

New Jersey

UNIFORM APPLICATION

FY 2023 Mental Health Block Grant Report

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 03/31/2022 - Expires 03/31/2025
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Center for Mental Health Services
Division of State and Community Systems Development

A. State Information

State Information

State DUNS Number

Number 806418257

Expiration Date

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

Agency Name New Jersey Division of Mental Health and Addiction Services
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III. State Expenditure Period (Most recent State expenditure period that is closed out)

From 7/1/2021
To 6/30/2022

IV. Date Submitted

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

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Footnotes:

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B. Implementation Report

MHBG Table 1 Priority Area and Annual Performance Indicators - Progress Report

Priority #: 1
Priority Area: Pregnant Women/Women with Dependent Children
Priority Type: SAT
Population(s): PWWDC

Goal of the priority area:

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

Objective:

Increase number of pregnant women or women with children entering substance use disorder treatment.

Strategies to attain the goal:

- **Annual Provider Meetings:** These meetings are held with licensed contracted women's treatment providers, system partners representing NJ Department of Children and Families (DCF), Division of Family Development (DFD), Work First New Jersey Substance Abuse Initiative (WFNJ-SAI), the Maternal Wrap Around Program (MWRAP) providers, and Integrated Opioid Treatment and Substance Exposed Infants (IOT-SEI) providers. Meetings address a variety of topics ranging from information sharing, best practices, continuum of care, medication assisted treatment, referrals and access to services, recovery supports, Plans of Safe Care, systems collaboration, Substance Exposed Infants (SEI) and Neonatal Abstinence Syndrome (NAS), challenges, and training needs.
- **Professional Development:** Contracted licensed women's treatment providers that receive funding through the women's set aside block grant are required to address the full continuum of treatment services: family-centered treatment, evidence-based parenting programs, trauma-informed and trauma-responsive treatment using Seeking Safety, Strengthening Families, evidence-based parenting classes, recovery supports, etc. and assist women with housing supports by linking women to transitional, permanent and/or supportive or sober living homes such as an Oxford House. All providers who have DMHAS contracts for specialty services ranging from prevention, treatment and recovery supports for pregnant and parenting women (PPW) with opioid use disorder are required to have new staff successfully complete the National Center on Substance Abuse and Child Welfare (NCSACW) online tutorials "Understanding Child Welfare and the Dependency Court: A Guide for Substance Abuse Treatment Professionals" and document completion of tutorials in their employee personnel files.
- **Plans of Safe Care:** All women's treatment and pregnant and parenting specialty services (MWRAP and IOT-SEI Initiatives) provider contract language requires Plans of Safe Care for pregnant and postpartum women. Plans of Safe Care will address the needs of the mother, infant and family to ensure coordination of, access to, and engagement in services. For a pregnant woman, the Plan shall be developed prior to the birth event whenever possible and in collaboration with treatment providers, health care providers, early childhood service providers, and other members of the multidisciplinary team as appropriate. Documentation of the Plan must be included in the woman's file.
- **Interim Services:** In 2019 NJ DMHAS added language to Fee for Service (FFS) Network Annex A's to ensure all FFS funded treatment agencies provide Interim Services as an engagement service at all levels of care to ensure priority PPW consumers awaiting admission to their assessed level of care anywhere in the state could receive interim services within 48 hours at facilities closer to home. Interim services for PPW consumers is designed to reduce the adverse health effects of substance use, promote individual health, and reduce the risk of transmitting disease to sexual partners and their infants by providing individualized education, case management, referrals and MAT if needed, while awaiting admission. Statewide technical assistance on interim services was provided to all provider contractees.
- **In Depth Technical Assistance (IDTA) Neonatal Abstinence Syndrome and Substance Exposed Infants (NAS SEI):** As a SAMHSA Prescription Drug Abuse Policy Academy State, NJ applied for a unique technical assistance opportunity through the SAMHSA supported NCSACW to address the multi-faceted problems of NAS and SEI. NJ DHS/DMHAS as the lead State agency, partnered with DCF and DOH, and submitted a successful application (no funding attached). The IDTA goal was to develop uniform policies/guidelines that address the entire spectrum of NAS and SEI from pre-pregnancy, prevention, early intervention, assessment and treatment, postpartum and early childhood. The IDTA provided technical assistance to NJ to strengthen collaboration and linkages across multiple systems such as addictions treatment, child welfare, and medical communities to improve services for pregnant women with opioid and other substance use disorders and outcomes for their babies. The Core Team included over 60 individuals representing multiple State Departments and Divisions, community stakeholders, treatment providers, and the medical community. Three goals were established (1) Increase perinatal SEI screening at multiple intervention points (2) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women screening positive on the 4P's Plus get connected for a comprehensive assessment by establishing formal warm-handoffs and other safety net measures; (3) Leverage existing programs and policy mechanisms to collaboratively increase the rate at which women delivering SEIs and their babies and any other eligible children, receive early support services for which they are eligible. Workgroups were formed.

- IDTA Birthing Hospital Survey: Labor, Delivery and Engagement (Infants) Workgroup developed a comprehensive survey with input from the medical community and perinatal cooperatives. The Birthing Hospital Survey was disseminated statewide March 2017 to the labor and delivery hospitals. The survey sought to understand how pregnant women with SUD and SEI are identified, treated, and triaged with partners at discharge, and if treatment for NAS was explored. The results were intended to guide Departments in establishing statewide guidelines for best practice; aid in the development of cross system models to ensure families get access to services; establish education needs on issues of SEI/NAS and identify high risk areas. In an effort to increase access to SUD treatment and reduce unmet treatment needs of pregnant or parenting women with an Opioid Use Disorder (OUD), based from the Birthing Hospital Survey findings, the DMHAS engaged Rutgers/Robert Wood Johnson Medical School (Rutgers/RWJ) to provide technical assistance and training through the ECHO Program.

- Project ECHO Maternal Child Health. Pregnant and Parenting Women with Opioid Use Disorder (MCH PPW OUD): This ECHO provides education and training to primary care practitioners, SUD treatment providers, behavioral health practitioners, and other stakeholders in multiple clinic settings and at home, utilizing a web-based video collaboration between a multi-disciplinary team of specialists and primary care practitioners on best practices for the assessment, case management, intervention, treatment and recovery support services for PPW with an OUD. The goal is to increase the capacity and competency of providers, community support organizations and clinical teams to support prevention, treatment and recovery of PPW with OUD. ECHO will position communities to reduce the NAS birth rates, improve use of medication assisted treatment, family formation and early infant development; improve access to physical and mental health care by educating more providers, midwives, doulas, and other health care professionals on best practices during prenatal and perinatal periods. The anticipated start date for the Program was set for March 2020. However, with the advent of the global COVID-19 pandemic, and the national and state orders to shelter in place effective late March 2020, limitations on who could go to the hospital added a level of complexity to care for those mothers expecting to give birth during this time or in recovery at home. These events required an immediate response to address the public health emergency. In late March, 2020 the DMHAS agreed to postpone the traditional MCH PPW-OUD ECHO Series until such time that the providers could return to a focus on pregnant and parenting women with an OUD. The ECHO team (DMHAS, Rutgers/RWJ and Hub members) refocused resources to provide COVID-19 MCH & OUD ECHO sessions. This temporary change in scope enabled the MCH PPW-OUD ECHO team to address treatment issues, access to healthcare services and how to meet the needs of specific populations of women during this crisis. The MCH PPW-OUD Hub team completed a 7 COVID-19 maternal child health and OUD sessions between April and the first week of June. The MCH PPW-OUD Hub team completed a 7 COVID-19 maternal child health and OUD sessions between April and the first week of June, 2020, and MCH PPW-OUD ECHO with COVID-19 (included as a discussion topic) reconvened June 15, 2020 through December 2020. MCH PPW-OUD ECHO series is scheduled after July of 2021. Each series is designed as 12 bi-weekly sessions.

- Maternal Wrap Around Program (MWRAP): MWRAP is a statewide program located in six regions with each region serving approximately 30 unduplicated opioid dependent pregnant women, their infants and families. MWRAP provides intensive case management and recovery support services for opioid dependent pregnant and postpartum women. Opioid dependent women are eligible for services during pregnancy and up to one year after the birth event. The MWRAP goal is to alleviate barriers to services for pregnant opioid dependent women through comprehensive care coordination that is implemented within the five major timeframes when intervention in the life of the SEI can reduce potential harm of prenatal substance exposure: pre-pregnancy, prenatal, birth, neonatal and early childhood. MWRAP is intended to promote maternal health, improve birth outcomes, and reduce the risks and adverse consequences of prenatal substance exposure.

