Inventory and Need Assessment for New Jersey Behavioral Health

Pursuant to P. L. 2009, c.243 (*N.J.S.A. 30:4-177.63)*, this is a report to the Governor, the Senate Health, Human Services and Senior Citizens Committee, and the Assembly Human Services Committee concerning activities of the Department of Human Services (DHS) Division of Mental Health and Addiction Services (DMHAS) with respect to available mental health and addiction prevention, treatment and recovery support services for adults in New Jersey.

The report provides detailed information into how the state determines and estimates service needs on an annual basis and accompanying state financial resources used to meet that need. The report provides a detailed review of the key initiatives, programs, and campaigns completed and ongoing that aim to meet the growing need for access to mental health and substance use care for adults in New Jersey. These efforts include the yearslong endeavor to transition financing of mental health and substance use treatment services from cost-based, deficit funded contracts to a fee-for-service (FFS) model. As of January 2017, the following services had all successfully transition to FFS, including: Outpatient, Partial Care, Partial Hospital, Residential Services, Supported Employment, Supported Education, Integrated Case Management Services (ICMS) and Programs in Assertive Community Treatment (PACT).

Over the last several years, the Division has utilized state and federal resources to bolster treatment, prevention, and recovery support options through the adoption of Certified Community Behavioral Health Clinics, creation and expansion of opioid prevention and recovery programs, and promoting helplines and crisis lines like 1-844-ReachNJ and the 988 Suicide and Crisis Lifeline. The report also details the successes achieved and programs funded through both the federal State Opioid Response Grants and the Substance Abuse and Mental Health Service Administration Block Grants awarded annually and supplemented by multiple pandemic-related financing packages.

The Department of Human Services and Division of Mental Health and Addiction Services are dedicated to ensuring every individual in the state has access to affordable, quality health care services. It welcomes opportunities to continuing working with the Murphy Administration and the Legislature to ensure every New Jerseyan gets the help they need, when they need it.

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A. Inventory of Behavioral Health Services

The Division of Mental Health and Addiction Services (DMHAS) serves as the Single State Agency (SSA) for Substance Abuse and the State Mental Health Authority (SMHA) as designated by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). The Division oversees the provision of a broad range of community mental health and addiction services throughout the State, and contracts with approximately 320 agencies to provide and support community-based prevention, early intervention, treatment, education and recovery services, including for at-risk and special populations. 258,824 individuals were served in mental health contracted services (adults and some children), 128,733 duplicated (if someone is admitted to two or more different levels of care or is admitted to the same level of care multiple times they are included in this number). There were 125,275 individuals served in substance use disorder (SUD) licensed clinic treatment programs in SFY 2022. Of these 74,705 were unduplicated. There were approximately 200,000 served by SUD prevention, early intervention and recovery support services.

A mechanism has been developed to inventory all public and private behavioral health services in New Jersey. An inventory of all New Jersey mental health and substance use treatment and service providers under contract with the Division of Mental Health and Addiction Services (DMHAS) is prepared and regularly updated to list every agency, the agency's address and type of service provided (e.g., inpatient, outpatient, residential, etc.) by county. Below is a catalog of statewide inventories detailing current mental health and substance use treatment and service providers under contract.

Contracted Mental Health Providers: An inventory of New Jersey licensed mental health treatment and service providers under contract with the DMHAS is available in the form of a Mental Health Services Treatment Directory. This is available at https://www.nj.gov/humanservices/dmhas/home/hotlines .

Contracted Substance Use Treatment Providers: An inventory of New Jersey licensed substance use treatment providers is available in the form of the New Jersey Substance Abuse Monitoring System (NJSAMS). The is available at https://njsams.rutgers.edu/TreatmentDirectory/.

NJ Psychiatric Bed Availability: DMHAS regularly receives Healthcare Facility Licensing data from New Jersey Department of Health. Information on psychiatric beds in acute care facilities was included in the Healthcare Facility Licensing data, from which occupancy rates for psychiatric beds in general hospitals and county psychiatric hospitals are calculated. The occupancy rates by hospital and region make it possible for DMHAS to identify service needs and gaps.

Short Term Care Facilities: STCFs are acute care adult psychiatric units. They are located in general hospitals for individuals who meet the legal standards for commitment and require intensive treatment. All admissions to STCFs must be referred through an emergency or designated screening center. STCFs are designated by DMHAS to serve a specific geographic area, usually by county. The listing of Short Term Care Facilities (STCFs) may be found in the Mental Health Services Treatment Directory, available at: https://www.nj.gov/humanservices/dmhas/home/hotlines.

Designated Screening Centers: A comprehensive listing of the locations and contact information for the Division's 23 Designated Screening Centers (DSCs) and 12 Affiliated Emergency Services (AES) can be found at http://tinyurl.com/MHScreening. Designated Screening Centers are public or private ambulatory care providers authorized to evaluate individuals for involuntary commitment in conformance with the provision of the Mental Health Screening Law (P.L. 1987, ch. 116). Screening Centers are responsible for

providing emergency psychiatric assessment, evaluation crisis intervention and referral services for residents of a specified geographic area.

SAMHSA Behavioral Health Treatment Services Locator: The Substance Abuse and Mental Health Services Administration (SAMHSA) hosts a nationwide directory on its website for all mental health and substance use treatment programs. The locator has extensive search and sorting capabilities allowing for searching by address, city, or zip code, the user can locate specific types of programs within a geographic area. This is available at http://findtreatment.samhsa.gov/.

ATLAS: NJ joined ATLAS® (Addiction Treatment Locator, Assessment, and Standards Platform) in July 2022. ATLAS® is the first free resource of its kind to give transparent, unbiased information about the quality of addiction treatment facilities. The not-for-profit website is designed for clients and family members alike, and features evidence-based information to help individuals navigate the addiction treatment system. This is available at https://www.treatmentatlas.org/.

National Substance Use and Mental Health Services Survey: New Jersey participates in an annual survey conducted by SAMHSA to create the National Substance Use and Mental Health Services Survey (N-SUMHSS). It is a combination of two previous surveys – the National Survey of Substance Abuse Treatment Services (N-SSATS) and the National Mental Health Services Survey (N-MHSS). The survey respondents are the treatment facilities, not the clients of the facilities. This is available at https://www.samhsa.gov/data/data-we-collect/n-sumhss-national-substance-use-and-mental-health-services-survey

B. Methodology to Estimate Behavioral Health Services Needs

Mental Health

DMHAS utilizes a Relative Needs Assessment Scale (RNAS) using social indicators with known correlations to estimate state and county mental health and substance use treatment needs. The scale calculates an index of risk for each jurisdiction of the same size (county, municipal, zip code, etc.) for which the indicators can be obtained. Because the scale is an interval level of measurement that sums to one, scores are comparable and easily interpreted across jurisdictions.

