement in community mental health services after hospital discharge, decrease unnecessary Emergency Department utilization through connection to appropriate community services, and improve safety and well-being for youth and families. Through the innovative role of the Regional Care Coordinator (RCC), Project Connect works in partnership with hospitals to enhance discharge planning for youth with suicide ideation and/or attempts. After youth are medically stabilized, screened, and determined to be safe for discharge, hospital staff will engage in a warm transfer process to connect families to PerformCare and community resources. Hospital staff also obtain consent to connect the family to the RCC who will make contact with the caregiver post-discharge to provide the youth and family with follow up support and ensure linkage and engagement with community behavioral health services. 3. DCF continues its collaboration with the Department of Community Affairs (DCA) to operate the DREAMS initiative. DCF, through its system partners is currently engaging with interested schools to begin implementation of the project for the 2025-2026 school year. Participating districts will receive access to on demand training, virtual live webinars, train the trainer slots for NHA as well as mentoring from a community-based provider for the duration of the school year.

4. Please indicate areas of technical assistance needs related to this section.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

13. Support of State Partners - Required for MHBG and SUPTRS BG

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? Yes, see below.

Division of Mental Health and Addiction Services (DMHAS) New Partnerships

SSA New Partnerships

Data Leadership Team (DLT) for Childhood Preventing Adverse Childhood Experiences (ACEs)

DMHAS joined the DLT in 2024 along with the Center for Health Care Strategies, and Departments of Education, Health, Children and Families and Medicaid to better capture both adverse and positive childhood experiences in the state and ensure that the data is useful and actionable.

Healthy New Jersey 2030

The New Jersey Department of Health (NJDOH) is in the development phase of the [Healthy New Jersey 2030](#) (HNJ2030) State Health Improvement Plan to promote, strengthen, and evaluate the State's efforts to improve the health and well-being of all people, and advance health access, statewide health assessment and health improvement plan. DMHAS was a member of the Healthy New Jersey (HNJ) Action Teams between 2022-2023 and will be participating in the re-convened HNJ Advisory Council to evaluate and prioritize the strategies that were proposed. The teams have been reorganized based on the 2025 SHIP Priority Areas: Access to Quality Care, Healthy Communities, and Healthy Living. DMHAS will serve on the Healthy Living Action Team.

Responsible Gaming Task Force

On June 14, 2024, Governor Phil Murphy signed Executive Order No. 360, which established a Responsible Gaming Task Force to provide advice and offer recommendations for government actions to support Responsible Gaming (RG) and to address Problem Gambling (PG) in New Jersey. The Task Force is composed of seven members with the Attorney General serving as Chair. The Office of the Attorney General ("OAG") supervises the divisions, offices, and commissions within the Department of Law and Public Safety ("LPS"). The New Jersey Division of Consumer Affairs ("DCA"), a division of LPS, regulates and certifies operators to offer permitted fantasy sports activities. DCA also provides investigative and operational support to the Legalized Games of Chance Control Commission ("LGCCC"). LGCCC licenses and regulates bingos, raffles, and amusement games. In addition, DCA, through its professional licensing boards, licenses and regulates mental health professionals who treat gambling disorders. The New Jersey Division of

Gaming Enforcement (“DGE”), also a division of LPS, is responsible for licensing and regulating land-based casino gambling, internet gaming, and retail and mobile sports wagering. The New Jersey Racing Commission (“NJRC”) is the division of LPS that regulates the sport of horse racing and the pari-mutuel wagering that takes place on horse races. From the Department of Treasury, the Division of the State Lottery sells lottery tickets through its retail vendors and online through lottery couriers. The New Jersey Casino Control Commission (“CCC”) is an independent commission, “in” but not “of” the Department of Treasury, which licenses casinos and certain casino employees. The Department of Human Services (“DHS”) through its Division of Mental Health and Addiction Services (“DMHAS”) plans and funds an array of mental health and addiction programs, including prevention, early intervention, treatment, and recovery support services. DMHAS oversees RG funding, now provided by the casino gaming and racing industries, for compulsive gambling treatment, education, and prevention programs.

Since its creation in June 2024, the Task Force has met with numerous stakeholders to explore different areas to strengthen RG in New Jersey. The Task Force recommends actions that are designed to increase prevention and education efforts throughout New Jersey. These recommendations include providing RG education beginning in elementary school; requiring identified underage gamers to complete educational programs; and providing state-funded RG resources more uniformly available across multiple forms of gaming.

Alcohol Policy Academy

DMHAS provided a letter of commitment to indicate New Jersey's desire to participate in the State and Community Policy Academy on Building Capacity to Address Alcohol Use and Alcohol Use Disorder: Breaking Down Silos and Fostering Collaboration with support from SAMHSA. NJ expressed its intent to participate in the required activities to improve alcohol policies, practices, and programs across the continuum of care.

Specifically, New Jersey hopes to improve its system of care for individuals with problem alcohol use and alcohol use disorder (AUD). This includes the promotion of evidence-based treatment services, with an emphasis on the provision of medication for alcohol use disorder (MAUD) in our treatment network. Another goal is to increase utilization and acceptance of established evidence-based prevention interventions and of early intervention and preventative services, placing an emphasis on individuals aged 55 and older and on young females. Additionally, we hope to increase knowledge and understanding of the risks associated with AUD, including its occasional use, which includes an increased risk of cancer, and hope to equip medical and healthcare providers with evidence-based tools to address alcohol related issues. Working with the state Department of Health, and with our medical and primary care partners, we want to promote a policy of universal screening for alcohol and substance misuse in primary care settings and emergency rooms throughout the state as well as increase the use of multiple pathways to prevention and MAUD. The six-member NJ team consisted of representatives from DMHAS, a DMHAS Consultant, the Director of the Office of Opioid Response in the Department of Health and the Director of the Southern New Jersey Center of Excellence for Medication Assisted Treatment at Cooper University Healthcare.

Naloxone Saturation Policy Academy

SAMHSA, in collaboration with the Association of State and Territorial Health Officials (ASTHO) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD), sponsored a 2024 Naloxone Saturation Policy Academy which was open to 10 states. DMHAS was a successful applicant and participated in the academy with a state team of six attending the in-person meeting in April.

It allowed state teams the opportunity to continue to build on evidence-based and innovative strategies to expand access to naloxone and other opioid overdose reversal medications across their communities and high-risk populations. The agenda included successful state models and evidence-based and innovative strategies to expand access to naloxone and other opioid overdose reversal medications across settings and high-risk populations. In addition, the agenda focused on topics most requested by states, such as funding considerations to reach populations in need, using data to inform saturation efforts, and partnerships across governmental agencies and non-governmental organizations. The NJ State six-member team consisted of representatives from: DMHAS, Director of the Office of Opioid Response and Policy in the Department of Health, a Senior Policy Advisor from the Department of Human Services, the NJ Jersey State Police.

Partnership with the Division of Medical Assistance and Health Services (DMAHS) for Integration of Behavioral Health

DMHAS has been an active partner with NJ's State Medicaid Agency, DMAHS as they implement the state's 1115 Waiver. Specifically, NJ is partnering with Medicaid to implement the Integration of Medicaid Behavioral Health Care Services into NJ's five Managed Care Organizations (MCO). Phase I of this Integration was implemented in January 2025. During that phase of the Integration, ambulatory SUD and MH treatment services were integrated into the MCO management. Phase II is expected no earlier than January 2026 and will include MH and SUD residential services and Opioid Treatment Program services.

The process includes multiple opportunity for stakeholder review and recommendations as well as multiple trainings, online manuals and assistance and an ongoing email for providers to use to report problems or complaints about the process.

Partnerships for Success

Needs assessments conducted during the initial year of PFS project funding showed that access to tobacco and vaping products are a significant issue in the high-need communities that are served by the county-based prevention coalitions. Therefore, DMHAS submitted a Change of Scope request to focus its efforts on this issue of concern.

DMHAS reviewed the needs assessments conducted by PFS sub-grantees (14 county-based prevention coalitions) The assessments provided insight regarding the use/misuse of alcohol, marijuana, and tobacco among populations in the counties served by the coalitions. Based on our review, DMHAS requested and was approved for a change of scope by SAMHSA A more efficacious utilization of funds from the 2023 PFS award is to focus on environmental strategies

involving tobacco retailers. Data demonstrated the need to serve youth 12-25, schools, and colleges.

With regard to retailers, the TASE violation rate was consistently around 10% until 2023 when it dramatically increased to 26%. The rate remained over 20% for FY 24/25. Efforts will serve this group.

Tobacco Free for a Healthy NJ is working with NJ Youth through the Youth Tobacco Action Groups - a prevention and cessation program for youth 13-18. Each county in NJ has a county youth tobacco action group. These groups are working to decrease youth tobacco use and initiation. PFS coalitions collaborate with the Youth Tobacco Action Groups in their counties.