The onset of the COVID-19 pandemic resulted in many significant safety precautions at the national and state level. The stay-at-home orders, such as closures of businesses, schools, restrictions in gatherings has had an impact on the social determinants of health (food, security, employment, income, access to medical care, etc.). Pregnant and parenting women with a history of substance use disorder could be at risk for increase in substance use or experience relapse due to feelings of isolation, lack of family supports, or social support systems. Their mental health could be adversely affected exhibiting depression during pregnancy and postpartum. State fiscal year, 2022 the MWRAP statewide initiative eligibility criteria will be expanded to include pregnant women with substance use disorder, not exclusive to opioid dependency and providers will serve a total of 50 (fifty) unduplicated women per region.

- Integrated Opioid Treatment and Substance Exposed Infants (IOT-SEI) Initiative: Five awards across the State, funded with the Governor's State Opioid funds. This Initiative provides an array of integrated services for opioid dependent pregnant women, their infants and family. Providers are required to ensure a full continuum of services and to establish mechanisms to develop a coordinated and cohesive approach for working together across systems that include, SUD treatment, medical community, maternal child health, and child welfare. Initiative focuses on alleviating barriers to services. Services range from: mother's medical/prenatal and obstetrical care, SUD treatment for OUD including MAT, new born/infant medical care, child welfare services as identified, intensive case management, recovery supports, assistance with housing, case management and other wraparound services. Providers must ensure that there is comprehensive care coordination from prenatal through the birth event, postpartum, and early childhood

- Data Collection (MWRAP and IOT-SEI): DMHAS Researcher is collecting and analyzing data to understand the impact of each program on outcomes for the mother and her child, to evaluate program effectiveness, make recommendations for program improvement and sustainability. As of July 2020 COVID19 specific data is also being collected; the purpose of this data is to understand how individual participants are being affected and what specific steps are being taken to address COVID19 related challenges – Data is on impact of social determinants of health on health outcomes in the time of COVID 19 such as housing, transportation and healthcare.

- Supportive Housing: DMHAS developed a Women's Intensive Supportive Housing (WISH) Program. WISH provides permanent supportive housing for pregnant and/or parenting women with a co-existing substance abuse disorder and mental illness who are homeless or at risk of homelessness and being discharged from a licensed long-term residential substance abuse treatment and/or halfway house facility. An RFP was developed and released in January 2015 for the development of a WISH team to provide case management and supportive housing services for 10 women and their children. The RFP was awarded in 2015 to a licensed treatment provider who specializes in women's gender specific treatment, offers a continuum of care, and has a longstanding history of providing supportive housing and has demonstrated success in managing permanent supportive housing programs.

Since 2014, DMHAS has a Memorandum of Understanding (MOU) with NJ DCF, DCP&P to fund ten (10) supportive housing subsidies annually for the "Keeping Families Together" (KFT) program for parents involved with the child welfare system who are homeless or at imminent risk and in which one or more adults in the family is diagnosed with a co-occurring mental health illness and substance use disorder. DCP&P contracts with a provider for the KFT program in Essex County.

• Systems Collaboration PPW: Twelve (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, Plans of Safe Care, and reunification for children in out of home placement. Through collaboration, multiple agencies working with the same family can improve communication to reduce the gaps in service delivery and improve coordination of services. The Consortia allow for cross systems collaboration with local treatment programs and other community partners who can provide the expertise needed to better serve families in the child welfare system.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of pregnant women or women with children entering substance use disorder treatment.

Baseline Measurement: SFY 2021: 27,210 admissions

First-year target/outcome measurement: Increase number of pregnant women or women with children entering substance use disorder treatment in SFY 2022 by 1%.

Second-year target/outcome measurement: Increase number of pregnant women or women with children entering substance use disorder treatment by 2% by the end of SFY 2023. The change in SFY 2023 will be measured by calculating the percent difference from SFY 2020 to SFY 2023.

New Second-year target/outcome measurement(if needed):

Data Source:

The number of pregnant women and women with children from SFY 2021 – 2023 will be tracked by the SSA's New Jersey Substance Abuse Monitoring System (NJSAMS).

New Data Source(if needed):

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.

New Description of Data:(if needed)

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.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved *(if not achieved, explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

Priority #: 2
Priority Area: Heroin/Opioid Users
Priority Type: SAT
Population(s): Other ()

Goal of the priority area:

To ensure medication assisted treatment (MAT) is provided as an option to individuals with an opioid use disorder (OUD) who are entering into substance use disorder (SUD) treatment.

Objective:

Increase the number of heroin/other opiate admissions for whom MAT is planned.

Strategies to attain the goal:

- Continue to utilize a public awareness campaign focusing on reducing stigma/discrimination regarding MAT to assist in engaging individuals with an OUD, their families, friends, loved ones, providers and other community members so that they understand the use of MAT is a best practice in the treatment of an OUD.
- Buprenorphine Medical Support Initiative- Continuing this initiative which will focus on the challenges faced by licensed mental health programs that require start-up funds to increase their capacity to offer MAT, specifically buprenorphine to their clients. MH programs will be expected to build capacity to offer MAT in compliance with all federal and New Jersey state regulations.
- 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).
- DMHAS will launch a Buprenorphine Enhancement, similar to the one created for Vivitrol, that will reimburse FFS Network providers for the provision of buprenorphine at their agencies. Licensed SUD agencies will be able to participate in the enhancement will proper approval from CN&L.
- DMHAS collaborates with 20 county jails that have established MAT programs or enhanced existing MAT services for inmates. In addition, DMHAS works with county correctional facilities and have established justice involved re-entry services for detainees where case managers at county jails conduct intake assessments and establish pre-release plans for needed services in the community, which include linking individuals to community MAT services.
- DMHAS will continue to provide a statewide distribution of American Society of Addiction Medicine (ASAM) booklets entitled "Opioid Addiction Treatment: A Guide for Patients, Families and Friends" which provide facts about treatment, including MAT as a best practice, and provides NJ-specific resources to accessing treatment and recovery services. These guides are provided in both English, Spanish and Braille, and will include a video link of the booklet made in American Sign Language (ASL).
- DMHAS developed and will continue its Memorandum of Agreement (MOA) with Rutgers University, Robert Wood Johnson Medical School for a train-the-trainer program on Medication Assisted Treatment (MAT), the opioid epidemic (specific to New Jersey) and concepts of SUD (specific to OUD) for a minimum of 40 graduate students at Rutgers University. The goal of this project has been to educate, support, and mentor graduate students to give free educational talks, through use of PowerPoint presentations, to community businesses and organizations.
- Expand low threshold buprenorphine induction programming at all statewide Harm Reduction Centers (HRCs) while also continuing to encourage collaboration and affiliation agreements between the HRCs and substance use disorder agencies to ensure referral to comprehensive treatment programs, when clinically indicated.
- Development and expansion of its 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.
- DMHAS will be issuing a Request for Proposal (RFP) which will fund cultural competence training that will be provided to narrow the treatment gap experienced by Black/African Americans (AA) who are diagnosed with opioid and stimulant use disorders and who are statistically less likely to receive or access services. A second goal of this initiative is to increase access to MAT through increased prescribing to the Black/AA community.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Increase the number of heroin/other opiate admissions for whom MAT was planned.
Baseline Measurement: SFY 2021: 21,227 heroin/other opiate admissions for whom MAT was planned.
First-year target/outcome measurement: Increase the number of heroin/other opiate admissions for whom MAT is planned by 1%
Second-year target/outcome measurement: Increase the number of heroin/other opiate admissions for whom MAT is planned by 2%. The change in SFY 2023 will be measured by calculating the percent difference from SFY 2021 to SFY 2023.

New Second-year target/outcome measurement(if needed):

Data Source:

The number of heroin/other opiate admissions for whom MAT was planned from SFY 2021 - 2023 will be tracked by the SSA's New Jersey Substance Abuse Monitoring System (NJSAMS).

New Data Source(if needed):

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.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

Priority #: 3

Priority Area: Persons Who Inject Drugs (PWID)

Priority Type: SAT

Population(s): PWID

Goal of the priority area:

To expand access to comprehensive treatment, including Medication Assisted Treatment (MAT), in combination with other treatment modalities, for individuals with an opioid use disorder, including PWID, through mobile medication units and other innovative approaches.