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

Low socioeconomic status	
• Poverty [A]	Poor families below the poverty level, 2020
• No high school education [A]	Number of people age 25 years & over, with no high school diploma, 2020.
Marital status	
• Divorced families [A]	Families in 2020 who were separated or divorced.
• Female householder [A]	Female householder, no husband present with own children less than 18 years, 2020.
• Living alone [A]	Nonfamily householder living alone, 2020.
Environmental and Other Social Factors	
• Unemployment [B]	Population 16 and over unemployed in 2020
• Housing tenure [A]	Ratio of occupied housing which are renter occupied, 2020
• Suicide attempts [C]	Suicide attempts Among 10-24 year olds. New Jersey Youth Suicide Report, 2017.

Sources:
A US Census Bureau, 2020 American Community Survey derived from 5-Year population estimate.
B New Jersey Department of Labor Market & Workforce Development, 2020.
C New Jersey Youth Suicide Report 2017, NJ Department of Children and Families.

A key assumption in the use of the RNAS to estimate the prevalence of mental health treatment need is that the population at risk of mental illness can be estimated by using demographic data from the U.S. Census and other data, like rates of suicides, divorce, or crime, found in other publically provided databases. This assumption was evaluated by Cagle (1984) who suggested that a small set of carefully chosen indicators can serve the purpose of estimating mental health treatment need.[1] Cagle's purpose was to assess need for acute psychiatric services in New York State. The epidemiological evidence was grouped into three categories: socioeconomic status; marital status; and other social factors.

DMHAS conducted its own review of recent epidemiological literature to determine the strongest social correlates of mental illness while retaining Cagle's original classifications. The social indicators and their definitions that were used to produce a mental health treatment needs assessment in New Jersey are presented in Table 1 and are partially based on Cagle's work. Table 2 presents the mental health treatment need by county. DMHAS seeks to refine the RNAS model for both substance use and mental health so that indices may be calculated by level of care, e.g., inpatient, outpatient and residential services. However, this would require validated social correlates of the full range of levels of care in each system and these have not been identified yet.

The DMHAS will explore further needs assessment methodology in order to refine our mental health need assessment by level of care, e.g., inpatient, outpatient and residential services. The publicly funded behavioral health system in New Jersey has gone a significant change, specifically due to the move from cost based contracting to fee-for-service reimbursement contracting.

Table 2
RNAS By County
New Jersey 2020

County	Index	Percent
Essex	0.153	15.3
Hudson	0.126	12.6
Middlesex	0.073	7.3
Bergen	0.07	7.0
Camden	0.07	7.0
Passaic	0.07	7.0
Union	0.069	6.9
Ocean	0.057	5.7
Monmouth	0.049	4.9
Mercer	0.044	4.4
Atlantic	0.042	4.2
Burlington	0.036	3.6
Morris	0.03	3.0
Cumberland	0.026	2.6
Gloucester	0.023	2.3
Somerset	0.018	1.8
Cape May	0.012	1.2
Warren	0.01	1.0
Sussex	0.009	0.9
Salem	0.008	0.8
Hunterdon	0.007	0.7
Total	**1.0**	**100.0**

DMHAS deployed a statewide level household survey (described more fully on page 6), which included a new mental health section that uses validated questions from the federal behavioral risk factor surveys to estimate New Jersey's mental health treatment needs. The DMHAS will incorporate findings from this statewide household survey to refine its needs assessment for mental health. A draft report was submitted in December 2022 and is currently under review. More than 17% of NJ adult residents screened positive for at least one mental health problem, including 11% for anxiety, 9% for depression and 8% for PTSD. The highest rate of positive screens was found for women (20%) versus men (14%).

[1] Cagle, Laurence T. Using Social Indicators to Asses Mental Health Needs: Lessons from a Statewide Study. Evaluation Review; Vol 8 No 3, June 1984 389-412. New York State Office of Mental Health @ 1984 Sage Publications, Inc.

Substance Use

DMHAS employs a variety of scientifically-valid methods for estimating substance use treatment needs. Primary among these are 1) surveys, 2) social indicator analysis, and 3) "synthetic" statistical estimation techniques, called modeling. For 24 years, New Jersey has used a household survey to estimate: 1) the prevalence of both legal and illegal substance use, 2) alcohol treatment need and 3) unmet treatment demand. Obtaining reliable substance use treatment need estimates is critical to the state's ability to promote a rational planning and resource allocation process.

NJ Household Survey on Drug Use and Health

The household survey is used to assess the prevalence of both legal and illegal substance use and the need and demand for substance use treatment. A random sample of households is interviewed that yields sample proportions of both alcohol and illicit drug use, and alcohol treatment need and demand that can be applied beyond the sample itself to the adult populations of New Jersey and individual counties to obtain estimates of alcohol treatment need and illicit drug use at both the state and county levels. Survey trend data is available for 1998, 2003, 2009, 2016 and 2018.

The 2018-20 survey differs from prior surveys in that it was administered across three rolling statewide surveys annually between August 2018 and February 2021. Data for this survey were collected through telephone interviews with a stratified, random sample of 7,145 respondents who were 18 years or older. The study was administered by the Department of Psychiatry, Rutgers-Robert Wood Johnson Medical School. Also, the 2018-20 sample is large enough to generate county-level estimates of substance use treatment need.

The need for alcohol treatment is derived from a series of questions based on Diagnostic Statistical Manual (DSM) criteria. Questions address use, quantity, effect on behavior, symptoms experienced, associated health problems, etc. As noted above, proportions obtained are applied to state and county population estimates. While the same questions are asked for drug use, the household survey underestimates illegal drug use due to under-reporting of illicit drug misuse or dependence and, therefore, drug treatment need. As a result, a statistical technique known as the two-sample capture-recapture model is applied to illicit drug treatment unique admissions data to estimate drug treatment need at both the state and county levels.

The admissions data for the model are obtained from the web-based New Jersey Substance Abuse Monitoring System (NJSAMS), DMHAS' real-time, administrative, client information system for substance use treatment. Together with the derived alcohol treatment need obtained from the household survey technique described above, DMHAS produces an annual estimate of treatment need that is used in the distribution of alcohol and drug use treatment funds. Table 3 presents the 2020 estimates of substance use treatment need for the state and each county.

The survey was recently completed and the data analysis is being finalized. A draft report was prepared in December 2022 and under review. The findings will be utilized in next year's needs assessment for substance use disorder. Some findings were: 7.4% of NJ adults met DSM-IV diagnostic criteria for abuse or dependence on illicit drugs and/or alcohol, a rate comparable to the national average. Marijuana was the most frequently reported drug, used by 16% in the last year. Young adults (21-25) had the highest rates of past year marijuana use (35%) and use of of other illicit drugs (11%) of all age groups.