Office of Population Health

The New Jersey Department of Health (NJDOH) is in the development phase of the [*Healthy New Jersey 2030*](#) (HNJ2030) State Health Improvement Plan to promote, strengthen, and evaluate the State's efforts to improve the health and well-being of all people and advance health access. The Office oversees the statewide health assessment and health improvement plan. DMHAS was a member of the Healthy New Jersey (HNJ) Action Teams between 2022-2023 and will be participating in the re-convened the HNJ Advisory Council to evaluate and prioritize the strategies that were proposed. The teams have been reorganized based on the 2025 SHIP Priority Areas: Access to Quality Care, Healthy Communities, and Healthy Living. DMHAS will serve on the Healthy Living Action Team.

Division of Disaster Preparedness, Resiliency and Emergency Medical Services (DPREMS).

DMHAS has been collaborating with DPREMS for years. DMHAS works with this Division's Office of Data Analytics, Resources, and Infrastructure to receive information on EMS transports of individuals who were reversed from an overdose with naloxone to emergency departments. This allows DMHAS to better monitor the performance of our OORP programs that provide recovery support to these individuals at the specific hospitals where they are located. The OORP program is in 75% of NJ Acute care hospitals.

DOH Office of Women's Health (OWH).

DMHAS has formed a new partnership with the DOH Office of Women's Health. The Office for Women's Health (OWH) is dedicated to protecting and strengthening women's health in New Jersey by fostering healthy families and communities. OWH promotes, evidence-based healthcare services with a focus on accessibility, innovation, and integration to empower women to live long, healthy, and autonomous lives. The New Jersey Maternal Data Center aims to assure data regarding maternal health and related outcomes are transparent to policy makers, consumers, and relevant stakeholders in New Jersey, through dissemination of data visualizations focused on the maternal health ecosystem.

In partnership with the OWH and the Department of Human Services (DHS) Division of Mental Health and Addiction Services (DMHAS), this project aims to develop a comprehensive spatial

analysis and mapping initiative focused on substance use disorder (SUD) among the maternal health population. Utilizing data from the Maternal Data Center and matched hospital discharge and birth certificate records, the project will map treatment access points, including Maternal Wrap-Around (MWRAP), Intensive Outpatient Treatment for Substance Exposed Infants (IOT-SEI), and Medication-Assisted Treatment (MAT) programs, alongside key maternal and infant health outcomes. This visualization will identify geographic gaps in treatment and prevention services, particularly in the critical postpartum period, to support interventions and improve maternal and infant health outcomes.

The project will involve mapping NJ women who gave birth with a SUD diagnosis and DMHAS' various women's programs. The goal is to determine where more women's programs may be needed.

Department of Labor.

The New Jersey Department of Labor and Workforce Development (NJDOLE) Pathways to Recovery Initiative launched in 2019 connects residents impacted by the opioid crisis to employment and offers supportive services in job readiness, skill building and obtaining industry recognized credentials. NJDOLE announced in March 2025 the availability of an additional \$5 million in grant funding for organizations to offer training, employment, and retention services for individuals in recovery. Eligible applicants—including nonprofits, for-profits, government entities, and higher education institutions connected to mental health or opioid treatment centers—can receive up to \$1 million over 24 months starting June 1, 2025. Since its inception, the program has expanded statewide, forged over 1,550 employer partnerships, and supported more than 4,150 participants.

NJ Higher Education Student Assistance Authority

In June of 2024, the Department collaborated with the Department of Children and Families and Higher Education Student Assistance Authority to launch the Home and Community Based Services (HCBS) Provider Loan Redemption Program. The program provided eligible workers with up to \$50,000 in loan relief in exchange for one year of service at an approved HCBS location and is funded with \$17.5m in funding from the American Rescue Plan Act.

- o Eligible professions included psychiatrists, social workers, registered nurses, alcohol and drug counselors, marriage and family therapists, and numerous other HCBS positions providing healthcare, behavioral health, and social services to individuals with medical needs, mental health conditions, and disabilities.
- o 448 individuals enrolled in the loan redemption program, selected from over 1,000 applicants, with the largest groups of participants being registered nurses, licensed social workers, DCF care managers, and licensed professional and associate counselors.

Law and Public Safety.

The Office of Alternative and Community Responses (OACR) within the Department of Law and

Public Safety (LPS) strives to, among other things, incorporate public health strategies into public safety responses to the opioid and addiction crises. The Opioid Policy and Response Bureau (OPRB) within OACR provides funding for Operation Helping Hands (OHH), which supports programs in which law enforcement officers play an active role in identifying individuals with substance use disorders (SUD) and together with community partners serve as an entry point to treatment and/or recovery support services. DMHAS and the Office of Alternative and Community Response (OACR) are meeting concerning naloxone distribution and better coordination of services with the goal of continued sustainability. Another goal is to better align where naloxone is distributed and where actual overdoses are occurring.

SMHA New Partnerships

Administrative Office of the Courts (AOC)

In 2019, a Mental Health Advisory Committee was formed, co-chaired by the Chief Justice and DHS Commissioner and recommended the development of mental health pilot programs for individuals with suspected serious mental illness and criminal charges. From this, DMHAS and Administrative Office of the Courts (AOC) recognized the need for a multidisciplinary concerted effort in identifying individuals with a mental illness quickly, sharing information efficiently, and coordinating efforts with the appropriate entities. Currently, there are five counties with mental health pilot programs with the goal of connecting individuals to mental health and other services that address needs. With the exception of one county, these services were procured through a competitive bid process administered by DMHAS in 2022. Programs were underway in 2023 and throughout the implementation, DMHAS has maintained ongoing collaboration with the AOC along with county judges, prosecutors and the public defender's office.

ARRIVE Together

ARRIVE Together is an initiative out of the Attorney General's Office in partnership with DMHAS' contracted providers that has been in effect since 2021 and expanded in 2023 to all 21 NJ counties. ARRIVE Together is a program that pairs law enforcement officers with mental health professionals to respond to behavioral health crises. The goal is to provide immediate support, de-escalate situations, and connect individuals in crisis with appropriate mental health services. This collaborative approach aims to improve outcomes for those experiencing mental health crises and enhance the safety of both the individuals in crisis and the responding officers. DMHAS continues to partner with the Attorney General's Office of Alternative Community Response throughout the implementation of this key initiative.

Children's System of Care (CSOC) New Partnerships

Project Connect

In November 2020, the Garrett Lee Smith Youth Suicide Prevention Grant was awarded to the

New Jersey Department of Health (NJDOH) from the Substance Abuse and Mental Health Services Administration (SAMHSA). This federal grant was awarded to implement NJDOH's Readiness to Stand United Against Youth Suicide (R2S Challenge). The Department of Children and Families (DCF) is collaborating with the DOH on a portion of the grant. This collaboration is to assist New Jersey hospitals to effectively connect youth to services following suicide attempts. As a result of this initiative and partnership, DCF developed Project Connect in 2023 to increase engagement in community mental health services after hospital discharge, decrease unnecessary Emergency Department utilization through connection to appropriate community services, and improve safety and well-being for youth and families. Through the innovative role of the Regional Care Coordinator (RCC), Project Connect works in partnership with identified hospitals to enhance discharge planning for youth with suicide ideation and/or attempts. After youth are medically stabilized, screened, and determined to be safe for discharge, hospital staff will engage in a warm transfer process to connect families to PerformCare and community resources. Hospital staff are also coached on how to obtain consent to connect the family to the RCC who will make contact with the caregiver post-discharge to provide the youth and family with follow up support and ensure linkage and engagement with community behavioral health services.

Assertive Community Treatment (ACT)

The CSOC awarded the Youth Assertive Community Treatment (Youth ACT) pilot to Legacy Treatment Services, which began service delivery in Cape May and Atlantic Counties in July 2024. Youth ACT uses evidence-based and promising practices to provide flexible, comprehensive, in-home treatment, rehabilitation, and support services to youth ages 5 to 20 who are likely to experience psychiatric crises, and their families. Youth ACT is designed to serve a total of 40 youth and young adults at any given time. Service goals include stabilizing youth so they may remain in their home, decreasing the likelihood of inpatient psychiatric hospitalization and residential placement, and preventing youth from further decompensation and presentation at emergency rooms, psychiatric screening centers, and psychiatric inpatient units.

Two multi-disciplinary treatment teams (one in each county) are comprised of licensed therapists and psychiatric experts, supported by a team of other professionals, including those with lived experience as a family member, and provide services tailored to each youth and family based on an assessment of the youth and family system.

Services are provided using evidence-based and best practices, including Motivational Interviewing, Cognitive Behavioral Therapy, Strengths- Based Approaches, Dialectical Behavior Therapy, and Stages of Change.