Objective:

Increase the number of PWID entering treatment and number of heroin and other opiate dependent individuals entering treatment.

Strategies to attain the goal:

- Expand low threshold buprenorphine induction programming at all statewide Harm Reduction Centers (HRCs) while also continuing to encourage collaboration and affiliation agreements between the HRCs and substance use disorder agencies to ensure referral to comprehensive treatment programs, when clinically indicated. Providing services in convenient locations, specifically continuing to utilize and start-up new mobile medication programming, in order to reduce barriers and engage individuals in care as easily as possible.

- Development and expansion of its 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. Promoting the use of medication assisted treatment (MAT) (e.g., methadone, buprenorphine, injectable naltrexone) for individuals with an opioid use disorder (OUD) who seek treatment at any level of care.
- Providing substance use disorder treatment services for individuals who are Deaf and hard of hearing and whose primary language is American Sign Language (ASL) and have a primary diagnosis of an opioid use disorder or stimulant use disorder. The goal is to provide regional services that are both culturally and linguistically accessible and utilize substance use counselors, case managers, and qualified ASL interpreters at three (3) site locations and refer to MAT programming, when appropriate.
- Educating providers, individuals with an OUD, family members and the public about the benefits of MAT through its public awareness campaign that was launched in 2020, as well as providing public presentations, in-person or virtually, on this topic.
- Contracts with three regional Opioid Overdose Prevention Program (OOPP) providers and an Opioid Overdose Prevention Network (OOPN) provider to continue to offer community education and trainings for individuals at-risk for an opioid use disorder, their families, friends and loved ones to recognize an opioid overdose and to subsequently provide naloxone kits to individuals in attendance. A component of these trainings have been and will continue to be to discuss treatment, including MAT.
- Increase the number of naloxone trainings specifically for underserved populations, such as schools, jails, licensed substance use disorder (SUD) treatment providers, Offices of Emergency Management, Emergency Medical Services teams, fire departments, homeless shelters and community health clinics.
- Linking individuals reversed from an opioid overdose, who are seen bedside by recovery specialists and patient navigators at emergency departments, via the 21 county Opioid Overdose Recovery Programs (OOPP) to treatment and/or recovery support services in their communities.
- Statewide contracts awarded to providers in all 21 counties for a Support Team for Addiction Recovery (STAR) program to provide case management and wraparound services for individuals with an OUD. Goals include linking clients to needed services, housing, primary care and treatment to include MAT.
- Maternal Wrap Around Program (MWRAP) – MWRAP is a statewide program located in six regions with each region serving approximately 30 unduplicated opioid dependent pregnant women, their infants and families. MWRAP provides intensive case management and recovery support services for opioid dependent pregnant and postpartum women. Opioid dependent women are eligible for services during pregnancy and up to one year after the birth event. The MWRAP goal is to alleviate barriers to services for pregnant opioid dependent women through comprehensive care coordination that is implemented within the five major timeframes when intervention in the life of the SEI can reduce potential harm of prenatal substance exposure: pre-pregnancy, prenatal, birth, neonatal and early childhood. MWRAP is intended to promote maternal health, improve birth outcomes, and reduce the risks and adverse consequences of prenatal substance exposure. The onset of the COVID-19 pandemic resulted in many significant safety precautions at the national and state level. The stay-at-home orders, such as closures of businesses, schools, restrictions in gatherings has had an impact on the social determinants of health (food, security, employment, income, access to medical care, etc.). Pregnant and parenting women with a history of substance use disorder could be at risk for increase in substance use or experience relapse due to feelings of isolation, lack of family supports, or social support systems. Their mental health could be adversely affected exhibiting depression during pregnancy and postpartum. State fiscal year, 2022 the MWRAP statewide initiative eligibility criteria will be expanded to include pregnant women with substance use disorder, not exclusive to opioid dependency and providers will serve a total of 50 (fifty) unduplicated women per region.
- In September 2016, DMHAS was awarded a “Strategic Prevention Framework for Prescription Drugs (SPF Rx)” five-year grant from SAMHSA to implement the NJAssessRx initiative. NJAssessRx expands interagency sharing of the state’s Prescription Drug Monitoring Program data and gives DMHAS the capability to use data analytics to identify prescribers, prescriber groups and patients at high risk for inappropriate prescribing and nonmedical use of opioid drugs. Informed by the data, DMHAS and its prevention partners will strategically target communities and populations needing services, education or other interventions. The target population is youth (ages 12-17) and adults (18 years of age and older) who are being prescribed opioid pain medications, controlled drugs, or human growth hormone (HGH), and are at risk for their nonmedical use.
- In FY 2020, New Jersey received a total of \$120.3 million through SOR for a two-year period. In FY 2021, NJ received \$65.97 million through SOR 2.0. The goal of the SOR is to address the State’s opioid crisis as well as a rising issue of stimulant use disorder by providing treatment, family and peer recovery support, community prevention and education programs and training. The key objectives of funding are to increase access to medication-assisted treatment (MAT), reduce unmet treatment need, reduce opioid-related deaths, and provide services to address individuals who have a stimulant use disorder.
- As part of SOR and state funding, DMHAS collaborates with 20 of 21 counties in NJ who have established MAT programs or enhanced existing MAT services for inmates with OUD at county correctional facilities. DMHAS will utilize funds to have its Centers of Excellence provide technical assistance to correctional facilities to assist them in the provision of these services. In addition, DMHAS has worked with county correctional facilities to establish justice involved re-entry services for detainees where case managers at county jails conduct intake assessments and establish pre-release plans for needed services in the community.
- Interim Services is a requirement of DMHAS provider contracts. A new 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.
- DMHAS is proposing to increase access to buprenorphine and other ancillary services for individuals with a substance use disorder through current

programming available at homeless shelters. It is proposed that providers will 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 services when appropriate.

- DMHAS will continue a train-the-trainer program through Rutgers University on MAT and NJ-specific treatment and recovery resources for graduate students. The goal of this project is to educate, support, and mentor graduate students to give free educational talks to community groups throughout the State.
- DMHAS will be issuing a Request for Proposal (RFP) which will fund cultural competence training that will be provided to narrow the treatment gap experienced by Black/African Americans (AA) who are diagnosed with opioid and stimulant use disorders and who are statistically less likely to receive or access services. A second goal of this initiative is to increase access to MAT through increased prescribing to the Black/AA community.
- DMHAS to develop a pilot program to fund one of its university partners to develop a few pilot paramedicine programs in the State to administer buprenorphine for opioid withdrawal symptoms and provide next day linkage to care to community MAT providers.
- The Division of Medical Assistance and Health Services, in collaboration with DMHAS, launched a program to cover and support MAT and Office Based Addiction Treatment (OBAT). This program coordinates the delivery of multiple reimbursable services provided by primary care providers and community behavioral health specialists to NJ FamilyCare members with an addiction diagnosis. OBAT providers link patients to OTP or other treatment services when appropriate.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of PWID entering treatment.

Baseline Measurement: SFY 2021: 21,921 admissions

First-year target/outcome measurement: Increase the number of PWID entering treatment by 1%.

Second-year target/outcome measurement: Increase the number of PWID entering treatment by 2% by the end of SFY 2023. The change in SFY 2023 will be measured by calculating the percent difference from SFY 2020 to SFY 2023.

New Second-year target/outcome measurement(if needed):

Data Source:

The number of PWID in SFY 2021 through SFY 2023 will be tracked by the SSA's New Jersey Substance Abuse Monitoring System (NJSAMS).

New Data Source(if needed):

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.

New Description of Data:(if needed)

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.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved *(if not achieved, explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

Indicator #: 2

Indicator: Increase the number of heroin and other opiate dependent individuals entering treatment.

Baseline Measurement: SFY 2021: 39,771 admissions

First-year target/outcome measurement: Increase the number of heroin and other opiate dependent individuals entering treatment by 1%.

Second-year target/outcome measurement: Increase number of opiate dependent individuals entering treatment by 2% by the end of SFY 2023. The change in SFY 2023 will be measured by calculating the percent difference from SFY 2021 to SFY 2023.

New Second-year target/outcome measurement(if needed):

Data Source:

The number of opiate dependent individuals from SFY 2021 - 2023 will be tracked by the SSA's New Jersey Substance Abuse Monitoring System (NJSAMS).

New Data Source(if needed):

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.