Table 3					
Estimate of Treatment Need for Alcohol and Drug Addiction, New Jersey 2020					
County	**Adult Population 2020**	**Need for Alcohol Treatment**	**Need for Drug Treatment**	**Total Need for Alcohol and Drug Treatment**	**Total Need as % of the Adult County Population**
	[1]	**[2]**	**[3]**	**[4]**	**[5]**
Atlantic	216,333	12,115	10,070	22,185	10.3
Bergen	753,117	30,878	13,813	44,691	5.9
Burlington	365,793	24,508	10,429	34,937	9.6
Camden	404,654	15,377	17,709	33,086	8.2
Cape May	78,592	3,144	4,041	7,185	9.1
Cumberland	117,310	6,921	5,279	12,200	10.4
Essex	659,888	47,512	25,405	72,917	11.0
Gloucester	236,394	12,292	8,502	20,794	8.8
Hudson	576,984	30,003	14,276	44,279	7.7
Hunterdon	104,060	4,266	2,475	6,741	6.5
Mercer	304,837	15,242	10,522	25,764	8.5
Middlesex	675,856	17,572	23,258	40,830	6.0
Monmouth	507,169	33,980	13,595	47,575	9.4
Morris	401,826	28,128	6,634	34,762	8.7
Ocean	484,294	30,995	20,025	51,020	10.5
Passaic	399,378	24,362	11,396	35,758	9.0
Salem	50,962	3,363	1,607	4,970	9.8
Somerset	269,727	12,677	9,075	21,752	8.1
Sussex	115,665	8,212	5,332	13,544	11.7
Union	440,714	3,966	11,371	15,337	3.5
Warren	88,034	8,099	3,151	11,250	12.8
Total	**7,251,587**	**373,614**	**227,965**	**601,579**	**8.3**

[1] Source: U.S. Census Bureau 2020 Census results -https:www.newjersey-demographics.com
Copyright 2021 Cubit Planning Inc. Release date: April 2021.
[2] Alcohol treatment need derived from the 2018 New Jersey Household Survey on Drug Use and health.
[3] Drug treatment need is estimated by applying a two-sample Capture-Recapture statistical model using the 2018 and 2020 NJ-SAMS data.
[4] Percent of drug treatment need was derived by dividing the population in need of treatment in each county (column 4) by the adult population in that county, times 100.

Center for Research and Evaluation on Education and Human Services (CREEHS)

In 2018, DMHAS commissioned the Center for Research and Evaluation on Education and Human Services (CREEHS) at Montclair State University to conduct the *New Jersey Middle School Risk and Protective Factors Survey* (NJRPFS). This statewide survey of middle school students measures the prevalence of student use of alcohol and illicit drugs, as well as student perceptions of risk and protective factors for substance use operative in their lives. The NJRPFS is an 80-item student health survey that asks seventh and eighth grade students about their use and perceptions of alcohol, tobacco, and illicit drugs. In the most recent survey, CREEHS collected 6,490 student surveys from 97 schools across all of NJ's 21 counties between 2019 and 2021.

This report presents key findings regarding students' self-reported substance use, engagement in antisocial behaviors, and risk and protective factors. It also presents findings about new and relevant issues that have emerged since the survey was last administered in 2015, including the use of e-cigarettes (i.e., vapes) with and without marijuana, the availability of substances in the community, mental health, and gambling activities, as well as student experiences during the COVID-19 pandemic. Data findings presented in this report represent data collected between November 2019 to March 2020 ("2020") and January to March 2021 ("2021").

A final report was prepared and 21 individual county reports are posted on the DMHAS website at https://www.state.nj.us/humanservices/dmhas/publications/surveys/.

C. Annual Assessment of Sufficient Services

With the establishment of a needs assessment methodology for mental health and the development of the inventory, it will be possible to annually assess the need for and availability of mental health services. Annual assessment of substance use treatment need using its existing methodologies also will continue. Information in Table 3 indicates that 601,579, or 8.3% of NJ residents were in need of alcohol and/or drug treatment. The NJ Household Survey on Drug Use and Health indicated mental health treatment was more accessible than substance use treatment. In 2018, 42% versus 11% of symptomatic adults received past year treatment.

D. Annual Breakdown of Key Funding for Mental Health and Addiction ProgramsTable 4
DMHAS FISCAL SUMMARY OF BEHAVIORAL HEALTH
FY 2022 Appropriations and Other Resources
(State, Fed & Other $)
(Amounts in Thousands - $000's)

Category	FY 2022
Direct State Services:	
DMHAS Administration	**$14,763**
Governor's Expanded Addictions Initiatives	**$22,215**
Total Direct State Services	**$36,978**
Grants-In-Aid and Federal/Dedicated Resources:	
Behavioral Rate Increase - State Share	**$17,984**
Enhanced Federal Match and Third Party Recoveries	**$159,250**
MH Community Care	**$339,341**
Justice Involved Mental Health Pilot	**$2,000**
MH Provider Safety Net	**$500**
Gun Violence/Suicide Prevention	**$500**
Monmouth Mental Health Association	**$250**
MH Block Grant, and PATH Grant & Other MH Federal	**$76,990**
Recovery Court/Mutual Agreement Program (MAP) - primarily appropriated in Judiciary and SPB	**$38,326**
SA Community Services	**$34,594**
Compulsive Gambling (includes Dedicated Internet/Sports Wagering/Racing Commission Fees)	**$4,284**
SA Block Grant & Other Federal	**$158,232**
SA Dedicated Funds & Other	**$12,316**
MH Dedicated Fund (Cop2Cop Warmline)	**$400**
	$844,967
Rutgers / UBHC Line-Items:	
Rutgers, UBHC- CMHC Newark	**$6,251**

Rutgers, UBHC-CMHC Piscataway	**11,945**
Subtotal Rutgers, UBHC	**$18,196**
Total Grants-In-Aid and Federal/Dedicated Resources	**$863,163**
State Aid - County Psychiatric Hospitals	**$127,787**
GRAND TOTAL DMHAS (State, Fed & Dedicated)	**$1,027,928**
State share Medicaid BH spending	**$159,213**
Federal share Medicaid BH spending	**$214,989**
Total Medicaid BH Spending (State & Fed)	**$374,202**
GRAND TOTAL DMHAS WITH MEDICAID	**$1,402,130**

E. Consultation with the Community Mental Health Citizens Advisory Board and the Behavioral Health Planning Council

The Community Mental Health Citizens Advisory Board[2] (Board) and the Behavioral Health Planning Council (Planning Council) meet monthly as a joint advisory body with the DMHAS and Division of Children's System of Care (DCSOC). The Board and the Planning Council function together under the auspices of the New Jersey Behavioral Health Planning Council which fosters the interests of clients and family members with serious mental illness, serious emotional disturbance (for parents of youth) or co-occurring disorders; and/or prevention, early intervention, treatment or recovery support services.