Children's Crisis Intervention Services (CCIS) IDD Qualified Project (IDD-Q)

CSOC was awarded a 2024 NASMHPD Technology Transfer Initiative 8 month grant to develop and implement training and technical assistance to increase the capacity of the NJ subsidized child and adolescent psychiatric inpatient units to effectively treat youth with intellectual and developmental disabilities. Each of the three pilot units (Trinitas, Inspira and Rutgers UBHC) received funds to purchase recommended items for individualized resource toolkits to support learned interventions and to ensure youth with Intellectual and Developmental Disabilities on their

units receive quality care, resources, and support.

In addition, and a vital part of this grant, caregivers/stakeholders with lived experience, provided valuable feedback regarding their experience, providing suggestions for trainings and advising on the initiative through regular stakeholder meetings. For their participation, these stakeholders received a stipend at the end of the initiative.

In FY26, the IDD Q project is expanding to three additional CCIS units (Hoboken, St. Claire's and Carrier Clinic).

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)

Certified Community Behavioral Health Clinics

The state continues to work in partnership with our sister division, the Division of Medical Assistance and Health Services (DMAHS) on a number of initiatives that will promote services and enhance the Medicaid behavioral health benefit. Recent examples, with assistance from DMHAS, DMAHS has included Substance Use Disorder Case Management and Peer Services in the Medicaid benefit package.

The Division of Mental Health and Addiction Services (DMHAS) was selected to be one of the eight Certified Community Behavioral Health Clinic (CCBHC) demonstration states. This project is a collaboration between the Department of Human Services' Division of Medical Assistance and Health Services (DMAHS) and DMHAS and the Department of Children and Families (DCF). There are seven behavioral health providers dually licensed in mental health and substance abuse participating as CCBHCs. The Federal Demonstration was extended to September 30, 2025, and the state partners are currently DMHAS, DMAHS and DCF are working collaboratively to develop a Medicaid State Plan Amendment which would include the CCBHC service in the Medicaid State Plan.

Behavioral Health Homes (BHH)

DMHAS has explored several models of integration. Health Homes is a Medicaid State Plan option that provides an opportunity to build a person-centered system of care that achieves improved outcomes and better services and value for the NJ Medicaid program. New Jersey maintains the original BHH services developed through Medicaid State Plan Amendments.

In a partnership with the Division of Medical Assistance and Health Services (Medicaid) and the Department of Children and Families, DMHAS launched health homes in select counties in July of 2014, Atlantic, Bergen and Mercer.

Promoting Integration of Primary Behavioral Health Care (PIPBHC)

In August 2024 New Jersey was awarded a SAMHSA Promoting Integration of Primary Behavioral Health Care Collaborative Care Mod (CoCM) grant. This is a five-year grant that will offer universal behavioral health, screening assessment, intervention and referral at three primary care clinics in Essex and Union County. There are two adult and one children's clinic in the program.

In Depth Technical Assistance (IDTA) Neonatal Abstinence Syndrome and Substance Exposed Infants (NAS SEI)

As a SAMHSA Prescription Drug Abuse Policy Academy State, in 2014, NJ applied for a unique technical assistance opportunity through the SAMHSA supported NCSACW to address the multifaceted problems of NAS and SEI. NJ DHS/DMHAS as the lead State agency, partnered with the Department of Children and Families (DCF) and Department of Health (DOH), and submitted a successful application (no funding attached). The IDTA goal was to develop uniform policies/guidelines that address the entire spectrum of NAS and SEI from pre-pregnancy, prevention, early intervention, assessment and treatment, postpartum and early childhood. The IDTA provided technical assistance to NJ to strengthen collaboration and linkages across multiple systems such as addictions treatment, child welfare, and medical communities to improve services for pregnant women with opioid and other substance use disorders and outcomes for their babies. The Core Team included over 60 individuals representing multiple State Departments and Divisions, community stakeholders, treatment providers, and the medical community. Three goals were established: (1) Increase perinatal SEI screening at multiple intervention points; (2) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women screening positive on the 4P's Plus get connected for a comprehensive assessment by establishing formal warm-handoffs and other safety net measures; and (3) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women delivering SEIs and their babies and any other eligible children, receive early support services for which they are eligible. Workgroups were formed. New Jersey was recently awarded technical assistance through the National Center on Substance Abuse and Child Welfare's (NCSACW) 2023 Policy Academy: Advancing Collaborative Practice and Policy: Promoting Healthy Development and Family Recovery for Infants, Children, Parents, and Caregivers Affected by Prenatal Substance Exposure. The Department of Health is the lead State Department and NJ Policy Academy State representatives include the Departments of Children and Families, Human Services, and the Governor's Office. The DMHAS Women's Treatment Coordinator represents the Department of Human Services. The overall goal is to increase awareness of pregnant women and SUD, through increased education and maximizing messaging through the perinatal work force, increase awareness and access to treatment, Plans of Safe Care, and improving screenings in hospitals and healthcare providers.

Housing

On January 1, 2019, the Supportive Housing Connection (SHC) was transferred to the Department of Community Affairs (DCA), Division of Housing and Community Services (DHCS). All direct care staff of the SHC were transferred to DCA, DHCS as hourly employees as they were for NJHMFA. DCA, DHCS employed an SHC supervisor and began recruitment for vacant positions within the SHC. The role and function of the SHC remains intact, the changes are in the physical location of SHC and its employees, now housed at the DCA's Trenton, NJ location. The

Memorandum of Agreement (MOA) between the NJHMFA and the Department of Human Services (DHS) / Division of Mental Health and Addiction Services (DMHAS), expired December 31, 2018; the new MOA between DCA and DHS/DMHAS, has an effective date of January 1, 2019.

In January 2019, the Department of Human Services/ DMHAS launched a partnership with the Department of Community Affairs (DCA) to administer housing subsidies to consumers receiving services from DMHAS. DCA/SHC is responsible for the following tasks on behalf of the Division: Housing Search Assistance, Landlord Recruitment, Housing Inspections, Subsidy Processing, Rental Subsidy Administration, and Tenant/Landlord Inquiry Resolutions. The goal of this partnership is to increase community-based living and enhance community tenure for consumers recently recovering from and/or at-risk for homelessness and/or placement in inpatient psychiatric settings.

Division of Developmental Disabilities

DMHAS' Office of Planning, Research, Evaluation, Prevention, and Olmstead (OPREPO) partners with DMHAS' Division of Developmental Disabilities (DDD) and the Department of Health's (DOH) State Psychiatric Hospitals on the discharge planning of individuals diagnosed with a serious mental illness and a co-occurring developmental disability (DD/MI). DDD Transitional Case Managers (TCMs) are stationed at each respective state hospital and focus on the referrals of DD/MI patients to community placements and collaborate with the OPREPO and state psychiatric hospital staff to address and ameliorate any discharge impediments that may be present. Joint DMHAS, DDD and State Hospital meetings occur at each hospital on a monthly basis to discuss discharge planning of DD/MI individuals and address systems issues. On a bi-weekly basis, administrative level meetings are scheduled between DDD and DMHAS to discuss issues that require a higher-level review.

Division of Medical Assistance and Health Services

DMHAS' Office of Planning, Research, Evaluation, Prevention, and Olmstead (OPREPO) staff partners with Department of Health's (DOH) State Psychiatric Hospitals and the DMAHS Office of Managed Care to facilitate state hospital discharges of individuals who are in need of Managed Long Term Support Services (MLTSS) or Medicaid state plan services such as nursing supports or personal care assistance. Coordinating these services allows for an alternative to nursing home placement; with additional supports individuals can be placed in the community residential settings or age in place in their own homes.

Olmstead Implementation

DMHAS' Office of Planning, Research, Evaluation, Prevention, and Olmstead (OPREPO), continues to focus its efforts on improving community integration for individuals in the state psychiatric hospital receiving services. The Department of Health operates three adult psychiatric hospitals and one adult forensic hospital that serve individuals with severe mental illness who are in need of intensive, inpatient care and treatment. OPREPO works collaboratively with the Division of Behavioral Health Services to facilitate community placement referrals for individuals in the state hospitals.

Centralized Admission – OPREPO has increased its scope from primary implementation, monitoring and facilitation of discharges for individuals at the state psychiatric hospitals to overseeing diversion to the state psychiatric hospitals. OPREPO has worked collaboratively with the Department of Health's Centralized Admissions within the state psychiatric hospitals on a process for providing diversionary activities for individuals that do not meet criteria for commitment to the state hospitals and are in need of less restrictive community settings. Olmstead staff assist in securing additional supports needed for individuals to remain in the most integrated setting possible within their required level of care addressing their individualized needs. This collaboration allows for decreased hospital admissions and census as well as enhanced community re-integration of persons receiving services.