New Description of Data:(if needed)

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.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

Priority #: 4

Priority Area: TB

Priority Type: SAT

Population(s): TB

Goal of the priority area:

Increase compliance rate of DMHAS' SAPT Block Grant contracted agencies offering every client a tuberculosis evaluation.

Objective:

Increase the percentage of DMHAS' SAPT Block Grant contracted agencies offering every client a tuberculosis evaluation

Strategies to attain the goal:

Ongoing monitoring. Monitors will review compliance during the annual site visit, and require an acceptable plan of correction for non-compliance. If repeat deficiencies are found, an alternate plan of correction and proof of implementation will be required.

Edit Strategies to attain the objective here:

(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Annual Site Monitoring Report of DMHAS' SAPT Block Grant contracted agency indicating that client was offered a tuberculosis evaluation.

Baseline Measurement: According to SFY 2021 Annual Site Monitoring Reports of DMHAS' SAPT Block Grant contracted agencies, 83% of the agencies that were monitored (30 of 36 agencies) were in compliance with offering every client a tuberculosis evaluation.

First-year target/outcome measurement: An increase of 5% above the baseline measure.

Second-year target/outcome measurement: An additional increase of 5% above the first-year target measure.

New Second-year target/outcome measurement(if needed):

Data Source:

Annual Site Monitoring Reports of DMHAS' SAPT Block Grant Contracted Agencies

New Data Source(if needed):

Description of Data:

The grants monitoring program at DMHAS monitor SAPT Block Grant recipients. Onsite visits are made to each SAPT Block Grant recipient a minimum of one time per calendar year. The reviewer conducts chart reviews for the selected sample and completes an Annual Site Monitoring Report. The Annual Site Monitoring Report addresses at a minimum five core areas of performance: Facility, Staff, Treatment Records, Quality Assurance, Specialized Services, and Other contract requirements.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved *(if not achieved, explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

Priority #: 5

Priority Area: Tobacco

Priority Type: SAP

Population(s): Other ()

Goal of the priority area:

Reduce the percentage of persons aged 12 – 17 who report using any type of tobacco product in the past month

Objective:

Decreased past month use of tobacco products among persons aged 12 to 17.

Strategies to attain the goal:

Beginning in January 2012, DMHAS funded 17 Regional Prevention Coalitions, all of whom utilize the SPF model to guide their work. These coalitions are all required to address tobacco use among youth. The coalitions use, primarily, environmental strategies along with occasional individual approaches as appropriate. Below is a listing of approaches used by the coalitions to address tobacco use among adolescents in their regions.

Environmental Strategies

- Enhance Access/Reduce Barriers – Enhance access to effective prevention strategies and information through the use of a social media campaign and the development of human capital and networks of support.
- Enhance Barriers/Reduce Access - Increase education among merchants who sell tobacco products.
- Enhance Barriers/Reduce Access – Work with municipal and county government to ban smoking from restaurants and other public places, including schools, workplaces, and hospitals.
- Change Consequences/Enhance Access/Reduce Barriers – Work with municipal and county government to assure that tobacco laws are enforced at the local level.
- Change Physical Design – Through the compliance check report and GIS mapping, provide municipalities and state tobacco control with details regarding how outlet density and location impact tobacco availability to youth.
- Modify/Change Policies – Enhance or create policies related to smoking among 12-17 years olds on a countywide level.

Individual Strategies

- Provide information – Educate parents and youth on the dangers of tobacco use by youth through awareness efforts, workshops, and countywide events. These programs will be provided through county alcohol and drug funding, municipal alliances, and other community organizations.
- Provide Information – Educate youth on the dangers of tobacco use through by means of evidence-based middle and elementary school prevention programs and other community-based initiatives.

Legislation

- The State of New Jersey enacted a statute to raise the age to sell tobacco products from persons 19 years of age to 21 years of age effective November 1, 2017 (P.L.2017, Chapter 118).

Additionally, DMHAS funds community-based services targeting high-risk individuals or groups in each of New Jersey’s 21 counties. Many of these providers are also focused on the prevention of tobacco use among youth.

**Edit Strategies to attain the objective here:
(if needed)**

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Past month tobacco product use (any) among persons aged 12 to 17.
Baseline Measurement:	According to 2018-2019 NSDUH data, 2.96 percent of the target population reported tobacco product use (any) during the month prior to participating in the survey.
First-year target/outcome measurement:	A reduction of .40% below the baseline measure.
Second-year target/outcome measurement:	An additional reduction of .15% below the first year measure.
New Second-year target/outcome measurement(if needed):	

Data Source:

National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia), Tobacco Product Use in the Past Month, by Age Group and State: Percentages, Annual Averages Based on 2018-2019 NSDUH data for New Jersey

New Data Source(if needed):

Description of Data:

Data from the NSDUH provide national and state-level estimates on the use of tobacco products, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health in the United States.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved *(if not achieved, explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

Priority #: 6
Priority Area: Alcohol
Priority Type: SAP
Population(s): Other ()

Goal of the priority area:

Reduce the percentage of persons aged 12 – 20 who report binge drinking in the past month

Objective:

Decreased past month of binge drinking among persons aged 12 to 20.

Strategies to attain the goal:

Beginning in January 2012, DMHAS funded 17 Regional Prevention Coalitions, all of whom utilize the SPF model to guide their work. These coalitions are all required to address underage drinking among youth. The coalitions use, primarily, environmental strategies along with occasional individual approaches as appropriate. Below is a listing of approaches used by the coalitions to address underage drinking among adolescents in their regions.

Environmental Strategies

- Enhance Access/Reduce Barriers – Enhance access to effective prevention strategies and information through the use of a social media campaign and the development of human capital and networks of support.
- Enhance Barriers/Reduce Access - Increase education among merchants, bars, and restaurants who sell alcoholic beverages. Also, provide education to parents and guardians.
- Change Consequences/Enhance Access/Reduce Barriers – Work with municipal and county government to assure that underage drinking laws are enforced at the local level.
- Change Physical Design – Through the compliance check report and GIS mapping, provide municipalities and state Alcoholic Beverage Commission with details regarding how outlet density and location impact tobacco availability to youth.
- Modify/Change Policies – Enhance or create policies related to underage drinking among 12-20 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.

**Edit Strategies to attain the objective here:
(if needed)**

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Binge Alcohol Use in the Past Month by persons aged 12-20.
Baseline Measurement:	According to 2018-2019 NSDUH data, 12.63 percent of the target population reported

binge drinking during the month prior to participating in the survey.

First-year target/outcome measurement: A reduction of .50% below the baseline measure.

Second-year target/outcome measurement: An additional reduction of .10% below the baseline measure.

New Second-year target/outcome measurement(if needed):

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 2018-2019 NSDUH data for New Jersey

New Data Source(if needed):

Description of Data:

Data from the NSDUH provide national and state-level estimates on the use of tobacco products, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health in the United States.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

Priority #: 7

Priority Area: Marijuana

Priority Type: SAP

Population(s): Other ()

Goal of the priority area:

Decrease the percentage of persons aged 12 – 17 who report Marijuana Use in the Past Year.

Objective:

Decreased use of marijuana in the past year among persons aged 12 to 17.

Strategies to attain the goal:

Beginning in January 2012, DMHAS funded 17 Regional Prevention Coalitions, all of whom utilize the SPF model to guide their work. These coalitions are all required to address marijuana use among youth. The coalitions use, primarily, environmental strategies along with occasional individual approaches as appropriate. Below is a listing of approaches used by the coalitions to address marijuana use among adolescents in their regions.

Environmental Strategies

- Enhance Access/Reduce Barriers – Enhance access to effective prevention strategies and information through the use of a social media campaign and the development of human capital and networks of support.
- Change Consequences/Enhance Access/Reduce Barriers – Work with municipal and county government to assure that marijuana use and possession laws are enforced at the local level.
- Modify/Change Policies – Enhance or create policies, laws, and ordinances related to marijuana use among 12-17 years olds on a countywide level.