Selected highlights of Planning Council activities for FY 2022 include:

- **Presentations from SMHA/SSA staff** to inform the Council of its activities that promote the behavioral health of New Jersey's residents, including: budgetary/fiscal overviews from the SMHA/SSA's Chief Financial Officer and Fiscal Staff (July 2021, March 2022), a review of the budget of the Children's System of Care (April 2022), and an update on Certified Community Behavioral Health Clinics (July 2021). A State Ethics Training was given to the Council members in September 2021.
- **Hosting informative presentations** from other parts of NJ State government (whose representatives sit on the Council) and its system partners that impact behavioral health including: quarterly updates on SAMHSA Community Mental Health Services and Substance Abuse Prevention Treatment Block Grant applications; overviews of substance use treatment programming in NJ State Prisons (June 2022), an overview of the SMHA's cultural competency initiatives (March 2022) , presentations on Peer Services (January 2022), eligibility for developmental disability services via the Children's System of Care (October 2021) and a review of the new 988 crisis hotline (March 2022), an overview of data trends at the Children's System of Care (May 2022).
- **Engaging other parts of state government** to provide monthly updates on their efforts and accomplishments. Each month brief presentations and opportunities for Q&A are given by representatives from: NJ Department of Corrections, the NJ Juvenile Justice Commission, NJ Department of Education, NJ Division on Aging, NJ Department of Children and Families, NJ

[2] The Board consists of eight public members recommended by the Board of Chosen Freeholders, the New Jersey League of Municipalities, providers of mental health services, the Chairpersons of the Assembly and Senate committees on Human Services, and the State Board of Human Services from among persons currently serving as members of the Board of Trustees of the four State psychiatric hospitals to be appointed in July of each year. The Assistant Commissioner of the Division of Mental Health and Addiction Services or a designee shall be a non-voting ex-officio member.

Division of Medical Assistance and Health Services (i.e., state Medicaid), NJ Division of Vocational Rehabilitation, and the NJ Division of Developmental Disabilities.

F. Consultation with Key Stakeholders

The Human Services Commissioner and the Assistant Commissioner of DMHAS, along with senior staff, conduct ongoing meetings with stakeholder leadership groups, trade organizations and client/family advocacy groups, inclusive of the New Jersey Hospital Association, to discuss services currently available, perceived service gaps, feedback on services working well and where services can improve to better meet the needs of individuals served. Ongoing stakeholder meetings are held with constituency and advocacy groups such as the Mental Health Association of New Jersey, New Jersey Association of Mental Health and Addiction Agencies, New Jersey Psychiatric Rehabilitation Association, Coalition of Mental Health Consumer Organizations, County Mental Health Administrators, County Alcohol and Drug Abuse Directors, National Alliance on Mental Illness New Jersey, NJ Association for the Treatment of Opioid Dependence, Disability Rights New Jersey, New Jersey Hospital Association, and the Supportive Housing Association.

Further, the DMHAS participates in regular, ongoing meetings with the New Jersey Department of Health, Administrative Office of the Courts, New Jersey Division of Medical Assistance and Health Services and the Division of Developmental Disabilities. The DMHAS is committed to consulting with these constituency and advocacy groups to discuss outcomes of needs assessment and plan development. This is in addition to the DMHAS' active, monthly participation in county-based system's review meetings, county advisory board meetings and county professional advisory committee meetings. In these meetings, local needs and plans are discussed.

G. Annual Report on Key Departmental Activities and Accomplishments

The landscape of behavioral health services for adults in New Jersey continues to change and to improve. The publicly funded behavioral health system in New Jersey currently is undergoing a significant change, specifically due to the influx of federal dollars in response to the COVID-19 pandemic, continued modifications and updates to the state financing of behavioral health services and coordinated state and federal response to the ongoing and worsening mental health and substance use crises.

<u>Transition to Fee-for-Service Contracting Model</u>

DHS is in the process of reforming how adult behavioral health treatment services are financed in New Jersey. Specifically, DMHAS has moved from a cost-based, deficit-funded contract model to one that is fee-for-service for many programs. Substance use services were 30% fee-for-service from July 2010 until July of 2016, at which time many substance use disorder services were moved to fee-for-service. In January 2017, DMHAS worked closely with the stakeholder community to successfully transition eight mental health program elements to a fee–for-service contracting system, including: Outpatient, Partial Care, Partial Hospital, Residential Services, Supported Employment, Supported Education, Integrated Case Management Services (ICMS) and Programs in Assertive Community Treatment (PACT). In July of that year Community Support Services (CSS) providers were offered the same opportunity.

The main objective of the transition was to ensure provider agencies remained fiscally viable under a fee-for-service contract structure and could adhere to the regulatory and staffing requirements needed to operate each program. Through an increase in state appropriations to support DMHAS contracted providers and Medicaid behavioral health providers' ability to recruit and retain their workforce, provider contracts, fee-for-service billing and Medicaid rates were increased.

Coordinated Specialty Care (CSC) for Individuals with First Episode Psychosis and Early SMI

Since November 2016, New Jersey has provided Coordinated Specialty Care (CSC) for First Episode Psychosis through three agenices - *Oaks Integrated Care, Rutgers UBHC, and Care Plus NJ Inc.* - serving all 21 counties in the state. Each CSC team may serve up to 70 individuals ages 15-35 years old with psychotic symptoms for less than 2 years with or without treatment. Services are provided via telehealth and in-clinic settings that include but are not limited to evidence-based pharmacological treatment, supported employment and education services, individual and group psychotherapy, family therapy and recovery support with 24-hour accessibility. Each CSC team includes: a Team Leader, two Clinicians, a Supported Employment and Education Specialist, a Prescriber, an Outreach and Referral Specialist, and a Peer Support Specialist.

Since the inception of the program in 2016 through June 30, 2022, the NJ CSC program has received over 1,648 referrals, served close to 700 individuals, and provided over 200,000 units of service. 86% of CSC clients were prescribed psychotropic medications as part of their treatment regimen. Of the total number of individuals prescribed psychotropic medications, 85.9% of CSC clients adhered to their psychotropic medication treatment plans.

ReachNJ

In 2015, NJ launched 1-884-ReachNJ, a central call-in-line for New Jersey residents who are looking for help to overcome a substance use disorder. Each call to ReachNJ is answered by a trained specialist 24/7 who will provide the caller with a referral to a local treatment provider or other supportive services. ReachNJ connects callers to help regardless of their insurance or ability to pay. In 2022, DHS dedicated federal and state resources to a multi-media promotion campaign, educating individuals on the availability of the resource and encouraging those in need to reach out. If he/she chooses, the caller is screened and receives a referral which is targeted to their needs, care coordination and follow up is provided when needed. These call lines offer ease of access to services but individuals can continue to access services by going directly to the treatment agency. In calendar year 2022 there were 12,462 calls to ReachNJ.

988: Suicide and Crisis Lifeline and Crisis Care Continuum

In 2020, Congress and the Federal Communications Commission approved the transition of the National Suicide Prevention Lifeline to a new three-digit dialing code 988. Through collaborations with 988 Key Stakeholder Coalition, the five NJ Lifeline contact centers, other states, and collaborating state agencies, the NJ Grant Team was able to organize and develop a timeline for transition for the 988 system.

- In January 2021, NJ DMHAS was awarded a 988 Implementation Planning Grant from Vibrant Emotional Health (Vibrant) to coordinate a successful transition to, and plan for, long-term development of a statewide 988 suicide crisis care system.
- In April 2021, the 988 Key Stakeholder Coalition began convening monthly to provide perspective and expertise to inform, guide and support DMHAS staff, ensuring that 988 planning and implementation was as comprehensive as possible. This group last met in July 2022.
- In February 2022, NJ DMHAS submitted its implementation plan to Vibrant.
- In April 2022, NJ DMHAS was awarded a SAMHSA 988 Capacity Building Grant to prepare centers for increased call volume resulting from the transition to 988. NJ DMHAS has also received funding from Mental Health and Substance Abuse Block Grants as well as the American Rescue Plan, which will be used capacity building, too.
- In May 2022, NJ DMHAS awarded $3.6 million to the five centers that make up the 988 Lifeline network in New Jersey. This network includes the establishment of a state-based chat and text response system operating through one of the Lifeline crisis centers. DMHAS continued to meet regularly with the Key Stakeholders Coalition and the Lifeline contact centers.