DMHAS Olmstead unit has provided a series of trainings for the state hospitals and Community Support Services providers, addressing level of care opportunities that are available in the community for individuals in need of mental health, substance use disorders, or co-occurring services. OPREPO and DBHS data and information technology staff have also been meeting to streamline data reporting, validate data and existing reports and queries, as well as establish data definitions for data fields and parameters for reports.

Integration of Behavioral Health into Managed Care Organizations

DMHAS has been an active partner with NJ's State Medicaid Agency, DMAHS as they implement the state's 1115 Waiver. Specifically, NJ is partnering with Medicaid to implement the Integration of Medicaid Behavioral Health Care Services into NJ's five Managed Care Organizations (MCO). Phase I of this Integration was implemented in January 2025. During that phase of the Integration, ambulatory SUD and MH treatment services were integrated into the MCO management. Phase II is expected no earlier than January 2026 and will include MH and SUD residential services and Opioid Treatment Program services.

The process includes multiple opportunity for stakeholder review and recommendations as well as multiple trainings, online manuals and assistance and an ongoing email for providers to use to report problems or complaints about the process.

Children's System of Care (CSOC)

Juvenile Justice

Decreasing the Number of Youth Justice Commitments

The Children's System of Care (CSOC) is fully accessible to youth involved with the youth 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 decrease of the number of county detention centers from seventeen to six. In the past few years, there has been an increase utilization of Bio-Psychosocial (BPS) evaluations by the youth justice system. These assessments ensure all youth that are need of mental or behavioral health services

have the opportunity to receive them.

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

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

Medicaid

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

CSOC Representation on the New Jersey Council for Youth Justice Improvement

Reentry processes are discussed by the sub-committees of the Council. Formal recommendations are presented to the full Council by the individual sub-committees.

DCF Cooperative Relationships with the Youth Justice Commission (YJC)

Since December 2004, the Department has maintained a Memorandum of Understanding with the YJC that outlines a distinct process by which youth in the YJC 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 YJC facility. Representation from both CP&P and CSOC participate in the YJC and Annie E. Casey Foundation driven Juvenile Detention Alternative Initiative (JDAI) in order to collaborate on developing alternatives to detention and to decrease the number of youth going into detention. Both systems participate in each other's planning and case review processes.

The Youth Justice Commission is responsible for operating state services and sanctions for youth and for developing a statewide plan for the effective provision of youth 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 YJC established the State/Community Partnership Grant Program. These Partnership Grants provide funding to each county for services to decrease 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 (SCRC)

The SCRC reviews those youth, both male and female, who present multi-system needs/issues and the need for particular attention or advocacy. Included are those who appear to have developmental

disabilities, those who need placement by DCF/CP&P due to court orders for aftercare, and/or those who have unique presenting problems, including homelessness, and those who are being referred, or are accepted by, DCF/CSOC.

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

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

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

CSOC maintains a "Protocol for Supervision of Juvenile Probationers Court-ordered to Attend and Complete a DCSOC Out-of-Home Treatment Program." This protocol was approved in 2018 by NJ Juvenile Probation Managers, NJ Conference of Chief Probation Officers, CSOC Representative for Programs, NJ Juvenile Committee of Family Presiding Judges, and the NJ Conference of Family Presiding Judges. Subsequent protocols were developed that address communication and collaboration for youth in either a residential treatment program or a substance use treatment program.

CSOC Training and Technical Assistance

CSOC offers a broad array of training and technical assistance to system partners through contracts with several entities including Rutgers University Behavioral Health Care, The Boggs Center on Disability and Human Development, and Autism New Jersey.

DCF/CSOC funds the Technical Assistance Center through University Behavioral Health Care - Rutgers, the State University, to provide training statewide. CSOC, through the UMDNJ Training contract, offers training to all Children's System of Care Providers free of charge.

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

Children's InterAgency Coordinating Council (CIACC)

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

- Evaluating the local county policies to understand and minimize the impact of local impediments to serving youth with behavioral and emotional health needs, substance use, and/or intellectual and developmental disabilities in their community.
- Identifying local strategies and mechanisms to promote the integration and coordination of county, State, or other resources serving youth with behavioral and emotional health needs, substance use, and/or intellectual or development disabilities.
- Assessing local systems needs using information received from DCF, the Contracted System Administrator (CSA), any child-serving agency identified by DCF, and other bodies to make recommendations regarding service and resource development priorities.
- Identifying and informing DCF/CSOC regarding gaps and impediments to local service effectiveness.
- Providing input to State, regional, and county entities regarding system performance and service need.

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

Educational Services

Educational Stability for Homeless Youth

The McKinney-Vento Act defines homeless children as "individuals who lack a fixed, regular, and adequate nighttime residence." This includes youth residing in out of home (OOH)/State facilities.

The Department of Corrections, the DCF, the DHS, and the JJC are required to provide educational programs to students in State facilities ages five through 20 and for students with disabilities ages three through 21 who do not hold a high school diploma. Students must be able to receive high school credit.

In general State agencies are required to: provide a program comparable to the Sp. Education student's current individualized education program (IEP), and implement the current IEP or develop a new IEP; develop an individualized program plan (IPP), within 30 calendar days, for each general education student, in consultation with the student's parent, school district of residence, and a team of professionals with knowledge of the student's educational, behavioral, emotional, social, and health needs to identify appropriate instructional and support services; discuss the IPP with the student and make a reasonable effort to obtain parental consent for an initial IPP, including written notice; and, review and revise the IPP at any time during the student's enrollment, as needed, or on an annual basis if the student remains enrolled in the State facility educational program, in consultation with the school district of residence.

Attendance in educational programs is compulsory for all students, except for a student age 16 or above who may explicitly waive this right. For a student between the ages 16 and 18, a waiver is not effective unless accompanied by consent from a student's parent or guardian. A waiver may be revoked at any time by the former student. The actual number of days a student with a disability must attend the educational program shall be determined by the student's IEP.

Each State agency shall ensure all students with a disability in the agency's State facilities are provided a free and appropriate public education as set forth under the Individuals with Disabilities Education Act, 20 U.S.C. §§1400 et seq., and shall provide Sp. Education and related services as stipulated in the individualized education program (IEP) in accordance with the rules governing Sp. 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

On October 7, 2008, the federal government signed into law the Fostering Connections to Success and Increasing Adoptions Act (P.L. 110-351). This act required all states to arrange for children and youth in foster care to remain in their "school of origin" to ensure educational stability unless it is determined to be in a child's best interest to go to the new district where the Resource Family Home is located. New Jersey responded to this charge by passing the Education Stability Law on September 9, 2010, which established a system that supports the act. The DCF, Department of Education (DOE) and Office of the Child Advocate (OCA) worked together to implement this law. For children, changing schools can affect their ability to thrive academically, socially, behaviorally and psychologically. This is especially true for children in resource family homes. For these children – who often suffer the lingering effects of abuse or neglect and the trauma of being removed from their homes and families – school can often be the most stable part of their lives.

Work continues to fully implement the requirements of coordination between the DCF and the local school districts. To support the continued progress “Improving the Educational Outcomes of Children in Out-of-Home Placements: An Interagency Guidance Manual” is available on the DCF website at

<https://www.nj.gov/dcf/families/educational/stability/GuidanceManual.pdf>

The guidance manual includes a model memorandum of agreement (MOA) and provides specific actions to reach the indicator and goals in the MOA.

Youth Suicide Prevention Resources

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

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

The Traumatic Loss Coalitions for Youth Program (TLC) at Rutgers-University Behavioral HealthCare is an interactive, statewide network that seeks to decrease suicide attempts, deaths by suicide, and to promote recovery of persons affected by suicide by offering collaboration and support to professionals working with school-age youth and direct crisis response services to staff and youth at youth-serving organizations following a traumatic event. The TLC offers county, regional, and statewide conferences, training, consultation, on-site traumatic loss response, and technical assistance. Since its inception, the TLC has trained thousands of individuals throughout the state with the purpose of saving lives and promoting post trauma healing and resiliency for the youth of New Jersey. In state fiscal year 2024, the TLC launched the HOPES Program to help others process the experience of a suicide loss. Adapted from the LOSS Team model, HOPES provides support and hope to families bereaved by the suicide loss of a child (21 and under); empowering survivors so they can thrive and lead meaningful lives. The TLC website can be accessed at <http://ubhc.rutgers.edu/tlc/>

Project Connect

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

community resources. Hospital staff also obtain consent to connect the family to the RCC who will make contact with the caregiver post-discharge to provide the youth and family with follow up support and ensure linkage and engagement with community behavioral health services.

2NDFLOOR Youth Helpline

Accredited by the American Association of Suicidology, 2NDFLOOR is a confidential call/text helpline and message board platform serving youth and young adults. Youth who contact the 2NDFLOOR are assisted with their daily life challenges by professional staff and trained volunteers. The 2NDFLOOR launched a mobile application in 2024 that allows youth to anonymously connect to their services via the app. The app allows call, chat, and message board and has additional features such as resources, polls, and emojis. The launch of the app significantly increased utilization of the message board and clicks to resources. The website can be accessed at <http://www.2ndfloor.org/>

Additional Suicide Prevention/Crisis Resources

Dialing 988 will connect you with the Suicide & Crisis Prevention Lifeline, which provides 24/7 free confidential support to anyone in emotional distress or suicidal crisis. Calls, texts, or chats to 988 will connect you with a trained counselor who will listen, understand, and provide support and access to resources to address your immediate needs as well as your ongoing care. Additional information is available at: www.njhopeline.com

New Jersey Youth Suicide Prevention Advisory Council

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

Zero Suicide

The Children's System of Care was granted the opportunity to work with the Educational Development Center (EDC) on Zero Suicide. Zero Suicide is a Transformational Framework for Health and Behavioral Health Care Systems. The foundational belief of Zero Suicide is that suicide deaths for individuals under the care of health and behavioral health systems are preventable. For systems dedicated to improving patient safety, Zero Suicide presents an aspirational challenge and practical framework for system-wide transformation toward safer suicide care. The Zero Suicide Institute at EDC (ZSI) provides expertise, customized consultation, and training for health and behavioral health care systems and providers, state agencies, tribal governments, health plans, and others as they launch evidence-based practices for suicide prevention, adopt continuous quality improvement efforts, and implement the Zero Suicide framework for safer suicide care. The Zero Suicide EDC website is zerosuicide.edc.org

Our partnership with EDC is a two-year investment, that started with the implementation of Zero Suicide within our Care Management and Family Support Organizations as well as some of our out of home treatment programs. Year 2 looks to include teams from additional OOH organizations as well as the organizations that oversee our Mobile Response Stabilization Services.

As a result of working with the EDC to implement the Zero Suicide Framework, our partners have created and updated policies regarding suicide prevention, attempts, and protocols and some have engaged in agency-wide staff training, policy consultation, workforce readiness surveys, and piloted screening projects that regularly assess a youth's potential for suicidal thoughts or ideations, and, if identified, guide the youth onto a pathway that will build their resilience and coping skills, decrease risk and helping them to thrive. Some of our partners have also included individuals with living experience on their Zero Suicide teams.

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

On September 30, 2018, SAMHSA awarded a 4-year grant to the Children's System of Care to address youth and young adults at clinical high risk for psychosis. CSOC worked in partnership with DMHAS to develop the NJ-PROMISE program, which provides outreach and intervention for youth and young adults up to age 25, who may be experiencing prodromal symptoms of psychosis. In 2022, CSOC was awarded a second 4-year grant from SAMHSA to continue delivering this important treatment in New Jersey.

NJ PROMISE provides intervention to approximately 60 youth and young adults across three regions annually. Through extensive outreach, coordinated care, the use of evidence-based, evidence-informed, best, and promising practices, as well as the expertise of a team of professionals, participants and their families will have the tools necessary to lead productive lives in their homes and communities.

The project's measurable goals are to:

- Decrease the percentage of youth/young adults at clinical high risk for psychosis who develop psychotic disorder
- Decrease the duration of untreated psychosis, for those who develop psychotic disorder
- Support youth and young adults at clinical high risk for psychosis to improve functioning in work/ school.
- Support youth and young adults at clinical high risk for psychosis to improve social functioning.

Division of Child Protection and Permanency

The Division of Child Protection and Permanency (CP&P) is New Jersey's child protection and child welfare agency within the New Jersey Department of Children and Families (DCF). Its mission is to ensure the safety, permanency, and well-being of children and support families. CP&P is responsible for investigating allegations of child abuse and neglect and, if necessary,

arranging for the child's protection and the family's treatment. The Child Abuse Hotline (State Central Registry) receives reports of child abuse and neglect 24-hours a day, 7-days a week. Reports requiring a field response are forwarded to the CP&P Local Office who investigates.

Clinical Consultants report to CP&P Area Offices and serve as liaisons, joined from the wraparound perspective, that translate system of care principles and values into case practice and planning and assist in the coordination of behavioral health services for youth involved in the child welfare system. The Care Management Organization (CMO) Clinical Consultant is a jointly owned and administered position between the CMO and CP&P. Clinical Consultants translate clinical information into user-friendly language to identify mental health concerns regarding youth involved in the child welfare system and propose interventions to address underlying issues. Clinical Consultants serve as an advocate for youth in permanency and discharge planning, speaking on a clinical level with the Contracted Systems Administrator (CSA), PerformCare, and provider agencies and facilitating communication between care management entities. Clinical Consultants are required to be master's level clinician's licensed by the New Jersey Board of Marriage and Family Therapists or Board of Social Work Examiners.

Office of Adolescent Services (OAS)

The New Jersey Department of Children and Families' (DCF) Office of Adolescent Services (OAS) supports adolescents' transition to adulthood, achieve economic self-sufficiency and interdependence, and engage in healthy lifestyles by:

- Ensuring services provided through DCF are coordinated, effective, meet best practice standards, are youth-driven, and adapt to the needs of families and communities,
- Developing linkages with other service providers to create a 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 approach,
- Assist youth to develop protective and positive attributes and decrease 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 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>

DCF Division of Family and Community Partnerships (FCP)

DCF's Family and Community Partnerships' (FCP) promotes the health, well-being and personal safety of New Jersey's children and families. It works with parents, caregivers, organizations, and communities to ensure an effective network of proven support services, public education, and community advocacy to prevent maltreatment.

The Office of Early Childhood Services is responsible for the planning, development, implementation and evaluation of prevention services for families and caregivers of children from pregnancy/birth to kindergarten. OECS provides oversight and technical support to ensure evidence-based practice, ongoing quality improvement, and positive impacts for participants of

funded programs. OECS works in close collaboration with local, state and national partners to ensure integration of maternal, parent, infant and early childhood services to promote family health and well-being, and prevent child neglect and abuse.

Family and Community Partnerships' Office of Early Childhood Services (OECS) works across state government and with state and local advocates to ensure child abuse and neglect prevention services and supports reach families before a child is born. Early childhood services are available up to a child's sixth birthday.

Programs include:

Connecting NJ

New Jersey's network of service hubs dedicated to providing essential services that help families, and care for children, primarily from pregnancy to age five. Connecting NJ agencies, partners and support systems offer access to information and referrals to local wellness services, including healthcare for mothers and children, early education programs, domestic violence support, addiction treatment, financial assistance, home visiting programs, behavioral health services, and more. For more information: <https://nj.gov/connectingnj/>

Help Me Grow

Help Me Grow (HMG) promotes infant and child health, development, and well-being; early learning and school readiness; and helps to prevent child neglect and abuse. HMG works with partners to improve the quality and availability of services at the state and local level, and eliminate variations in outcomes through early childhood systems integration.

Home Visitation

The Home Visitation Initiative seeks to improve the physical and emotional well-being of infants, children, and their families by providing community-based education and in-home support to parents.

Project LAUNCH (Linking Actions for Unmet Needs in Children's Health)

With the support of the Substance Abuse and Mental Health Services Administration and the New Jersey Department of Children and Families, Project LAUNCH links and enhances efforts to improve the overall wellness of young children in Essex County.

School-Linked Services

The Office of School-Linked Services (OSLS) contracts with private non-profit organizations and school districts to provide prevention and support services for youth in New Jersey's elementary, middle, and high schools. OSLS's programs aim to implement prevention and intervention programs that are comprehensive and multifaceted and build on the strengths of young people so

they can achieve their educational and life goals.

School Based Youth Services Program

The School Based Youth Services Program (SBYSP) is located in host schools and coordinate with existing resources in the community. All youth are eligible to participate and services are provided before, during, and after school. SBYSP services include: mental health counseling; employment counseling; substance abuse education/prevention; preventive health awareness including pregnancy prevention; primary medical linkages; learning support; healthy youth development; recreation; and information/referral.

Prevention of Juvenile Delinquency

Prevention of Juvenile Delinquency (PJD) is located in host schools to enhance services and collaborate with SBYSP. All youth enrolled in the host school where they display behaviors that can or have caused them to become involved in the juvenile justice system are eligible to participate. PJD services complement the SBYSP and focus specifically juvenile delinquency prevention strategies and self-regulation skills to prevent juvenile delinquent behaviors that can impede the student's achievement of their education and life goals. PJD services include case management and counseling services; collaboration with local law enforcement, state and school and community-based agencies, dropout prevention, life and coping skills.

Adolescent Pregnancy Prevention Initiative

Adolescent Pregnancy Prevention Initiative (APPI) is located in host schools to enhance services and collaborate with SBYSP where available. All youth enrolled in the host school where they display behaviors that could lead to an unplanned pregnancy are eligible to participate. Youth involved in the program will gain increased pregnancy prevention skills to support the achievement of their education and life goals. APPI services complement the SBYSP program, where available, and focus specifically on pregnancy prevention skills and knowledge to support the student's ability to achieve their education and life goals. APPI services include: case management and counseling services; education and awareness groups; linkages to available services and resources; and collaboration with school personnel.

Family Friendly Centers

Family Friendly Centers (FFC) is located in host schools to enhance afterschool programming in elementary and middle schools. FFCs provide constructive academic, recreational, and social enrichment activities to students and their families. All FFC programs emphasize positive youth development, encourage parental participation, and seek to establish partnerships with school and community stakeholders to meet the unique needs of youth and their families.

Parent Linking Program

Parent Linking Program (PLP) is located in host high schools to enhance services and to

collaborate with SBYSP. For expecting and parenting teen mothers and fathers, PLP works to minimize and eliminate impediments to earning a high school diploma. This is accomplished through the development and implementation of programs that strengthen pregnant and parenting teen's ability and access to complete their education (secondary and postsecondary); improve child and maternal health outcomes; improve pregnancy spacing and decrease the likelihood of repeat teen pregnancies; increase parenting skills for mothers, fathers, and families; strengthen positive young father involvement and co-parenting relationships, as appropriate, decrease intimate partner violence; and raise awareness of available resources.

New Jersey Child Assault Prevention

New Jersey Child Assault Prevention programs operate in every county, providing educational awareness training and implementing strategies to handle and/or prevent child assault/neglect to children in grades pre-school through twelve, their parents/guardians as well as educators.

Newark School Based Health Center

Newark School Based Health Center provides primary medical, dental, and behavioral health care services to students and families (up to age 21). Centers are located in several Newark schools and services are available to members of the school's surrounding community.

Additional State and Local Partnerships

Children's System of Care Planning

The Children's System of Care (CSOC) has previously reported on the collaboration with the Center for Health Care Strategies (CHCS) and Casey Family Programs through which a task force of sixteen stakeholders was convened to participate in building a behavioral and physical health integration model. Additional information on the task force, including meeting agendas and summaries can be found posted on the DCF website. Release of the report and recommendation from this task force was delayed due to the onset of the COVID-19 pandemic but are now also posted with the meeting agendas and summaries here: [DCF | Children's System of Care Stakeholder Task Force \(nj.gov\)](#). In August 2021, a final stakeholder advisory group was held. During this session, CSOC presented on the progress made toward the previously identified priorities, as well as provided an outline for initiatives in fiscal year 2022. Shortly thereafter, CHCS convened an internal meeting with CSOC leadership to focus on reviewing and committing to identified program initiatives organized under the three main priorities which continue as CSOC's priority areas of focus:

- Building capacity for integrated health;
- Increasing the availability of evidence-based and best practice interventions and services; and
- Improving access to CSOC services and supports, as well as including the priority of Service Excellence.

CSOC continues to partner around the following initiatives which have current cycles and updated program plans: the Infant and Early Childhood Mental Health (IECMH) Initiative, the Garrett Lee Smith (GLS) Suicide Prevention Grant, and the Developing Resiliency with Engaging Approaches to Maximize Success (DREAMS) Initiative, to implement the Nurtured Heart Approach in 50 school districts.

1. IECMH has identified three major objectives: staff development, community collaboration & increased support for families. CSOC has launched training as well as a guidance manual to support MRSS staff in working with youth birth to aged 5. Additionally, in partnership with Montclair State University, a consultation line as well as a resource navigator site has been made available to partners for this area of practice. Leadership level trainings and annual symposium have been instituted and the fifth cohort of clinicians is currently beginning training in best practice to support this population address their needs-
2. The GLS grant was awarded to the New Jersey Department of Health (DOH) in November of 2020 from the Substance Abuse and Mental Health Services Administration (SAMHSA). This federal grant was awarded to implement NJDOH's Readiness to Stand United Against Youth Suicide (R2S Challenge). The Department of Children and Families (DCF) is collaborating with the DOH on a portion of the grant. This collaboration is to assist New Jersey hospitals to effectively connect youth to services following suicide attempts. DCF developed Project Connect to increase engagement in community mental health services after hospital discharge, decrease unnecessary Emergency Department utilization through connection to appropriate community services, and improve safety and well-being for youth and families. Through the innovative role of the Regional Care Coordinator (RCC), Project Connect works in partnership with hospitals to enhance discharge planning for youth with suicide ideation and/or attempts. After youth are medically stabilized, screened, and determined to be safe for discharge, hospital staff will engage in a warm transfer process to connect families to PerformCare and community resources. Hospital staff also obtain consent to connect the family to the RCC who will make contact with the caregiver post-discharge to provide the youth and family with follow up support and ensure linkage and engagement with community behavioral health services.
3. DCF continues its collaboration with the Department of Community Affairs (DCA) to operate the DREAMS initiative. DCF, through its system partners is currently engaging with interested schools to begin implementation of the project for the 2025-2026 school year. -Participating districts will receive access to on demand training, virtual live webinars, train the trainer slots for NHA as well as mentoring from a community-based provider for the duration of the school year.

4. Please indicate areas of technical assistance needs related to this section.

Environmental Factors and Plan

14. State Planning/Advisory Council and Input on the Mental Health/Substance Use Block Grant Application – Required for MHBG, Requested for SUPTRS BG

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 assist with implementing and improving the Planning Council, states should consult the [State Behavioral Health Planning Councils: An Introductory Manual](#).

Planning Councils are required by statute to review state plans and annual 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 advocates for individuals with M/SUD. States should include any recommendations for modifications to the application or comments to the annual report that were received from the Planning Council as part of their application, regardless of whether the state has accepted the recommendations. States should also submit documentation, preferably a letter signed by the Chair of the Planning Council, stating that the Planning Council reviewed the application and annual report. States should transmit these documents as application attachments.

Please respond to the following items:

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, letter from the Council Chair etc.)

The New Jersey Behavioral Health Planning Council (BHPC) / NJ Mental Health Citizens Advisory Board (CAB) is a full partner in the development and review of the MHBG and SABG. The SMHA is very proactive in involving the community in the state planning process. In SFY 2024, SFY 2025, and so far for SFY2026 (July-August) the NJ Division of Mental Health and Addiction Services (DMHAS), which is both the State Mental Health Authority (SMHA) and the Single State Authority (SSA) for substance use hosted multiple separate public presentations at the meetings of the NJ Behavioral Health Planning Council on the MHBG, SUPTR and related topics:

July 2023 & August 2023 (MHBG Priority Indicators and logging into WebBGas),

September 2023 (fiscal overview of the Block Grant),

October 2023 (introduction of Technical Assistance (TA) to be provided by trainers from SAMHA/Advocates for Human Potential on the roles and responsibilities of the Planning Council in reviewing the MHBG and other responsibilities),

November 2023 the Planning Council received an update from the State Mental Health Planner, and related staff on the SFY 2023 MHBG Implementation report, and related URS Data Tables.

December 2023 the Planning Council received updates on the MHBG, SUPTRS and SYNAR Implementation Report, as well as an update on the Fiscal Tables of the 2024-2025 Community Mental Health and Substance Use Prevention, Treatment and Recovery Services Block Grants,

January 2024 a summary of the TA next steps were provided to the council, noting that Ann Denton and Ellen Radis will present at the next meeting their overall findings and recommendations.

February 2024 the Planning Council received TA from Ann Denton & Ellen Radis, Advocates for Human Potential (AHP, Consultants from the US Substance Abuse and Mental Health Services Administration (SAMHSA) on the role of Planning Councils and the block grants.

May 2024: The State Mental Health Planner briefed the Council on SAMHSA's then-upcoming MHBG Site Visit.

July 2024 the State Mental Health Planner provided the Council with a summary of SAMHSA's site visit to the SMHA, July 10-13, 2024.

August 2024, the State Mental Health Planner, Donna Migliorino provided the Council with an update on Combined MHBG/SUPTRS Application.

September 2024 the CFO of the SMHA provided the Council with an overview of the MHBG / SUPTRS BG Fiscal Tables

October 2024, SMHA and DCF staff provided the Council with an update on the progress of the MHBG and SUPTRS 2024 Implementation reports.

November 2024 SMHA staff provided the Council with an update on Mental Health & SUPTRS Block Grant Implementation Report: MHBG & SUBG Priority Areas, Indicators, URS Data Tables, which were subsequently submitted in December 2024.

December 2024 the Council received an overview of the FFY 2025 Annual Synar Report (ASR), and also a presentation from the SMHA's Fiscal Office on the Block Grant Implementation Report, URS Data Tables, related to expenditures & BG funding.

January 2025 the Research Unit of the SMHA provided the Council with a summary of the results of the 2024 DMHAS Adult Consumer Perception of Care Survey and related URS Data Tables (e.g., 9, 11, 11a).

March 2025 the State Mental Health Planner provided the Council with a brief preview of the workflow for the upcoming SFY 2026 -2027 two-year block grant application.

April 2025, the State Mental Health Planner asked the Council to begin to think about the "Needs and Gaps" section of the upcoming SFY26-SFY27 Block Grant report as their input is an important part of the block grant.

May 2025, the State Mental Health Planner asked the Council to continue work on the "Needs and Gaps" section of the upcoming SFY26-SFY27 Block Grant report.

June 2025, the State Mental Health Planner noted that the final guidance for the SFY26-SFY27 Block Grant application was received by SAMHSA. In addition, the final report of the SAMHSA monitoring visit was discussed as well as information on the Needs and Gaps survey sent to members.

July 2025, the State Mental Health Planner and other DMHAS staff provided a presentation on the narrative to the SFY26-SFY27 Block Grant application for both MHBG and SUPTRS. A public login was provided to the Council to view the application.

August 2025, the Council approved the final "Needs and Gaps" section of the Block Grant application and the State Mental Health Planner presented on the narrative section of the Block Grant Application. The Council recommended the Block Grant application for submission to SAMHSA.

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. Has the state received any recommendations on the State Plan or comments on the previous year's State Report?

- a. State Plan ☒ Yes ☐ No
- b. State Report ☒ Yes ☐ No

Attach the recommendations /comments that the state received from the Council (without regard to whether the State has made the recommended modifications).

3. What mechanism does the state use to plan and implement community mental health treatment, substance use prevention, SUD treatment, and recovery support services?

Substance use disorder services are planned based on a needs assessment process completed by the State. State funding is allocated to counties based on a funding formula. Substance Use Prevention and Treatment Block Grant funding is allocated to third party contracts and fee-for-service contracts for prevention, early intervention, treatment and recovery services based on the needs assessment. Since State funding for SUD services is limited, staff frequently apply for Federal discretionary grants in order to implement new SUD prevention, early intervention, treatment and recovery supports. Fortunately, the SSA has been very successful in being awarded discretionary grants. Current discretionary grants include: Prevent Drug Overdose (PDO), SPF Rx, Partnerships for Success (PFS), PIPBHC, and SOR. As needs emerge, new Requests Proposals are drafted for contracts, which may be renewed annually, as needed. Memoranda of Agreements (MOAs) are also developed for SUD service delivery and various need assessment and evaluation projects.

The SMHA includes and updates the Planning Council & Community on its mental health and SUD treatment and recovery support services, through regular updates on a range of topics and programs in New Jersey's System of Care. Between July 2023 and August 2025, the Council has had presentations and opportunities to question, comment, and make suggestions on the following behavioral health services:

July 2023: CCIS Clinical Capacity Improvement Project overview

August 2023: NJ ABLE Accounts (Achieving a Better Life Experience) overview from the NJ Division of Vocational Rehabilitation Services (NJ DVRS)

September 2023: an overview of the Quality Improvement Plan of the: RWJ/Barnabas Health Institute for Prevention and Recovery (SUD).

November 2023: an overview of the Prevention Hub Programs (SUD. <https://www.njpreventionhub.org/>)

December 2023: Mental Health Services in the NJ Department of Corrections.

March 2024: a discussion on Certified Community Behavioral Health Centers (CCBHCs) and outcomes.

April 2024: Presentations on 988 Crisis Call Centers and MCORT roll-out/implementation and also an update from the Rutgers University, Department of Psychiatry on advances in understanding the genetic underpinnings of SUDs

May 2024: The State Mental Health Planner provided an in-depth overview of: Coordinated Specialty Care-Community Integration (CSC-CI), Crisis Receiving Stabilization Centers (CRSCs), and Crisis Diversion Homes (CDHs). At that same meeting the Medical Director's Office of the SMHA provided the Council an overview of Psychiatric Advance Directives (PADs).

September 2024: Representatives from the NJ Department of Education shared with the Council a presentation on the use of mental health screeners in public Schools.

November 2024: Representatives from New Jersey's State Medicaid office provided an overview of Medicaid rules for behavioral health integration.

January 2025: The Assistant Division Director of the SMHA's Office of Planning, Research, Evaluation, Prevention & Olmstead (OPREPO) did an overview of the SMHA's Intensive Recovery Treatment Support (IRTS) Program (SUD).

February 2025: The Medical Director for RWJ/Barnabas Institute for Prevention shared information on Alcohol, Cancer and Warning Labels. (SUD).

March 2022 the Director of the NJ Office of Alternative & Community Responses, (NJ Office of the Attorney General) did an overview of the ARRIVE Together program (i.e., embedding of behavioral health professionals with law enforcement personnel).

April 2025: Members of a major peer-run organization did an overview of peer-run adult mental health programs in New Jersey.

May 2025: A presentation on substance use disorder prevention and NJ Psychiatric Rehabilitation Association.

June 2025: A presentation on alcohol use disorder .

July 2025: A representative from the NJ Department of Health presented on behavioral health services within state psychiatric hospitals.

August 2025: Representatives from the Division of Mental Health and Addiction Services' Fiscal office presented on the SFY2026 budget highlights.

In addition to guest speakers, all meetings of the BHPC include mandatory "System Partners Updates", wherein representatives from parts of state government who are members of the Council are mandated to present updates and overviews to what is happening in their respective parts of state government. At each meeting of the Planning Council representatives from the following entities provide updates: NJ Division of Mental Health and Addiction Services, the Department of Health, the Department of Children and Families/Children's System of Care, Division of Vocational Rehabilitation Services, Division of Aging, Division of Developmental Disabilities, New Jersey State Medicaid, NJ Department of Education, NJ Department of Corrections, NJ Housing Mortgage & Finance Agency,

In all of the aforementioned presentations, there was a substantial amount of time provided for Q&A, general discussion, and attendees/members to offer suggestions and provide input. In these wide-ranging and candid conversations (and follow-up emails to the presenters) the members of the Council and the public-at-large have unfiltered opportunities to help inform and impact decision-makers across New Jersey's system of care.

4. Has the Council successfully integrated substance use prevention and SUD treatment recovery or co-occurring disorder issues, concerns, and activities into its work? ☒ Yes ☐ No
5. Is the membership representative of the service area population (e.g., rural, suburban, urban, older adults, families of young children?) ☒ Yes ☐ No

6. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The NJ Behavioral Health Planning Council is a dynamic, evolving entity that strives to be a relevant forum where people in recovery, and their families/other stakeholders can advocate for people with SMI and/or SED. The issue of "Advocacy" is so deeply embedded in the Council, from 2012 to 2024 the Council has had a long-standing "Advocacy Committee", specifically designed to be a dedicated mechanism where the Council can identify, advocate for, and correct issues and gaps in the system of care that are most profoundly experienced by individuals (and families) facing SMI/SED. In February 2024, the Council received Technical Assistance from SAMHSA/Advocates for Human Potential, wherein the Council was rightfully reminded that "all activities of the Council must be 'advocacy'- and not simply relegated to a small committee." This caused an important conceptual "reset" and reinvigoration of the Council and expanded the "voice" and empowerment of many Council members.

7. Please indicate areas of technical assistance needs related to this section.

In the wake of the TA from SAMHSA/AHP--wherein the Council was educated on having more structured committees, the Council could benefit from reinforcement on the importance of keeping the number of activities of each committee more tightly focused.

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Footnotes:

The New Jersey Behavioral Health Planning Council letters and minutes are available upon request.

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 Mental Health Agency
 State Education Agency
 State Vocational Rehabilitation Agency
 State Criminal Justice Agency
 State Housing Agency
 State Social Services Agency
 State Medicaid Agency

Start Year: 2026 End Year: 2027

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Tonia Ahern	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)		230 Route 50 Petersburg NJ,	tahern1128@aol.com
Kurt Baker	Parents of children with SED	Attitudes in Reverse	PO Box 3017 Princeton NJ,	kurt@air.ngo
Julia Barugel	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)		9 Bromley Court Morganville NJ,	barugel@optonline.net
Darlema Bey	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)		507 Arch St	darlemabey@gmail.com
Tatyana Brown	State Employees	NJ Division of Vocational Rehabilitation	PO Box 0398 Trenton NJ, 08625	Tatyana.Brown@dol.nj.gov
Angela Calzone	Parents of children with SED		16 Silver Lake Drive Barnegat NJ, 08005	acalzone@inroadsto.com
Winifred Chain	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		21 Gateshead Drive Lumberton NJ,	winifredchain@gmail.com
Harry Coe	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		152 Sunnymede St Englishtown NJ,	harrybcoe@gmail.com
Krista Connelly	State Employees	NJ Department of Corrections	PH: 609-292-4036	
MaryAnn Evanko	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)		NJ, PH: 609-583-3128	Maryanneevanko2@gmail.com
Lisa Federico	Advocates/representatives who are not state employees or providers	NJ County Drug & Alcohol Directors Association	NJ,	lfederico@co.somerset.nj.us
Ann Marie Flory	State Employees	Nj Department of Health		annmarie.flory@doh.nj.gov

Jennifer Gielka	State Employees	NJ Division of Family Development	PO Box 716 Trenton NJ, 08625 PH: 609-588-0153	Jennifer.Gietka@dhs.nj.gov
Connie Greene	Providers	RWJ/Barnabas Health - Institute for Prevention	442 Rt 35 , 08754	cgreene@barnabashealth.org
Joseph Gutstein	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		770 Anderson Avenue Cliffside Park NJ, 07010	Joe@joegutstein.com
Michael Ippoliti	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		307 Wilson Avenue Edgewater Park NJ,	Michael.ippoliti@gmail.com
Kate Kelly	Advocates/representatives who are not state employees or providers	Supportive Housing Association of NJ	NJ,	kate.kelly@shanj.org
Elisabeth Marchese	Advocates/representatives who are not state employees or providers	NJ Assoc. of County Mental Health Administrators	1027 Hooper Ave Toms River NJ,	elisabeth.marchese@co.middlesex.nj.us
Donna Migliorino	State Employees	NJ Division of Mental Health & Addiction Services	5 Commerce Way Hamilton , 08625 PH: 732-547-1400	
Lisa Negron	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		NJ,	rayandlucy1952@gmail.com
Damian Petino	State Employees	NJ Department of Education	100 Riverview Plaza Trenton NJ, 08625	
Thomas Pyle	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)		50 Balsam Lane Princeton NJ, 08540	thpyle@gmail.com
Stacy Reh	State Employees	NJ Children's System of Care (NJ CSOC)	NJ,	Stacy.Reh@dcf.nj.gov
Jennifer Rutberg	State Employees	NJ Division of Aging		Jennifer.Rutberg@dhs.nj.gov
Regina Sessoms	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		2747 Hooper Avenue, Brick , 08723	rsessoms59@aol.com
Heather Simms	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)	Collaborative Support Programs of NJ, Inc.		hsimms@cspnj.org
Suzanne Smith	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)		NJ, PH: 856-241-2166	STSSHSA@aol.com
Donna Spencer	State Employees	NJ Housing Mortgage and Finance Agency	PH: 609-278-7449	dspencer@njhmf.gov
Irina Stuchinsky	State Employees	NJ Div. of Medical Assistance and Health Services	7 Quakerbridge Plaza Hamilton , 08619	Irina.Stuchinsky@dhs.state.nj.us
Pamela Taylor	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		162 Brighton Avenue East Orange NJ, 07017	ptaylor@mhanj.org

Morgan Thompson	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)		14 Crevling Road Bloomsbury NJ, 08804	morgants90@gmail.com
Chelesa Vietch	Advocates/representatives who are not state employees or providers	NJ League of Municipalities	1027 Hooper Ave Toms River NJ,	
Francis Walker	State Employees	NJ Juvenile Justice Commission	NJ,	Frrancis.Walker@jjc.state.gov
Debra Wentz	Advocates/representatives who are not state employees or providers	NJ Assoc of Mental Health and Addictions Agencies	NJ,	dwentz@njamhaa.org

*Council members should be listed only once by type of membership and Agency/organization represented.

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Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2026 End Year: 2027

Type of Membership	Number	Percentage of Total Membership
1. Individuals in recovery (including adults with SMI who are receiving or have received mental health services)	9	
2. Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)	6	
3. Parents of children with SED	2	
4. Vacancies (individuals and family members)	4	
5. Total individuals in recovery, family members, and parents of children with SED	21	53.85%
6. State Employees	11	
7. Providers	1	
8. Vacancies (state employees and providers)	1	
9. Total State Employees & Providers	13	33.33%
10. Persons in Recovery from or providing treatment for or advocating for SUD services	0	
11. Representatives from Federally Recognized Tribes	0	
12. Youth/adolescent representative (or member from an organization serving young people)	0	
13. Advocates/representatives who are not state employees or providers	5	
14. Other vacancies (who are not individuals in recovery/family members or state employees/providers)	0	
15. Total non-required but encouraged members	5	12.82%
16. Total membership (all members of the council)	39	

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Footnotes:

Environmental Factors and Plan

15. Public Comment on the State Plan – Required for MHBG & SUPTRS BG

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, that 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 the federal government.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? ☒ Yes ☐ No

b) Posting of the plan on the web for public comment? ☒ Yes ☐ No

If yes, provide URL:

Public Access to Block Grant Applications (WebBGas): <https://bgas.samhsa.gov/Module/BGAS/Users>

User name: citizennj

Password: citizen

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

Previous plan posted on DMHAS website: <https://www.nj.gov/humanservices/dmhas/publications/federal/>

Public Access to Block Grant Applications (WebBGas): <https://bgas.samhsa.gov/Module/BGAS/Users>

User name: citizennj

Password: citizen

c) Other (e.g. public service announcements, print media) ☒ Yes ☐ No

d) Please indicate areas of technical assistance needs related to this section.

The attached Notice of Solicitation Comment was posted on the Division Mental Health and Addiction Services' website at <https://www.nj.gov/humanservices/dmhas/provider/notices/>.

The Notice was also published on August 19, 2025 in the following newspapers: Asbury Park Press, The Times of Trenton, Bergen Record, Press of Atlantic City, and the Camden Courier Post.

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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 Community Mental Health Services Block Grant and Substance Use Prevention, Treatment, and Recovery Services Block Grant FY 2026 – 2027 draft Application Plan from any interested person, including any Federal or other public agency, during the development and after submission of the application to the Federal Substance Abuse and Mental Health Services Administration.

Please email dmhas@dhs.nj.gov to receive login credentials to view the report as it is drafted and posted online.

Written comments concerning the State Application Plan can be sent to DMHAS at the email or postal address indicated below.

New Jersey Department of Human Services
Division of Mental Health and Addiction Services
P.O. Box 362
Trenton, NJ 08625-0362

Electronic Mail: dmhas@dhs.nj.gov

Environmental Factors and Plan

16. Syringe Services Program (SSP) – Required for SUPTRS BG if Planning for Approval of SSP

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Narrative Question:

Use of SUPTRS BG funds to support syringe service programs (SSP) is authorized through appropriation acts which provide authority for federal programs or agencies to incur obligations and make payment, and therefore are subject to annual review. The following guidance for the application to budget SUPTRS BG funds for SSPs is therefore contingent upon authorizing language during the fiscal year for which the state is applying to the SUPTRS BG.

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SUPTRS BG to fund elements of an SSP other than to purchase sterile needles or syringes for the purpose of illicit drug use. States interested in directing SUPTRS BG funds to SSPs must provide the information requested below and receive approval from the State Project Officer.

States may consider making SUPTRS BG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SUPTRS BG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to persons who inject drugs (PWID), SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers. Federal funds cannot be supplanted, or in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

The federal government released three guidance documents regarding SSPs, These documents can be found on the [HIV.gov website](#).

Please refer to guidance documents provided by the federal government on SSPs to inform the state's plan for use of SUPTRS BG funds for SSPs, if determined to be eligible. The state must follow the steps below when requesting to direct SUPTRS BG funds to SSPs during the award year for which the state is eligible and applying:

Step 1 - Request a **Determination of Need** from the CDC

Step 2 - Include request in the SUPTRS BG Application Plan to expend the funds for the award year which the state is planning support an existing SSP or establish a new SSP. Items to include in the request:

- Proposed protocols, timeline for implementation, and overall budget
- Submit planned expenditures and agency information on Table 16a listed below

Step 3 - Obtain SUPTRS BG State Project Officer Approval

Use of SUPTRS BG funds for SSPs future years are subject to authorizing language in appropriations bills, and must be re-applied for on an annual basis.

Additional Notes:

1. Section 1931(a)(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (**42 U.S.C. § 300x-31(a)(1)(F)**) and **45 CFR § 96.135(a)(6)** explicitly prohibits the use of SUPTRS BG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

2. Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (**42 U.S.C. § 300x-24(a)**) and **45 CFR § 96.127** requires entities that receives SUPTRS BG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

3. Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (**42 U.S.C. § 300x-24(b)**) and **45 CFR 96.128** requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SUPTRS BG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (**42 U.S.C. 300x-28(c)**) and **45 CFR 96.132(c)** requires states to ensure that substance use prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to health services.

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Budget of SUPTRS BG for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone or other Opioid Overdose Reversal Medication Provider (Yes or No)
No Data Available					
Totals:		\$0.00		0	

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Footnotes:
Not Applicable. New Jersey does not use SUPTRS Block Grant funds to support Syringe Services Programs (SSPs).