Individual Strategies

- Provide information – Educate parents and youth on the dangers of marijuana use by youth through awareness efforts, workshops, and countywide

events. These programs will be provided through county alcohol and drug funding, municipal alliances, and other community organizations.
• Provide Information – Educate youth on the dangers of marijuana use by means of evidence-based middle and elementary school prevention programs and other community-based initiatives.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Marijuana Use in the Past Year by persons aged 12-17.
Baseline Measurement: According to 2018-2019 NSDUH data, 11.48 percent of the target population reported marijuana use during the year prior to participating in the survey.
First-year target/outcome measurement: A reduction of .05% below the baseline measure.
Second-year target/outcome measurement: An additional reduction of .05% below the baseline measure.
New Second-year target/outcome measurement(if needed):

Data Source:

Marijuana Use in the Past Year, by Age Group and State: Percentages, Annual Averages Based on 2018-2019 NSDUH data for New Jersey

New Data Source(if needed):

Description of Data:

Data from the NSDUH provide national and state-level estimates on the use of tobacco products, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health in the United States.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved *(if not achieved, explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

Priority #: 8
Priority Area: Prescription Drugs
Priority Type: SAP
Population(s): PP ()

Goal of the priority area:

Decrease the percentage of persons who were prescribed opioids in the past year.

Objective:

Decreased prescribing of analgesic opioids in the past year to all persons in New Jersey

Strategies to attain the goal:

Education: Educational programs and webinars regarding CDC Guideline for Prescribing Opioids for Chronic Pain.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Opioid Dispensations in New Jersey.

Baseline Measurement: According to data from NJ CARES – A Realtime Dashboard of Opioid-Related Data and Information (maintained by the Office of the New Jersey Attorney General), in 2020, 3,637,522 prescriptions for opioids were provided in New Jersey.

First-year target/outcome measurement: A reduction of 1% below the baseline measure.

Second-year target/outcome measurement: An additional reduction of .50% below the baseline measure.

New Second-year target/outcome measurement(if needed):

Data Source:

NJ CARES – A Realtime Dashboard of Opioid-Related Data and Information (maintained by the Office of the New Jersey Attorney General)

New Data Source(if needed):

Description of Data:

Statewide Prescription Drug Monitoring Program data provided by the NJ Attorney General's Office

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved *(if not achieved, explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

Priority #: 9

Priority Area: Heroin

Priority Type: SAP

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

Objective:

Increased perceptions of Great Risk from Trying Heroin Once or Twice among persons aged 12 to 17

Strategies to attain the goal:

Beginning in January 2012, DMHAS funded 17 Regional Prevention Coalitions, all of whom utilize the SPF model to guide their work. These coalitions are all required to address the use of illegal substances (including heroin) among youth. The coalitions use, primarily, environmental strategies along with occasional individual approaches as appropriate. Below is a listing of approaches used by the coalitions to address perceptions of risk regarding heroin use among adolescents in their regions.

Environmental Strategies

- Enhance Access/Reduce Barriers – Enhance access to effective prevention strategies and information through the use of a social media campaign and the development of human capital and networks of support.
- Change Consequences/Enhance Access/Reduce Barriers – Work with municipal and county government to assure that laws regarding the use of illegal substance (including heroin) are enforced at the local level.
- Modify/Change Policies – Enhance or create policies designed to increase perceptions of risk and harm related to the use of heroin among 12-17 years olds on a countywide level.

Individual Strategies

- Provide information – Educate parents and youth on the dangers of illegal substances (including heroin) by youth through awareness efforts, workshops, and countywide events. These programs will be provided through county alcohol and drug funding, municipal alliances, and other community organizations.
- Provide Information – Educate youth on the dangers of illegal substance and heroin use by means of evidence-based middle and elementary school prevention programs and other community-based initiatives.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Perceptions of Great Risk from Trying Heroin Once or Twice among persons aged 12-17.

Baseline Measurement: According to 2018-2019 NSDUH data, 66.82 percent of the target population reported Perceptions of Great Risk from Trying Heroin Once or Twice.

First-year target/outcome measurement: An increase of .25% above the baseline measure

Second-year target/outcome measurement: An additional increase of .10% above the first year measure

New Second-year target/outcome measurement(if needed):

Data Source:

Perceptions of Great Risk from Trying Heroin Once or Twice, by Age Group and State: Percentages, Annual Averages Based on 2018-2019 NSDUH data for New Jersey

New Data Source(if needed):

Description of Data:

Data from the NSDUH provide national and state-level estimates on the use of tobacco products, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health in the United States

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved *(if not achieved, explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

Priority #: 10
Priority Area: Housing Services in Community Support Services
Priority Type: MHS
Population(s): SMI

Goal of the priority area:

Maintain housing stability in community settings and improve utilization of housing service slots for mental health consumers served in Community Support Services (CSS).

Objective:

SMHA continues to increase opportunities for community living among mental health consumers by developing additional housing units and maintaining levels of occupancy to satisfy the needs of consumers served in Community Support Services.

Strategies to attain the goal:

Community Support Services (CSS) is a mental health rehabilitation service that assists the consumer in achieving mental health rehabilitative and recovery goals as identified in an individualized rehabilitation plan (IRP). CSS promotes community inclusion, housing stability, wellness, recovery, and resiliency. Consumers are expected to be full partners in identifying and directing the types of support activities that would be most helpful to maximize successful community living. This includes use of community mental health treatment, medical care, self-help, employment and rehabilitation services, and other community resources, as needed and appropriate. The adoption of CSS enhances Supportive Housing.

The SMHA will utilize a number of strategies to help attain the objective.

1. The Office of Planning, Research, Evaluation, Prevention and Olmstead works collaboratively with provider agencies, state hospital key personnel, DMHAS staff and other Divisions across the state to implement an overall paradigm of community integration.
2. Continued use of the Individual Needs for Discharge Assessment (INDA) facilitates the treatment and discharge planning processes. The INDA serves as both an assessment tool geared toward evaluating needs or barriers that the consumer may face upon discharge and a mechanism by which to assign state hospital consumers to prospective community service providers. The INDA will be continually used by the SMHA to facilitate transition into the community and anticipate and address any barriers that may hinder or preclude placement within the community.
3. Separation of Housing and Services in service delivery has enabled consumers to choose a housing provider and a different service provider. Consumers will no longer be restricted to the same agency. This separation will also enable the SMHA to track expenditures, utilization, outcomes, and demands for services.
4. The Bed Enrollment Data System (BEDS)/Vacancy Tracking System was developed to help DMHAS manage and track vacancies. The system has replaced the process of cold calls to agencies and the utilization of quickly outdated paper tracking sheets. Utilization of a web-based system provides real-time access to vacancy information and helps facilitate assignments and avoid outdated spreadsheets. Analysis of the utilization of Supportive Housing vs. supervised settings (e.g. group homes and supervised apartments) allows for assessment of the Division's progress toward community integration. The system will also enable planning at both the individual consumer level for placement purposes and system-wide for purposes of enhancements in community resources.
5. Assignment Process - In May 2015, New Jersey DMHAS revised its Administrative Bulletin 5:11 directing engagements of consumers by community providers. Under this revision, assignments of consumers replaced the concept of referrals to community providers by hospital treatment teams, requiring providers to either accept the assigned consumer or communicate their needs to DMHAS for additional supports necessary to serving the assigned consumer. The goal of this new policy was the early familiarity of consumers and providers through mandatory provider participation in the discharge planning process and engagements such as recreational day trips; visits to prospective apartments for rent; discharge preparations; and overnight visits (upon request of the consumer and/or hospital treatment team).

SMHA staff will monitor the continued development of new Supportive Housing opportunities. The BEDS data system will foster more timely and accurate tracking of residential resources, as well as facilitate their more efficient utilization (e.g., to reduce vacancy rates and increase community placements), and enable monitoring of compliance with Administrative Bulletin 5:11 (Residential Placement from Psychiatric Hospital).

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Consumers who remain in Community Support Services (CSS) during the fiscal year as a proportion of total consumers served in Community Support Services.
Baseline Measurement:	The total number of clients served in CSS in SFY 2020 was 5535 with 651 individuals terminated. The percentage for SFY 2020 was 88.24%. The total number of clients served in

CSS in SFY 2021 was 4,952 with 796 terminated. The percentage for SFY 2021 was 83.9%.

First-year target/outcome measurement: The percentage of consumers who remain in Community Support Services during SFY 2022 will be no less than 88% of total consumers served in Community Support Services.

Second-year target/outcome measurement: The percentage of consumers who remain in Community Support Services during SFY 2023 will be no less than 88% of total consumers served in Community Support Services.

New Second-year target/outcome measurement(if needed):

Data Source:

The number of consumers served by Community Support Services is tracked by the SMHA's QCMR database.