- In July 2022, DMHAS received $12,8 million in the State FY2023 budget to expand the response to crisis calls, chats and texts, and create a more robust 988 Suicide and Crisis Lifeline system. Programs that offer additional community-based services are being developed by DMHAS including a Mobile Crisis Response System and Crisis Receiving and Stabilization centers.
- On July 16th, 2022, New Jersey successfully transitioned to 988, relying on its strong acute care and crisis response system currently in place. DMHAS continues working to develop and implement additional programs that will establish the 988 system as a comprehensive mental health response to people experiencing a suicidal, mental health or substance use crisis.

NJ DMHAS continues working closely with multiple agencies including 911, NJ211, the Division of Developmental Disabilities (DDD), ReachNJ (substance use treatment resources and referrals) and PerformCare/CSOC (serving children and adolescents) to develop warm transfer protocols and understand clearly how these programs operate in response to Mental Health crises. For the last two years, DMHAS has also co-chaired the Governor's Challenge for Service Members, Veterans and their Families (SMVF),which has engaged a number of state stakeholders to implement a plan that aligns local and state-wide suicide prevention efforts. Three workgroups have been meeting to prioritize goals and to carry out activities to address suicide prevention in SMVF.

NJ DMHAS receives state funding that is specifically directed to suicide prevention activities in the state. The funding has supported Zero Suicide Academies for outpatient behavioral health providers statewide. Based on the belief that suicide deaths for individuals under the care of health and behavioral health systems are preventable, the Zero Suicide framework trains providers on a set of core principles and evidence-based activities, and also provides follow-up technical assistance. State funding to DMHAS has also supported work with the Rutgers Gun Violence Research Center (GVRC), which provides technical assistance on preventing firearm suicides and on access to lethal means, and is conducting training and developing a firearm storage map.

Early Intervention and Support Service

The Early Intervention and Support Service (EISS) existed in 11 Counties in NJ. In FY23 this service was expanded to the remaining 10 Counties so there is now a program in every County. EISS is designed as a mental health urgent care service where individuals in crisis can receive rapid access to mental health services with the goal of avoiding an unnecessary hospitalization and stabilization.

Underserved Populations

DMHAS is also expanding services to Special Populations.. There were 7 Mental Health programs and 10 SUD programs awarded $150,000 each to outreach an identified underserved special population in NJ to offer outpatient services, including crisis related services. Underserved populations served in this initiative include: LGBTQ+ adult community, individuals transitioning from an emergency department discharge to the next level of community-based services, BIPOC (black, indigenous, persons of color), individuals experiencing homelessness, individuals whose primary language is Spanish, veterans and their families, older adults, and co-occurring. These programs will be implemented in FY23. The list of providers and the population served may be found at https://www.state.nj.us/humanservices/dmhas/provider/funding/RFP_Awards/Special%20Populations%20Final%20Award%20Notice%20(revised).pdf.

Mental Health Diversion Initiative

DMHAS received $2.2 million to establish Mental Health Diversion programs in four counties; Camden, Middlesex, Essex and Morris. The diversion programs target individuals with mental illness who are discharged from the county jail on pre-trial release, typically within 12 to 48 hours. The jails conduct a preliminary screening for mental health issues and refers the inmate going out on pre-release to the

mental health diversion provider who conducted a mental health evaluation to confirm the presence of a mental illness and develop a services plan. The provider will obtain or provide the mental health treatment and other social determinants of health such as housing, medical, etc. The provider will also help the individual to apply for the prosecutor diversion portion of the program, and if accepted, continue to provide the array of support as part of the diversion team. The mental health diversion programs cost approximately $450,000 each. The DMHAS anticipates expanding the number of programs in state fiscal year 2024.

New Jersey Jail Medication Assisted Treatment Initiative

The New Jersey Jail Medication Assisted Treatment Initiative (JMAT) is a state and Federally funded project providing resources that initiated and or expanded the use of FDA approved medications for opioid use disorders (MOUD) such a methadone, buprenorphine, naltrexone and others within the jail population in all NJ jails to treat opioid addiction. As a result of criminal justice reform, a majority of those detained in jail are released within 24 – 72 hours of their booking and are in particular at heightened risk of overdosing. The JMAT looks to assist inmates with an opioid use disorder (OUD) who are going out on pretrial release; 24-72 hours and those who are in jail for longer stays. Funding has paid for medications, medical and clinical staff to prescribe and provide counseling and case managers and peer specialists to assist in community reintegration. Since the program began in 2019, 23,726 inmates were screened for an OUD with 11,616 accepting an MOUD. Continuing funding is crucial to combat the high rates of MOUD in the jail population.

Certified Community Behavioral Health Clinics

New Jersey has participated in a Medicaid demonstration program since 2016 designed to provide comprehensive and integrated care services to indiviuals with behavioral health concerns. Certified Community Behavioral Health Clinics (CCBHCs) serve youth and adults with serious mental illness, substance use disorder, serious emotional disturbance, Post Traumatic Stress Disorder and those with generalied anxiety or depressive disorders. Participating clinics are paid a monthly bundled rate per client based on providers costs.

New Jersey's CCBHCs are proven to decrease client wait times; increase access to mental health and substance use services; expand the use of mental health and substance use peer supports; increase use of evidence-based practices such as Medications for Opioid Use Disorder (MOUDs); and provide timely and ample crisis services. New Jersey's CCBHCs operate 24-hour crisis care and follow-up, treatment for co-occurring substance use disorder and mental illness, ambulatory and medical withdrawal management, outpatient counseling, case management, and family support services.

CCBHC Case Load and Demographic Characteristics

In Demonstration Year 4, which ran July 1, 2020 to June 30, 2021, CCBHCs collectively served 22,027 clients. CCBHCs have reported an overall increase of 23% in client enrollment between the first year of the Demonstration (July 1, 2017 to June 30, 2018) and Demonstration Year 4 (DY4).

Eleven percent (11%) of the overall CCBHC patient population in DY4 were children and adolescents aged 0 to 17, four-fifths (82%) of patients were aged 18 to 64, and 7% were seniors aged 65 years and older. By gender, CCBHCs served a majority (57%) of females in DY4. By race, nearly two-thirds (64%) of CCBHC clients were white, 14% were black/African American, 3% were persons of another race, and 3% were persons indicating More than one race. Race information was missing for 16% of cleints. In terms of ethnicity, 8% of CCBHC consumers were Hispanic, although information on consumers' ethnicity was missing for more than one-third (35%) of clients in DY4. An average of 2% of CCBHC clients at each provider reported being homeless or living in a shelter during Demonstration Year 4.