New Data Source(if needed):

Description of Data:

The QCMR Database collects quarterly, cumulative, program-specific data from each of the service providers contracted by DMHAS. The current QCMR for Community Support Services contains 50 data elements. The key data fields relevant for this performance indicator are "Ending Active Caseload (Last Day of Quarter)" and Number of terminations in the Quarter. In SFY 2020, 37 agencies contracted by the SMHA to provide QCMR data for Community Support Services.

New Description of Data(if needed)

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.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

The total number of clients served in CSS in SFY 2022 was 5575. The total number of individuals terminated in SFY 2022 was 808. Therefore, the percentage of consumers who remain in Community Support Services is 85.5%, which is less than the target rate of "no less than 88%". A number of factors were identified. They include (1) a lack of available housing stock; (2) insufficient Fair Market Rate (FMR) to cover rents; and (3) COVID effected agency staff to assist with apartment searches.

How first year target was achieved (optional):

Priority #: 11

Priority Area: Olmstead Access to Service/Occupancy Rate

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Maintain housing stability in community settings and improve utilization of housing service slots for mental health consumers served in Community Support Services (CSS).

Objective:

SMHA continues to increase opportunities for community living among mental health consumers by developing additional housing units and maintaining levels of occupancy to satisfy the needs of consumers served in Community Support Services.

Strategies to attain the goal:

Community Support Services (CSS) is a mental health rehabilitation service that assists the consumer in achieving mental health rehabilitative and recovery goals as identified in an individualized rehabilitation plan (IRP). CSS promotes community inclusion, housing stability, wellness, recovery and

resiliency. Consumers are expected to be full partners in identifying and directing the types of support activities that would be most helpful to maximize successful meaningful community living. This includes use of community mental health treatment, medical care, self-help, employment and rehabilitation services, supported education, and other community resources, as needed and appropriate. The adoption of CSS enhances Supportive Housing.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Improved Utilization of Housing Service Slots measured by occupancy rates of Community Support Services (CSS) housing units.

Baseline Measurement: In SFY 2020, the occupancy rate (i.e., occupied CSS housing units and those units with an assignment) was 95%. COVID-19 has caused a reduction in community placement. With the pandemic situation likely persisting for the majority of SFY 2021, the situation of community placement will not likely improve. The occupancy rate for SFY 2021 was 96%.

First-year target/outcome measurement: In SFY 2022, the occupancy rate (i.e., occupied CSS housing units and those units with an assignment) is expected to be 96%.

Second-year target/outcome measurement: In SFY 2023, the occupancy rate (i.e., occupied CSS housing units and those units with an assignment) is expected to be 97%.

New Second-year target/outcome measurement(if needed): In SFY 2023, the occupancy rate (i.e., occupied CSS housing units and those units with an assignment) is expected to be 91%.

Data Source:

The 2020 baseline value was generated from newer and slightly improved Provider Weekly Reports (PWR). The 2020 values were calculated by dividing the sum of the reported number of requested assignments, by the sum of the reported capacities at each program. The SMHA collected this data from 33 CSS providers at the end of SFY20.

New Data Source(if needed):

Description of Data:

For the 2020-2021 application, this priority indicator has been refined to focus on increased access to community-based housing among its largest segment—those served by Community Support Services (CSS). Although DMHAS has developed data systems (e.g., the Bed Enrollment Data System/BEDS) that are well-suited for the tracking of group homes and supervised apartments, different reporting mechanisms are preferable for the tracking of CSS housing—which is uniquely client-driven. Therefore, the data used for this indicator is from an analysis of Provider Weekly Reports, which are submitted to the SMHA on a weekly basis by each contracted CSS agency. Provider Weekly Vacancy Reports gather data from the community providers regarding their current census, current occupancy, and identify availability for state hospital assignments. These reports provide current information regarding active assignments, which includes any unforeseen post-assignment barriers, identifies any follow-up needed, and provides additional information used for tracking the progress of the assignment to allow for timely discharge and/or intervention. Prior to the development of this report, two of the three catchment areas implemented a similar tool. The new report has standardized the process in all three regions and across all providers. The Provider Weekly Vacancy Report provides information in order to validate the current BEDs Data System, as well as provide continuous updates to maintain its accuracy. This report is also used to develop and maintain the Hospital Vacancy Report, which is used for notifying state hospital treatment teams of bed vacancies and assignment opportunities. All DMHAS community providers were invited to participate in a webinar training on June 19, 2019. The Provider Weekly Vacancy Report went into effect on July 1st, 2019.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

The reporting of occupancy strictly among CSS provider agencies necessitated the use of the Provider Weekly Reports (PWRs). The rollout of the standardized PWRs came late in SFY19, so there is a small number of providers who have yet to submit their data in the proscribed fashion. This performance indicator is expressed as a proportion, and therefore it is unlikely that the SFY19 occupancy rate of 95.9% would be materially different if/when all of the data was reported.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target:

Achieved

Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

The proposed SFY 2022 rate was 96%. The actual calculated rate for SFY 2022 using the PWR data was 90.8%. Factors affecting the occupancy rate for housing include pandemic related staffing shortages, inflated costs for apartment rentals, and low inventory of affordable housing units.

For SFY 2023, SMHA have lowered the target to 91% as many of the challenges in FY 2022 are still an issue, particularly the staffing.

How first year target was achieved (optional):

Priority #: 12

Priority Area: Early Serious Mental Illness (ESMI)

Priority Type: MHS

Population(s): ESMI

Goal of the priority area:

Early treatment and intervention of psychosis helps change the trajectory of psychotic disorders in young adults by improving symptoms, reducing the likelihood of long-term disability and leading to productive independent meaningful lives.

Objective:

Among consumers who received coordinated specialty care services for individuals with early serious mental illness, including first episode psychosis, a majority will show improved symptoms and adhere to psychotic medication after receiving treatment for six months.

Strategies to attain the goal:

Objectives will be addressed through the implementation of a Coordinated Specialty Care (CSC) model. CSC is an evidence-based recovery-oriented approach involving clients and family members as active participants. All services are highly coordinated with primary medical care.

New Jersey's CSC services are provided for youth and adults between the ages of 15 to 35 years who have experienced psychotic symptoms for less than 2 years with or without treatment. Since November 2016, three teams in New Jersey have been funded to provide CSC services. They cover all 21 counties using extensive outreach efforts. The three provider agencies are Oaks Integrated Care for Southern region, Rutgers University Behavioral Health Center for Central region, and CarePlus NJ for Northern region.

Each CSC team is comprised of six members, mostly masters level clinicians, who contribute to high levels of care. They take on the roles of Team Leader, Recovery Coach, Supported Employment and Education Specialist, Pharmacotherapist, Outreach and Referral Specialist, and Peer Support Specialist. The New Jersey CSC model emphasizes treatment through the following components: outreach, low-dosage medications, cognitive and behavioral skills training, Individualized Placement and Support (IPS), supported employment and supported education, peer support, case management, and family psychoeducation.

In SFY 2021, the three CSC programs had 285 referrals and served 364 clients in their programs. New Jersey plans to continue utilizing the 10% set-aside funding in the FY 2022-23 to support the CSC teams in providing evidence-based services for individual with FEP. The CSC programs serve up to 70 clients per agency with clinical staff at 6.6 FTE levels in FY 2021.

Edit Strategies to attain the objective here:

(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Medication adherence among clients who need psychotropic medication prescribed for ESMI treatment.

Baseline Measurement: In SFY 2020, among clients who were taking or in need of antipsychotic medication for the treatment of their psychosis at intake, 87% adhere to their medication regimen. In SFY 2021, the proposed target is that 88% of the client who are taking or in need of antipsychotic medication adhered to their psychotropic medication regimens.

First-year target/outcome measurement: In SFY 2022, it is anticipated that at least 88% of the client who are taking or in need of antipsychotic medication adhere to the medication regimen.

Second-year target/outcome measurement: In SFY 2023, it is anticipated that at least 88% of the client who are taking or in need of antipsychotic medication adhere to the medication regimen.

New Second-year target/outcome measurement(if needed):

Data Source:

The Division of Mental Health and Addiction Services (DMHAS) maintains a CSC clinical diagnostic database, which is used for tracking medication monitoring in all 3 agencies.

New Data Source(if needed):

Description of Data:

The three CSC service providers submit the client level clinical diagnostic data quarterly to DMHAS. The CSC clinical diagnostic database tracks client referral and intake; functional status; program involvement; education and employment; medication and substance use; suicide ideation; hospitalization; and client discharge information.

The DMHAS is in the process of creating a comprehensive client level data system that includes data elements from all DMHAS contracted community programs. The client level data system will include all CSC program elements currently collected through the CSC clinical diagnostic database and additional measures required by federal and state data reporting and evaluation. The client level data will provide a detailed description of the ESMI population receiving CSC services in New Jersey and will help capture the treatment and recovery progress of CSC clients so that DMHAS can improve services for early serious mental illness population in New Jersey.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

Clients who participate in medication monitoring may not always be forthright with service providers about medication adherence patterns and this may introduce possible errors in data interpretation.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

Of the 359 clients in program in SFY 2022, there were 317 (88%) prescribed psychotropic medicine. Of these 317, 289 (91%) were adherent to their medications.

Priority #: 13

Priority Area: System wide assessment for delivering services to diverse populations

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

System wide assessment for delivering services to diverse populations

Objective:

All agencies are required to have a Cultural Competence Plan in place. The multicultural plans are required of both mental health and substance use agencies.

Strategies to attain the goal:

The Division of Mental Health and Addiction Services (DMHAS) is committed to creating and maintaining an environment that supports "Cultural

Competence” by promoting respect and understanding of diverse cultures, social groups, and individuals. To address issues of culture and diversity, DMHAS formed a Multicultural Services Advisory Committee (MSAC) in 1981. The MSAC devises strategies that are appropriate to the lifestyles, special needs, and strengths of New Jersey’s diverse populations and cultural groups, and most recently, addresses challenges to ensure that BIPOC (Black, Indigenous, People of Color) receive quality equitable services in the behavioral health system of care. Additionally, MSAC makes recommendations to DMHAS regarding training content, membership eligibility, statewide Cultural competency goals, agency self-assessment processes, and in collaboration with other stakeholders, ensures that cultural competency principles are disseminated across the State and to other disciplines. MSAC membership includes broad representation from providers in the behavioral health treatment community, consumer representatives, peers, LGBTQ, administrators, and academics.

All DMHAS funded behavioral healthcare agencies are required to have a written Cultural Competency Plan describing the integration of cultural and linguistic competency throughout the organization including direct attention to issues or race, ethnicity, gender, age, religion, disability, and sexual orientation. The plan establishes culturally and linguistically appropriate goals, policies, and management accountability and infuses them throughout the organization’s planning and operations adhering to Culturally and Linguistically Appropriate Services (CLAS) in their delivery of services. The CLAS standards “provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.” Additionally, the plan acts as a template for creating a workforce that improves outcomes for clients, delivers culturally responsive services, and reflects the diversity of the communities they serve. An organizational self-assessment helps prioritize the steps needed to develop those congruent behaviors and improve Culturally responsive services.

To assist agencies with preparing and maintaining a culturally and linguistically responsive delivery plan, the DMHAS contracts with two Multicultural Training and Technical Assistance Centers. The Centers provide technical assistance in the form of workshops, groups, and customized individualized support to assist agencies in the development of Cultural Competency Plans. Additionally, a statewide diversity consultant assists the two Centers with collecting, reviewing, and analyzing the plans. As a result of DMHAS commitment to Cultural Competency and the efforts of the Centers, the number of agencies that have submitted a Cultural Competency Plan has increased from less than 10% to over 50%. The remaining DMHAS agencies will submit plans by September 1, 2021. Agencies who meet cultural competency benchmarks will receive a certificate from the DMHAS Cultural Competence Training Center of Excellence that indicates their achievement in meeting this goal.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Proportion of agencies that have three areas identified from their self-assessment included in their Cultural Competence Plans.
Baseline Measurement:	The baseline variable is the number of provider agencies that complete their self-assessments and have a written Cultural Competency Plan containing at least three of the areas needed to enhance cultural competency. The establishment of a baseline is still in process and is expected to be completed in SFY 2022. The MSAC will complete the “Center for Cultural Competency Excellence” designation for agencies.
First-year target/outcome measurement:	In SFY 2022, seventy-five percent (75%) percent of all providers will have written Cultural Competence Plans which include at least three areas identified in their self-assessment. Agencies will apply for “Center for Cultural Competency Excellence” designation.
Second-year target/outcome measurement:	In SFY 2023, one hundred percent (100%) of all providers will have written Cultural Competence Plans which include at least three areas identified in their self-assessment. Agency “Center for Cultural Competency Excellence” designations will be reviewed and awarded.
New Second-year target/outcome measurement(if needed):	In SFY 2023, ninety percent (90%) of all providers will have written Cultural Competence Plans which include at least three areas identified in their self-assessment. Agency “Center for Cultural Competency Excellence” designations.

Data Source:

Self assessments and written plans checked by SMHA, Multicultural Training and Technical Assistance Center staff, and analyzed by the diversity consultant.

New Data Source(if needed):

Description of Data:

The establishment of written organizational plans for addressing culture and diversity based upon agency self-assessment. The areas

covered: Governance, Leadership, and Workforce; Communication and Language Assistance and Engagement, Continuous Improvement, and Accountability. Plans identify a minimum of at least three activities from these areas.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

n/a

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

As a result of DMHAS commitment to Cultural Competency and the efforts of the Centers, the number of agencies that have submitted a Cultural Competency Plan has exceeded 50% of the total agencies by September 1, 2021. By the end of the SFY22, an additional 25% of the total agencies have submitted a Cultural Competency Plan.

Priority #: 14

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.

Objective:

Implement workforce development initiative, "Zero to Five: Helping Families Thrive," which will increase community collaboration and support of families and will provide youth-serving agencies with increased capacity to serve youth aged 0 to 5.

Strategies to attain the goal:

Direct service staff at all 15 agencies providing MRSS will have 39 hours of training related to supporting very young children and their families. Additionally, clinicians will be trained in professional formation and reflective supervision methods, as well as Child Parent Psychotherapy, providing capacity to support very young children and their caregiving system with urgent, and/or complex needs.

Edit Strategies to attain the objective here:

(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: 85% of direct service staff at all 15 agencies providing MRSS will have 39 hours of training related to supporting very young children and their families by June 30, 2022, or within one year of program implementation. The remainder of MRSS direct service staff will be trained in the second year of the initiative. Supports for ongoing capacity building will be implemented during this phase of the initiative to ensure sustainability.

Baseline Measurement: 0

First-year target/outcome measurement: 85% (approximately 408) of direct service staff in all MRSS programs will receive training.

Second-year target/outcome measurement: The remainder of MRSS direct service staff will receive training (15%, approximately 72). Additional staff will be trained, as needed, as it is assumed that some staff trained in the prior year will be lost to normal, voluntary turnover. Supports for ongoing capacity building will be implemented during this phase of the initiative to ensure sustainability.

New Second-year target/outcome measurement(if needed): 25% of direct service field and supervisory staff from across all 15 MRSS programs will received the 21-hour KBCM training.

Data Source:

Internal Data

New Data Source(if needed):

Description of Data:

We will count MRSS direct service staff who complete the training.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

None.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

Unprecedented workforce challenges and an historic rise in utilization rates across all services lines, inclusive of Mobile Response Stabilization Services, resulted in a limited number of direct service staff being able to complete this training. For the first year, 28% were trained in Keeping Babies and Children in Mind (KBCM), a 21-hour training course. Another component of this program, referred to as "Special Topics," that would have provided the additional hours of training has not yet been implemented, as the necessary stakeholdering process had to be postponed due to staff availability. This collaborative process, which will identify the specially tailored training needs of MRSS staff and the appropriate total number of hours of this overall training initiative, will continue through FY23 and is anticipated to be implemented in FY24. Given this delay, and the continued stress on the system, we will be adjusting our second-year target, to state: 25% of direct service field and supervisory staff from across all 15 MRSS programs will received the 21-hour KBCM training.

How first year target was achieved (optional):

Indicator #: 2

Indicator: A cohort of 24 clinicians will be trained in professional formation and reflective supervision methods, as well as Child Parent Psychotherapy, providing capacity to support very young children and their caregiving system with urgent, and/or complex needs, by June 30, 2022, or within one year of program implementation. Additional cohorts will be trained annually.

Baseline Measurement: 0

First-year target/outcome measurement: 24 clinicians will be trained.

Second-year target/outcome measurement: an additional 24 (for a total of 48) clinicians will be trained.

New Second-year target/outcome measurement(if needed):

Data Source:

Internal Data

New Data Source(if needed):

Description of Data:

We will count clinicians who complete the training.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

None.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved *(if not achieved, explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

The training in professional formation and reflective supervision methods was renamed the Clinical Practice Series in Infant/Early Childhood Mental Health. 30 clinicians received six months of this training between July 1, 2021, and June 30, 2022. Twenty-seven clinicians received the separate training in Child-Parent Psychotherapy within the same time period.