By primary diagnosis, 43% of CCBHC clients from July 1, 2020 to June 30, 2021 were General Population clients, 42% had a primary diagnosis of Serious Mental Illness, 12% had a primary diagnosis of Substance Use Disorder, 2% were children and adolescents with Serious Emotional Disturbance, and less than one percent (1%) were former or current military personnel with Post Traumatic Stress Disorder. Fifty-six percent (56%) of CCBHC clients overall, had Medicaid insurance as their primary insurer. An additional 4% were dually Medicare/Medicaid insured for a total of 60% of clients during Demonstration Year 4 who had primary Medicaid or dual Medicare/Medicaid insurance. The percentage of CCBHC clients by Medicaid insurance status and CCBHC provider during Demonstration Year 4 ranged from a low of 48% to a high of 78%.

Care Coordination and Identification of Co-Occurring Conditions

Care coordination through case management has been described as the "linchpin" of the person-centered CCBHC model. CCBHC case management includes a range of services provided to support CCBHC clients to develop skills to gain access to needed medical, behavioral health, housing, and employment resources as well as to other social, educational, and community services essential to meet basic needs of living. Specified targets for CCBHCs include the provision of support during times of transitions between care facilities such as from an emergency department or psychiatric hospitalization to outpatient care. The CCBHCs collectively provided case management to 16,885 consumers during Year 4 of the demonstration, or more than four-fifths (77%) of all clients served. Case management services increased substantially from Demonstration Year 1 when less than one-third of CCBHC clients received case management.

Through systematic screening, the CCBHCs were able to identify and provide brief cessation counseling and referral to 3,456 clients who screened positive for unhealthy drug use in DY4. Of those identified with unhealthy drug use in DY4, three-fifths did ***not*** have a primary substance use disorder diagnosis, 29% had a primary serious mental illness diagnosis and 30% were clients in the General Population. Similarly, of the 800 clients served during Demonstration Year 4 with Medications for Opioid Use Disorder, nearly half (48%) did ***not*** have a primary Opioid Use Disorder diagnosis. Twenty-nine percent (29%) had a primary SMI diagnosis and 18% were from the General population. Thus, the integrative treatment model embodied in the CCBHC appears to promote improved screening and greater access to care, as well as facilitates a greater *coordination* of care to address the multiple domains of health for each client.

Promoting Integration between Primary and Behavioral Health Care

In March 2020, NJ was awarded the Promoting Integration between Primary and Behavioral Health Care (PIPBHC) 5-year federal grant from SAMHSA. The resulting initiative, the NJ Collaborative HIV/HCV Opioid Care, addresses barriers to medical services and related care to individuals with an opioid use disorder (OUD) who are at risk for HIV and HCV as a result of intravenous drug use, by integrating care with participating opioid treatment programs (OTPs), Harm Reduction Centers (e.g., syringe access programs) and primary care providers. Clients receive screening, assessment, treatment, referral, and direct services for HIV and HCV, other medical issues, substance use disorder (SUD), and co-occurring mental health services.

PIPBHC Patient Characteristics

As of September 8, 2022, the PIPBHC providers enrolled 630 clients. Three-fifths (61%) of PIPBHC clients overall indicated their gender as "Male" and nearly two-fifths (38%) of PIPBHC patients indicated their gender as "Female." PIPBHC providers served two-thirds (66%) White clients, 22% Black/African American clients and three percent clients of Other or More than One race. Thirteen percent (13%) of PIPBHC clients overall indicated Hispanic or Latino/a/e/x ethnicity. Overall, more than half (54%) of PIPBHC clients were aged 26-44, the largest age group of patients served. Four percent (4%) of clients served in the military.

The largest percentage (83%) of clients across all providers at baseline were listed as having an opioid-related disorder as a ***primary*** diagnosis. Medications for Opioid Use Disorder (MOUDs) were provided for 99% of all PIPBHC consumers. In addition to opioids, PIPBHC clients were also frequently diagnosed with cannabis, cocaine and alcohol related disorders as well as with nicotine dependence and mental health disorders as secondary and tertiary diagnoses.

Hepatitis C and HIV

Nineteen percent (19%) of PIPBHC clients across the three sites were positive for hepatitis C during Year 2 of the grant, and 2% of clients overall were positive for HIV. Clients were only considered positive for hepatitis C if they were HCV Ab + and also PCR +. Furthermore, percentages do not include patients who were screened positive for HCV and HIV prior to enrollment in PIPBHC. In Year 2, 43% of HCV PCR + clients received treatment onsite from a PIPBHC provider, and 78% of those who received HCV treatment onsite complete treatment during the second year of the grant. Thirty-eight percent (38%) of HIV positive clients received treatment onsite for their HIV infection.

PIPBHC Client Changes Between Intake and Six-month Follow-Up

Of the 630 clients cumulatively enrolled in the PIPBHC as of September 8, 2022, 189 completed a 6-month follow-up GPRA interview. New Jersey PIPBHC had a follow-up rate of 75% for federal fiscal year 2022 as calculated by SAMHSA's Performance Accountability and Reporting System (SPARS) as of October 24, 2022.

Daily/weekly use of alcohol, cannabis, and street opioids decreased between intake and follow-up with street opioid use decreasing the most of the three substances among the 189 PIPBHC clients who completed both an intake and 6-month follow-up interview.

The overall level of education rose for PIPBHC clients who completed both the baseline and six-month reassessment interviews, as the percentage of clients who completed a high school or high school equivalent education rose by seven percent. In addition, clients increased their full-time employment status between baseline and six months, by 39%. Correspondingly, the number of clients who reported being unemployed and looking for work decreased. The largest overall measurable changes between intake and 6–month follow-up were observed by an increase in the percentage of clients who were employed full time and the decrease in percentage of clients who used street opioids daily or weekly.

Client Discharge Data

Half (313) of all clients cumulatively enrolled in PIPBHC were discharged from the program as of September 8, 2022. The average length of treatment stay for all clients was 6.9 months. The largest proportion of PIPBHC clients were discharged due to mutually agreed cessation of treatment. The most frequently provided services to all discharged PIPBHC clients, include screening and assessment (96% and 95% respectively) for conditions such as substance use disorders, mental health issues, and physical health problems; treatment planning (86%); HIV testing (79%); and medical care (78%). In addition to these services, clients of one PIPBHC provider frequently received psychopharmacological therapies (62%), mental health care (74%), case management (79%), transportation (32%) and housing support services (41%).

Response to the Opioid Epidemic

The opioid epidemic has impacted NJ residents. To help address the issue and need DMHAS has taken action by applying for, and being awarded, several federal grants from SAMHSA to implement numerous initiatives. DMHAS has also initiated other state-funded efforts to address the need through the issuance of Request for Proposals and Memoranda of Agreements. New Jersey seeks to further its commitment to

addressing opioid addiction by utilizing the information it has gained and the expertise and relationships it has developed through its involvement in numerous national and state initiatives.

Opioid Overdose Prevention Network

Beginning in September 2016, DMHAS partnered with Rutgers University, Robert Wood Johnson Medical School (RWJMS) to develop and implement a comprehensive prescription drug/opioid overdose prevention program that includes Naloxone training and distribution for schools, colleges, police departments, medical facilities, substance use treatment agencies and other community-based organizations. Between September 30, 2021 and September 30, 2022, 3,606 persons were trained and 5,928 naloxone kits were distributed. DMHAS was awarded $1 million over five years from SAMHSA to develop and operate this program. Subsequently, State Opioid Response funds have been used to continue the program.

NJAssessRx

In September 2021, DMHAS was awarded a second five-year "Strategic Prevention Framework for Prescription Drugs (SFP Rx)" grant from SAMHSA to expand interagency sharing of the state's Prescription Drug Monitoring Program data and give DMHAS the capacity to use data analytics to identify prescribers, prescriber groups and clients at high risk for inappropriate prescribing and nonmedical use of opioid drugs. New Jersey's target population includes youth (ages 12-17) and adults (18 years or older) who are being prescribed opioid pain medications, controlled drugs, or Human Growth Hormone (HGH), and are at risk for their nonmedical use.

DMHAS effort focus specifically on young athletes, as this population may be more likely than non-athletes to receive prescription pain medication for sports related injuries. Future reports from this initiative will be shared with other state agenices to inform planning and prevention in local communities and will serve as the basis for public awareness campaigns for providers, family members, athletes and those who work with athletes.

Opioid Overdose Recovery Program

In October 2015, DMHAS collaborated with, the Governor's Council on Alcoholism and Drug Abuse (GCADA) and the Department of Children and Families (DCF) to develop an Opioid Overdose Recovery Program (OORP) to respond to individuals who are reversed from opioid overdoses and who are subsequently treated at hospital emergency departments. The OORP's goal is to link individuals reversed from an opioid overdose to withdrawal management, substance use disorder treatment, recovery support services, and follow-up. Over the next several years, the program was expanded to serve all 21 counties and is now solely funded by DMHAS.

OORPs have affiliation agreements with 56 of 75 (75%) hospital emergency departments throughout New Jersey. The program utilizes Recovery Specialists and Patient Navigators to engage individuals who were reversed from an opioid overdose and provide non-clinical assistance, recovery supports and appropriate referrals to substance use treatment services while also maintaining follow-up with these individuals for at least eight weeks. At a minimum, Recovery Specialists are accessible and are on-call 84 hours a week. During the 8-week follow-up period, Recovery specialists are expected to contact clients eleven times.

Since its implementation, NJ's OORPs have cumulatively served nearly 25,000 individuals who were reversed from an opioid overdose and were taken to a participating hospital emergency department through the first half of 2022. Twenty percent (20%) of clients were referred to either withdrawal management or substance use disorder treatment while more than 40% sought recovery support services including self-help, transportation supports, mental health and medical services and housing supports including sober living. Twenty-three percent (23%) refused services bedside while 12% did not receive

OORP services for involuntary reasons, including clients who are in crisis services, jail, hospitalized, or who left a medical facility Against Medical Advice (AMA), and clients who do not have a phone or a way for the Recovery Specialist to contact them.

Opioid Overdose Prevention Program

In October 2015, DMHAS established regional (North, Central and South) Opioid Overdose Prevention Programs (OOPP) to provide education to enable participants to recognize an opioid overdose and be equipped to provide life-saving rescue measures to reverse the effects of the overdose. Funded OOPPs provide individuals at-risk for overdose, their family members, friends, and loved ones with naloxone rescue kits and educate and train them on how to prevent, recognize and respond to an opioid overdose.

These contracts were further expanded with State Targeted Response (STR) and State Opioid Response (SOR) funds and include training and naloxone kit distribution for homeless shelters, Offices of Emergency Management (OEMs), Emergency Medical Service (EMS) teams, HIV primary care offices, fire departments, community health clinics, recovery courts, school nurses and/or other personnel at statewide school districts, medical and clinical staff at jails/prisons and medical and clinical staff at substance use disorder treatment programs.

State Targeted Response to the Opioid Crisis

In May 2017, New Jersey was awarded the State Targeted Response (STR) to the Opioid Crisis grant from SAMHSA for approximately $13 million annually for two years. The goal of the State Targeted Opioid Response Initiative (STORI) is to address the opioid crisis confronting New Jersey using a variety of strategies. The key objectives of this initiative is to increase access to treatment, reduce unmet treatment need, reduce opioid related deaths, and address retention in care and the provision of peer and recovery supports.

To address these objectives, DMHAS completed the following:

- Developed a new STORI fee-for-service (FFS) treatment initiative to provides access to treatment for underinsured and uninsured clients including a wide range of services within the continuum of care and includes the use of evidence-based practices (EBPs), particularly medication assisted treatment (MAT). The STORI FFS went live July 3, 2017.
- Expanded DMHAS' OORP to an additional 10 counties in New Jersey to achieve state-wideness. Developed a series of new services and programs including: the Support Team for Addiction Recovery (STAR) program to prevent opioid overdoses and help prevent relapse. STAR teams include peer recovery specialists; a peer-delivered statewide Telephone Recovery Support (TRS); and family support services provided through the development of three regional Family Support Centers (FSCs).
- Conducted trainings related to best practices for prescribing opiates and expanded use of Medication-Assisted Treamtent (MAT). Training includes the implementation of an Extending Community Health Outcomes (ECHO) project on substance use disorder (SUD) to expand the knowledge and capacity of primary care providers to implement best practices for SUDs related services in the primary care setting. Also, Rowan University School of Osteopathic Medicine developed a self-paced learning series to train and inform healthcare providers on the most up-to-date practices and guidelines regarding MAT for opioid use disorder.

While the STR grant ended April 30, 2019, SAMHSA granted NJ a no-cost extension until April 30, 2020. Many of the initiatives started were continued with the SOR federal grant.

Partnership for Success

In September 2018, DMHAS was awarded a five-year Partnerships for Success grant for $2.3 million annually from SAMHSA to provide prevention, education, and outreach services to young people and their

families who are involved with the Department of Children and Families Children's System of Care. Concurrent with these servies, DMHAS-funded county coalitions provide community-based prevention services resulting in a cohesive, unified statewide prevention system. This initiative focuses on decreasing underage drinking and marijuana use among New Jersey youth and adolescents and is a vital piece of CSOC's statewide prevention and education infrastructure.

State Opioid Response Grant Program

Beginning in 2018, Congress created and funded State Opioid Repsonse (SOR) grant program, providing federal resources to states to address the nation's opioid crisis by expanding access to treatment, bolstering family and peer recovery support services, and enahcning community education and training programs. New Jersey has applied for, and been awarded, three such SOR grants through the Substance Abuse and Mental Health Services Administration.

SOR 1.0	Sept. 30 2018 - Sept. 30 2020	Approximately $21.6 million annually for two years ++ supplemental funding for $11.3 million for one year
SOR 2.0	Sept. 30 2020 - Sept. 30 2022	Approximately $66 million annually for two years
SOR 3.0	Sept. 30 2022 - Sept. 30 2024	Approximately $66 million annually for two years

The goal of the NJ SOR is to address the State's opioid crisis by increasing access to medication-assisted treatment (MAT), reducing unmet treatment need, and reducing opioid-related deaths. With NJ SOR funding, DMHAS continued and expanded a host of programs and innovative prevention, treatment and recovery offerings to aid those in need across the state. The state has expanded access to life-saving medications like naloxone nasal sprays, expanded education and training programs including hosting an annual Opioid Summit, and expanded partnerships with sister agencies across the state to roll out to new treatment and recovery programs, create new prevention networks and initiatives, and expand access where possible to those most underserved in our communities. NJ SOR-funded initiatives include: (1) medication for opioid use disorder through the expansion of clinic hours in opioid treatment facilities, outpatient treatment programs, mobile medication services with a focus on indiciduals who are homeless, contracts with all county jails across the state; (2) contingency management program for individuals who have a stimulant use disorder; (3) public awareness campaign (ReachNJ) to help eliminate stigma and discrimation around the use of medication for a substance use disorder; (4) education/information to older adults regarding the use of alternative to opioids to manage pain; (5) distribution of opioid addiction patient guidelines; (6) opioid overdose recovery program (recovery supports provided to individuals brought to the emergency room following an overdose); (7) naloxone distribution through a centralized portal for emergency medical service, law enforcement and fire to administer and leave behind for individuals who do not want to go to the emergency room, entities such as libraries, harm reduction centers, mental health and substance use disorder provider agencies and shelters also have access through the portal; (8) distribution of fentanyl test strips; (8) purchase and disitribution of Deterra kits and lock boxes to destroy unused medications/opioids and safely store them to prevent diversion; (9) case management and recovery support services; (10) telephonic support services provided by individuals with lived experience; (11) community peer recovery expansion; (12) family support services; (13) college recovery services and (14) training for the workforce.

SABG COVID Supplemental

In March 2021, SAMHSA awarded DMHAS approximately $45 million in Substance Abuse, Prevention and Treatment Block Grant (SABG) COVID-19 supplemental funds to enhance its prevention, treatment, and

recovery services and infrastructure in response to the COVID-19 pandemic. Funds are available until March 2023. In early September 2022, DMHAS submitted and received a 12-month No Cost Extension request to SAMHSA for the continuation of these funds.

Prevention	- Create and bolster Prevention Hubs in each of the state's 21 counties. Prevention Hubs are localized one-stop shops where individuals, local government entities, and community organizations youth, families and community members can obtain information and resources, get connected to outreach events, and do brief screenings and/or be connected to needed services. - Contract with an outside entity to serve as the lead agency across the state and oversee the strategic coordination of prevention services. - Create and promote PreVenture – an evidence-based prevention program designed to help at-risk youth ages 12-17 learn useful coping skills, set long term goals, and channel their personality towards achieving them. - Expand web-based/mobile tools for risk messaging for adolescents and young adults and enhance social media utilization. DMHAS will also implement the interactive web-based *Hidden in Plain Site* to educate parents on current trends in youth substance use and concealment of illicit drugs and alcohol. - Expand the Strengthening Families Program (SFP) to address the needs of targeted underserved communities within our counties. DMHAS will make available transportation, connect individuals to additional financial supports and health resources like COVID-19 vaccine centers, and provide families with meals, support and family activities and engagement. - Create a coordinated, state-wide, scientifically designed digital data collection tool (survey) for the 18 to 25- year old population. This is a population for which the state lacks information on drug use behaviors and trends.
Early Intervention	- Implement another Screening, Brief Intervention and Referral to Treatment (SBIRT) program to enhance screening for pregnant women. - Bolster the crisis care continuum by supporting the transition of the National Suicide Prevention Lifeline to 988.
Treatment	- Add care coordination to its fee-for service treatment programs to help clients transition to the next level of care and access the referrals that are made by the treatment agencies. - Develop crisis stabilization and crisis receiving centers for individuals in crisis to receive assistance until the individual can be placed in the appropriate level of care. This model results more efficient and effective care through the reduction in avoidable emergency department visits, psychiatric admissions, police engagement, arrests, incarcerations and 911 calls.
Recovery Services	- Expand the statewide Maternal Wrap-Around Program (MWRAP) that provides screening and treatment services to pregnant women and new mothers who have an OUD to include additional substances other than opioids. - Increase peer workforce training to deploy peers acros numerous settings, such as recovery centers, EDs, STAR programs, law enforcement programs, prisons, jails, treatment agencies, etc.

Infrastructure	- Make funding available to purchase PPE and improve IT infrastructure to enhance service delivery.

SABG American Rescue Plan Act

In May 2021, SAMHSA awarded DMHAS approximately $39 million American Rescue Plan Act (ARPA) funds through its SA Block Grant to address the effects of the COVID-19 pandemic for Americans with mental illness and substance use disorders. Funds are available until September 2025. A majority of the funding will be used to continue initiatives that were developed under its SABG COVID-19 supplemental plan.

Prevention	- Continue funding Prevention Hubs under in each of NJ's 21 counties. - Develop and launch a Youth Take Back Campaign to encourage high school and middle school students to turn in any vape electronic nicotine delivery systems (ENDS) products anonymously with no repercussions or questions asked during school hours. DMHAS plans involve working with the NJ State Police and coordinating appropriate state and local officials. - Issue planning grants to support the development of six additional Recovery High Schools in the state, in order that all 21 counties be served. A Recovery High School is exclusively for young people that struggle with substance use disorders and provides students with a safe, non-judgmental environment where they can continue their education and receive recovery support. Every member of the staff, faculty and administration in each school is required to attend numerous trainings regarding addiction and recovery. - Expand the Strengthening Families program for women in our treatment programs and expanded to other marginalized groups in need of such programming. - Upgrade the existing grant management and prevention services monitoring program - Prevention Outcomes Monitoring System (POMS)- the state developed in 2008 - Enhance education and awareness of available prevention and recovery support services by creating a "user friendly" website for the public.
Early Intervention	- Make naloxone nasal spray - a life-saving opioid overdose reversal medication – widely available throughout the state.
Treatment	- Continue funding for ongoing initiatives including: care coordinators for treatment programs to assist clients in transitioning to the next level of care and access the referrals that are made by treatment agencies; and Crisis Stabilization and Receiving Centers. - Employ peers within the treatment environment, particularly within the inpatient/residential environment where such services are not Medicaid reimbursable. - Expand hours for outpatient services rendered at treatment agenices.
Recovery Services	- Continue expanding the Maternal Wrap-Around Program (MWRAP) to address substances other than opioids - Contiune bolstering peer workforce training

	- Bolster mobile recovery services to include six new programs (21 in total) that offer critical support for persons living with addiction. These programs offer access to treatment services and provide education and training resources directly in the community. - Develop transitional housing/case management services for clients with SUD that are in need of housing while they complete treatment.
Infrastructure	- Continue ongoing initiatives to assist treatment providers serving those in early recovery or those recently discharged from SUD treatment. Funding will continue to assist agencies with their IT infrastructure as well as bolstering the workforce to add diversity, include peers and provide needed training and educational opportunities.