Priority #: 15

Priority Area: Integration of community-based physical and behavioral health services for children, youth, and young adults with chronic medical conditions and mental/behavioral health and/or substance use challenges.

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Plan to implement at least one expansion or enhancement of integrated health and behavioral health services.

Objective:

Increase the number of youth authorized for Behavioral Health Homes (BHH) services across the five counties (four service areas) in which this service is available. BHH services sit within the Care Management Organizations (CMO).

Strategies to attain the goal:

Strategies will be evaluated on an ongoing basis. Collaboration among partners will be essential. CSOC will engage in a quality improvement effort by working with staff at the CMOs in order to support their ability to take up a more assertive, standardized approach to identifying and engaging BHH eligible youth, including data collection around identifying eligibility, screening/engagement with youth and families, and youth engagement in or utilization of BHH services, in order to increase the percentage of eligible youth who are screened for BHH services. Youth eligibility is based on medical and mental health diagnoses; for a list of eligible mental health diagnoses see: https://www.state.nj.us/humanservices/dmhas/initiatives/integration/Diagnosis_Code.pdf
Continued monitoring of the Behavioral Health Homes utilization rates will inform outcomes with regard to the performance indicator.

Edit Strategies to attain the objective here:

(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of eligible youth who are screened for BHH services will increase as a result of the quality improvement work done by CSOC in collaboration with the CMOs.

Baseline Measurement: To be determined through a quality improvement process, utilizing data from FY20 as FY21 is an outlier year due to the public health emergency.

First-year target/outcome measurement: 75% of eligible youth will be screened for BHH services.

Second-year target/outcome measurement: 100% of eligible youth will be screened for BHH services

New Second-year target/outcome measurement(if needed):

Data Source:

To be determined by a quality improvement process.

New Data Source(if needed):

Description of Data:

Data will include, for each of the four BHH programs, the number of youth eligible for BHH services and the number of youth screened for BHH services. Percentages will be formed by dividing the total number of eligible youth by number of youth screened.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

Depending on the outcome of the quality improvement process, CMOs may be required to manually count eligible youth and screened youth, which could result in some data quality issues related to human error.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved,explain why)

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

Quality improvement of Behavioral Health Homes' processes around identifying youth eligible for Behavioral Health Home services resulted in 100% of youth eligible for Care Management Organization services being screened for BHH services.

Indicator #:

2

Indicator:

The number of eligible youth provided with integrated services through the Behavioral Health Homes program will increase.

Baseline Measurement:

To be determined by a quality improvement process, utilizing data from FY20 as FY21 is an outlier year due to the public health emergency.

First-year target/outcome measurement:

75% of eligible youth will engage in and utilize BHH services.

Second-year target/outcome measurement:

80% of eligible youth will engage in and utilize BHH services.

New Second-year target/outcome measurement(if needed):

Of the BHH eligible youth newly identified within the fiscal year, 50% will be enrolled in BHH services.

Data Source:

To be determined by a quality improvement process.

New Data Source(if needed):

Description of Data:

Data will include, for each of the four BHH programs, the number of youth eligible for BHH services, with percentages formed by dividing the total number of eligible youth by the number of youth who engaged in or utilized BHH services.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

Depending on the outcome of the quality improvement process, CMOs may be required to manually count eligible youth, which could result in some data quality issues related to human error.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved,explain why)

Reason why target was not achieved, and changes proposed to meet target:

As this is a voluntary program, it is expected that some families with BHH eligible youth, despite the best engagement efforts of staff, will choose not to engage in services. Additionally, unprecedented workforce challenges and an historic rise in utilization rates across all services lines, inclusive of Care Management Organizations, resulted in Behavioral Health Homes being unable to provide services to 75% of BHH eligible youth. We will be adjusting our second-year target, to state: Of the BHH eligible youth newly identified within the fiscal year, 50% will be enrolled in BHH services.

How first year target was achieved (optional):

Priority #: 16

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.

Objective:

We will enhance Intensive In-Community services providers' ability to provide healing-centered, evidence-based interventions, by collaborating with the CARES Institute to train clinicians in Trauma Focused Cognitive Behavioral Therapy (TFCBT).

Strategies to attain the goal:

A cohort of 10 clinicians who provide Intensive In-Community services to CSOC involved youth will be trained in TFCBT within one year of implementation of the training program.

Edit Strategies to attain the objective here:

(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: A cohort of 10 clinicians who provide Intensive In-Community services to CSOC involved youth will be trained in TFCBT within one year of implementation of the training program.

Baseline Measurement: 0 clinicians trained

First-year target/outcome measurement: 10 clinicians trained

Second-year target/outcome measurement: An additional 10 clinicians trained (for a two year total of 20)

New Second-year target/outcome measurement(if needed):

Data Source:

Internal Data

New Data Source(if needed):

Description of Data:

Data will be a count of clinicians who completed the training program.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

None.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target:



Achieved



Not Achieved *(if not achieved, explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

After re-evaluating workforce readiness for professional development, it was determined that more than 10 IIC Clinicians could be offered this training. Ultimately, 17 IIC Clinicians were trained in Trauma-Focused Cognitive Behavioral Therapy between July 1, 2021 and June 30, 2022.

0930-0168 Approved: 03/31/2022 Expires: 03/31/2025

Footnotes:

New Jersey Department of Human Services
Division of Mental Health and Addiction Services
MHBG COVID-19 Mitigation Progress Report for October 1, 2021 – September 30, 2022
December 30, 2022 Revised January 23, 2023

By the end of September 30, 2022, the Division of Mental Health and Addiction Services, DMHAS, expended \$84,700.37 from the Mitigation grant. These expenditures include:

1. **COVID-19 Rapid Testing and Technology Expenses for DMHAS contracted mental health providers:** \$ 51,303.58 was expended for DMHAS-contracted mental health provider agencies to purchase COVID-19 rapid tests to administer to clients and staff onsite.
2. **Personal Protective Equipment (PPE):** \$33,396.79 was spent for agencies to purchase PPE such as gloves and masks necessary for the administration of COVID-19 Rapid Testing.

A summary table of the proposed spending and actual spending is included:

Description	Budget Approved and Award by SAMHSA	Actual spending by September 30, 2022
(1) COVID-19 Rapid Testing	\$970,959	\$51,303.58 spent on COVID-19 testing.
(2) Prevention / Virus Mitigation	\$134,631	\$0
(3) Personal Protective Equipment (PPE)	\$134,631	\$33,396.79
(4) Public Education	\$38,774	\$0
(5) Consultant	\$13,463	\$0
Sub-TOTAL	\$1,292,458	\$84,700.37
(6) State Administration	\$53,852	\$0
Total	\$1,346,310	\$84,700.37

C. State Agency Expenditure Report

MHBG Table 3 - Set-aside for Children's Mental Health Services

Reporting Period Start Date: 7/1/2021 Reporting Period End Date: 6/30/2022

Statewide Expenditures for Children's Mental Health Services			
Actual SFY 1994	Actual SFY 2021	Estimated/Actual SFY 2022	Expense Type
\$20,612,000	\$196,956,638	\$237,485,093	<input checked="" type="radio"/> Actual <input type="radio"/> Estimated

If estimated expenditures are provided, please indicate when actual expenditure data will be submitted to SAMHSA: _____

States and jurisdictions are required not to spend less than the amount expended in FY 1994.

0930-0168 Approved: 03/31/2022 Expires: 03/31/2025

Footnotes:

C. State Agency Expenditure Report

MHBG Table 6 - Maintenance of Effort for State Expenditures on Mental Health Services

Period	Expenditures	B1 (2020) + B2 (2021) 2 (C)
(A)	(B)	(C)
SFY 2020 (1)	\$490,412,748	
SFY 2021 (2)	\$470,319,447	\$480,366,098
SFY 2022 (3)	\$539,252,266	

Are the expenditure amounts reported in Column B "actual" expenditures for the State fiscal years involved?

SFY 2020	Yes	<u> X </u>	No	_____
SFY 2021	Yes	<u> X </u>	No	_____
SFY 2022	Yes	<u> X </u>	No	_____

If estimated expenditures are provided, please indicate when actual expenditure data will be submitted to SAMHSA: _____

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Footnotes: