

I: State Information

State Information

Plan Year

Start Year:

2012

End Year:

2013

State DUNS Number

Number

806418257

Extension

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

Agency Name

Division of Mental Health and Addiction Services

Organizational Unit

Mailing Address

Capital Center, 50 East State Street, PO Box 727

City

Trenton

Zip Code

08625

II. Contact Person for the Grantee of the Block Grant

First Name

Lynn

Last Name

Kovich

Agency Name

Division of Mental Health and Addiction Services

Mailing Address

Capital Center, 50 East State Street, PO Box 727

City

Trenton

Zip Code

08625

Telephone

609-777-0711

Fax

609-777-0835

Email Address

Lynn.Kovich@dhs.state.nj.us

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

From

7/1/2010

To

6/30/2011

IV. Date Submitted

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

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name

Last Name

Telephone

Fax

Email Address

Footnotes:

I: State Information

Assurances - Non-Construction Programs

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

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

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name

Chris Christie

Title

Governor

Organization

State of New Jersey

Signature: _____ Date: _____

Footnotes:

I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

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

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

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

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

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

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

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

3. Certifications Regarding Lobbying

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

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

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

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

Name	Chris Christie
Title	Governor
Organization	State of New Jersey

Signature: _____ Date: _____

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements/Certifications (Form 3) [SAPT]

FY 2012 Substance Abuse Prevention and Treatment Block Grant Funding Agreements/Certifications as required by Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act

Title XIX, Part B, Subpart II and Subpart III of the PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.

SAMHSA will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

- I. FORMULA GRANTS TO STATES, SECTION 1921
- II. Certain Allocations (Prevention Programs utilizing IOM populations ; Pregnant women and women with dependent children) Section 1922
- III. INTRAVENOUS DRUG ABUSE, SECTION 1923
- IV. REQUIREMENTS REGARDING TUBERCULOSIS AND HUMAN IMMUNODEFICIENCY VIRUS, SECTION 1924
- V. Group Homes for Recovering Substance Abusers, Section 1925
- VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926
- VII. TREATMENT SERVICES FOR PREGNANT WOMEN, SECTION 1927
- VIII. ADDITIONAL AGREEMENTS(IMPROVED REFERRAL PROCESS, CONTINUING EDUCATION, COORDINATION OF ACTIVITIES AND SERVICES), SECTION 1928
- IX. IX SUBMISSION TO SECRETARY OF STATEWIDE ASSESSMENT OF NEEDS, SECTION 1929
- X. MAINTENANCE OF EFFORT REGARDING STATE EXPENDITURES, SECTION 1930
- XI. Restrictions on Expenditure of Grant, Section 1931
- XII. APPLICATION FOR GRANT; APPROVAL OF STATE PLAN, SECTION 1932
- XIII. Opportunity for Public Comment on State Plans, Section 1941
- XIV. Requirement of Reports and Audits by States, Section 1942
- XV. ADDITIONAL REQUIREMENTS, SECTION 1943
- XVI. Prohibitions Regarding Receipt of Funds, Section 1946
- XVII. Nondiscrimination, Section 1947
- XVIII. Continuation of Certain Programs, Section 1953

XIX. Services Provided By Nongovernmental Organizations, Section 1955

XX. Services for Individuals with Co-Occurring Disorders, Section 1956

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

Name	Chris Christie
Title	Governor
Organization	State of New Jersey

Signature: _____ Date: _____

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements/Certifications (Form 3) [CMHS]

Community Mental Health Services Block Grant Funding Agreements FISCAL YEAR 2012

I hereby certify that New Jersey agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

I. Section 1911:

Subject to Section 1916, the State will expend the grant only for the purpose of:

- i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved;
- ii. Evaluating programs and services carried out under the plan; and
- iii. Planning, administration, and educational activities related to providing services under the plan.

II. Section 1912:

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

III. Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")

(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.

(C) 24-hour-a-day emergency care services.

(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.

(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

IV. Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:

(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;

(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and

(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:

(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and

(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;

(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;

(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and

(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:

(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

V. Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

VI. Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;

(2) to make cash payments to intended recipients of health services;

(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

VII. Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

VIII. Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and

(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United States Code. [Audit Provision]

(c) The State will:

(1) make copies of the reports and audits described in this section available for public inspection within the State; and

(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

IX. Section 1943:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and

(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);

(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and

(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

Notice: Should the President's FY 2008 Budget be enacted, the following statement applies only to States that received the Mental Health Transformation State Infrastructure Grants:

This Agreement certifies that States that received the Mental Health Transformation State Infrastructure Grants shall not use FY 2008 Mental Health Block Grant transformation funding to supplant activities funded by the Mental Health Transformation Infrastructure Grants.

Name	Chris Christie
Title	Governor
Organization	State of New Jersey

Signature: _____ Date: _____

Footnotes:

I: State Information

Disclosure of Lobbying Activities (SF-LLL)

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

[Standard Form LLL \(click here\)](#)

Footnotes:

II: Planning Steps

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

Page 22 of the Application Guidance

Narrative Question:

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the State, intermediate and local levels differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other State agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities as well as youth who are often underserved.

Footnotes:

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

Overview of the Department of Human Services

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

DHS serves as the umbrella organization to the following Divisions: Commission for the Blind and Visually Impaired; Division of the Deaf and Hard of Hearing; Division of Developmental Disabilities; Division of Disability Services; Division of Family Development, Division of Medical Assistance and Health Services; and the newly merged Division of Mental Health and Addiction Services (DMHAS). DHS and its operational Divisions strive to assist, support and improve the lives of individuals and families in need. The placement of these seven Divisions within one organization allows for ease of cross-divisional planning and collaborations.

The Division of Mental Health Services and the Division of Addiction Services began their merger in SFY 2011 and have formally been joined together as the Division of Mental Health and Addictions Services (DMHAS). The SMHA and the SSA are in the initial planning stages of the merger and are working with DHS to establish the basic framework for the merger i.e. co-locating space and human resources. The merger will provide an opportunity to integrate mental health and co-occurring disorders treatment at all levels of service in an efficient and coordinated manner from the statewide and regional level to the local levels, thus enhancing access to services, coordination of services, alignment of policies and contracts, and workforce development efforts. In addition, a new Assistant Commissioner has been appointed to lead the combined Division. We are fortunate to have a former provider, and member of the Mental Health Planning Council, now serving as our Assistant Commissioner.

DHS works to maximize resources, establish community resources, and expand procedures and programs for accountability and continuous quality improvement across the Department. DHS also provides many support systems for the families served by the Division of Children and Families (DCF). Interdivisional and Interdepartmental Collaboration between DMHAS and the Division of Child Behavioral Health Services (DCBHS) in DCF is frequent. Executive Staff from each division have collaborated to make system recommendations for youth with mental illness and families currently served in DCBHS whose youth "age out" into the adult system. Recommendations were made in the form of policies, procedures and protocols that will ensure a seamless transition of youth and their families to all adult mental health services. Youth with substance abuse disorders are currently served through Memorandum of Understanding between the SSA and DCF/DYFS. In addition, several staff from DCBHS attends monthly Mental Health Planning Council meetings in order to better coordinate services.

Joint Initiatives Impacting Future Planning

Bi-Directional Integration of Behavioral Health and Primary Care Services. The State is well positioned to take advantage of the PPACA and move forward with a number of related initiatives that will promote medical homes, reform its Medicaid program, and further promote illness self management for individuals with serious mental illness, in order to address the major health disparities in this population. New Jersey has been fortunate to have several Health Homes initiatives that have developed at the grass roots level. Two New Jersey providers are implementing SAMSHA-funded Behavioral Health Home Pilots. In addition, the Nicholson Foundation, through a public-private partnership, has provided funding to two FQHCs to implement health homes providing integrated behavioral health care. New Jersey DMHAS and the Division of Medical Assistance and Health Services (Medicaid) have been at the table to help these efforts overcome obstacles created by the current regulatory and funding mechanisms.

New Jersey's Medicaid Waiver Application includes a proposal under Section 2703 of the ACA to include Health Homes as part of its Medicaid State Plan, thereby becoming eligible to receive additional Federal funds (90/10 match) for Health Home services in the first two years after implementation. This component of the waiver includes provisions for Behavioral Health Homes (BHHs) for people with severe mental illness, addictions and one other chronic condition, or co-occurring mental health and addiction disorders.

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

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

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

the State's largest consumer organization, provided a presentation to the hospital wellness committee in December 2010. .

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

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

The New Jersey Primary Care Association (NJPCA), the trade association representing federally qualified health centers in New Jersey, is also working with the SMHA in regard to the bi-directional integration of behavioral health services. With the help of a foundation grant, the NJPCA has a pilot program in which two FQHCs are screening patients for depression and anxiety and then treating them or referring them to an affiliated behavioral health agency. The State has a very active and strong consumer movement, and these organizations have been instrumental in these efforts, including Dr. Swarbrick, who also works on a national level with the SAMHSA "10 X 10" wellness campaign. The State has a number of peer specialists working as wellness coaches in a variety of settings, and the consumer-run Self Help Centers that are funded by the SMHA that are providing a number of wellness activities.

The SSA will continue to establish relationships with Federally Qualified Health Centers throughout the State to implement SBIRT programs as well as deliver primary prevention

programming in those settings. The SSA received a letter of support from New Jersey Primary Care Association on the SSA's recent application for a federal SBIRT grant.

The population in New Jersey is diverse in its ethnic and cultural makeup, and several counties have significant minority ethnic populations. As such, staff providing services must be culturally competent, and education must ensure consumer access. Mental health agencies are required to adhere to licensing standards that require culturally competent services. The State has not announced specific goals in regard to the PPACA, but it has been actively working to promote structures to support the medical home component, and these are required to be culturally competent and meet the needs of a diverse population.

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

The intention is to expand addiction recovery support services throughout the State to mirror the extensive mental health support system, which includes both self-help support centers and supportive housing. While the SSA currently has one Addiction Recovery Center and 63 units of supportive housing, the SMHA provides self-help centers in every county and at every State hospital, as well as over 1,000 supportive housing units.

The SSA provides for a 24 hour addictions hotline that provides pre-treatment screening, motivational counseling, and case management/care coordination which can better engage and support individuals who reach out in search of addictions help. The SMHA provides a Statewide WarmLine utilizing an intentional peer support model to support consumer's recovery.

Co-Occurring Services. On July 1, 2010, the SSA and the SMHA officially merged to become one Division, DMHAS. The operationalization of this merger is ongoing; the staff from both Divisions have begun meaningful collaboration on a series of projects (including this joint application), and physical co-location of the Divisions into a single facility is anticipated in SFY 2012.

Co-occurring services are provided by the Co-Occurring Services Network (COSN). In SFY 2010, the COSN was comprised of 53 substance abuse licensed treatment providers that met eligibility criteria for the network. These agencies provided treatment, on a fee-for service basis, to clients with co-occurring disorders. In addition, the Detoxification Initiative is a contract wherein DMHAS provide funding to four (4) licensed residential subacute detoxification facilities located throughout the State. These funds provide 14 bed slots for persons with co-occurring disorders referred through designated SMHA screening centers.

The SMHA fully supports and promotes creation of a co-occurring competent and seamless system of services for persons living with, and recovering from, mental illness and substance use disorders. Integrated Dual Diagnosis Treatment (IDDT) was implemented in April, 2004. The SMHA currently has 10 contracted community mental health providers who have fully

implemented IDDT into their existing program (ICMS, Partial Care, and Supported Housing) in five different counties. However, IDDT is unevenly implemented across the State. IDDT is provided a diverse mixed of consumers; male and female as well as individuals of Caucasian, African American, Hispanic, Asian and Asian Indian backgrounds and from many different countries.

In addition, the Co-occurring Task Force comprised the SSA, the SMHA and community stakeholders, and was convened to create a three-to-five-year strategic plan that articulated the vision of a co-occurring and competent system of care for New Jersey. Visit http://www.state.nj.us/humanservices/dmhs/home/CoOccurring_TF_Report-Sept_2010.pdf to view the report. Through subcommittee work focusing on the areas of best practices, financing, policy, and regulatory and legal issues, the Task Force reviewed the current systems and identified issues and concerns within and across systems of care; and put forth recommendations to assist in the creation of a co-occurring competent and seamless system of services for persons living with, and recovering from, mental illness and substance use disorders.

The Single State Authority on Substance Abuse

Overview of State's Behavioral Health System – Substance Abuse Services

The Division of Mental Health and Addiction Services (DMHAS) is the Single State Authority (SSA) on substance abuse in New Jersey. The following is an overview of New Jersey's substance abuse treatment and prevention planning and services delivery system. Between the Substance Abuse Prevention and Treatment (SAPT) Block Grant and other federal and State resources, in FFY 2012 and 2013, the SSA will fund: a) 17 community-based prevention coalitions for the provision of prevention programs with a focus on environmental strategies, b) over 60 community-based prevention providers that offer a variety of evidence-based curricula, c) two State institutions of higher education for early intervention services, d) a 24 hour Addictions Hotline, e) 96 agencies for the provision of substance abuse treatment services, f) two non-profit corporations for the operation of recovery support centers, g) tobacco cessation services, h) a workforce development initiative, and i) 21 county governments for the provision of services in each of these four domains of the continuum of care. Planning processes are tailored to the requirements of each domain and level of governmental responsibility, but all follow the basic principals of technically rational planning: Future Vision, Need Assessment, Setting Goals and Objectives, Implementation, Monitoring, Evaluation and Plan Improvement based on evidence of best practices.

In Calendar Year 2010 there were 71,874 treatment admissions and 70,594 discharges reported to the SSA through its New Jersey Substance abuse Monitoring System (NJ-SAMS). Of these admissions, 51,985 were unduplicated. For primary drug at admission, 40% reported heroin and other opiates and 34% reported alcohol. Methadone was planned to be used in treatment for 11% and Suboxone for 12% of the clients. Most admissions were to outpatient care (28%), followed by intensive outpatient care (20%). Regarding age, 5% were under 18 years old, 11% were 18-21 years old, 27% were 22-29 years old, 51% were 30 to 54 years old and 5% were over 55 years old. For race/ethnicity, 63% were white, 23% were black and 14% were of Hispanic origin. Most clients did not have insurance at admission (61%).

The services described below represent the SSA's continuum of care—prevention, early intervention, treatment and recovery support.

Prevention

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

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

Employing the CSAP five-step Strategic Prevention Framework (SPF) and a recent Addictions Prevention Strategic Planning Committee process, the SSA plans prevention and early intervention services in the State, and awards funding to providers through Requests for Proposals (RFP) and funds more than 60 community-based providers that offer a variety of evidence-based curricula to reduce substance abuse related problems in the communities they serve. The SSA monitors contracts, provides on-going technical assistance to contracted provider agencies, and oversees outcome evaluations for each program.

The following are SSA specific prevention initiatives.

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

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

Services to Families of Military Veterans. Working with the New Jersey National Guard Family Program and its eight Family Assistance Centers based at armories around the state, the New Jersey Prevention Network is funded to provide programs to serve returning military personnel and their families through two evidence-based programs, Coping with Work and Family Stress and the Strengthening Families Program. Both programs are designed to enhance protective

factors to support military members and their families in making responsible parenting and individual choices in regards to drug and alcohol use.

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

Culturally and Linguistically Competent Prevention Services. To ensure access to quality services by diverse populations, the SSA awarded funding to PROCEED to develop new and/or enhance existing systems for assuring the provision of culturally and linguistically competent prevention services among DAS-funded providers throughout New Jersey. Training and technical assistance services are individualized for each prevention provider and based upon the results of an extensive assessment of the provider's needs and capacity.

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

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

The SSA works collaboratively with the Governor's Council on Alcoholism and Drug Abuse (GCADA) on various addiction prevention related projects, including participation on the Addictions Prevention Strategic Planning Committee. The recent Addictions Prevention Strategic Plan will provide vital information and guidance in the upcoming cycle of Prevention Unification planning efforts undertaken in collaboration with GCADA that will culminate in an additional Request for Proposals in 2013.

Through the Municipal Alliance Program, the GCADA unites New Jersey's communities in a coordinated and comprehensive grass roots prevention effort. Municipal Alliances are local planning and coordinating bodies established in all twenty-one counties to assess needs, set priorities, develop plans and implement programs that form the foundation of New Jersey's substance abuse prevention activities. New Jersey's Municipal Alliances provide over 3,800 prevention programs statewide. GCADA's Municipal Alliance Program provides 395 grants to

529 municipalities throughout New Jersey, with the majority of grants averaging between \$10,000 - \$20,000. The primary CSAP strategy utilized by the alliances is education, followed by alternatives, which provide social, athletic and recreational activities as an alternative to situations in which alcohol and drug use might occur. The majority of programming is delivered in communities and schools served by the alliances.

Early Intervention

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

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

SBIRT. The SSA has acted to develop and support community-based early intervention in the form of Screening, Brief Intervention (including Brief Treatment) and Referral to Treatment (SBIRT). In May of 2011, the SSA partnered with the Trenton Health Team (THT) to submit a grant proposal to the Substance Abuse and Mental Health Services Administration (SAMHSA) to implement a new five-year, \$8.3 million SBIRT initiative in the City of Trenton. The aim of the proposal was to integrate SBIRT into primary medical care as a routine program of patient intake assessment at five local healthcare delivery sites operated by one hospital and one federally qualified health center (FQHC). New Jersey's SBIRT proposal was grounded in a public health model of holistic care that would expand Trenton's continuum-of-care by making SBIRT universally available to Trenton patients ages 18 and over. The plan included care coordination services and the formation of a new Specialty Treatment Network of intensive outpatient treatment providers to receive referrals generated by SBIRT. Aligned with SAMHSA's strategies for health care reform, the initiative was designed to permit a rigorous cost benefit analysis of Medicaid costs of health care utilization in comparison to health care outcomes for Trenton healthcare consumers, the results of which were expected to justify to Medicaid activation of Medicaid reimbursement codes for SBIRT services. Unfortunately, we recently learned that the project did not receive funding, but the SSA will continue to pursue avenues to implement SBIRT.

College Campuses. This initiative awarded funds to two universities to provide recovery support and/or environmental prevention strategies to systematically identify and help students who have a substance use disorder (SUD) diagnosis as well as those who intermittently abuse AODs. Each

college or university is required to provide: individual and group substance abuse recovery-oriented programs and services, assessment, academic and personal counseling services, and/or offer recovery-based housing for students. Environmental Management strategies seek to reduce the supply of and demand for AODs by making them less available and their use less acceptable within the campus environment.

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

Treatment

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

Residential. New Jersey's system of care for residential treatment services is comprised of the following levels: 1) medically monitored detoxification Level 111.7D, and 2) medically monitored detoxification enhanced Level 111.7D Enhanced, 3) short-term residential treatment Level 111.7, 4) long-term residential treatment Level 111.5, and 5) halfway house services Level 111.1. Certain providers offer specialized programs for women, women with dependent children, children and adolescents, which are consistent with the level of care classification but include services appropriate to these populations. Enhanced co-occurring services are also available. Services provided at each level of care will meet or exceed current New Jersey licensure standards.

Outpatient. New Jersey's level of care for outpatient treatment services is comprised of the following levels: 1) early intervention Level .5, 2) outpatient Level 1, 3a) intensive outpatient (IOP) Level 11.1 and 3b) methadone intensive outpatient (MIOP), 4) partial care Level 11.5, 5) ambulatory detoxification, and 6) opioid maintenance therapy. Services are offered on site as well as at some mobile medication sites. Services provided at each level of care will meet or exceed current New Jersey licensure standards.

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

SAPT Women's Set-Aside. The SSA provides funding through the women's set aside federal block grant to a statewide network of licensed substance abuse treatment providers in all modalities of care: outpatient, methadone outpatient, short term and long-term residential for

substance abuse treatment to pregnant women and parenting women. The women's programs are designed to meet the specific needs of women such as gender specific substance abuse treatment and other therapeutic interventions for their children. Gender responsive treatment is trauma informed and trauma specific, strengths based and relational. Gender specific treatment includes gender specific therapies with family focused services, such as individual and group sessions, child care, transportation, services for children, parenting, linkages and recovery supports.

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

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

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

Drug Court. Drug Court is a cooperative initiative between the Administrative Office of the Courts (AOC) and DAS which commenced in 2002. This agreement allows the AOC to transfer treatment funding to DAS who then secures and implements a complete continuum of care for Drug Court offenders sentenced in New Jersey Superior Court. Drug Court participation is voluntary and clinically-driven. Fifteen vicinage Drug Courts function within the existing Superior Court structure to provide treatment along the full continuum of care and diversion opportunities for non-violent offenders who otherwise may be incarcerated in State prisons for drug related offenses.

Mutual Agreement Program. The SSA oversees the Mutual Agreement Program (MAP), an Inmate/Parolee Substance Abuse Treatment Project implemented through Memorandums of Agreement between the SSA and the Department of Corrections (DOC), and the State Parole

Board (SPB). This funding is a combination of direct appropriations to DAS and funds transferred from the DOC and SPB. Funding for long term residential is available for DOC inmates pending parole through a network of fee-for-service providers. For SPB, these funds support a similar fee-for-service network which offers the full continuum of care including long term and short term residential care, halfway house, partial care, detoxification, intensive outpatient, and outpatient treatment for SPB parolees.

Juvenile Justice Services. State funds are provided, via a Memorandum of Agreement with the Juvenile Justice Commission, to treat adolescents who had been committed to a State juvenile institution and adolescents placed on probation. This initiative allows for coordinated planning and joint funding of services to juvenile offenders. The SSA funds 33 of 41 residential adolescent substance abuse treatment beds, with the remaining eight (8) beds being supported by a transfer of funds from the JJC.

Child Welfare Adolescent Services. The SSA, through State funding, provides a coordinated network of enhanced substance abuse treatment services in licensed facilities targeted to adolescents with first priority to those under the supervision of the Division of Youth and Family Services (DYFS). Services include long-term residential treatment that provide a structured recovery environment, combined with professional clinical services designed to address addiction and living skill problems for adolescents with substance abuse diagnosis who require longer treatment stays to support and promote recovery. Intervention focuses on reintegrating into the greater community with emphasis on education and vocational development. Outpatient services include individual, group and family counseling and include access to support services. Joint case planning and case conferencing between the DYFS case worker and the treatment provider are an essential component to this initiative.

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

South Jersey Initiative. This State funded initiative targets adolescents (ages 13-18) and young adults (ages 18-24) from eight (8) counties (Ocean, Atlantic, Burlington, Camden, Gloucester, Cape May, Salem and Cumberland). It provides a continuum of care that includes methadone maintenance, detoxification, residential, halfway house, and outpatient treatment services.

Services for the Deaf and Hard of Hearing. This funding provided for prevention, education, treatment, intervention, communication accessibility, and advocacy services for the population of individuals who are Deaf, hard of hearing, and/or disabled. Communication accessibility is coordinated to provide sign language interpreters or Computer Assisted Real-Time Translation

(CART) for individuals who were identified as Deaf or hard of hearing seeking substance abuse treatment at any level of care.

Driving Under the Influence Initiative. New Jersey has set aside \$7.5 million in State funds to support the treatment of financially indigent residents of New Jersey who have been convicted of Driving under the Influence (DUI). These treatment funds, which cover the full range of the continuum of care throughout the state, became available in November 2005. Financially indigent drunk drivers can receive the appropriate level and duration of treatment warranted, thus reducing the incidence of recidivism and ultimately creating safer highways. There are over 150 DAS licensed sites in the DUII network providing all levels of treatment services.

HIV Set Aside. The Division funds Early Intervention Services (EIS) and HIV Specialist positions at seventeen substance abuse treatment providers statewide at eighteen sites, one of which is in a rural locale. Services were available in areas of the State that had the highest rate of HIV infection, as well as the greatest need for these services.

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

Intravenous Drug Abuser (IVDA) Services. The SSA will continue to require all drug treatment agencies providing treatment to IVDA to provide outreach activities to encourage IVDA clients to seek and undergo treatment. The SSA will continue to incorporate a provision within the requirements section of each contract with the agencies providing treatment to IVDA to ensure that these entities: 1) admit all individuals who request and are determined to be in need of treatment for intravenous drug abuse within 14 days of their request; or, 2) make interim services available to the individuals within 48 hours of the request, and should the individual actively remain on the waiting list, admit the clients within 120 days. Each program will be notified that the following information about each client, who cannot be admitted to treatment within 14 days, shall be documented on the provider's standard waiting list: 1) date of placement on the waiting list; 2) unique client identifying number; 3) categorical priority status for admission; 4) record of provision of interim services by type and date; 5) record of weekly contact between client and entity; and 6) date and reason for removal from the waiting list.

Recovery Support

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

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

Sober Housing. Funding is provided to Oxford Houses to provide administrative and programmatic oversight of the statewide network of peer-led group recovery homes in New Jersey. This funding is provided only for the maintenance of the 72 existing homes in New Jersey.

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

Recovery Centers. The SSA opened New Jersey's first Recovery Center at Eva's Village in Paterson in September 2009 and its programs have continued to grow. The client-centered and client-directed center, which is opened 365 days per year, provides the following services in the large metropolitan area and surrounding communities: referral to treatment, peer support services, housing assistance, employment assistance, language assistance, self-help advocacy, childcare assistance, recreational activities, wellness classes of interest to the community and advocacy activities in support of recovery. Client choice to participate in program activities is paramount. Additionally, the Recovery Center's participants and staff continue to take leadership roles in community oriented recovery activities such as hosting the SSA's Citizen Advisory Council Linkage Event (September 2010) and organizing the New Jersey registration for the nationally sponsored Recovery Walks in New York and Philadelphia.

Building upon the success of the State's first recovery center located in the northern city of Paterson, the SSA plans to issue a Request for Proposals (RFP) to develop a second recovery center in New Jersey in FFY 2012-2013. The planned recovery center will offer those in recovery a place where they can belong, gather in support of one another and experience sober living in a community setting. It will serve as a safe place for recovering individuals to establish mutually beneficial friendships and connection to other recovering individuals. The Recovery Center - developed, maintained and operated by persons in recovery - will foster a recovery lifestyle where those in recovery can feel comfortable receiving peer-to-peer support and guidance in acquiring a number of basic life-skills, such as: budgeting, time management, planning and shopping for a nutritional diet, food preparation, parenting, caring for one's health and wellness, finding employment and housing, obtaining education and learning to enjoy sober recreation. Finally, the Recovery Center will create opportunities for those in recovery to give back to the community, and, thereby, attain a mature sense of self-efficacy.

Supportive Housing. The SSA has two supportive housing pilot programs modeled on Housing First and incorporated into its MATI. These two contracts combined provide for a total of 63 housing units, 31 units in Camden and 32 units in Atlantic City. Services are provided to individuals with substance abuse problems who are homeless or at risk of becoming homeless,

and are intravenous drug users. Women with children are given top priority. It includes rental subsidies and support services.

The SSA will also be engaged in a new supportive housing project with planning grant funds from the Robert Wood Johnson Foundation to the Corporation for Supportive Housing (CSH) during FFY 2012 to develop a Keeping Families Together (KFT) model of housing for women who are involved with New Jersey's child welfare agency, the Division of Youth and Family Services (DYFS), and also have substance abuse issues. This project will involve collaboration with DYFS, CSH, the Department of Community Affairs and other State agencies with the goal of leveraging other financing for this project.

Role of the SSA With Respect to the Delivery of Behavioral Health Services

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

The SSA is also responsible for: 1) the Statewide Intoxicated Driving Program (N.J.S.A. 39:4-50), which processes the conviction records of drivers convicted of driving under the influence and schedules these drivers for detention, evaluation, education, and treatment referral by the county-based intoxicated driver resource centers and makes funding available to address the treatment needs of indigent individuals convicted of a DUI who meet diagnosis criteria for treatment through the DUII, 2) the development of treatment services for people involved in the criminal justice system, 3) the Co-Occurring Network to serve individuals with co-occurring mental illness and substance abuse problems, 4) the special substance abuse treatment needs of people who are deaf, hard of hearing or disabled; women who are pregnant or have dependent children; minorities; adolescents; and middle-aged or senior citizens, and 5) promoting and training on evidence based programs such as Medication Assisted Treatment, co-occurring services, motivational interviewing and ASAM PPC-2R.

Description of Regional, County, and Local Entities That Provide Behavioral Health Services or Contribute Resources That Assist in Providing the Services.

Contributions of Resources by New Jersey's 21 County Governments

Chapter 51 of the Laws of 1989, C.26:2BB-12 et seq, amended an act of 1983 that established the "Alcohol, Education, Rehabilitation and Enforcement Fund" (AEREF). The AEREF is a non-lapsing, revolving fund from which the twenty-one counties receive annual allocations equaling 10.75% of the annual revenues from a tax on the sale of alcoholic beverages to plan and deliver comprehensive addiction services across the full continuum of care, including prevention,

early intervention, treatment and recovery support, based on a county-sponsored, community-based needs assessment and planning process. Under this program, counties must match 25% of their respective annual AEREF allocation with a contribution of county revenues. The funds support county-wide needs assessment, planning, coordination and provision of the full range of addiction services for indigent adult and adolescent county residents.

As of April 2011, there were 292 licensed outpatient providers and 65 residential providers.

The SSA collaborates with the twenty-one counties of New Jersey in a joint State and County comprehensive behavioral health planning process intended to: 1) coordinate system development and service delivery at state and local levels, and 2) unify community-based planning for prevention and treatment. As established by statute, a key component of the county comprehensive planning system is the County Local Advisory Committee on Alcoholism and Drug Abuse (LACADA), an independent, citizen's advisory group. The LACADA is required to develop and present to the county board of freeholders a County Comprehensive Plan (CCP) for adoption. The LACADA is also required to establish a County Alliance Steering Subcommittee (CASS). The CASS is the county-level planning body for each county's Municipal Alliance (MA), which stem from the Governor's Council on Alcoholism and Drug Abuse (GCADA). The MAs are coalitions of municipal level residents and other stakeholders who volunteer to conduct data analysis and prevention service inventories as the basis for adopting a set of local prevention priorities and recommending these to the LACADA. Through the CASS, the MA plans are coordinated with the LACADA's CCP through a process known as "Unification Planning." Beginning in FFY 2012 with the next cycle of Unification Planning, the SSA, in collaboration with the GCADA, intends to: 1) help counties identify and implement a greater number of evidence-based prevention programs and 2) support counties to establish environmental approaches to prevention planning at the county and municipal levels. The plan will also provide direction in the development of future prevention funding opportunities made available by the SSA over the next five years.

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

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

Based upon its National Evaluation Data Systems (NEDS) sponsored research on the proportion of treatment recipients with co-occurring disorders (2001), as well as its CSAT-sponsored special population surveys of drug using behaviors of persons in outpatient mental health treatment, driving-under-the-influence programs, homeless shelters, the State's Temporary

Assistance for Needy Families program, pre-natal care, middle and high school, as well as the needs of veterans returned from foreign wars, the SSA has the planning data to design policies and programs that address the needs of diverse racial, ethnic, sexual, and transgendered minorities. For instance, the SSA attends to the needs of the gay, lesbian, bisexual, transgendered and questioning youth in the design of its prevention programs. Also, in the course of its planning efforts, the SSA has examined the demographic characteristics of substance abusing persons accessing and not accessing treatment to identify treatment outcomes over a three-year period by age, sex and race as measured by mortality rates, treatment goal achievement scores, and future hospital costs. Finally, the SSA has provided SAMHSA with valid and reliable data necessary to file the treatment needs assessment tables by age, sex, and race on each of its previous SAPT Block Grant applications.

The SSA provides programming to assure the delivery of culturally and linguistically-competent prevention services in New Jersey. Cultural competence refers to a system of policies, skills and attitudes that eliminates service and participation disparities for people of diverse racial, ethnic, and linguistic populations, as well as consideration of gender, disabilities, and sexual orientation. To ensure access to quality services by diverse populations, the SSA awarded funding to PROCEED to establish or enhance existing systems for assuring the provision of culturally and linguistically competent prevention services among SSA-funded providers. Training and technical assistance services are individualized for each prevention provider and based upon the results of an extensive assessment of the provider's needs and capacity.

The SSA provides prevention services to Gay, Lesbian, Bisexual, Transgendered, and Questioning (GLBTQ) youth. The odds of substance use for GLBTQ youth are on average 190 percent higher than for heterosexual youth, according to a study by University of Pittsburgh researchers published in the March 2008 issue of *Addiction*. For some sub-populations of GLBTQ youth, researchers found the odds were substantially higher, including 340 percent for bisexual youth and 400 percent for lesbians. The SSA awarded funding to the North Jersey Community Research Initiative to expand their existing programs for high-risk GLBTQ youth of color by using a "Street Smart" prevention model developed by the Centers for Disease Control and Prevention, as well as early intervention services, social marketing, and structured recreational activities.

Other Special Populations

Military. The SSA awarded funding to the New Jersey Prevention Network to serve military families by providing prevention education, addressing military community risk levels, striving to mitigate the risk factors, and enhancing the protective factors to support military members and their families in making responsible parenting and individual choices in regards to drug and alcohol use. Children in military families are often subject to stressful conditions stemming from difficult transitions. The frequent moving characteristic of military life disrupts children's school and social lives while a parent's deployment disrupts family life. In addition to the direct effects of these events, children are affected by their parents' circumstances and ability to cope. The various stressors that arise from these transitions increase children's risk for emotional distress, substance abuse, and other risky behavior. In addition, a culture favorable to alcohol

use and abuse puts children in military families and communities at increased risk for underage drinking.

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

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

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

Women and Women with Dependent Children. The SSA is a nationally recognized leader in women's services. The SSA continues to address this population, as evidenced by the SSA being awarded an In-Depth Technical Assistance (IDTA) grant by the National Center on Substance Abuse and Child Welfare to improve outcomes for children and families involved with child welfare, substance abuse and the courts by the. The SSA will continue to work with DCF's Division of Youth and Family Services (DYFS) and AOC to facilitate systems change and move towards having a shared role in achieving safety, permanency, and well being outcomes for substance abusing families.

The State Mental Health Authority

Overview of State's Behavioral Health System – Adult Mental Health Services

The Division of Mental Health and Addiction Services (DMHAS) is the state mental health authority (SMHA) that oversees the State's public system of adult mental health services. The SMHA operates four non-forensic, regionally-based, adult psychiatric hospitals, one adult forensic hospital, and contracts with approximately 120 not-for-profit community provider agencies. In addition to its network of state psychiatric hospitals and contracted community providers, there are also six county-operated psychiatric facilities which operate as part of the continuum of services and receive most of their funding from the SMHA.

The State of New Jersey is comprised of 21 counties which are organized into three mental health service regions; North, Central, and South. Each county has a Mental Health Board that is

staffed by a Mental Health Administrator. The Boards advise the SMHA and the Planning Council of issues and programs that are of significance to their locale and residents. In addition, an Acute Care System's Review Committee (SRC) is convened monthly in each county in accordance with State regulation. This SRC is comprised of representation of acute care service providers from: state and county hospitals, short-term care facilities (inpatient units serving individuals on commitment status), voluntary psychiatric inpatient units, the county Mental Health Board, family and consumer organizations and the SMHA. The SRC is charged with the collection and review of service data as well as monitoring the provision of acute care services statewide. In addition, each county has at least one Designated Screening Center with mobile outreach and 24-hour access. The county-based Designated Screening Centers generally determine who meets the commitment standard and requires county/state inpatient treatment within the public system.

The community mental health system of services provides for three levels of care in each county: (1) acute care programs and crisis stabilization; (2) intermediate care and rehabilitation; and (3) extended/ongoing support programs. The SMHA contracts for statewide, regional and county/local behavioral health services. Statewide contracted services include services for specialty populations such as: Statewide Clinical Consultation and Training (SCCAT) program which provides consultation and training to our hospital and community provider community regarding individuals dually diagnosed with a mental illness and developmental disability; *ACCESS* which provides consultation, residential, outpatient and case management services to individuals who are deaf or hard of hearing and diagnosed with a mental illness. Additional statewide contract services include contracts to provide training and technical assistance to specialized segments of the provider workforce and statewide depositories of behavioral health resource information and self-help information. SMHA contracts for regional services including: multicultural resource centers to provide training and information to providers regarding cultural competence, co-occurring inpatient services for individuals with substance use issues and a mental illness, and housing for specialty populations.

In SFY 2010, the SMHA has served 281,138 unduplicated adult consumers in community settings—including county hospitals and STCFs, of whom 121,361 or 43.17% were Seriously Mentally Ill (SMI). Of the 121,361 SMI consumers served in FY 2010, 54,548 or 44.95% were ethnic minorities. Although complete FY 2011 USTF data is unavailable at the time of writing, the number of unduplicated consumers served in community agencies, county hospitals and short term care facilities in the first three quarters of SFY 2011 (spanning the time period between July 1, 2010 and March 31, 2011) is 267,085, of whom, 111,019 or 41.57% were SMI. If county hospitals were excluded, then 2727,799 unduplicated adults were provided services in the community in FY 2010, of whom 113,801 or 41.72% were SMI. Of the 113,801 SMI consumers served in FY 2010, 51,937 or 45.64% were ethnic minorities. The number of unduplicated consumers served in community agencies, excluding county hospitals, in the first three quarters of SFY 2011, was 258,901 of whom, 103,630 or 40.03% were SMI.

Persons with serious mental illness are the primary target population for SMHA funded services, however, the SMHA also prioritizes services to persons with special access needs, including older adults, ethnic and linguistic minorities, and individuals with co-occurring mental health and substance abuse problems, hearing impairment, developmental disabilities, and criminal justice

involvement. Many of the activities of the SMHA focus on inter-organizational coordination and collaboration to improve access by special needs populations. This is achieved through interface with the various Divisions within the Department of Human Services including the Division of Developmental Disabilities, the Division of Deaf and Hard of Hearing, the Division of Family Development (welfare), the SSA and the Division of Medical Assistance and Health Services. In addition, there is coordination with the Division of Youth and Family Services, the Department of Health and Senior Services, the Department of Community Affairs (housing/homeless) and the New Jersey Housing and Mortgage Financing Agency. There is also coordination with the Division of Vocational Rehabilitation Services within the Department of Labor; and with the Department of Corrections.

In accordance with the Wellness and Recovery Transformation Plan, the DHS and the SMHA have developed four task forces to address the special needs of mental health consumers. These Task Forces focus in the areas of acute care services, integration of primary care and mental health, developmental disability and mental health care, and co-occurring substance abuse and mental health care.

SMHA/Division of Medical Assistance and Health Services (DMAHS): The SMHA and DMAHS collaborated to implement a prior authorization process for community partial care that began on 7/1/09. As a result, both the SMHA and DMAHS have realized both cost savings from this initiative as well as the first step in transforming the long-term day program into one that is more recovery oriented, shorter term, focusing on rehabilitation and attaining community integration and inclusion goals.

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

SMHA/Division of Developmental Disabilities (DDD): In October 2008, the statewide Task Force on Developmental Disabilities (DD) / Mental Illness (MI) completed the New Jersey DD / MI Task Force report (please visit http://www.state.nj.us/humanservices/dmhs/news/publications/DD_task_force_report.pdf). The implementation of the Task Force's recommendations and plans involves an executive oversight board that includes executive staff from DHS' Divisions, the DCF and DCBHS. Some of the priorities to be implemented include the development of a continuum of crisis response services and case management capacities to serve individuals with DD/MH diagnoses. SMHA staff collaborate with DDD staff regarding discharge planning of DD/MI consumers in the State psychiatric hospitals. Staff from DDD attend monthly Mental Health Planning Council meetings. A follow-up Clinical Workgroup was convened to develop a continuum of crisis responses and service models that could serve children and adults with DD/MI (and be eligible for Medicaid reimbursement). These service models included: 1. Mobile response with a clinical outreach capacity, 2. Short-term emergency treatment, 3. Crisis Respite Beds and 4. Outpatient Service Centers.

SMHA/Department of Health and Senior Services: Chaired by the SMHA Medical Director, the Primary Care and Behavioral Health Care Task Force is examining the specific causative factors for early mortality, most of which is related to potentially preventable risk factors that shorten life expectancy (e.g., smoking, lack of exercise, poor nutrition, substance use, and exposure to communicable diseases). The main goal of the Task Force is to increase access to primary care and improve collaboration between mental health agencies and health care providers. In addition, the aim of the Task Force was to address the co-morbidity issues experienced by persons with serious mental illness and to address disparities in primary health indicators among SMI and non-SMI populations¹. The SMHA implemented this task force as an essential component of its Wellness and Recovery Transformation Action Plan (see http://www.state.nj.us/humanservices/dmhs/recovery/Welln_Recov_action_plan_jan2008_Dec2010.pdf). This Task Force and its subcommittees included consumers, family members and medical professionals. There were three subcommittees: 1. Integration of Behavioral Health and Primary Care; 2. Promotion of Consumer Self-Management; and 3. Morbidity and Mortality Surveillance. The goal of this Task Force is to provide recommendations that will improve the care and integration of mental health consumers for both physical and mental health. The recommendations from the Primary Care and Behavioral Health Care Task Force are expected to be completed in the near future.

In collaboration with Medicaid, the SMHA initiated work on a disease management program with the goal of educating physicians in the Best Practices of prescribing medications to mental health clients. The SMHA launched this as a pilot program with Medicaid and the Department of Health and Senior Services (DHSS) to coordinate and provide primary medical care services between a community mental health program and a FQHC, thus meeting a consumer's mental health care needs in a primary health care facility (the FQHC). The pilot phase has ended, and due to its success, this program continues on its own without DMHAS funding. This program (Greater Trenton) is still operating as described, and is now one of four mental health agencies that are being funded by a SAMHSA Primary and Behavioral Health Care Integration Grant to coordinate with FQHCs for primary care services. The grant, which is in the first year, has consumers being medically screened and referred to the local FQHC by a nurse care manager situated at the mental health agency. This is combined with wellness activities in the mental health program.

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

Role of the SMHA With Respect to the Delivery of Behavioral Health Services

¹ <http://www.state.nj.us/humanservices/dmhs/recovery/>

The SMHA for adult services serves in the following capacities: (1) direct service provider; (2) purchaser of services; (3) regulator of standards and services; (4) coordinator for immediate mental health disaster response; and (5) systems planner. In executing these functions, the SMHA must take the lead to ensure that there is continuity of care and coordination of services within the State and between the public and private sectors. In doing so, the SMHA must provide leadership in the following areas: (1) interface between the State and County psychiatric hospitals and community providers; (2) establish or participate in key advisory boards and committees whose missions impact upon the delivery of mental health care and treatment; (3) promote effective communication internally as well as the broader mental health and human services communities; (4) represent and advocate for the needs of the mental health community at the state and federal levels; and (5) initiate planning activities with input from key constituents and interested parties, that address the changing needs of New Jersey's residents.

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

The SMHA contracts for county/local services including: Consumer Run and Operated Self-Help Centers, Programs for Assertive Community Treatment (PACT), Integrated Case Management Services (ICMS), a continuum of Residential Services, Supported Housing (SH), Outpatient Services (OP), Supported Employment (SE) and Supported Education (Sed), Partial Care, Intensive Family Support Services (IFSS), Systems Advocacy including Legal Services, Intensive Outpatient Treatment and Support Services (IOTSS), Designated Screening Centers (DSC), Affiliated Emergency Services (AES), Early Intervention Support Services (EISS), Justice Involved Services (JIS) and PATH (outreach to persons who are homeless). The SMHA currently designates 405 Short Term Care Facility (STCF) beds in New Jersey. These services are funded with CMHBG, other federal or State funds.

State Plan Amendment

THE SMHA has obtained Medicaid's approval for reimbursement for Community Support Services (CSS), under the Rehabilitation Option. Funds are being invested in further achieving the Olmstead settlement objective agreements. CSS consist of mental health rehabilitation services and supports necessary to assist the client in achieving mental health rehabilitative and recovery goals as identified in the individualized rehabilitation plan; including achieving and maintaining valued life roles in the social, employment, educational and/or housing domains; and to restore a consumer's level of functioning to that which allows the consumer to achieve community integration, and to remain in an independent living setting of his/her choosing.

Olmstead

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

http://www.state.nj.us/humanservices/dmhs/olmstead/CEPP_Plan_1_23_08_FINAL.pdf to view the CEPP Plan. Although the Olmstead Settlement agreement was a result of a lawsuit initiated in 2005, this Settlement has resulted in an investment in the mental health system in needed community residential and other services. The Olmstead Settlement agreement can be viewed at http://www.state.nj.us/humanservices/dmhs/olmstead/olmstead_settlement_agreement.pdf. From July 2006 to June 2011, the state hospital census (excluding Anne Klein Forensic Center) has decreased from 2,173 to 1,554, a reduction of 619 or 28.49%. On July 29, 2009, DHS and DRNJ came to a settlement in the Olmstead litigation that began in New Jersey in 2005. The SMHA has been working toward fulfilling the requirements of the settlement agreement and its Home to Recovery - CEPP Plan. Some of the items listed below are the SMHA's accomplishments since the signing of that agreement:

The settlement called for the creation of 145 beds expressly for the placement of consumers on CEPP status in the hospitals, and 70 beds to be created for consumers who are in the community and at high-risk for hospitalization and/or homelessness, for a total of 215 placements to be created in FY 2011. The SMHA has met and exceeded this goal for FY 2011 by creating 171 placements for consumers on CEPP status and 82 placements for consumers at risk, for a total of 253 placements created during the fiscal year. In 2010, with the Olmstead Housing Expansion, the SMHA created an additional 196 placements for consumers who were CEPP and awaiting discharge and 50 placements for consumers who were in the community and at risk of hospitalization or homelessness. In addition, from 2006 to 2009, the SMHA created 1,424 community placements. Therefore, since 2006, the SMHA has created 1,923 new placement opportunities and currently are in the beginning stages of planning for the 2012 placements to be developed.

In addition to the accomplishments listed above, the SMHA has been able to close several units at its State hospitals. As of 6-30-11, the census was 1,554, excluding Anne Klein Forensic Center (AKFC). The SMHA has been able to close beds in its state hospitals primarily due to its Olmstead Initiative. Some of activities leading to the decrease in census are the following:

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

addressed, systemic issues are addressed, and compliance with length of stay targets are maintained.

4. The SMHA has seen a decrease in the overall census in the four State hospitals. The census at the end of FY 2009 was 1724 and the census at the end of FY 2011 was 1,554 which is a difference of 170, or 9.86%. Due to the efforts to enhance community residential placements and the continued reduction in census at New Jersey State Hospitals, the SMHA has been able to close several units at its State hospitals. In addition, the FY 2012 State budget calls for the closure of a State Psychiatric Hospital. In early July, a decision was made to close Hagedorn Psychiatric Hospital, a 288 bed State hospital located in the northern region. As the Olmstead efforts continue and the SMHA develops more opportunities for individuals living in the community, the SMHA will continue to evaluate and manage the hospital resources in an efficient and clinically appropriate manner.

Promoting Health and Behavioral Health (Smoking Cessation, IMR, and APN Program)

THE SMHA contracts with agencies to work collaboratively to treat the physical and emotional needs of our consumers. There are initiatives in place to promote a better understanding of the role of mental health to overall health. These initiatives are: Smoking Cessation; Illness Management and Recovery (IMR), and the Advanced Practice Nurse (APN) Program.

On April 7, 2008, a law was passed banning smoking on State hospital grounds provided that a smoking cessation program is offered one full year in advance of the ban. On July 8, 2009, Ancora Psychiatric Hospital and Greystone Park Psychiatric Hospital became tobacco free as a result of this legislation. Both Trenton and Hagedorn Psychiatric Hospitals became smoke free in the fall of 2009. Accepted research in the field reflects that people with mental illness live an average of 25 years less than the general population, and approximately 75% are addicted to nicotine. The smoking cessation program is a SMHA funded university-based program targeted towards educating staff and patients in State hospitals and provider agencies about cardiac risk factors associated with smoking. The goal is to have a smoke-free environment for consumers and staff.

The IMR program initiated in the community and state hospital programs is on-going. Training of staff started in our central region with 5-10 staff in each agency being trained. This initiative is specifically geared toward helping mental health consumers acquire the information and skills needed to collaborate effectively with others in the development of their treatment plan. The goal of the IMR is to help the consumer learn about mental illness and strategies for treatment; decrease symptoms; reduce relapses and hospitalizations; and make progress towards personal goals through recovery. The SMHA, in partnership with UMDNJ's School for Health Related Professions, is providing training in this model which consists of 10 modules to targeted staff in 5 State Psychiatric hospitals and 102 partial care programs/partial hospitals.

Lastly, through the APN Program, comprehensive health and mental health assessments of acute and chronic conditions are completed; medication is prescribed under joint protocols; and there is APN participation in the development, implementation, and evaluation of treatment plans. Consumers are referred to APNs from a variety of sources, including State and County hospitals, ERs, short-term care facilities, family members, self referrals and community providers. APNs

are accessible on site at the hospitals, some community programs, and in homeless shelters. The SMHA funds approximately 68 APN positions. The State hospitals are responsible to ensure that consumers receive all necessary medical treatment (including mammography, dental care, etc). Some of the state and county hospitals have dental offices within their facilities.

ICMS works collaboratively with the consumer, their family/significant others (as appropriate) and other collateral contacts to assesses the individual's strengths and needs, develop a service plan based on this assessment, refer and link individuals to needed services and monitor their engagement in services.

Rehabilitation services are provided within partial care and include engagement strategies that are designed to connect with individuals in order to enter into therapeutic relationships supportive of the individual's recovery. Activities to assist a consumer to identify, achieve and retain personally meaningful community integration and other personal goals over time which help the person resume normal functioning in valued life roles in self-chosen community environments.

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

- Coping skills, adaptive problem solving, and social skills training that teach individuals strategies to self-manage symptoms;
- Psycho-education that provides factual information, recovery practices, including evidence-based models,
- Development of a comprehensive relapse prevention plan that offers skills training and individualized support;
- Medication self-management, behavioral tailoring, simplifying a consumer's medication regimen, and motivational interviewing assist and support consumers in adhering to their medication regimens;
- Wellness activities that are consistent with the consumer's self-identified recovery goals. Wellness activities may address common physical health problems, such as tobacco dependency, alcohol use, sedentary lifestyle and lack of physical exercise, and overeating and/or poor nutrition including connection to primary medical and dental services;
- Skill development needed for consumer-chosen community environments, facilitating consumer-directed recovery and re-integration into valued community living, learning, working and social roles by developing critical competencies and skills; and
- Age-appropriate learning activities which are directly tied to the learning of daily living or other community integration competencies such as financial literacy, learning basic computer literacy, and recognition of directions and safety warnings.

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

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

Contracted providers such as Steininger Behavioral Care (PACT and ICMS), NewPoint Behavioral Care (PACT and ICMS), and South Jersey Behavioral Health Services (Residential and Partial Care) programs are working more closely with Primary Care Physicians on medical issues and spend more time with the boarding homes ensuring that consumers are able to get to their doctor's appointments. Also, there is an increased utilization of, or referrals to, Medical Day Care Centers; i.e. Guardian, Communicare, Senior Aid and Senior Housing. Several PACT consumers are currently in Senior Housing and one PACT consumer just went to an Assisted Living facility. Also, since consumers are not willing or able to attend programs, many are using the medication monitoring groups, like the old "Social Clubs".

The following describes mental health services that are funded with either CMHBG or other federal or State funds.

Consumer Operated Services

At the State level, the Division involves peers in upper level management decision-making, program development, proposal reviews, community site reviews, state hospital monitoring, and participation in key committees and workgroups including the Olmstead Advisory Committees, the Acute Care Task Force and the Statewide Mental Health Planning Council. DMHAS continues to provide funding and support for peer providers working in the system. All PACT Programs are required to employ at least one peer advocate, licensing standards stipulate that consumers be given special consideration for ICMS positions, and each of the 33 self-help centers has a designated peer working as the center manager. There are also peers working in designated screening centers/psychiatric emergency rooms, and plans are underway to develop peer-operated alternatives to crisis and screening. The Division's Patient Service Compliance Unit (PSCU) continues to use peers on site review teams, and peers will be receiving specialized training to assist with the state's hospital family monitoring program. Most recently, there has been greater emphasis by the Division and its collaborating agencies to expand the peer workforce through promoting practices and principles that support the necessary culture change within traditional mental health agencies, by addressing the need for quality supervision, and the training and certification of peers. The Division is also moving forward with a State Plan Amendment to draw down Medicaid reimbursement for peer provided services such as wellness coaches, Peer Outreach Support Teams (POST), workers and other appropriate roles for which consumers are uniquely qualified.

Consumer Operated Recovery Support Services:

1. Wellness Recovery Action Plans (WRAPs) are used extensively in services funded by the SMHA using peer support interventions. WRAPs are utilized statewide.
2. Psychiatric Advance Directives (PADs) – The SMHA has a PAD Policy that promotes the empowerment of consumers to direct their own care with regard to the care and

treatment they receive. This document is a permanent record in the consumer's chart which can be revoked or amended by legal authority. PADs are submitted to the SMHA and available on a 24-hour basis.

3. Peer Wellness Coaching - UMDNJ-SHRP is continuing to prepare both peer and non-peer wellness coaches, recently completing a training series to improve the skills of 25 job coaches and IMR facilitators, giving them a new set of intervention tools to remove barriers to employment and help individuals formulate individualized employment and education goals. UMDNJ-SHRP is currently delivering wellness coaching services to 12 peer providers, the target is to serve 30 in the next years. Wellness for Life is the adjunct program to wellness coaching and has served 40 individuals this year. The population that is served is consumers with serious mental illness who have metabolic syndrome. They receive exercise support, nutritional services and wellness coaching.
4. The Hearts & Minds Program is a statewide prevention program that is consumer-managed. The program focuses on prevention and wellness for consumers with metabolic syndrome. The services are peer delivered through education, most of which is through consumers sharing their experiences.
5. Peer Run Self-help Centers – The SMHA currently funds and supports 33 consumer operated self-help centers statewide, including a self-help center on the grounds of three of our State hospitals.
6. Consumers Helping Others Improve their Condition by Ending Smoking (CHOICES) – This is an innovative peer outreach program targeting smokers with mental illness by offering technical support and outreach.
7. Peer-run self-help groups – The self-help centers operate a number of peer run self-help groups such as: Dual Recovery Anonymous, women's groups, men's groups, walking clubs, etc.
8. Financial Literacy Program – This is a SMHA funded initiative through Collaborative Support Programs (CSP) where consumers receive education about money management, budgeting, and credit repair. This program is offered statewide.
9. Individual Development Accounts (IDA) – These are accounts where consumers receive a monetary match for saving for education, employment, or for personal needs. The match is a 3:1 match for education and employment savings. Any consumer in a self-help center can apply.
10. Consumer-run Transportation Services – Riverbank Self-Help Center has two transportation services. One is for transporting consumers to return to work and for vocational training opportunities, and the other is to transport consumers to dual recovery groups in the community.
11. Peer Operated Warm Line – the peer operated warm line is a statewide initiative through the Mental Health Association of NJ where consumers receive interventions and/or assistance during times of concern, need, or crisis using the Intentional Peer Support Model.
12. Planned Parenthood – comes to the self-help center and provides educational programs for consumers. These educational opportunities are provided at a few of the self-help centers during the year.
13. Re-Entry Groups - Several self-help centers in the Northern Region of the State conduct groups at the local jails. The groups are a combination of Anger Management, Family

Involvement, Coping with Stress and Community Resources along with open peer support.

14. Dual Recovery Groups – Due to the high prevalence rate of dual disorders, the SMHA sponsors and funds a small program to provide specialized dual recovery groups at self-help centers to provide specialized approaches to start and run nine centers to participate in the initiative.
15. Parent Advocacy Project – These services are provided by the Mental Health Association of Passaic County. These groups are also offered as bi-lingual.
16. Health Screenings – are offered at a few of the self-help centers in the central region.
17. Visits to Homeless Shelters – the self help centers provide outreach to homeless shelters. During the visits to the shelters, the goal is to engage the homeless consumers into peer operated self-help centers using peer support, dual recovery groups, etc.
18. Development of a “How to Guide” on broadening consumer population (including racial and ethnic populations and ways of creating warm welcoming environments).

Behavioral Health Prevention Efforts of the New Jersey Stigma Council

The New Jersey Governor’s Council on Mental Health Stigma (Stigma Council) utilizes its core initiative, “A Community Effort”, for its prevention and public awareness and education efforts. A Community Effort, recognizing that mental health is not a one-size-fits-all issue, is built upon a principle of community connectedness. A Community Effort utilizes a series of public awareness campaigns and powerful community partnerships to engage in prevention, education and awareness efforts.

The Stigma Council engages in partnerships with different audiences in the community as part of “A Community Effort” Initiative – a set of outreach campaigns targeted to increase mental health awareness among the following groups: veterans and military personnel, law enforcement, educators and students, employers, communities of faith, multicultural communities, and providers by engaging in local, regional and statewide public awareness campaigns, initiatives and programs. The paragraphs that follow provide brief descriptions of the SMHA’s behavioral health prevention campaigns.

“Stigma is the Disease, Knowledge is the Cure” campaign is directed toward college-age populations and the educational community. This campaign is designed to increase participation by students and educators in mental and behavioral health treatment, prevention and awareness. In October 2011, the Stigma Council and SMHA Planning and Evaluation staff will be coordinating a mental health awareness day at 19 community colleges to engage students and educators in the importance of mental health awareness and early identification of mental illness.

New Jersey’s law enforcement community is being engaged by the Stigma Council’s “Tough Cops Ask for Help – Don’t Let Stigma Stand in Your Way” campaign. The goal of this effort is to increase participation of law enforcement personnel in mental health treatment, prevention and awareness programs. The Cop2Cop Program—an adjunct effort, provides counseling resources and attempts to engage law enforcement personnel to take an active interest in their own individual mental health.

New Jersey's business community is engaged by the Stigma Council through the "Start the Conversation – Employ Mental Health" campaign. This effort is creating partnerships with local business leaders and is aimed at increasing employment opportunities for SMI populations, as well as prevention and awareness in the workplace.

The Stigma Council is attempting to leverage existing local-level community networks through partnerships with New Jersey's many communities of faith. The "Have Faith in Your Mental Health" campaign is forging partnerships with clergy and houses of worship from a range of denominations to increase statewide awareness of mental illness, prevention and treatment.

A multi-lingual, multi-ethnic and multi-cultural approach is being employed in the Stigma Council's "Mental Illness Does Not Discriminate, Only People Do" campaign, which is messaged in 8 languages. The campaign is being used with already existing multicultural community partners and has been enthusiastically embraced and utilized in multicultural mental health awareness activities statewide.

The Stigma Council "A Community Effort" recognizes the importance of cultural competency in all of its efforts and inclusion of all groups in prevention efforts. All community partnerships focus on collaboration with all groups to ensure that all input, information and guidance in regard to messaging, content and approach are accurate and culturally competent.

Supported Employment

The SMHA has been providing the evidence-based practice of supported employment (SE) since 1988. SE is provided statewide and jointly funded by the Division of Vocational Rehabilitation and the SMHA. Adults (18 years of age and older) with severe mental illness and or co-occurring mental illness and substance use disorders (COD) are assisted to choose, obtain and keep integrated employment in jobs of their choosing within their skill and credential set. The SMHA provides SE through 22 contracted community mental health provider organizations; at least one in each county. SE is provided to a rich mix of diverse consumers; male and female as well as individuals of Caucasian, African American, Hispanic, Asian and Asian Indian backgrounds and from many different countries.

Supported Education (Sed)

Although the SMHA has been promoting Sed since 1993, contracts for Sed services have only been offered by the SMHA since 2006. Sed programs target individuals with severe mental illness and or co-occurring disorders who either want to or are currently matriculating in post secondary education. The SMHA provides through four existing contracted supported employment community provider organizations Sed mobile outreach services aimed to assist people with psychiatric disabilities to reach their postsecondary academic goals. Services are individualized and flexible based on student choice and career goals. Sed is provided to a diverse population of consumers; male and female as well as individuals of Caucasian, African American, Hispanic, Asian and Asian Indian backgrounds and from many different countries.

Justice Involved Services (JIS)

The SMHA has been providing JIS since 2000. The program works to divert from incarceration, individuals whose legal involvement may be a result of untreated mental illness or co-occurring

mental health and substance abuse disorders. It is a short-term case management program designed to help consumers to successfully link to mental health or co-occurring and other services in order to stabilize and enter valued community roles reducing their incidence and length of incarceration. The program provides access to community-based health and substance abuse treatment services. Clients receive treatment services, case management, housing and medications. The SMHA provides JIS services through 15 contracted community mental health provider organizations in 15 of the 21 counties in the State. JIS is provided to a diverse mixed of consumers; male and female as well as individuals of Caucasian, African American, Hispanic, Asian and Asian Indian backgrounds and from many different countries.

Illness Management Recovery (IMR)

SMHA has been advancing consumer access to the evidence-based practice of Illness Management and Recovery (IMR) services for the past six years. The provision of IMR is presently required in regulation for partial care/partial hospital (pc/ph) and PACT. SMHA provides IMR through existing partial care and PACT contracted community provider organizations. There are over 120 pc/ph programs and 35 PACT Teams statewide with penetration into every county in the State. IMR training and technical assistance is provided by the University of Medicine and Dentistry of New Jersey (UMDNJ), University Behavioral Healthcare (UBHC) under contract with SMHA. IMR training will be expanded to additional SMHA contracted services. IMR is provided to a diverse population of consumers; male and female as well as individuals of Caucasian, African American, Hispanic, Asian and Asian Indian backgrounds and from many different countries.

Veterans' Services

The SMHA has consistently provided mental health and related support services to members of the armed forces and veterans as part of its regular behavioral health service deliver system. When possible, the service member is transferred to the VA healthcare system if eligible. In SFY 2010 over 7,000 individuals were provided with services. The SMHA and SSA participate in the State's Veterans Services Enhancement Team, the result of participating in SAMHSA's Policy Academy on Service Members, Veterans and their Families to better coordinate and provide services to this group in New Jersey.

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

The SMHA provides a comprehensive array of services many of which are available to service members in their counties. The most frequently used services are outpatient (individual, group and family counseling, psychiatric evaluation and medication management), partial care, Intensive Case Management Services (ICMS) and emergency crisis screening.

SMHA services are provided to a diverse population of consumers; male and female as well as individuals of Caucasian, African American, Hispanic, Asian and Asian Indian backgrounds and from many different countries.

Acute Care Services

The SMHA funds and regulates a full range of acute mental health care programs for individuals with intensive outpatient mental health needs and for those experiencing psychiatric crisis. In order to meet the needs of individuals who require involuntary in-patient services, the SMHA allocates roughly \$25 million in subsidies for 405 Short Term Care Facility (STCF) beds in New Jersey. These beds are operated by 24 different agencies and serve all 21 New Jersey counties. Most of these agencies are community hospitals and these beds permit the state's residents to access a hospital based level of care at the local community level. Since the end of 2007, community hospital based involuntary psychiatric inpatient service capacity has been increased by approximately 17% (59 beds).

The SMHA funds 23 Designated Screening Service Programs across the 21 Counties at a total cost of approximately \$41.4 million per year. The Screening and Screening Outreach Program is designed to provide screening, assessment, crisis intervention, referral, linkage, and crisis stabilization services, 24 hours per day, 365 days per year, in every geographic area in the State. From FY 2006 through FY 2009, \$14.8 million was added to the State's designated screening centers, to create new and expanded Screening and Screening Outreach services. As of the time of writing, the State's designated screening centers have reported over 79,600 episodes of crisis care in SFY 2011. This number will increase as a few facilities have not submitted their complete 12-month datasets as of yet but are planning to do so in the weeks ahead.

In 2008, the SMHA began investing \$3.0 million annually in Early Intervention Support Service (EISS) programs in Morris and Atlantic Counties. These programs are intended to provide rapid access to short-term, non-hospital based crisis intervention and stabilization services for persons with a mental illness. These early intervention programs are community-based programs aimed at offering individuals mental health service options that can divert undue use of emergency room and in-patient programs. Access to this intensive diversionary program is intended to provide a direct and specific alternative to hospital emergency department based crisis services. During the past fiscal year, an additional \$3.0 million been awarded to bidders to implement these programs in Camden, Middlesex and Ocean Counties.

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

By virtue of setting (e.g. hospital emergency departments), coverage (e.g. urban, suburban, rural entities) admissions practices, and regulatory protections, acute mental health care programs serve individuals of racial, ethnic and sexual/gender minorities. Cultural competence mandates (e.g. licensing boards) also ensure workforce development toward the end of meeting the needs of all service users.

Supportive Housing

The SMHA has 25 Projects for Assistance in Transition from Homelessness (PATH) programs in all 21 counties. These programs conduct outreach to locations known to be frequented by homeless individuals in an attempt to continuously assess and identify individuals with serious mental illness that may benefit from linkage to mental health and housing programs. All programs are involved in the annual Homeless Count. Information from these programs is used to assist SMHA in developing Requests for Proposals (RFPs) for the “At Risk” population.

The SMHA contracts with approximately 52 Supportive Housing providers (including Medically Enhanced and Enhanced Supportive Housing models) and Supervised Residential providers in all 21 counties. These services range from being completely consumer-driven in the consumer’s leased-based housing to supervised settings with 24/7 staffing. In addition, the State funds eleven Residential Intensive Support Teams (RIST) in 13 of the 21 counties – a Supportive Housing model with a higher staff-consumer ratio and SMHA funded rental subsidies serving consumers discharged directly from the State hospital system, as well as those at risk of hospitalization.

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

Housing opportunities and program design will demonstrate the principles of supportive housing including lease-based or similar occupancy agreements that prohibit removal due to lack of service participation or hospital admission. Preservation of housing is primary and recognized as essential to overall wellness and recovery. The housing setting will provide private bedrooms, comfortable living space, and adequate kitchen and bathroom facilities.

The overall service focus will demonstrate the development of skills and supports that promote community inclusion, housing stability, wellness, recovery, and resiliency. Other areas to be addressed are illness management, socialization, work readiness and employment, peer support, and other skills that foster increased self-direction and personal responsibility for one’s life. Consumers are expected to be full partners in identifying and directing the types of support activities that would be most helpful to maximize successful community living. This includes use of community mental health treatment, medical care, self-help, employment and rehabilitation services, and other community resources, as needed and appropriate.

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

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

Homeless Adults/Housing First

The SMHA, the United Way of NJ, and Mercer County are members of the Mercer County Housing First Collaborative and contributing funders of supportive services for the Mercer Housing First Program. The program includes the identification of homeless individuals with disabilities, including serious mental illness and substance use disorders, the provision of permanent supportive housing through vouchers and an array of wrap around services, including behavioral health, primary health monitoring and linkage, referral to financial assistance and vocational services. As of mid-February 2011, 62 homeless individuals and families had been permanently housed.

Homeless Adults/PATH

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

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

PATH is widely distributed across the State. The SMHA contracts with 24 non-profit agencies (and one County) to operate 25 PATH programs within the State's 21 counties. A small number of PATH programs use PATH funding to directly provide psychiatric assessment and outpatient mental health services. Hudson County PATH has a PATH funded substance abuse counselor. Many PATH providers are Community Mental Health Centers and link their consumers to mental health in their agency outpatient or partial care programs. All PATH programs link individuals to behavioral health and co-occurring services within their communities.

All PATH providers are required to complete Intended Use Plans in which they identify the gender, race and ethnicity of the individuals they are serving in their community; the gender, racial and ethnicity of their staff; and to specify how their staff will provide culturally sensitive services and what cultural competency training and support their staff is provided. At minimum, all agencies provide cultural competency training at hire and at least annually. A number of agencies take advantage of the trainings offered by the regional Cultural Competency Training Centers and other regional training opportunities. All PATH programs are informed by SMHA

staff of any and all cultural awareness trainings being offered through SAMHSA or the Homeless Resource Center that addresses special populations, including gender identity, sexual orientation, gender and trauma informed care, racial, ethnic and the hearing impaired.

Programs in Assertive Community Treatment (PACT)

PACT is an evidence-based model of service delivery in which a multi-disciplinary, mobile, treatment team provides a comprehensive array of mental health and rehabilitative services to a targeted group of individuals with serious mental illness. The program is designed to meet the needs of consumers who are at high risk for hospitalizations, are high service users and who have not benefited from traditional mental health programs. In order to meet the unique needs of this targeted population, PACT teams offer highly individualized services, employ a low staff to consumer ratio, conduct the majority of their contacts in natural community settings (e.g. consumer's residence) and are available for psychiatric crises 24 hours a day. Service intensity is flexible and regularly adjusted to consumer needs and services are offered for an unlimited time period. Consumers are eligible for PACT throughout the lifespan.

As a long-term program, in which the course of treatment has no pre-determined end point, most New Jersey PACT teams are staffed with eight to ten full-time equivalent direct care staff and can serve between 60-75 consumers at any point in time. There are 31 PACT teams in New Jersey, serving all of the 21 counties. The SMHA contracts with 12 different non-profit agencies that operate these teams.

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

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

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

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

Intensive Family Support Programs (IFSS)

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

Services offered include psycho-education groups, family support groups, single family consultation, respite activities and referral/linkage. Services are delivered in the family home, at the agency or at other sites in the community convenient to individual family members. Minority families, with the exception of one northern county whose caseload is largely Hispanic, are reluctant to utilize IFSS. Individual caseloads are overwhelmingly comprised of Caucasian families with only a few at most in each program having an African American, Hispanic or Asian American ethnicity. To remedy this gap, the New Jersey Chapter of the National Alliance on Mental Illness is contracted with the SMHA to provide support, education, advocacy and referral services to four separate ethnic groups through the following programs: Family to Family en Español, South Asian Mental Health Awareness in New Jersey (SAMHAJ), Chinese American Mental Health Outreach Program (CAMHOP), and the African American Community Takes New Outreach Worldwide (AACT-NOW!).

Older Adults

The SMHA is currently seeking proposals for the development of a program to provide specialized clinical consultation, assessment, treatment and intervention to older adults diagnosed with a mental illness. It is expected that the awarded program will be available to older adults aged 55 years and older who present and/or are referred to a designated screening center, affiliated emergency service provider, contracted SMHA residential providers, the SMHA Preadmission and Resident Review (PASRR) Unit and/or the SMHA Centralized Admissions Unit. These specialized services will ensure the appropriate assessment and treatment of this at risk population in order to facilitate and support their continued residence in the community. The target population is older adults aged 55 years and older who are diagnosed with a mental illness. The individual is a resident of a nursing facility, long-term care setting or currently engaged in contracted residential services through the SMHA and at risk of psychiatric hospitalization.

The awarded program will also provide training to increase the knowledge and positively affect the attitudes and behaviors of staff from designated screening centers, affiliated emergency service providers, contracted SMHA residential providers, nursing facilities and other long term care settings who are responsible for the care of the target population resulting in improved management of behavioral disturbances and crisis and enhanced lifestyle for these individuals.

The awarded program will have the capacity of statewide service provision which may include multiple service sites. All service sites will collaborate and use uniform and consistent promising practices and/or evidence-based practices and policy and procedures for training, assessing,

developing treatment, providing treatment, managing behavioral disturbances and stabilization of crises for the targeted population.

The awarded program must ensure that the program will be culturally and linguistically competent, accessible, and responsive to agencies, consumers and families. Older adult is defined in this specific section as individuals over the age of 55 years and with a psychiatric diagnosis. The older adult mental health service system in New Jersey does not discriminate with regard to diverse racial, ethnic and sexual /gender minorities.

Workforce Development

The SMHA contracts directly with several programs within University Behavioral Health Care of the University of Medicine and Dentistry of New Jersey (UBHC-UMDNJ) to provide for workforce development needs of our hospitals and agency staff. Within the UBHC-UMDNJ Technical Assistance Center, training and technical assistance is provided on Integrated Dual Disorders Treatment to contracted agencies and hospitals. Training is available on several other evidence-based practices such as CBT and IMR. Through UBHC there is training available on gang violence and case management given to crisis staff throughout the State. UBHC, through its contract with the SMHA, is focused on early identification and recovery and wellness supports.

Family Services provides extensive training to clinicians who are seeking their credentials in addictions counseling. Until budget cuts last year, New Views Training Academy provided training in all addictions domains toward licensure, with over 300 individuals attending sessions annually. Collaborative Support Programs is funded to provide training and technical assistance to consumer-run activities and supports. Until funding was cut, they were providing scholarships toward certification in Psycho-social Rehabilitation, Co-occurring Associate, and towards full LCADC certification.

The SMHA has approximately 120 contract agencies that provide behavioral health intervention and treatment services that span all levels of the continuum of care. In addition, the State has an extensive peer network of peer support teams, peer run self-help centers and family support models. Those agencies and consumer activists all are in need of extensive training and workforce development that range from basic skill to advanced clinical and best practice knowledge, as well as knowledge and skill for special populations such as those with co-occurring mental illness and substance use disorders. SMHA training and workforce development efforts are all funded directly from the State budget. Some funds are disbursed into training agencies as mentioned above; however the SMHA had also disbursed funds to counties for training and workforce development as well as funding extensive training directly.

The SMHA has several initiatives to provide the service delivery system with training and technical assistance on the needs of multicultural populations in the State. Through a bi-lingual/bi-cultural human resource development initiative the SMHA has maintained the number of culturally competent bi-lingual outreach clinicians at 26. SMHA funds three regional cultural competence training centers to provide the technical assistance and trainings to build and improve cultural competency throughout the system. Trainings are designed to provide agency staff with the skills necessary to improve their capacity to deliver quality cultural centered

services and to improve measurable cultural competence skills for providers. The performance of the training centers and bilingual/bicultural outreach clinicians are monitored by the SMHA Multicultural Liaison. As the Training and Workforce Development offices within SMHA and SSA Multicultural Staff merge over the next year, additional resources may emerge to address the multicultural and multilingual issues within the system. As the SSA/SMHA merge continues, the SMHA will become increasingly more involved with planning efforts and workforce development/training on sexual/gender issues within the overall merged system of care.

Medical and Dental

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

SMHA Programs for Persons with Disabilities and Mental Health Issues for the Deaf and Hard of Hearing

It is the SMHA's mission to be able to provide mental health services to individuals in New Jersey who have other disabilities. New Jersey has an array of services throughout the State for individuals who have mental health issues who are also deaf or hard of hearing.

Statewide, there are services provided through ACCESS, a contracted agency who provides on-site coverage by Master's level clinicians trained in ASL and consultation psychiatric emergency services, inpatient settings and outpatient programs across the State. There is also TTY capacity to ACCESS staff. ACCESS staff are able to provide onsite screening services during working hours and is available for consultation after hours. ACCESS staff participates in the New Jersey training for Certified Psychiatric Screeners so that they are able to understand and explain the State's screening process. ACCESS is also available to provide onsite clinical consultation and liaison services to New Jersey's Short-Term Care Facilities to assist in the treatment and discharge planning process for each deaf patient. ACCESS also provides outpatient services throughout the State at various locations.

Also, New Jersey has a Statewide Specialized Inpatient (SSIP) Deaf Program at Greystone Park Psychiatric Hospital. The SSIP consists of a 25 bed capacity inpatient unit in the main hospital building and an eight bed capacity to less restrictive residential cottage to prepare individuals for discharge. The SSIP staffs across all shifts are trained in ASL and deaf culture.

There is a residential services home in Paterson, operated by ACCESS, which is an eight bed community residence for deaf individuals with mental illness who are ready to be discharged from a New Jersey State hospital. ACCESS also has three semi-supervised apartments and offers other supportive housing services to consumers who are deaf and hard of hearing with mental health issues living in the community.

Services for LGBTQ

Across the State there are State funded outpatient mental health providers who have staff that are trained to work with the LGBTQ populations. There are groups and other providers throughout the State that offer group counseling and support groups, primarily to adolescents, to the LGBTQ consumers. At this time, there is no SMHA State funding for LGBTQ specific services or programs.

Services for Parents with Mental Health Issues Who Have Dependent Children

While most of the specific programs offered in the State are for parents with substance abuse who have dependent children, the SMHA funded outpatient programs offer family therapy and other resources for parents such as parenting skills and support groups. For example, there is one program in Passaic County through the Mental Health Association called the Consumer Parent Support Network that specializes in working with parents with mental health issues providing individualized therapy, outreach, linkage, advocacy, referral, parenting skills and education.

The Division of Child Behavioral Health Services (DCBHS)

Overview of State's Behavioral Health System – Children's Mental Health Services

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

The Children's Initiative concept operated on the following abiding principles:

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

Between 1999 and 2004, CSOCI and its successor, Partnership for Children, underwent several expansions and changes. In 2004, legislation was enacted creating the Office of Children's Services within DHS. This Office acted as a single umbrella over three Divisions most

concerned with children's welfare: the Division of Youth and Family Services (DYFS - the state's child welfare agency) and two new Divisions, the Division of Child Behavioral Health Services (DCBHS) and the Division of Prevention and Community Partnerships (DPCP). An Office of Training was also created as a vital component of the Office of Children's Services.

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

On July 11, 2006, legislation was signed creating the Department of Children and Families (DCF), the state's first Cabinet-level department focused solely on child and family well-being. The new, freestanding Department includes DYFS, DCBHS, DPCP, the Office of Education and the New Jersey Child Welfare Training Academy.

In New Jersey, the DCF includes three Divisions which provide services to youth and families. Although youth with serious emotional disturbances may be involved with more than one agency or service system, DCBHS has the primary State responsibility for mental health service provision to this target population. DCBHS coordinates the state mental health plan for children, allocates State and Federal resources for mental health programs and promulgates standards for services. DYFS also provides services to seriously emotionally disturbed children and adolescent through its legislative mandate for child protective services. As the child welfare agency, DYFS is responsible for child protection services for New Jersey youth. DCBHS provides support and assistance to child welfare youth who need to access intensive or multiple mental health services. The Division of Developmental Disabilities within DHS shares responsibility with DCBHS for providing services for youth with developmental disabilities who also have serious emotional and behavioral disturbances.

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

DCBHS developed the following system partners for its System of Care:

Contracted System Administrator (CSA)

A Statewide CSA was developed to support utilization management, care coordination, quality management, and information management for the statewide children's system of care. The CSA provides DCBHS, the case management entities and other system partners, with the

information needed to manage the Individual Service Planning process toward child and family satisfaction, quality outcomes and cost effectiveness. The CSA provides data to the DCBHS. The CSA creates a virtual single point of processing that registers all enrollees, authorizes services, is a single electronic record, tracks and coordinates care for all New Jersey children who are screened into the system at any level. The CSA acts as an agent of State government contracted by and accountable to the DCBHS to manage services. The CSA is not risk based and has no incentive to restrict care.

Care Management Organizations (CMOs)

CMOs were developed to organize and coordinate community-based services and informal resources through face-to-face care management at the local level of individual children and families with multi-service needs and multi-system involvement. These non-profit organizations provide a full range of treatment and support services to children with the most complex needs. They work with Child-Family Teams to develop Individual Service Plans (ISPs). The CMOs' goals are to keep children in their homes, their schools and their communities. The CMOs are fully operational in 12 vicinages in New Jersey.

Youth Case Management (YCM)

YCM is a case management service for children/youth and their families who require a moderate level of face-to-face case management. YCMs are fully operational in all 18 counties in New Jersey.

Unified Care Management (UCM)

These entities are community-based organizations that combine advocacy, service planning and delivery, and care coordination into a single, integrated, cross-system process, in order to assess, design, implement and manage child-centered and family-focused individualized service plans for youth and young adults whose needs require either intensive or moderate care management techniques that cross multiple service systems. Unified care management entities provide the level of care coordination that is provided separately by CMOs and YCMs in other areas of the State. UCMs are fully operational in three New Jersey counties.

Family Support Organizations (FSOs)

FSOs provide direct peer support and assistance to children and families by family members of children with current system involvement. FSOs paralleled the development of each CMO. FSOs are parent run organizations that provide assistance to families in CMO/UCM counties through peer mentorship, education and advocacy, information, referral and the hosting of parent and peer support groups. FSOs act as a guide for professionals and provide direct peer support to families whose children are enrolled in DCBHS services. The FSOs are fully operational in all 15 vicinages covering all 21 counties in New Jersey.

Mobile Response and Stabilization Services (MRSS)

MRSS provide face-to-face intervention to children who are experiencing escalating emotional and/or behavioral issues. The goal is to prevent the disruption of children's living situation and to help maintain children in their current living environment. Staff responds within one hour of the initial call and provides de-escalation, assessment and crisis planning and may initiate stabilization services for up to eight weeks. This service is available 24 hours per day, seven

days per week. MRSS are fully operational in all 15 vicinages covering all 21 counties in New Jersey.

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

Intensive In-Community (IIC) and Behavioral Assistance (BA) Services

IIC/BA services, developed as a needed component of the new system of care, are flexible, multi-purpose, in home community rehabilitative services for parents/ caregivers/ guardians and children/youth with behavioral and emotional needs. Intervention is geared toward strengthening the family and preserving the family constellation within the community setting. Services include, but are not limited to, group, individual or family therapy, clinical consultation/evaluation, instruction in anger management, parenting skills and problem solving behavioral management and psycho-social education. IIC services strengthen the family, provide family stability and to preserve the family constellation in the community setting. Services are flexible as to where and when they are provided based on the family's needs. Interventions may be provided as a component of MRSS or as a longer-term treatment intervention. This family-driven treatment is based on targeted needs as identified in the Individual Service Plan (ISP). The ISP also includes specific interventions with target dates for accomplishments of goals that focus on the restorative functioning of the child/youth and family. Also developed as part of an ISP, BA services provide specific, outcome-oriented interventions that are components of a detailed plan of care prepared by a licensed clinical behavioral healthcare practitioner. BA is a dynamic process of intervention and ongoing evaluation resulting in effective modification of specific identified behaviors. BA services involve applying positive behavioral principles within the community using culturally based norms to foster behaviors that are rehabilitative and restorative in nature. The model is flexible allowing for some interventions to be provided in small (no more than 31) group settings. These services are available statewide.

Evidence-Based Programs

Beginning in the Fall of 2008, DCBHS began offering two types of Evidence-Based Programs (EBPs), Functional Family Therapy (FFT) and Multisystemic Therapy (MST), for delinquent and at-risk youth. These therapies, which last four months on average, treat the entire family, not just the youth referred for treatment. FFT, available through five providers in eleven counties (Atlantic, Burlington, Cape May, Cumberland, Gloucester, Mercer, Middlesex, Ocean, Salem, Somerset, and Union), is an outcome-driven prevention/intervention program for 11-18 year-olds. MST, available through two providers in three counties (Camden, Essex, and Hudson), is an intensive family and community-based treatment for 12-17 year-olds. FFT and MST both support DCBHS' core principles of keeping kids at home (with their families and not in out-of-home settings), in school (in their regular school in their district), and out of trouble (not involved with the juvenile justice system or at risk of detention or incarceration). In the summer of 2009, DCBHS awarded grants to fund four new Therapeutic Nursery programs, two each in Hudson and Essex counties. These programs join three other Therapeutic Nursery programs in Burlington, Passaic, and Salem counties in serving this vulnerable population of children between the ages of 2½ and 7, bringing the total number of Therapeutic Nursery beds to 157. Therapeutic Nurseries provide intensive outpatient, behavioral health services to young children

who evidence unusually challenging behavioral patterns that interfere with their ability to adaptively function at home and in the community. These programs help children develop problem solving skills, interpersonal skills, self-esteem, anger management skills, and internal controls to regulate impulses and emotions, and a foundation for lifelong healthy attachments. In addition, therapeutic nurseries provide family interventions and related training and support services to parents and caregivers.

Screening/Emergency Services

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

Children's Crisis Intervention Services (CCIS)

Located in community hospitals, CCIS are acute inpatient units that provide screening, stabilization, assessment and short-term intensive treatment. The Department of Health and Senior Services, following designation by the DCBHS, licenses these units.

Intermediate Inpatient Unit (IIU) Treatment Services

These are sub-acute inpatient psychiatric units licensed as closed child/adolescent inpatient facilities by the Department of Health and Senior Services and located in community hospitals. These units serve youth who require additional inpatient treatment following stabilization in a CCIS with a typical length of stay of up to 60 days.

Intensive Residential Treatment Services (IRTS)

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

Residential Treatment Centers (RTC)

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

Group Home Treatment

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

Treatment Homes

New Jersey's approach to Therapeutic Foster Care, this level of care is for children who require more intensive treatment and supervision than is found in a traditional or kinship foster care

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

Detention Alternative Programs (DAP)

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

Partial Care Programs

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

Partial Hospital Programs

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

Outpatient Treatment Programs

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

Flexible Wraparound Funds for Non-Traditional Supports

These funds ensure that non-traditional supports are available to children and families served by MRSS and by all levels of case management.

County Inter-Agency Coordinating Councils (CIACCs)

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

DCBHS Initiatives, Collaborations, Services and Supports

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

Clinical Consultants report to DYFS Area Offices four days per week and serve as liaisons, joined from the wraparound perspective, that translate system of care principles and values into case practice and planning and assist in the coordination of behavioral health services for youth involved in the child welfare system. The CMO/UCM Clinical Consultant is a jointly owned and administered position between the CMO/UCM and DYFS. Clinical Consultants translate clinical information into user-friendly language identify mental health concerns regarding youth involved in the child welfare system and propose interventions to address underlying issues. Clinical Consultants serve as an advocate for youth in permanency and discharge planning, speaking on a clinical level with PerformCare and provider agencies and facilitating communication between case management entities. Clinical Consultants are required to be master's level clinician's licensed by the New Jersey Board of Marriage and Family Therapists or Board of Social Work Examiners.

DCF Transitions for Youth Initiative

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

All TFY programs are rooted in best practices and integrate Positive Youth Development, a model for improving outcomes for youth by addressing the following domains: housing stability; improved academic functioning; job-readiness skills; financial literacy; emotional regulation and physical wellness; and peer, adult and community partnerships. TFY services for

Special Populations include: gay, lesbian, bisexual, transgender, questioning and intersex youth (GLBTQI); parenting youth; youth living with HIV/AIDS and youth with juvenile justice involvement/ mental health concerns.

A complete description of the programs and supports available through TFY can be accessed at: TFY can be accessed at: <http://www.transitionsforyouth.org/index.aspx>

DCF Division of Prevention and Community Partnerships (DPCP)

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

Collaboration with the New Jersey Juvenile Justice Commission (JJC)

The DCF and its Divisions have established cooperative relationships with the Juvenile Justice Commission (JJC). In December 2004, the Department signed a Memorandum of Understanding with the JJC that outlines a distinct process by which youth in the JJC can be referred directly into the Children's Behavioral Health System before being discharged from a JJC facility. Representation from both DYFS and DCBHS participate in the JJC and Annie E. Casey Foundation driven Juvenile Detention Alternative Initiative (JDAI) in order to collaborate on developing alternatives to detention and to reduce the number of youth going into detention. Both systems participate in each others planning process and in case review process.

The JJC is responsible for operating State services and sanctions for juveniles and for developing a statewide plan for the effective provision of juvenile justice services and sanctions at the State, county and local levels. To emphasize New Jersey's commitment to provide coordinated quality services and appropriate sanctions for youthful offenders while ensuring the public's safety, the JJC established the State/Community Partnership Grant Program. These Partnership Grants provide funding to each county for services to reduce detention overcrowding, to provide treatment for sex offenders, to increase disposition options, and to provide aftercare to youth and their families.

Collaboration with Juvenile Detention Centers

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

management information system was modified to incorporate information about detention status for system-involved children. The information in the contracted system administrator's management information identifies children for whom proactive placement is initiated.

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

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

The New Jersey DHS Dual Diagnosis Task Force released its report, *Collaborating to Provide Services and Supports for Children and Adults with Co-Occurring Developmental Disabilities and Mental Health/Behavior Disorders*, on October 10, 2008. Visit http://www.state.nj.us/humanservices/dmhs/news/publications/DD_task_force_report.pdf to view the report. Task Force membership is comprised of individuals with developmental disabilities, family members, advocates, service providers, professionals, state officials and representatives. Leadership from DDD, DMHAS and DCBHS respectively pledged their support and expressed their commitment to bring about change to efficiently and effectively serve the dually diagnosed population. The Task Force makes recommendations for system and service change which are cognizant of the difficult economic climate and its impact on implementation, focusing on identifying opportunities to maximize existing resources to make incremental changes. An Executive Oversight Board was convened to manage the implementation plan to ensure that the vision for system change is achieved. The Task Force re-convened in SFY 2010 to continue its work and is now creating a plan for implementing the most important recommendations outlined in the report, which include:

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

DCBHS will continue to increase the availability of services and supports to youth with co-occurring developmental disabilities and mental health/behavioral challenges and their families. DCBHS administration will continue to meet with DDD administration to develop collaborative services for youth with mental/behavioral health challenges who function in the lower ranges of developmental disability.

Transition of Aging Out Youth to the Adult Mental Health System

DCBHS and DMHAS continued their effort in long-term joint planning for easing the transition of aging-out youth who need to move from the child system to the adult mental health system. Guidelines for the pilot were developed as well as “The Tool” to document information and inform participants. DCBHS and DMHAS established relationships amongst the DCBHS case management organizations, the DMHAS program analysts and the DMHAS service providers. Over the last year multiple meetings were held in the pilot counties of Burlington, Middlesex, Monmouth and Ocean. Successful outcomes from this collaboration include: understanding the language of each system; education of DCBHS system partners about services offered by DMHAS; preparation of youth to seamlessly transition from the child serving system to the adult system; identification of gaps in services as well as the development of services to fill those gaps.

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

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

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

Cooperation with the New Jersey Department of Education (DOE)

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

DCBHS Services to Homeless Youth

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

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

DCBHS Services to Rural Youth

DCBHS defines a county as “rural” if, according to US Census figures, 25 percent or more of its population lived in rural areas. Using this definition, six New Jersey counties are considered rural, three on the State’s southwestern border, and three along the northwestern border. This configuration, along the Delaware River, places rural counties in each region – in the North, Warren and Sussex; in the Central, Hunterdon; and in the South, Cape May, Cumberland and Salem. One of the six rural counties is among New Jersey’s highest per capita income counties and one is the lowest, illustrating the diverse resources and needs of even this small subset of our 21 counties. As part of New Jersey’s children’s System of Care, a full array of children’s mental health services is available to all rural counties. These services include but are not limited to psychiatric community residences, Youth Case Management, Care Management Organizations, Family Support Organizations, Mobile Response and Stabilization Services, children’s partial care, outpatient services. The DCBHS monitors the adequacy and effectiveness of the acute care system in each region.

In-State Specialty Beds

Reducing DCBHS reliance on out-of-state providers to treat New Jersey’s children, youth and young adults has resulted in keeping children in treatment close to their families, a clinically desirable goal. Relying on New Jersey providers to treat New Jersey’s children is also a key policy goal incorporated into the Child Welfare Settlement Agreement. DCBHS developed clinical profiles of children in out-of-home, out-of-state treatment settings. The information derived from these profiles helped clearly define the type of treatment needs that New Jersey providers were not able to provide. In SFY 2011 DCBHS released RFPs for the following levels of intensity for in-state out-of-home treatment services: Psychiatric Community Residence, Specialty Services, and Residential Treatment Center (RTC) Intensity of Service provided in group home settings.

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

In addition to services provided by the Transitions for Youth initiative, DCBHS contracts with two agencies for group homes beds for this population.

Strengths of the Service System

- The consolidation of youth mental health services under one Department, the Department of Children and Families.
- DCBHS maintained full implementation of the System of Care, which includes CMO/UCM, YCM, FSO, and MRSS in every county/vicinity in New Jersey and 171 contracts with 321 service components. The SFY 2011 DCBHS appropriated budget is \$401 million.
- The DCBHS Youth Development Council Guiding Document serves as DCF’s plan to ensure youth are decision-makers in their own care, empowered as self-advocates and supported as community advocates with a distinct voice.

- The inclusion of families in planning and implementing system change and the focus on the importance of family participation in treatment decision. DCBHS recognizes the importance of the role of parents and caregivers in determining the most appropriate services for their children is central to New Jersey's new service system. Parent input in policy and service development has become the accepted standard throughout the DCBHS System of Care.
- DCBHS developed the New Jersey Youth Suicide Prevention Plan, which will serve as the guiding document for suicide prevention and intervention throughout the State.
- DCBHS successfully transitioned to a new CSA, PerformCare.
- DCBHS continues to support the expansion of evidence-based programs. MST/FFT programs became fully operational. DCBHS added 98 Therapeutic Nursery beds. Countywide EBP programs were initiated, including TF-CBT, CBT, Real Life Heroes, PIT, Kendall Coping Cat, Motivational Assessment, Motivational Interviewing, Strengthening Families, Structural Family Treatment, Brief Strategic Family Treatment.
- The number of youth receiving services in out-of-state treatment settings has been reduced from over 300 in October 2006 to 145 in August 2008. In July 2009 the number was reduced to 67. In July 2010 the number of youth receiving treatment in out-of-state treatment settings was 22. DCBHS continued success is due to the Division's focus on managing new authorizations to out-of-state care, a year-long case planning initiative focusing on returning youth from out-of-state care, and continuing efforts to develop appropriate in-state resources for these youth.
- The implementation of New Jersey's Child Welfare Reform Plan that coincides with and is integrated with the Child Behavioral Services System.
- County Inter-Agency Coordinating Councils exist in each county in New Jersey and provide a forum where the system of services for children with emotional and behavioral challenges is developed, reviewed, revised and/or redirected, through collaborative decision-making process with DCF to promote optimal services provided in the least-restrictive, but most appropriate setting possible.
- The development and implementation of uniform assessment tools and assessment process.
- The inclusion of youth involved with juvenile justice in the DCBHS System of Care.
- The creation of new pathways to services to increase access for underserved populations.
- The provision of specialized statewide and local training and retraining on a host of topics.

II: Planning Steps

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

Page 22 of the Application Guidance

Narrative Question:

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

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

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

Footnotes:

B. Planning Step 2: Identify the Unmet Service Needs and Critical Gaps Within the Current System

The Single State Authority on Substance Abuse

Data Sources Used To Identify Needs and Gaps

The SSA uses a wide variety of data sources in its needs assessment process in order to identify needs and gaps. These include:

Information Systems

- New Jersey Substance Abuse Monitoring System (NJ-SAMS)
- Prevention Outcomes Management System (POMS)
- Block Grant Support System (BSS)
- Contract Information Management System (CIMS)
- Intoxicated Driving Program (IDP) Data System

Surveys

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

Other Data Sources

- NJ Epidemiological Profile for Substance Abuse (2008)
- Social Indicator Chartbooks (County and Municipal)
- NJ Provider Performance Reports
- NJ Substance Abuse Overviews
- NJ Intoxicated Driving Reports
- NJ DHSS Uniform Billing (UB-04)

Data Driven Planning Process

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

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

At both the State and local levels, the New Jersey substance abuse planning process is designed to employ quantitative and qualitative data to assess the relative need for alcoholism and drug abuse prevention, early intervention, treatment, and recovery support services. It uses various

sources of administrative data collected and prepared by federal, state, and local governments that meet validation standards. A variety of population and provider studies have provided the SSA with the ability to engage in both baseline “gap” analysis of unmet treatment demand as well as to estimate future prevalence of substance use, treatment need, access to care and unmet treatment demand among the broadest possible spectrum of New Jersey residents. These surveys are of sufficient sample size. Thus, data collection and analysis drives New Jersey’s State planning and policy development for substance abuse services.

Needs Assessment: Treatment

In 1993, 1998 and again in 2003, the SSA was awarded a State Treatment Needs Assessment Program (STNAP) grant from SAMHSA’s Center for Substance Abuse Treatment (CSAT) to conduct a “family of studies” centered around a statewide household survey supplemented by special surveys of sub-populations not expected to be included in the telephone sampling frame. For example, in 1993, 500 in-person interviews of adults were completed in each of six regional health planning areas (N= 3,000) as well as an in-person survey of 1,000 inmates from a sample of jails across the State yielding, thereby, estimates of treatment need both statewide and by region among adults living in both residential and county holding facilities.

Over time, the SSA expanded the size of its household sample to 4,200 completed telephone interviews in 1998 and to 14,700 in both 2003 and 2009. This expansion provides 700 completed household interviews per county, enough to allow survey data analysis for planning purposes in each county. After the STNAP came to an end in 2003, the SSA conducted its 2009 needs assessment “family of studies” using SAPT Block Grant funding. The SSA is now planning a fifth “family of studies” needs assessment program for FFY 2012 and FFY 2013 again using the SAPT Block Grant.

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

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

Surveys of sub-populations not found in the telephone sampling frame have included: tri-annually since 1993, middle school students; in 1998, Medicaid eligible clients in managed behavioral health care, Temporary Assistance for Needy Families (TANF) recipients, adults and youth in the criminal justice system, convicted intoxicated drivers, residents of homeless

shelters, women receiving pre-natal care; in 2003, outpatient mental health patients, and in 2008, high school students.

For the 2003 STNAP contract, the SSA employed techniques of administrative database linkage to evaluate long-term treatment utilization patterns, recidivism, mental health, mortality, hospital discharge histories and access to care. Longitudinal database linkage studies are also planned for the FFY 2012-2013 program which will include the findings from a four-year evaluation of treatment outcomes for injecting heroin users receiving medically assisted treatment (methadone and buprenorphine) and a newly launched study of alcohol dependent persons participating in the SSA's Driving Under the Influence Initiative (DUII) who will be treated with Vivitrol.

Finally, the county AEREF comprehensive planning process detailed under "Step 1: Assessing the strengths and needs of the service system..." contributes significantly to the SSA's planning for treatment services by both applying State treatment needs assessment data to planning the county's treatment system and supplementing the assessment of treatment need with data developed at the community level, such as: 1) key informant and stakeholder focus group data, and 2) quantitative data produced from locally-funded research or made available to county planners from multiple health and behavioral health care planning initiatives occurring in their counties. The county level planning process is most informative regarding the identification of gaps in the delivery of services and recommendations for system level changes that can close these gaps.

A wide range of service gaps were identified in the county plans. Often access to services is hampered by: lack of transportation, particularly in the more rural areas of the State; personal finances; stigma; linkage to other needed supports such as employment, health care, day care, case management; waiting lists; language; cultural insensitivity.

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

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

The SSA also utilizes local input such as this to help guide its overall statewide program development. As some specific examples, the Medication Assisted Treatment Initiative (MATI) has helped improve access to medically assisted treatment. The SSA developed a co-occurring network as part of its fee-for-service initiatives to enhance treatment for those with mental health issues. One County noted a service gap for of early intervention services and planned for better integration of ASAM Level .5 into Level 1.0 outpatient programs and advocated for the inclusion of Level .5 (Early Intervention) into NJSAMS reporting, which was in fact accomplished. The SSA is currently receiving technical assistance from CSAT on improving adolescent treatment services and is participating in an IDTA effort concerning its women's programs.

Estimation of the Population in Need of Treatment. The estimated size of New Jersey's resident adult population in need of treatment for alcohol abuse or dependence is 576,819 persons. It is found by applying the proportion in need identified by the 2009 NJ-HSDUH to the U.S. Census Bureau's estimate of New Jersey's resident adult population for 2009. The size of the 2009 adult population needing treatment for drug abuse or dependence in New Jersey is 380,436 persons. It is found by applying a procedure known as the two sample capture-recapture method to the count of unique clients receiving drug abuse treatment in 2008 and 2010 as reported in the New Jersey Substance Abuse Monitoring System (NJ-SAMS). This technique was utilized due to the small number of people who were identified as either abusing or dependent upon illicit drugs in the household survey. The sum of these two estimates of treatment need, one for alcohol abuse and one for drug abuse, equals the 2009 New Jersey total substance abuse treatment need or 957,255 persons.

Special Treatment Capacity Assessment Initiatives. In 2007, using its agency licensure database, the SSA mapped the spatial distribution of treatment services across all counties and modalities of care and used this information in county comprehensive planning.

In FFY 2008, the SSA conducted a web-based survey of SSA licensed, substance abuse treatment providers to assess provider capacity to serve New Jersey's dually-diagnosed treatment population. The survey was adapted from the Dual Diagnosis Capability in Addiction Treatment (DDCAT) tool. It was found that, among 120 agencies responding, 76.7% did NOT qualify as Dual Diagnosis Capable. NJSAMS data indicate that approximately 40% of New Jersey's substance abuse clients also have a mental health issue, but with 76.7% of substance abuse treatment agencies lacking dual-diagnosis capability, there is clearly a need to develop dual-diagnostic capability among substance abuse treatment providers in order to increase both their referrals to and their acceptance of referrals from mental health treatment providers. The DDCAT survey results were used in the planning and development of the SSA's co-occurring network (COSN). Presently, the SSA is working with the SMHA to develop a co-occurring learning collaborative and will be offering the opportunity for agencies to participate in this effort. The learning collaborative will use the DDCAT at baseline and at the conclusion of the collaborative to measure the impact of the technical assistance on the agency's capacity to provide integrated co-occurring services. In addition, the learning collaborative will focus on having agencies that represent a full continuum of addictions and mental health services develop a workplan specific to co-occurring service integration and foster cross collaboration as a strategy for improving their capacity to provide integrated care.

In FFY 2011, the SSA converted the survey questionnaire for use among community mental health treatment providers, and in the fall of CY 2011, plans to repeat the original survey among substance abuse treatment providers.

Workforce Development. The SSA has developed a workforce development initiative with the Rutgers University School of Social Work and the Rutgers Center for Alcohol Studies to address the workforce gap currently existing in SSA licensed addiction treatment programs throughout the State. In particular, the proposal will target the needs of SSA licensed treatment agencies with less than 50% credentialed staff by recruiting program candidates from their current staff. Current regulations require at least 50% of staff have credentials. Rutgers will offer master's

level addiction courses leading to credentialing as a Licensed Alcohol and Drug Counselor (LCADC), internship placement, and oversight for alcohol and drug counseling interns in accordance with the New Jersey Office of the Attorney General, Division of Consumer Affairs, State Board of Marriage and Family Therapy Examiners', Alcohol and Drug Counselor Committee Statutes and Regulations for licensure, N.J.C.A.13:34C-6.2. Upon completion of the program, candidates will meet the licensing requirements to become dually licensed as a LCADC and other clinical licensed professional (social worker, counselor, psychologist, etc). DMHAS will benefit from this initiative in two key ways: 1) students will perform field work at SSA licensed agencies which helps to serve more individuals at provider agencies without additional expense during the field placement periods; and 2) students who go through the curriculum are required to work at a SSA licensed agency for 2 years post-credentialing or they must re-pay the State for their course work. This initiative will produce 400 dually licensed clinicians to the field.

Data from NJSAMS for Calendar Year 2010 indicates that only 11% of Methadone is planned in treatment for clients, yet heroin and other opiates is the primary drug of admission for 40% of clients entering New Jersey's addiction treatment system. The development of the MATI is an attempt to help reduce this gap by providing more access to medication assisted treatment for opiate addicted individuals. Also, the Division has mandated trainings on medication assisted treatment for treatment providers, incorporated language requiring acceptance of clients on medication assisted treatment into contract requirements, and has provided training for systems partners in Drug Court and Child Welfare on medication assisted treatment. Most significantly, the SSA has incorporated course work requirements in the workforce development initiative described above.

Needs Assessment: Prevention

In December 1993, the SSA was awarded a three-year contract with the Center for Substance Abuse Prevention (CSAP) to conduct a family of studies to assess needs for prevention of alcohol, tobacco, and other drugs misuse and abuse in the State and in its health planning regions. The contract consisted of the Middle School Survey, the Mature Citizen Survey and the Community Leaders Survey. In addition, a social indicators study and companion chart books of social and health indicators for each of New Jersey's 21 counties and selected municipalities were completed. The data generated by these surveys and studies were utilized in policy formulation, resource allocation and the provision of revised data requested within the SAPT Block Grant Application process beginning in FFY 1998.

Due to the perceived importance of monitoring levels of risk for substance abuse among New Jersey's youth, the SSA has supported continuation of the Middle School Survey beyond the CSAP funding period. The SSA subsequently conducted a second Middle School Survey in 1998, a third survey in SFY 2001, a fourth survey in 2003 and a fifth survey in 2007. Plans are underway to conduct a sixth Middle School Survey during the 2011-2012 school year.

Implementation of the SSA's first High School Survey was completed in June 2008. It used the same survey instrument as the middle school survey (Pride Survey) and is the first New Jersey report at the county level on 9th through 12th grade youth. The SSA has also been collaborating with the NJ Department of Education (DOE) on its Student Health (High School) Survey and has

provided financial assistance for the 2010-2011 survey. While the DOE does not sample at the county level, the findings still provide important information regarding factors protecting and posing risk to adolescents concerning substance use.

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

The SSA also developed the Relative Needs Assessment Scale (RNAS) for alcohol and drug prevention planning in 1995 and updated it in 2008. The RNAS is calculated using social indicators. Average risk indices were calculated for each county, so the relative level of risk among counties could be utilized for resource allocation; it was utilized in the last Request for Proposals (RFP) process for awarding three-year prevention contracts utilizing SAPT Block Grant funding. In FFY 2012 and FFY 2013, the SSA will provide RNAS indexes down to the municipal level for use in the county comprehensive planning process for 2014 to 2017.

Addictions Prevention Strategic Plan. In 2010, the SSA began an addictions strategic prevention planning process in order to articulate a data-driven approach to focus the Division's statewide prevention efforts on a selected number of meaningful priorities, identified through a data-driven process, for which measurable change can be achieved at the State and community levels via the development and implementation of targeted, evidence-based prevention strategies, with a particular focus on environmental management strategies. The Plan aligns stakeholder group prevention efforts and resources with the identified priority areas and will guide prevention decision-making and policy development at the State, County, and provider levels for all DMHAS-funded prevention services over the next five years. A draft Addictions Prevention Strategic Plan was distributed to Planning Committee members in August, 2011. In keeping with the purpose of the Plan - to focus statewide prevention efforts on specific data-driven priorities for which measurable change can be achieved at the state and regional levels - the priorities identified were included in the recent RFP entitled, "Funding for Regional Coalitions to Utilize Environmental Strategies to Achieve Population-Level Change". The primary goals of the RFP are to identify and fund regional coalitions to utilize the SPF and undertake a rigorous needs assessment process to identify which of the statewide DMHAS prevention priorities identified in the Plan are the most significant in their region.

State Epidemiological Outcomes Workgroup (SEOW). The SSA was awarded a Strategic Prevention Framework State Incentive Grant (SPF-SIG) by SAMHSA in October 2006 to prevent the onset and reduce the progression of substance abuse, including childhood and underage drinking. In addition, it was intended to build prevention capacity and infrastructure at the State and community levels. A key component of this grant is the use of a data-driven strategic approach and conducting a statewide needs assessment through collection and analysis of epidemiological and community readiness data.

As one requirement of the SPF-SIG, the SSA convened the New Jersey SEOW, comprised of individuals from various State Departments including Health and Senior Services, Transportation, Education, Human Services, Juvenile Justice, county offices, universities, community provider agencies and statewide organizations. The SEOW has been meeting regularly to discuss ways to prevent the onset and reduce the progression of substance abuse disease in New Jersey.

The SSA continues to actively recruit for new members of the SEOW. This past year has seen the addition of members from the NY/NJ High Intensity Drug Trafficking Area (HIDTA), the Department of Health and Senior Services' Division of Family Health, Department of Military and Veterans Affairs, the NJ Poison Information and Education System (NJPIES), and the New Jersey Hospital Association Behavioral Health Group. In the midst of the merge between the SMHA and the SSA, the role of mental health in the SEOW proceedings is currently being formulated. The SEOW is also planning to develop linkages with the Prescription Drug Monitoring Program which will become operational in September 2011.

Originally, the role of SEOW was to conduct a statewide prevention needs assessment to recommend a statewide priority for the SPF-SIG project. Beginning in late 2006, the SEOW developed a State Epidemiological Profile which it submitted to SAMHSA in April 2007.

Examples of datasets reviewed for production of the Epidemiological Profile included:

1. The Behavioral Risk Factor Surveillance System (BRFSS)
2. The Core Alcohol and Drug Survey (CORE)
3. The National Survey on Drug Use and Health (NSDUH),
4. The New Jersey Middle School Substance Use Survey (MSSUS)
5. The Treatment Episode Data Set (TEDS),
6. The Uniform Crime Report (UCR)
7. The New Jersey Uniform Crime Reporting (UCR) Program
8. The Youth Risk Behavior Survey (YRBS)
9. New Jersey Student Health Survey (NJSHS)
10. The New Jersey Youth Tobacco Survey (NJYTS)

Other sources of governmental administrative data used to compile the above mentioned profile included:

1. The New Jersey Division of Youth and Family Services (DYFS)
2. The National Highway Traffic Safety Administration (NHTSA)
3. The Intoxicated Driver Program (IDP)
4. The New Jersey Center for Health Statistics (NJCHS)
5. The New Jersey Department of Health and Senior Services: Division of HIV/AIDS Services (NJDHSS)
6. Violence, Vandalism and Substance Abuse in New Jersey Public Schools. The Commissioner's Annual Report to the Education Committees of the Senate and General Assembly (CRVV)

The profile served as the basis for recommending prevention priorities to be addressed through the SPF-SIG grant. The SEOW conducted an extensive review of data describing substance use and its consequences available from a multitude of sources. Using prevalence and incidence

rates, severity ratings and trends, the SEOW developed a formula incorporating these variables to produce need scores and ranked the needs in order of importance. “Alcohol dependence of 18-25 year olds in the past year”, “drug dependence of 18-25 year olds in the past year” and “past month use of illicit drugs by 18-25 year olds” were the three highest ranked indicators. Based on these data, the priority “to reduce the harmful consequences of alcohol and drug use among 18-25 year olds,” was selected as the guideline for the SPF-SIG project. It was noted that there are very few prevention programs tailored for the 18-25 year old population. In 2008, the SSA awarded eleven community contracts to implement this prevention priority. As the projects have been implemented, most are focused on the harmful consequences of alcohol consumption and in particular, motor vehicle crashes.

The role of the SEOW was expanded in 2010 when the SSA charged the group with developing both treatment and prevention priorities. Upon further review of the data as described above, which included updated information, the SEOW then identified the following statewide prevention priority problems/issues in 2010: 1) Drug dependence of 18-25 year-olds in the past year; 2) Binge drinking by college students; 3) Use of illicit drugs by persons 12-17/18-25 in the past 30 days; 4) Drug dependence of persons 12-17 years old in past year; and 5) Use of alcohol by high school students in the last 30 days.

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

County Planning for Treatment and Prevention

The SSA collaborates with the County Alcohol and Drug Abuse Directors in the administration of the aforementioned AEREF program. In SFY 2012, the AEREF program distributed \$9,065,796 to the States’ 21 counties, based on county population size, per capita income and estimated treatment need. The SSA supplemented these awards with an additional \$6,908,396 for a total investment of \$15,974,165 by the State in county provision of services.

Further, according to the AEREF enabling legislation, each participating county is required to submit “an annual [county] comprehensive plan (CCP) for the provision of community services to meet the needs of alcoholics and drug abusers.”¹ Further, this plan “shall...demonstrate linkages with existing resources which serve alcoholics and drug abusers and their families.” The law also stipulates that counties pay “special attention” to the needs of youth, drivers-under-the-influence, women, persons with disability, workers, and offenders committing crimes related to substance abuse.

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

Thus, the counties are mandated to develop data informed plans for the provision of community-based prevention, early intervention, treatment, and recovery support services for all medically indigent county residents. The SSA collaborates with the 21 counties of New Jersey in a joint State and County comprehensive behavioral health planning process intended to: 1) coordinate system development and service delivery at State and local levels, and 2) unify community-based planning for prevention and treatment.

The SSA is responsible to review each CCP to determine: 1) whether the plan complies in form and function with the requirements of Chapter 51 by rationally relating county resources with the needs of county residents, and 2) whether it is designed and developed in a manner consistent with the State's quality assurance standards for county planning.

Local Citizen Advisory Planning Boards. A key component of the county comprehensive planning system is the county Local Advisory Committee on Alcoholism and Drug Abuse (LACADA), an independent, citizen's advisory group. The LACADA is required to develop and present to the County Board of Freeholders the aforementioned CCP for adoption. The LACADA is also required to establish a County Alliance Steering Subcommittee (CASS). The CASS is the county-level planning body for each county's Governor's Council on Alcoholism and Drug Abuse (GCADA) municipal alliances which, in turn, are coalitions of municipal level residents and other stakeholder volunteers that recommend a set of local prevention priorities to the LACADA based on their own data analyses and prevention service inventories. Municipal alliance plans are coordinated by the CASS with a county's comprehensive plan through a process known as Unification Planning. The SSA works closely with GCADA to prepare for and implement the Unification process. Additionally, the counties are required to allocate approximately 12% of the county AEREF dollars to support prevention education services.

Length of County Planning Cycle. In 2004, the SSA established a three-year planning cycle for the county AEREF program that allowed counties to submit multi-year plans for the period 2006-2008. In 2008, the SSA lengthened the planning cycle to four years from 2009 through 2012, in order to establish the principle that county RFPs for substance abuse services were to be published subsequent to SSA certification of the county comprehensive plan and in accordance with its goals and objectives. In January of 2011, the SSA extended the effective period of the current CCPs to a fifth year, through 2013, in order to coordinate with the scheduled implementation of federal health care reform. Thus, the next CCP will govern the four-year period beginning 2014 and ending 2017.

SSA Planning Standards. Additionally, in 2008, the SSA established planning processes and quality standards that required: 1) State certification of CCP compliance with all Chapter 51 and the SSA planning requirements as a condition of recommending the release of county AEREF and other State discretionary funding; 2) engagement of community stakeholders in a formal community needs assessment based upon State and local data describing substance abuse treatment needs and gaps in the delivery of services required to meet those needs; 3) a logic model of the interrelationships of needs, goals, objectives, strategies, and outcomes for prevention, early intervention, treatment, and recovery services; 4) one system-level change to enhance the local continuum-of-care; 5) a resource allocation plan that implements the CCP according to its goals, objectives, strategies and intended outcomes; 6) a draft Request-For-

Proposal (RFP) for the provision of those services that would implement the CCP in accordance with its corresponding planned resource allocation; and 7) establishment of a plan implementation and outcomes monitoring procedure to document plan implementation obstacles encountered and corrective actions taken to overcome them.

Thus, the SSA in collaboration with its county governments has established planning standards leading to rational, goal-oriented, data-driven county plans for the development of the full continuum of care from primary prevention through recovery support. The SSA supplies counties with data from the SSA's needs assessment program. For instance, the counties review data from: a) the State's needs assessment, including the Household Survey findings and social indicator data from the county and municipal chart books, b) the SSA's NJ-SAMS and facility licensure data, and c) other relevant State department data. The planning process also incorporates local perceptions of substance abuse issues and treatment system capacity by means of county focus groups and other encouragements to citizen participation. The SSA also provides planning education, training, and technical assistance to the county directors.

Future Developments in the State-County Collaborative Planning Process. Beginning in FFY 2012 with the next cycle of Unification Planning, the SSA, in collaboration with the GCADA, intends to: 1) help counties identify and implement a greater number of evidence-based prevention programs and 2) support counties to establish environmental approaches to prevention planning at the county and municipal levels using training by the National Community Anti-Drug Coalitions of America (CADCA) in New Jersey. CADCA trains counties and their GCADA municipal alliances to develop coalitions that focus on problem "spots" or "types" that harm quality of life at the community level. Planning will consist of data-driven problem assessments, community mobilization strategies, and partnership development with affected communities to better regulate identified problems and improve or restore quality-of-life standards damaged by problem drinking and drug use. The SSA will support this effort by providing County Alcohol and Drug Abuse Directors with specialized data sources, analyses, planning education, continued training and technical assistance.

Planned System Prevention Enhancements

SPE Grant. In May 2011, the SSA submitted a Strategic Prevention Enhancement (SPE) grant to SAMHSA. New Jersey's SPE Project will serve six high-need counties: Bergen, Camden, Hudson, Essex, Middlesex, and Monmouth. The SPE grant will provide intensive training and technical assistance on the effective use of the Strategic Prevention Framework (SPF) to agencies and local government in these high-need communities to enable them to identify or collect data regarding substance abuse and its consequences in their communities and develop a local approach to addressing the consequences. The SSA computed county estimates of need for prevention of alcohol and other drugs. Archival data of social indicators were used to develop composite indices of risks to estimate need for prevention services among the 21 New Jersey counties. Risk factors related to alcohol and drug misuse in these identified counties are far more prevalent than in other counties throughout the State. Additionally, these counties' alcohol and drug-related problems are significantly higher relative to other New Jersey counties.

In addition to serving these high-need communities, New Jersey proposes to utilize SPE funding to make numerous enhancements to its prevention infrastructure by: addressing gaps in data

regarding older adults and binge drinking rates among young adult women of child bearing age (21-29 years), expanding the capacity of the Prevention Outcomes Monitoring System (POMS), the SSA's prevention management information system, to collect data on environmental strategies and programs, creating a Social Indicator Database, updating the *New Jersey State Epidemiological Profile for Substance Abuse*, updating its *Chartbooks of Social and Health Indicators*, the information in which can be used to identify health problems directly or indirectly related to substance use and to aid in the assessment of needs for prevention and treatment services, and creating a database of all prevention services and programs being delivered throughout the State.

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

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

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

The SSA has identified seventeen coalition regions in New Jersey. These regions were selected based the "Prevention Needs Assessment Using Social Indicators: State of New Jersey Substance Abuse Prevention County Level Needs Assessment, 2008." The "Prevention Needs Assessment" utilized archival data of social indicators to develop composite indices of risks to estimate the need for prevention services among New Jersey's 21 counties. Criteria including population, substance abuse treatment admissions and rates within the region as well as prevalence of alcohol and prescription drug misuse among middle and high-school students were also considered in identifying the seventeen regions.

Planned System Treatment Enhancements

DUII Vivitrol Pilot. The SSA's goal is to develop a system of care that offers high risk clients the means to enter and sustain recovery. In this effort, the SSA has implemented a pilot program for the alcohol dependent, Driving Under the Influence (DUI) offender that includes medication-

assisted therapy using the FDA approved medication Vivitrol. A comprehensive research protocol was developed and numerous client outcomes will be assessed. The pilot will be launched in September 2011 and clients will receive the medication for up to six months. There will be a follow-up survey six months after the client's last injection.

Adolescents. The SSA has received technical assistance from CSAT as a result of its 2009 Core Technical Review to improve adolescent service demand and appropriateness and ensure that clinical decisions regarding adolescent placement and services are clinically sound. Discussions have centered on: 1) developing a statewide adolescent services menu, 2) marijuana specific treatment, 3) identifying leading national evidence-supported assessment, placement, continued stay and outcome measurement instruments, 4) addressing adolescent engagement, retention and utilization issues and practices, and 5) outlining a strategy and action steps to shift the service delivery system toward community- and family-based recovery-oriented care utilizing more flexible outpatient and home-based services.

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

Pay for Performance. In 2009, the SSA implemented its first pay-for performance project with drug court providers that provided long-term residential care. Using a statistical technique known as survival analysis, key retention points of 21, 45 and 91 days were identified where 25%, 50% and 75% of the clients dropped out of treatment, respectively. Data were examined for the percentage of clients who completed treatment at those points in order to set benchmarks. The SSA decided to "raise the bar" and set 95%, 90% and 80% client retention rates for those three intervals, respectively, in order for agencies to receive an incentive. The incentive structure was \$1000, \$500 and \$500, respectively, so an agency could earn up to \$2000 per month. A 95% utilization requirement was also instituted to insure contract beds were not left vacant. The results for the first quarter (7/1/09 - 9/30/09) indicated that for the six agencies participating, all received an incentive which ranged from \$1000 to \$5000; the maximum that could be attained for the quarter was \$6000. However, since this was the first time the incentive was paid, the 95% utilization requirement was waived. Agencies continue to receive incentives to date.

Payment for Episode of Care. The SSA is beginning to explore a financing strategy involving payment for an episode of care. Since the SSA has a fee-for-service billing system for several of its treatment initiatives, it has the data available to conduct this analysis. Preliminary work has begun by examining the episode costs for the different initiatives by the level of care initially entered. The analysis has indicated the episode costs vary widely across initiatives even though they start at the same level of care. This data will help inform the SSA in developing benefit management strategies for high cost services such as residential with the goal of ensuring that

individuals get the right service at the right time in the right amount (as per SAMHSA's recommendation) . Maximizing the appropriate use of services in the most cost effective manner, allows the SSA to provide more services to clients in need and helps reduce the treatment gap between met and unmet demand.

Other Planned System Improvements and Strategies

Technical Assistance to County Alcohol and Drug Directors. The SSA continues to work on developing support systems to provide the County Alcohol and Drug Directors with necessary needs assessment information, planning, technical assistance, evaluation expertise, and other supports to foster the development of comprehensive county plans to improve behavioral health outcomes in their communities. This has been a long standing request from the County Alcohol and Drug Directors. Monthly Learning Collaboratives are held via webinars. Work continues on developing a Behavioral Health certification program with the Graduate School of Social Work at Rutgers University.

The State Mental Health Authority

The State of New Jersey is geographically, demographically, culturally, and socioeconomically diverse. Identifying populations historically under-served by mental health services is vital to the SMHA's success at facilitating the wellness and recovery of all of its citizens. Although the SMHA has undertaken needs assessments to determine underserved areas for targeting RFPs and contract efforts (e.g., Outpatient Services, Supportive Housing), the SMHA has not conducted a comprehensive, generalized needs assessment for the entire State. The SMHA is in the early stages of conducting such an assessment, using a myriad of sources (e.g., US Census Bureau, New Jersey Department of Labor and Workforce Development, SMHA consumer satisfaction survey data) in order to understand the needs and service gaps on a statewide basis. Examples of relevant indicators to be observed on a county level include (but are not limited to): population density, racial composition, proportions of residents age 65 and older, unemployment rates, numbers of minority owned firms, median household income, screening center admissions, and crime rates.

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

Mental Health Promotion, Needs Assessment and Goals

Information Systems: A major initiative currently underway is the development and implementation of a web-based comprehensive client registry and tracking system to support DMHAS' transformation into a recovery oriented service organization. The primary goal is to implement highly integrated and effective information and reporting system that will be used as the single entry point for all data from all the service providers into the SMHA database. This effort will be in accordance with recent NASMHPD/NRI's guidelines (NRI 2011). The new system will provide the ability to more easily create unduplicated statistics on consumers served, as well as, to identify service utilization across the mental health system. Several databases are

being combined into one to avoid duplication of effort, decrease user input error, and streamline data collection. The new database will provide the opportunity to update consumer information (i.e. level of function, employment status, involvement with the criminal justice system, etc.) at intervals during their enrollment in a program. Currently, this information can only be entered upon admission or termination from a program.

The comprehensive system will integrate data from contracted service providers and consolidate all client level data (CLD) into one centralized tracking and reporting application by applying an enterprise design that is consistent with a service oriented architecture that supports the sharing of business processes, technical services, and common data platforms. The design plan will convert all existing database applications from Access to a more secure SQL server database, thus providing the opportunity to integrate and share data in accordance with current standards for privacy, security, and interoperability. The newly developed CLD will be integrated with the State Hospital Census database. This database is currently in Oracle but the front end of the application is being re-programmed into a SQL.Net application. This web-based SQL application will provide an application that is significantly more user friendly for the State Hospital staff than the current version of Oracle, thus enhancing the utilization of the application and compliance with reporting.

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

The SMHA will engage in direct communications with both county administrators and contracted service providers to better assess county needs and gaps. Such contacts will lay the ground work for the identification and continued monitoring of needs at the state and local level.

The SMHA is planning to conduct two surveys which will permit fine-grained assessments of county needs, gaps and priorities. The respondents of the first proposed survey are the twenty one county mental health administrators. Questions will be from a county-wide perspective, and such inferences will be invaluable in helping the SMHA to determine both absolute and comparative county needs. The second survey will be administered to the program managers of all community providers contracted by the SMHA. To provide guidance on the completion of both surveys, the SMHA provide technical assistance. This survey will provide closer 'on the ground' perspectives from the service providers themselves. The comparison and juxtaposition of responses from both survey endeavors will provide two meaningful views---one 'top down'; the other 'bottom up', of county needs and gaps. Both of these surveys will be expediently conducted using web-based SurveyMonkey² technology.

The SMHA's efforts at better elucidating county gaps and needs (as described here) will allow for a more seamless integration of "mental health needs" with "substance abuse needs" in the

² <http://www.surveymonkey.com/>

upcoming four-year planning cycle starting in SFY2014. This more holistic view of behavioral health (encompassing both mental health and substance abuse) will permit the merged SMHA/SSA to do truly strategic planning for 2014 to 2017.

At the time when this application was prepared, the SMHA has limited capacity to organize mental health promotion initiatives due to the lack of prevalence estimates and epidemiological analyses at the State and County levels to guide the planning processes. However, the SMHA has built a partnership with the New Jersey Department of Health and Senior Services (NJDHSS) to implement mental health depression and anxiety module (PHQ-8) in the New Jersey Behavioral Risk Factor Survey (BRFSS) in 2010 and 2011. In 2012, NJDHSS has committed to include stigma questions in the BRFSS survey. The data will soon be available and help to define the mental health promotion goals at the State level. For the time being, New Jersey aligns the State goals with the Healthy People 2020 Objectives on Mental Health and Mental Disorders. For example, on the aspect of treatment expansion, we strive to “increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral to the target 87 percent,” achieving 10 percent increase from the baseline in 2006.

The data sources SMHA will continue to utilize in driving the planning for the prevention and mental health promotion initiatives include:

- Annual Demographic Profiles summarized by New Jersey Department of Labor and Workforce Development based upon Census 2010, Intercensal Population Estimates, and Population projection estimates by the U.S. Census Bureau.
- New Jersey State Health Annual Assessment Data, Center for Health Statistics, New Jersey Department of Health and Senior Services (DHSS).
- The New Jersey Violent Death Reporting System (NJVDRS), a CDC-funded surveillance system, which records suicide (with known circumstances).
- CDC-funded New Jersey Behavioral Risk Factor Survey, in which mental health modules were implemented (Depression and Anxiety Module, 2010 and 2011; and Mental Illness and Stigma Module, 2012).
- Mental Health Consumer Satisfaction Survey (MHISP), Mental Health Statistics Improvement Program.
- New Jersey DHSS Uniform Billing from which we can derive prevention quality indicators (using the algorithm provided by AHRQ) to calculate preventive hospitalizations.

The State of New Jersey is currently developing a master-patient index, a data protocol which will give the SMHA increased access to many State registries. This will give the SMHA greater access to a wide range of health data and will result in more highly targeted (and hopefully increasingly more effective) behavioral health service programs. In addition the SMHA is attempting to increase its functional access to State Medicaid data. Such increased access will give additional SMHA staff the opportunity to better view behavioral health utilization across the State.

The SMHA has identified the following gaps in service delivery: minority populations, transgender, lesbian and gay populations, persons with dual disorders, consumers with co-occurring medical conditions, persons in dual recovery from substance abuse and mental health

disorders as well as those who have past criminal involvement. Due to the high prevalence rate of dual disorders, DMHAS sponsors and funds a small program to provide specialized approaches to starting and running dual recovery groups at self-help centers. Nine self-help centers participate in the initiative. Due to the early mortality and medical co-morbidity of the mental health consumer population, self-help centers have begun to offer free health screenings for cardio-metabolic syndrome by measuring blood glucose levels, weight, blood pressure, and body mass indicator.

A Needs Assessment Law was enacted by the Senate and General Assembly of the State of New Jersey in January 2010, which takes effect in March 2010. This Act concerning services for persons with mental illness and supplementing Title 30 of the Revised Statutes requires the SMHA to estimate and implement a methodology, based upon nationally recognized criteria, to qualify the usage of and need for inpatient, outpatient, and residential behavioral health services throughout the State, taking into account projected patient care level needs. It requires the SMHA to provide an annual report in accordance with this act with the first report provided no later than 18 months after the effective date of this act.

With the development and implementation of the web-based client level database-- as well as with the other databases and datasets described above, the SMHA will be able to significantly enhance its planning efforts and capacity for data informed decision making. The SMHA will be able to prepare a comprehensive needs assessment inclusive of county based needs, barriers, critical gaps, and reporting on target populations. To enhance this, the SMHA has recently acquired Geographic Information Software (GIS) technology (ArcView³) which will allow for sophisticated statewide analyses of need to be conducted on a county-by-county basis. Such technology allows the SMHA to conduct geographically-informed queries using existing tabular datasets (e.g., US Census data, SMHA client utilization information, etc.).

Opportunities for Data to be Used for Planning Efforts

Consumer Operated Services: The Fidelity Assessment Common Ingredients Tool (FACIT) Project is beginning to provide data that will document the contributions of self-help centers and inform decision making about refining and improving these services. The consumer operated self-help center service element in the State has expanded considerably. The FACIT is helping to meet the growing need for objective review of Self Help Centers and to provide feedback in terms of how well the Self Help Centers will follow the intended model. It will be useful in identifying areas for improvement. The project provides a method for monitoring the extent to which consumer operated Self Help Centers are adhering to the consumer operated service principles. Thus far, training of raters has taken place and an inter-rater agreement is being established. Baseline data for several Self Help Center sites is currently being collected. The SMHA has begun a collaborative relationship with UMDNJ to implement the FACIT tool in approximately 12 of the Self Help Centers. Self Help Outcomes and Utilization Tracking (SHOUT) is an outcome-based measurement system based on the CSP-sponsored consumer operated self-help centers (SHC) model. It is utilized by CSP in evaluating performance and

³ <http://www.esri.com/software/arcgis/index.html>

fidelity to the SHC model. The SHOUT system provides CSP with information on Self Help Center operations, activities, and consumer participation.

Peer Recovery Warm Line: This is a successful peer-operated warm line that allows consumers in need the opportunity to talk to other peers on a 24/7 basis. The quarterly data for total calls answered from 2009 to the present indicates a steady increase each quarter in number of calls handled by the Peer Recovery Warm line. Additional staff hours were added early in 2010, resulting in the ability to answer more calls during the 3rd and 4th quarters of that year.

Total calls handled in 2010 increased 55% over 2009. Currently there is a high demand for the Peer Recovery Warmline service. A large number of calls go into “queue” or on hold until the next available Peer Specialist can speak with that caller. Given this consistent demand, the SMHA anticipates that with the addition of staff hours, as was done in 2010, the program would demonstrate another significant rise in level of service provided. In addition to the issue of reaching as many callers as possible, the experience of the staff on the Warmline is also an issue for consideration. The supervisory staff has observed first-hand the stress created in the work environment for Peer Specialists. Certainly the nature of the calls can often be emotionally demanding. However, when callers are waiting, staff are then also struggling with that additional pressure. In addition to being aware of the callers’ wait, this situation also results in decreased time between calls to “decompress” and participate in co-supervision, an essential component of the IPS model. Regarding the Warmline impact on the NJMentalHealthCares helpline, the SMHA is in the process of a database upgrade that will allow the SMHA to track exactly how many callers are referred between the Warmline and Helpline.

Supported Employment: The provision of Supported Employment is regulated by the SMHA to provide services to Adults with Serious Mental Illness (SMI) through the use of contract performance commitments (Annex A) and subsequent quarterly contract monitoring reports (QCMR). These protocols provide data on the number of consumers to whom services are delivered and become employed.

Supported Education (Sed): Contract performance commitments (Annex A) and subsequent quarterly contract monitoring reports (QCMR) provide the number of successfully completed semesters consumers complete.

Justice Involved Services (JIS): While JIS does serve individuals with co-occurring disorders, intravenous drug users, woman who are pregnant, adults with dependent children, and those with/at risk of contracting communicable diseases (e.g., tuberculosis, HIV/AIDS), the SMHA has not focused efforts specifically on these cohorts. JIS programs do not discriminate against persons in any of these categories.

IDDT: The providers that have implemented this service are evaluated every year by the University Behavioral Health Care, University of Medicine and Dentistry of New Jersey (UBHC/UMDNJ). In 2008, one of the SMHAs’ contracted community providers, Park Place, received an Excellence Award from SAMSHA for its implementation of IDDT.

IMR: Contract performance commitments (Annex A) and subsequent quarterly contract monitoring reports (QCMR) provide the number of consumers to whom services are delivered and become employed. IMR is provided to individuals with co-occurring disorders as well as parents who have the same disorders. SMHA has not focused efforts specifically on these cohorts. The SMHA is provided with data on the number of agencies trained annually in this EBP by the IMR Program Coordinator at Behavioral HealthCare (UBHC) Unit of the University of Medicine and Dentistry of New Jersey (UMDNJ). In addition, UBHC provides the SMHA with annual data on the number of consumers who received IMR services by those programs trained by UBHC on this use of this EBP.

Veterans Services: Contract performance commitments (Annex A) and subsequent quarterly contract monitoring reports (QCMR) provide data regarding the number of consumers to whom services are delivered for each behavioral health and support service, including Veterans Services. Veteran's status data is collected by the SMHA via the USTF database. This dataset is far from definitive—many provider agencies solicit veteran's status data from their consumers on an inconsistent basis. The upcoming web-based, client-specific consumer database will remedy this, with business rules and data validation tools that will enhance the collection of veteran status data.

Supportive Housing: The recent Olmstead lawsuit settlement (*Disability Rights New Jersey, Inc. v. Velez*) has clarified the needs for supportive housing. In FY 2012, a total of 145 placements are targeted to be created (with 95 set aside for individuals on Conditional Extension Pending Placement (CEPP) Status) and 50 set aside to prevent homelessness and/or institutionalization. In 2013, these values increase to 225 (125 set aside for CEPP designees, and 100 set aside to prevent homelessness and/or institutionalization). The SMHA shapes its Supportive Housing efforts based on: 1. the aforementioned Olmstead settlement agreement and 2. service gaps identified through the States' Homeless Management Information System (HMIS), which tracks homeless adults with serious mental illness. This data is used to generate Requests for Proposals in order to develop Supportive Housing initiatives for the "At Risk" population.

Individualized Needs for Discharge Assessment (INDA) State hospital staff currently report data on the Individualized Needs for Discharge Assessment (INDA) on every consumer in the State hospital. The data that is reported is essential in planning at the individual client level, the local level, regional and statewide. The INDA provides key clinical information with regards to discharge planning such as barriers to discharge, and consumers' needs upon discharge. This data is used to develop Supportive Housing initiatives for consumers being discharged from the State Psychiatric Hospital System. In addition, each hospital maintains a Housing Preference Interviews for all consumers. Currently the INDA can be accessed in the Oracle database and the data is utilized in the development of Requests for Proposals.

Homeless Adults/Housing First/PATH: There is a need for more community-based integrated treatment for consumers with co-occurring mental health and substance abuse issues. A number of PATH programs are based in the behavioral health care department of general hospitals or in primary health care centers. Greater access to primary healthcare and behavioral healthcare is needed, especially for those individuals who do not have Medicaid or another form of insurance or ability to pay for services. Data from the PATH program is collected using the Homeless

Management Information System (HMIS). This web-based software application stores client-specific information (demographics, needs) of homeless populations. HMIS data is accessed at the SMHA by the program coordinator for Homeless Services. *Acute Care Services*: The SMHA uses multiple data sources in monitoring acute care system trends. The Quarterly Contract Monitoring Reporting (QCMR) system provides data on basic volume measures (with relation to contract specifications) such as service episodes, numbers of persons served and units of service delivery. The United Systems Transaction Forms (USTF) provides data on demographic factors, system use, service needs and diagnosis. By regulation, Systems Review Committee (SRC) data is collected and reviewed monthly by localized county specific committees comprised of acute care providers and governmental staff. These SRC processes include review of trends related to volume, capacity, referral patterns, system flow, length of stay and disposition. In the past two years, the SMHA began the process of improving SRC data collection processes, pursuant to the recommendations of the Acute Care Task Force report. For example, reporting requirements have been revised to permit better assessment of local system trends, including mobile screening, emergency room diversion and transfer delays.

The challenges faced by the New Jersey acute mental health system appear to mirror many national trends, as reflected in the professional and popular literature. Demand for services can exceed the financial capacities of local and statewide systems and complex phenomena contribute to the ways in which residents use healthcare services. System challenges include: limited use of preventative options; long waiting times in emergency rooms for mental health services; use of emergency departments by consumers with non-emergent needs; consumers having insufficient after-hours access to outpatient providers; and difficulties related to meeting the needs of consumers with co-morbid medical conditions, co-occurring developmental disabilities and co-occurring substance use disorders.

Programs for Assertive Community Treatment (PACT): The SMHA collects data for all New Jersey PACT teams on a monthly basis. This data is submitted to the SMHA PACT coordinator on a monthly basis. The PACT dataset is a simple MS-Excel spreadsheet of agency specific data with fields regarding: census/enrollment, consumer readmissions for psychiatric hospitalization, consumer employment and agency staffing levels. PACT agencies that do not increase their maximum (target) caseload capacities will be reviewed by the SMHA for possible remediation. Subsequent failures can result in contract termination. The current PACT data structure permits monitoring of caseload, staff-fill rates and consumer outcomes related to psychiatric hospital use, employment, education involvement and housing. This data has been used to assess program performance. The data is shared regularly with the provider community.

As referenced above, PACT provides a comprehensive array of mental health and rehabilitative services to a targeted group of individuals with serious mental illness. The program is designed to meet the needs of consumers, who are at high risk for hospitalizations, are high acute service users and who have not benefited from traditional mental health programs. The PACT admissions criteria ensures that only individuals who have been prone to involuntary psychiatric hospitalization can access this program. Approximately 15% of the individuals served by PACT are aged 60 years or older. At the conclusion of SFY 2011, the caseload for the six designated rural counties was 214, which represents 99% of the maximum service capacity of 216. Thus, access to services (e.g. PACT enrollment) in the designated rural counties continues to mirror

access rates for the State as a whole. For SFY 2012, the PACT team serving Warren and Hunterdon counties will be expanded in order to create capacity for an additional eight individuals discharged from State psychiatric hospitals. At the conclusion of SFY 2010, the maximum (target) capacity caseload of the PACT program was 1997. On June 30, 2010, 1986 individuals were being served by a PACT team. This represents 99.4% of the maximum (target) caseload amount.

Anti-Stigma: The Stigma Council relies on both qualitative and statistical data provided by community partners to identify needs and then craft strategies that address those needs. “A Community Effort” is completely built upon information provided directly by the target audiences and this information is used to create strategies to address inequities, advocate for change and engage in education and prevention. The Stigma Council gains tremendous insight through its community partnerships within “A Community Effort.” Because of the diversity, strength and continuity of these partnerships, the Stigma Council is continually receiving current feedback from all groups and thus able to have finger on the pulse of how best to strategize prevention and awareness efforts.

Intensive Family Support Programs (IFSS): Historically, minority families have been difficult to engage in IFSS programs thus depriving these families who have a family member with serious mental illness of important support, education and advocacy services. Data regarding the usage of IFSS by minority families has been obtained via individual program monitoring visits, mental health licensing site reviews, IFSS Workgroup meetings and Quarterly Contract Monitoring Reports from NAMI NJ which document the number of referrals to IFSS.

Older Adults: According to the United States Census Bureau, the New Jersey population age 65 and older is projected to be 21.20% of New Jersey total adult population by 2020⁴. The need exists to develop a comprehensive program to serve older adults diagnosed with a mental illness in order to prevent unnecessary hospitalization and to support their continued residence in the community. The specialized needs of older adults is well known (e.g., medical fragility, ambulatory considerations, increased risks of falls, increased prevalence of depression and social isolation), yet the necessary resources still must be marshaled on an appropriate scale. Provisions are currently underway at the SMHA to facilitate clinically-appropriate and patient-centered relocations of Hagedorn’s older residents into safe community settings. It is evident that housing opportunities (appropriate for older adults) must be expanded throughout the State.

Workforce Development: Within each training session given by our contracted training providers, an evaluation is given to also track the needs and issues of our contract agency staff. In addition, in 2010 focus groups were held with consumers to determine how they saw staff knowledge base and ability to provide wellness and recovery oriented treatment approaches. Within those groups, consumers were asked to provide information about what additional skills and knowledge staff needed to improve the quality of treatment they received. All levels of care were discussed.

⁴ United States Census Bureau, <http://www.census.gov/population/projections/DownldFile3.xls>

In determining geographic concentrations to target training needs, the USTF database is used. That data is useful in identifying where in the system there are concentrations of special needs groups. This information--coupled with data from consumer input, provides information about areas in the state that demand improvement in skill building, attitudinal shift, best practice models or basic skill building.

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

Consumer Perception of Care Survey: The SMHA Consumer Perception of Care Survey will be distributed to a representative sample of consumers of all community-based programs and is expected to provide important insight on the needs of populations served (and possibly underserved) by the SMHA. A final target sampling ratio has yet to be determined (most likely 10% of all community-based State mental health consumers), but the increased size and scale of this survey effort, relative to previous years (when attempts were made to survey *entire* populations of consumers of *single* program elements) will ensure that this survey will provide a more comprehensive view of mental health service gaps and needs in New Jersey. The survey is to be administered in the later summer/early fall of 2011 and the results will be reported in the 2011 CMHSBG Implementation Report. An unmodified version of the Adult MHSIP Survey will be used as the survey instrument. The MSHIP questions related to the “Access” domain are expected to be particularly illuminating in identifying service gaps. The demographic questions posed to respondents will allow meaningful comparisons of perceptions of care to be drawn among different demographic categories. The results of this survey are expected to be studied and used to guide the SMHA’s planning efforts for future initiatives and resource allocation.

Use of Statewide and Nationwide Data Sets

The SMHA uses several independent datasets, alongside national and statewide datasets to shed light on goals, priorities and success. Each of the SMHA’s major datasets are described in detail in Section E. Data and Information Technology. Specifically, this constellation of datasets is most commonly used to identify counties that are most appropriate (in terms of need and access to mental health services) for new community services and RFPs. Additional statewide and county-specific data is obtained from the US Census Bureau (e.g. <http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>) to inform comparisons of population density, residential characteristics, racial diversity, unemployment rate, age distribution, household income, poverty levels and other factors helpful in determining need. The New Jersey Department of Labor and Workforce Development also generates important economic and employment data (<http://lwd.state.nj.us/lpaapp/app?service=page&page=CES>) which is often used by the SMHA in making inter-county comparisons of economic need. Data on crime statistics in New Jersey is compiled by the NJ State Police, and its reports (<http://www.state.nj.us/njsp/info/stats.html>) are utilized by the SMHA in obtaining a clear picture of county stressors and crime rates.

National data is often examined by the SMHA to shed light on New Jersey mental health efforts, relative to similar states. SAMSHA, through its compilation of URS data tables, and state level

detail reports provide useful information in this regard (<http://www.samhsa.gov/dataOutcomes/>). The National Research Institute (NRI) of the National Association of State Mental Health Program Directors (NASMHPD) is another source that the SMHA consults on a regular basis for national wide mental health data (http://www.nri-inc.org/reports_pubs/). The SMHA regularly receives and reviews the findings of both inter-state and regional mental health reports distributed by The Bristol Observatory and the University of Vermont (<http://www.thebristolobservatory.com/pubsformultistaterp.html>).

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

Prevalence for Adults with SMI and Children with SED

Prevalence: According to the Federal methodology proposed for estimating the prevalence of serious mental illness, the proportion of adults within the State with a serious mental illness is 5.4%.

According to figures released by the United States Census Bureau⁵, the 2010 adult population of New Jersey was 6,726,680⁶. The size of the New Jersey child population was 2,065,214. Using the same estimates (3.7% lower, 5.4% middle, and 7.1% upper), the estimates of adult SMI in New Jersey in 2010 was 248,887 (lower), 363,241 (middle) and 477,594 (upper). In 2011, the projected size of the total New Jersey adult population is 6,979,268. The estimate of adults with SMI in New Jersey in 2011 ranges between 258,233 (lower estimate), 376,880 (middle estimate) and 495,528 (upper estimate). The projected size of the total New Jersey adult population for year 2012 is 7,025,948⁷ - an increase of 0.67% relative to 2011. The projected estimate of adults with SMI in New Jersey for 2012 ranges between 259,960 (lower estimate), 379,401 (middle estimate) and 498,842 (upper estimate).

The demand for SMHA-funded community programs for people aged 65 and older has continued to grow in New Jersey. Rising enrollments are consistent with a general increase in the population size of older adult state residents. In 2009, New Jersey had an estimated 1,173,024 residents who were 65 years of age or older. In 2010, this population estimate increased to 1,185,993, as reported by the US Census⁸. This represents an increase of 12,969 from 2009 to

⁵ From DP-1: Profile of General Population and Housing Characteristics: 2010, 2010 Demographic Profile Data, New Jersey. Source: U.S. Census Bureau, 2010 Census.

⁶ <http://lwd.dol.state.nj.us/labor/lpa/census/2010/dp/njDP1.xls>

⁷ <http://www.census.gov/population/projections/DownldFile3.xls>

⁸ From DP-1: Profile of General Population and Housing Characteristics: 2010, 2010 Demographic Profile Data, New Jersey. Source: U.S. Census Bureau, 2010 Census.

2010 (an increase of 1.11%). The US Census projection for 2011 is 1,252,827 New Jersey adults aged 65 and older, a projected increase of 5.64%.

In accordance with nationally-accepted definitions, New Jersey has adopted the Federal definition that stipulates that adults with a serious mental illness are persons:

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

With the implementation of the Home to Recovery CEPP Plan and the expansion of community capacity, the number and types of community mental health services has grown and diversified in order to meet the needs of the New Jersey's mental health consumers. According to the USTF database, SMHA has served 281,138 unduplicated consumers in community settings—including county hospitals and STCFs in SFY 2010. Although complete FY 2011 USTF data is unavailable at the time of writing, the number of unduplicated consumers served in community agencies, county hospitals and short-term care facilities in the first three quarters of SFY 2011 (spanning the time period between July 1, 2010 and March 31, 2011) is 267,085.

When County hospitals are excluded from tabulation, the SMHA served 272,799 unduplicated adult consumers in community settings (excluding county hospitals), in FY 2010-- which was a 3.5% increase from 2009 (263,568).

US Census Bureau Estimates (2000 to 2010) and Interim Projections (2011 to 2012) of New Jersey								
Year	Fed %	Total Adults	Total Adult SMI	Fed%	Total Children	Total Children SED	Total	Source
2000	0.054	6,326,792	341,647	0.08	2,087,558	167,005	8,414,350	http://lwd.dol.state.nj.us/labor/lpa/dmograph/est/nj_agesex.xls
2009	0.054	6,661,891	359,742	0.08	2,045,848	163,668	8,967,868	http://www.census.gov/popest/states/asrh/tables/SC-EST2009-01.xls
2010	0.054	6,726,680	363,241	0.08	2,065,214	165,217	8,791,894	http://lwd.dol.state.nj.us/labor/lpa/census/2010/dp/njDP1.xls
2011	0.054	6,979,268	376,880	0.08	2,088,139	167,051	9,067,407	http://www.census.gov/population/projections/DownldFile3.xls
2012	0.054	7,025,948	379,401	0.08	2,089,904	167,192	9,115,852	http://www.census.gov/population/projections/DownldFile3.xls

Quantitative Targets: According to the USTF data (which includes all contracted community agencies and short-term care facilities) the number of adults served in non-emergency settings has steadily increased from 2009 to 2011. At the time of writing, the relevant data from the 4th Quarter of FY 2011 has not been submitted by the providers to the SMHA, thereby limiting

analysis. However, the number and percent served in non-emergency settings has continued to increase at this point in time.

Unduplicated Adults Served. When reporting the number of consumers served across the system and including those served in County Hospitals, there are 98,355 unduplicated seriously mentally ill (SMI) consumers that were served in non-emergency settings in the first three quarters of FY 2011. This represents 88.59% of the total SMI population served. Using this same dataset, 100,327 unduplicated SMI consumers were served in non-emergency settings, or 82.67% of the total served in FY 2010. In FY 2009, 96,503 unduplicated SMI consumers were served in non-emergency settings, or 82.08% of the total served when County hospitals were included. Looking at these same variables between FY 2009 – FY 2011, when those consumers served in County hospitals have been excluded from the data set, we see similar overall trends. In the first three quarters of FY 2011 there were 90,966 unduplicated SMI adult consumers served in non-emergency settings, (87.78% of total adults served). In FY 2010, there were 92,767 unduplicated SMI adult consumers served in non-emergency settings (81.52% of total adults served), and in FY 2009, there were 88,828 unduplicated SMI adult consumers served in non-emergency settings (80.83% of all adult consumers served) when the County hospitals were excluded from the data set.

Including consumers served in the County hospitals, in the first three quarters of FY 2011 (the fourth quarter's data has not been submitted to the SMHA at the time of writing) 51,189 adult ethnic minorities with SMI were served by the SMHA. This value represents 46.11% of all adult SMI consumers served. In FY 2010, 54,548 adult ethnic minorities were served, or 44.95% of the total SMI population served. In FY 2009, there were 52,528 ethnic minorities that were served, 44.68% of the population. If consumers in the County hospitals were not included in the data set above, 48,711 adult ethnic minorities with SMI were served in the first three quarters of FY 2011 or 47.00% served. In FY 2010, there were 51,937 adult SMI ethnic minority consumers served, or 45.64%. There were 49,969 adult SMI consumers served, or 45.47%, who were ethnic minorities in FY 2009.

The SMHA is able to determine treated prevalence within the publicly funded mental health system through its management information system. The Unified Services Transaction Form (USTF) database is a de-identified client registry for individuals seen in State and County psychiatric hospitals, short term care facilities and publicly-funded mental health programs in community mental health agencies. A USTF form is completed for every consumer upon admission, discharge and transfer from a public mental health service provider. The USTF was revised, effective July 1989, to be 100 percent consistent with the Mental Health Statistical Improvement Program (MHSIP) minimum data set. The USTF provides the State with information regarding treated prevalence within the public mental health system.

As has been done in previous years, the SMHA defines 'seriously mentally ill' (SMI) as those individuals who score 5 or less on the Global Level of Functioning (GLOF) scale (Carter and Newman (1976). The GLOF scale has 10 levels that provide an overall score integrating separate judgments of consumer functioning on four dimensions: personal self-care; social and interpersonal functioning; vocational and/or educational productivity; and emotional stability and stress tolerance. As noted in previous years, the SMHA's use of this measure to determine the

proportion of persons with serious mental illness served might slightly under-represent the numbers served as operationally defined by the Federal methodology, however in order to maintain consistency with previous years' results, this definition of SMI is still in use.

The Division of Child Behavioral Health Services (DCBHS)

A summary of the Division of Child Behavioral Health Services (DCBHS) strengths, as well as unmet service needs and gaps within the current system of care, is based on the following sources of information:

- DCBHS “10 Years of System of Care Implementation: *Letting the Data Tell the Story*” NJ Department of Children and Families, 2011.
- DCBHS CYBER (Child and Youth Behavioral Electronic Record) Data Collection and Reports SFY 2010-2011.
- DCBHS Internal Data Collection and Reports SYF 2010-2011.
- DCBHS Youth Services Survey for Families, NJ Department of Children and Families, November 2010.
- Independent Assessment of New Jersey’s Children’s Behavioral Health Care System, *Louis de la Parte*, Florida Mental Health Institute, October 2006.
- DCBHS Strategic Plan, 2007, NJ Department of Children and Families, September 2006.
- Traumatic Loss Coalitions for Youth Program Report 2008-10, University of Medicine and Dentistry of NJ – University Behavioral Health, Care Program, Behavioral Research and Training Institute, May 2010.
- New Jersey Kids Count 2011 – The State of Our Children, Advocates for Children of New Jersey, March 2011.
- The New Jersey Violent Death Reporting System (NJVDRS), Center for Health Statistics and the Violence Institute of New Jersey at the University of Medicine and Dentistry of New Jersey.
- New Jersey Student Health Survey, NJ Department of Education, January 2010.
- County Inter-Agency Coordinating Council (CIACC) Annual Needs Assessment, NJ Department of Children and Families, SFY 2009 and. SFY 2010.

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

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

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

In SFY 2010 DCBHS developed 12 in-State beds for children, youth and young adults with MI/DD; 18 in state beds for pregnant and parenting teens; and a six (6) bed group home for male youth with diabetes. In SFY 2011 DCBHS developed six (6) additional beds for pregnant and parenting teens and an additional ten (10) beds for youth with MI/DD.

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

In SFY 2012 DCBHS will continue to decrease the number of children, youth, and young adults receiving treatment for specialized needs out-of-State. At the close of SFY 2011 on June 30, 2011, nine (9) youth continued to receive services in an out-of-State treatment setting. Five (5) youth require treatment services for deaf/hard of hearing; two (2) youth require services from the Division of Developmental Disabilities; and two (2) youth await child welfare (DYFS) permanency plans.

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

- In March 2011, DCF released the New Jersey Youth Suicide Prevention Plan 2011-2014. This New Jersey Youth Suicide Prevention Plan seeks to build on the existing efforts in New Jersey by remaining focused on the risk and protective factors associated with the

prevention of suicide in children, youth, and young adults. The plan outlines goals, rationale, and objectives for increasing the prevention effort throughout the State. The plan presents the overall goals for the prevention of suicide and is broken down into ten sections and within each section are specific objectives. The plan was modeled in content and in form after the 2001 National Strategy for Suicide Prevention and the joint Suicide Prevention Resource Center and SPAN USA 2010 Progress Review of the National Strategy.

New Jersey's Youth Suicide Prevention Plan Goals

1. Improve and expand surveillance systems;
 2. Promote awareness that suicide is a preventable public health problem;
 3. Develop broad-based support for youth suicide prevention;
 4. Develop and implement strategies to reduce the stigma associated with needing and receiving mental health, substance abuse, and suicide prevention services;
 5. Strengthen and expand community-based suicide prevention and postvention programs;
 6. Implement professional training programs for those who are in regular contact with youth at-risk for self-injury or suicide;
 7. Develop and promote effective clinical practices to reduce suicide attempts and completions;
 8. Promote access to mental health and substance abuse services;
 9. Improve reporting and portrayals of suicide, mental illness, and substance use in the electronic and print media; and
 10. Promote and support research on youth suicide and suicide prevention, its dissemination and incorporation into clinical practice and public health efforts.
- 2^{NDFLOOR} was accredited as New Jersey's first statewide suicide hotline by the American Association of Suicidology.
 - In February 2011, DCBHS supported the Traumatic Loss Coalition (TLC) for Youth Program in applying for the Garrett Lee Smith Suicide Prevention and Early Intervention Grant. At the time of writing this application the grant awardees had not yet been announced.
 - DCF will continue to fund the New Jersey Youth Suicide Prevention Advisory Council (NJYSPAC), which was formed under legislation signed into law in January 2004. The 17 members of the Council meet monthly to examine existing needs and services and make recommendations to DCF for youth suicide reporting, prevention and intervention. The Council also advises DCF on the content of informational materials to be made available to persons who report attempted or completed suicides. DCBHS will work closely with the NJYSPAC to identify ways in which New Jersey can continue to improve our efforts to prevent youth suicides and implement the needed changes as outlined in the State Plan.

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

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

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

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

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

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

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

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

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

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

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

II: Planning Steps

Table 2 Step 3: Prioritize State Planning Activities

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Start Year:

End Year:

Number	State Priority Title	State Priority Detailed Description
1	Access to Mental Health Services in the Community for Adults	To increase access to services for adult consumers with mental illness and adult consumers with serious mental illness.
2	Access to Community-based Mental Health Services for Children, Youth and Young Adults	To increase access to community-based mental health services for children, youth and young adults with mental/behavioral health care challenges and children, youth and young adults with serious emotional disturbance (SED).
3	Pregnant Women/Women with Children	To expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children.
4	Youth Suicide	To decrease youth suicide attempts and completions and provide a coordinated mental health response to death by suicide or other traumatic incidents.
5	Intravenous Drug Users	To expand access to comprehensive substance abuse treatment, including MAT in combination with other treatment modalities, for opiate dependent individuals, including IVDUs, through mobile treatment units and other innovative approaches.
6	Tuberculosis	To continue to require that all residential and outpatient substance abuse treatment facilities receiving contracts from the SSA conduct TB testing as part of the consumer's admission process.
7	HIV	To provide funding and expand capacity for the provision of HIV early intervention services at designated substance abuse treatment facilities.
8	Supportive Housing	To increase the numbers of consumers served in Supportive Housing inclusive of consumers with Serious Mental Illness, substance use disorders and co-occurring

disorders.

9	Adolescents with Substance Use Disorders	To provide a comprehensive array of community based services for adolescents with substance use disorders utilizing evidence-based and best practice interventions.
10	Intoxicated Drivers	To protect public safety through improving services, increasing access to services and coordinating sanctions for intoxicated drivers.
11	Supported Employment	To monitor the number of consumers entering integrated employment as a result of Supported Employment services and establish a baseline in 2012.
12	Justice Involved Services	To divert consumers who become entangled in the criminal justice system by reducing the time detained in jail or State prison.
13	Older Adults	To decrease unnecessary emergency department designated screening visits, short term care facility, inpatient psychiatric hospitalizations and special care nursing facility admissions of the targeted population through focused training delivered to acute care and nursing facility staff.
14	Intensive Family Support Services (IFSS)	To increase enrollment of minority families in Intensive Family Support Services (IFSS)
15	In-State, Community-based Specialty Services to Children, Youth and Young Adults	Increase provision of in-state, community-based specialty services to children, youth and young adults with specialized treatment needs.
16	Mental Health Outpatient Services for Youth	To increase access to mental health outpatient services for youth.

Footnotes:

II: Planning Steps

Table 3 Step 4: Develop Objectives, Strategies and Performance Indicators

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Start Year:

End Year:

Priority	Goal	Strategy	Performance Indicator	Description of Collecting and Measuring Changes in Performance Indicator
		1) Quarterly Women's Steering Committee meetings with women's treatment providers to discuss issues related to best practices including retention, engagement, access and referrals, systems collaboration, and training needs. 2) Continuing contract with the community-based provider in Mercer County for the outstation of substance abuse counselors in four Health Care Centers that provide substance abuse screenings using the 4 P's Plus, assessment, case management and referrals to treatment		

Pregnant Women/Women with Children	To expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children.	for pregnant women 3) Implemented service elements from the National Association of State Alcohol/Drug Abuse Directors (NASADAD) "Guidance to States: Treatment Standards for Women with Substance Use Disorders" that emphasize best practice and modified women's treatment provider contracts to include language from the document that addresses the full continuum of treatment services. 4) Require programs to provide: Family-Centered Treatment, Evidence-Based Parenting programs, Trauma-Informed and Trauma-Responsive treatment using "Seeking Safety, Strengthening Families and complete National Center on Substance Abuse and Child Welfare (NCSACW) online tutorials "Understanding Child Welfare and the Dependency Court: A Guide for Substance Abuse Treatment Professionals". 5) Awarded In-Depth Technical Assistance (IDTA) from NCSACW	Increase number of pregnant women or women with children receiving substance abuse treatment in 2013 by 5%.	Data will be collected through NJSAMS at admission to establish the FY 2012 baseline. The change in FY 2013 will be measured by calculating the percent difference between the two years.

a joint initiative with substance abuse, child welfare and the courts to develop cross system partnerships and practice changes, improve cross system training and workforce development capacity to more effectively address the co-occurrence of substance abuse and child maltreatment. 6) Provide training and TA to selected child welfare funded IOP/Methadone and IOP providers in the NIATx Process Improvement Model to: A. Improve access to and retention in addiction treatment B. Make process improvement part of the culture of managing and delivering treatment C. Reduce organizational barriers that limit treatment access D. Reduce drop-out from treatment E. Support and improve service delivery infrastructure

1) Referral to specialty treatment

Intravenous Drug Users	To expand access to comprehensive treatment, including MAT, in combination with other treatment modalities, for opiate dependent individuals, including IVDUs, through mobile treatment units and other innovative approaches.	from sterile syringe programs operating in NJ 2) Providing services in convenient locations, particularly the mobile medication vans, in order to reduce barriers and engage individuals in care as easily as possible 3) Promoting the use of medication assisted treatment (e.g., methadone, buprenorphine) for opiate dependent individuals	Increase the number of opiate dependent individuals including, IVDUs, who obtain MAT in combination with other treatment modalities by 5%.	Data will be collected through NJSAMS at admission to establish the FY 2012 baseline. The change in FY 2013 will be measured by calculating the percent difference between the two years.
Tuberculosis	To continue to require that all residential and outpatient substance abuse treatment facilities receiving contracts from the SSA conduct TB testing as part of the patient's admission process.	1) Distribute guidelines and protocol regarding provision of TB services. 2) Continue to coordinate with the TB Program of DHSS Division of Epidemiology, Environmental and occupational Health (DEEOH). 3) Monitor compliance with TB protocols at least annually.	Increase the percent of clients being tested for TB to 95% by 2013.	NJSAMS includes a question on TB testing at discharge, including results and if the client refused testing. Data will be collected through NJSAMS at discharge to establish the FY 2012 baseline. The change in FY 2013 will be measured by calculating the percent difference between the two years. Also, the difference between the target (95%) and actual outcome will be determined.
	To provide funding and increase	1) Expend 5% of the SAPTBG award for HIV Early Intervention Services. 2) Continue MOA with the University of Medicine and Dentistry of New Jersey (UMDNJ) for		

HIV	capacity for the provision of HIV Early Intervention Services (EIS) at designated substance abuse treatment facilities.	Rapid HIV Testing. 3) Provide funding to the DHSS Public Health and Environmental laboratory (PHEL) for laboratory services. 4) Web-based survey of agencies to assess where HIV testing services are most needed and their interest in providing such services.	Increase the number of agencies engaged in the Rapid HIV Testing Initiative in 2013 by 30%.	Data on the number of SSA licensed agencies engaged in the Rapid HIV Testing initiative is provided by UMDNJ. The change in FY 2013 will be measured by calculating the percent difference between FY 2013 and FY 2012.
		1) Utilize a System of Care approach for adolescents with substance use disorders. 2) Coordinate care with other State agencies (e.g., child behavioral health, schools, child welfare, juvenile justice, primary care, etc.) to deliver evidence-supported treatments and supports. 3) Adopt recommendations of the Adolescent Substance Abuse Task Force for improvements in: service delivery, systems, and workforce development. 4) Implement recommendations resulting from the CSAT-sponsored TA: A. Improve adolescent service demand and		

Adolescents with Substance Use Disorders	To provide a comprehensive array of community-based services for adolescents with substance use disorders utilizing evidence-based and best practice interventions.	appropriateness and ensure clinical decisions regarding adolescent placement and services are clinically sound B. Develop a statewide adolescent services menu C. Marijuana specific treatment D. Identify leading national evidence-supported assessment, placement, continued stay and outcome measurement instruments E. Address adolescent engagement, retention and utilization issues and practices F. Outline a strategy and action steps to shift the service delivery system toward community and family based recovery oriented care utilizing more flexible outpatient and home based services 5) Established the Adolescent Treatment Planning Workgroup to start planning process for the integration of adolescent substance abuse treatment with Department of Children and Families (DCF) Division of Children's Behavioral Health Services	Increase the number of adolescents receiving substance abuse treatment in 2013 by 5%	Data on adolescent treatment admissions will be collected through NJSAMS to establish the FY 2012 baseline. The change in FY 2013 will be measured by calculating the percent difference between the two years.

(DCBHS).

Intoxicated Drivers

To protect public safety through improving services, increasing access to services and coordinating sanctions for intoxicated drivers.

1) Standardize the recording of both non-compliance warnings and non-compliance notifications throughout the state in an effort to trigger sanctions for non-compliance, thereby increasing client attendance at IDRC programs, as well as the number of referrals for clinical assessments. 2) Use of the medication assisted treatment Vivitrol will be made available to 100 clients participating in the DUI Vivitrol pilot study.

A 5% increase in DUI clients receiving ambulatory substance abuse treatment in FY 2013.

Data will be collected through NJSAMS at admission to establish the FY 2012 baseline. The change in FY 2013 will be measured by calculating the percent difference between the two years.

Supportive Housing	Increase opportunities for community living among consumers who currently reside in inpatient settings and for those consumers who are at-risk of being hospitalized and/or homeless.	The DMHAS will announce two or more Requests for Proposals (RFPs) for Supportive Housing Programs which are designed to develop and support community-based programs that promote: housing stability in community settings, engagement with mental health and addiction services, regular access to primary health services; community inclusion, and wellness & recovery.	The number of consumers served by Supportive Housing will increase by 7% in SFY 2012 (relative to the projected 2011 estimate) and will increase by 5% in SFY 2013 (relative to the projected 2011 estimate).	The number of consumers served by supportive housing in SFY 2012 – 2013 (and beyond) will be tracked by the SMHA's QCMR database. The projected number of consumers served by SH in SFY 2011 (4,347) increased by 10.6% from the actual number served in SFY 2010 (4,063). This value increased by 19% between SFY 2009 (3,393) and SFY 2010. Proposals awarded under these RFP will be monitored through contract negotiations and data will be maintained through the QCMR database. Failure to reach the performance indicator may result in review of agency admission and discharge policies to ensure that the target population receives this service and to ensure that consumers are not discharged prematurely nor unreasonably. The information on number of supported housing additions contracts will be obtained from the Contract Information Management System (CIMS) for 2012 and 2013.
Access to Mental Health Services in the Community for Adults	Increase access to services in the community for mental health consumers and for those mental health consumers with serious mental illness (SMI).	The SMHA will continue (and when possible) expand its community services throughout the State of New Jersey in SFY 2012 and 2013 in order to increase both the total number of persons (and the number of persons with SMI) served by the SMHA.	In SFY 2012 an additional 2% consumers with SMI will be served, and an additional 3% in SFY 2013. In SFY 2012 an additional 2% consumers with and without SMI, will be served and will be increased to 3% in SFY 2013.	The SMHA will use its USTF database to collect enrollment data for all consumers served by its programs.
		1) Collect SE Fidelity reports from SE Providers on an annual basis and		QCMR contains specific question as to the number of consumers placed for the first time or replaced. An average composite score on the SE Fidelity Scale will be used to compare from SFY2012 to SFY2013. Supportive Employment: SE providers must indicate on the QCMR form on a quarterly basis, the number of consumers that were placed for the first time (or returned) into an integrated work setting. This PI is the total

Supported Employment	Assist persons with severe mental illness to enter Supported Employment	audit a sampling of providers for accuracy: 22 reports will be collected and reviewed annually. 2) Monitor contract reports on a quarterly basis for first time and replacements of consumers.	The SMHA has requested that the 22 SE providers self evaluate their programs using SE Fidelity Scale Total: SFY 2012 – 90, SFY 2013– 95.	of those two numbers. Dartmouth University has an SE Fidelity Scale that provides for a total scale score which will be uses as a measure from year to year. QCMR will be the data source that the SMHA will use to develop baseline and subsequent measures for the Performance Indicator for 2012 and 2013. Individual SE providers who fall below their expected contract commitments per contract guidelines will be contacted by the SMHA. Those providers will be monitored and individual provider improvement plans will be required. The SMHA will provide technical assistance and or training to enhance employment strategies of staff when necessary.
	Decrease unnecessary	1) The awarded program will provide onsite and offsite individual client assessments, consultation, crisis intervention and stabilization and follow up care to the target population who are present at designated screening centers, affiliated emergency service providers, nursing facilities or other long term care settings, contracted DMHAS residential		PI1: The awarded program will be expected to

Older Adults	admissions of older adults to designated screening centers, short term care facilities, inpatient psychiatric hospitals & special care nursing facilities via training delivered to acute care and nursing facility staff.	providers and/or who are referred to the SMHA PASRR Unit and Centralized Admissions Unit. 2) The awarded program will provide training to increase the knowledge and positively affect the attitudes and behaviors of staff from designated screening centers, affiliated emergency service providers, contracted SMHA residential providers, nursing facilities and other long term care settings who are responsible for the care of the target population resulting in improved management of behavioral disturbances and crisis and enhanced lifestyle for these individuals.	20% increase in staff knowledge of behavioral crisis management in older adults with SMI-- measured in staff pre & post training tests. 7% admissions decrease to state non-forensic psychiatric hospitals of people aged >55. SFY2013 goal is 15% decrease.	provide data from both pre- and post- tests (and other indicators as necessary) in demonstrating the outcomes utilized to assess the impact of each training. Outcomes will be reported to the SMHA's PASRR Unit on a quarterly basis. To measure PI2, the Oracle Hospital Census Database will be used. If a performance indicator is not achieved the SMHA state will re-evaluate the awarded program and program model for effectiveness, identify and address problematic issues and implement a revised plan to improve the quality of mental health care provided to older adults.
		The SMHA will work with IFSS programs will increase networking opportunities and increase outreach efforts in the community in order		

Intensive Family Support Services (IFSS)	To increase enrollment of minority families in Intensive Family Support Services (IFSS)	to attract more minority families. An integral focus of networking/outreach will be the religious community i.e. churches, synagogues, temples, pastors, ministers, preachers, priests and rabbis etc. In addition, the SMHA will encourage IFSS providers to fill vacant positions and employ a more racially and ethnically diverse workforce. IFSS Quarterly Workgroup Meetings which will include as an agenda item strategies for increasing minority open cases.	Baseline data will be aggregated on the current proportion of minority families enrolled in IFSS, forming the basis of the 2013 performance indicator target. Relevant data on demographic/racial composition of its member families will be assessed annually.	Specific baseline data reflecting the volume of minority families in each of the twenty-one IFSS programs will be obtained in the late summer/early fall of 2011. Quarterly Contracted Monitoring Reports submitted by twenty-one IFSS programs which will document new as well as existing minority families in each program. Quarterly Contract Monitoring Reports (QCMR) submitted by NAMI NJ programs which serve minority families which will reflect the number of families referred to IFSS. Monitoring Visits to individual IFSS programs conducted with the county program analyst will be ongoing. Data and reports will be collected, aggregated and analyzed by the SMHA's Coordinator of Special Populations.
Access to Community-based Mental Health Services for Children, Youth and Young Adults	Increase access to community-based services for children, youth and young adults with mental/behavioral health challenges and for those children, youth and young adults with serious emotional disturbance (SED).	DCBHS will continue to expand its community-based services throughout the State of New Jersey in SFY 2012 and 2013 in order to increase both the total number of children, youth and young adults (and the number of children, youth, and young adults with SED) provided services through DCBHS.	In SFY 2012 DCBHS will serve an additional 2% (X) of children, youth and young adults with and without SED, relative to the number served in SFY 2011 (27,550). In SFY 2013 this value will be and additional 3% (X) of the SFY 2011 number.	DCBHS will utilize the CYBER database to collect enrollment data for children, youth and young adults receiving services through its System of Care.
Continue to identify gaps in service for				

In-State, Community-based Specialty Services to Children, Youth and Young Adults	Decrease the number of children, youth and young adults with specialized needs	children, youth and young adults with specialized needs. Develop in state services and supports to address the needs of children, youth and young adults with specialized treatment needs including, but not limited to: deaf/hard of hearing, mental illness/developmental disabilities and/or medical challenges.	At the close of SFY 2011, nine youth continued to receive services in an out of state treatment setting. Four youth require treatment services for deaf/hard of hearing; two youth require MI/DD services; and two youth await child welfare permanency plans.	DCBHS will utilize reports generated by the Special Residential Treatment Unit (SRTU) located within DCBHS. SRTU facilitates all referrals to out of state treatment settings.
Youth Suicide	Enhance the knowledge base of educators and school personnel regarding the occurrence of mental health disorders and suicide prevention.	The Traumatic Loss Coalition (TLC) for Youth Program provides a two-hour Suicide Awareness Training for Educators to fulfill the professional development requirement, in accordance with N.J.S.A. 18A:6-11. A team of clinicians experienced in the evaluation and treatment of children and adolescents with mental health disorders and suicidal behaviors provide this training. The content can be customized to meet the needs of a single school or an entire school district, as well as mental health and social agency staff. On-site school	The number of school personnel trained during SFY 2012 will serve as baseline. SFY 2013 will use the same database to measure a specified percentage of change.	The TLC will track the number of individuals trained in: Suicide Awareness Training for Educators.

counselors or administrators are included in the presentation to talk about the specific protocols outlined in their school's crisis plan for referring at-risk youth for further evaluation and treatment.

Youth Suicide	Enhance the knowledge base of school and community personnel who must respond to the needs of youth in the aftermath of suicide, homicide, accidental death, and other critical incidents such as a natural disaster or terrorist strike.	To continue to build suicide postvention and trauma response capacity, the TLC has been training TLC Coordinators, Lead Response Team (LRT) members, school crisis teams and community mental health clinicians throughout the state in the following evidence-based protocols: Post Traumatic Stress Management (PTSM) and Psychological First Aid – With Ethnocultural, Gender and Developmental Specificity; Trauma and Grief in Youth; Advanced PTSM Training in Suicide Postvention Protocols; Advanced PTSM Training in Homicide and Gang Violence Postvention Protocols; Classroom Based - Rainbowdance	The number of individuals trained during SFY 2012 will serve as baseline. SFY 2013 will use the same database to measure a specified percentage of change.	TLC will track the number of individuals trained in Post Traumatic Stress Management (PTSM) and Advanced PTSM Training in Suicide Postvention Protocols

Intervention (CBI®)
and Traumatic
Incident Intervention
(TII).

Mental Health Outpatient Services for Youth	Increased provision of Outpatient Services for children, youth and young adults and their families enrolled in the DCBHS System of care.	In SFY 2011 and 2012 DCBHS will provide CMOs and UCMs community development funding for start up of new and expansion of existing Outpatient services.	The number of Outpatient services slots available statewide and the number of children, youth and young adults receiving Outpatient services at close of SFY 2012 will serve as baseline. SFY 2013 will use the same database to measure a specified % change	DCBHS will utilize reports generated by the CMOs, UCMs, DCF Office of Licensing and DCF Contract Unit in addition to reports generated by PerformCare.
Justice Involved Services	To divert consumers who become entangled in the criminal justice system by reducing time detained in jail or state prison.	To develop and implement a diversion plan based upon clinical assessment and successful linkage to a range of mental health/substance abuse and other services in lieu of incarceration.	In SFY 2012 there will be 250 consumers successfully diverted, with reduced days in jail. In SFY 2013 this number will be increased to 275.	The Quarterly Contract Monitoring Report (QCMR) for JIS will collect relevant data. The PI that will determine if this strategy has been successful is the tabulation of enrolled consumers in JIS services who-- as a result of intervention with the criminal justice system and or successful linkage to services, either avoid incarceration or are given reduced sentences in county correctional facilities. If the state does not accomplish its goal as indicated by the performance indicator, then those JIS providers who fall below their expected contract commitments will receive technical assistance and or training to enhance positive outcomes.

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 CMHS - Services Purchased Using Reimbursement Strategy

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Start Year:

2012

End Year:

2013

Reimbursement Strategy	Services Purchased Using the Strategy
Encounter based reimbursement	None
Grant/contract reimbursement	*For mental health contracted services using reimbursement strategy: Screening Affiliated Emergency Services, Outpatient, Partial Care, Residential, Supportive Housing, Supported Employment, Self-Help Center, Integrated Case Management Services, Programs for Assertive Community Treatment, Justice Involved Services, Legal Services, Intensive Family Support Services, non-client Specific Programs.
Risk based reimbursement	None
Innovative Financing Strategy	None
Other reimbursement strategy (please describe)	None

Footnotes:

*Does not include Federal Grant dollars received by the State for the PATH programs.

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 SAPT - Services Purchased Using Reimbursement Strategy

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Start Year:

2012

End Year:

2013

Reimbursement Strategy	Services Purchased Using the Strategy
Encounter based reimbursement	Short term residential substance abuse treatment (women's set-aside)
Grant/contract reimbursement	For substance abuse contract services: residential long term, residential short term, residential long term women's set-aside, residential short term women's set aside, intensive outpatient, outpatient psycho/social, outpatient psycho/social adolescents, outpatient psycho/social women's set-aside, intensive outpatient women's set-aside, intensive outpatient methadone, outpatient methadone maintenance, outpatient methadone maintenance women, residential methadone, halfway house, halfway house women's set-aside, detoxification, intensive medical unit, partial care.
Risk based reimbursement	None
Innovative Financing Strategy	None
Other reimbursement strategy (please describe)	None

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5 CMHS - Projected Expenditures for Treatment and Recovery Supports

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Start Year:

End Year:

Category	Service/Activity Example	Estimated Percent of Funds Distributed
Healthcare Home/Physical Health	- General and specialized outpatient medical services - Acute Primary Care - General Health Screens, Tests and Immunization - Comprehensive Care Management - Care coordination and health promotion - Comprehensive transitional care - Individual and Family Support - Referral to Community Services	<10% 6
Engagement Services	- Assessment - Specialized Evaluation (Psychological and neurological) - Services planning (includes crisis planning) - Consumer/Family Education - Outreach	<10% 6
Outpatient Services	- Individual evidence-based therapies - Group therapy - Family therapy - Multi-family therapy - Consultation to Caregivers	10-25% 6
Medication Services	- Medication management - Pharmacotherapy (including MAT) - Laboratory services	<10% 6
Community Support (Rehabilitative)	- Parent/Caregiver Support - Skill building (social, daily living, cognitive) - Case management - Behavior management - Supported employment - Permanent supported housing - Recovery housing - Therapeutic mentoring - Traditional healing services	26-50% 6
Recovery Supports	- Peer Support - Recovery Support Coaching - Recovery Support Center Services - Supports for Self Directed Care	<10% 6
Other Supports (Habilitative)	- Personal care - Homemaker - Respite - Supported Education - Transportation - Assisted living services	<10% 6

	• Recreational services • Interactive Communication Technology Devices • Trained behavioral health interpreters	
Intensive Support Services	• Substance abuse intensive outpatient services • Partial hospitalization • Assertive community treatment • Intensive home based treatment • Multi-systemic therapy • Intensive case management	10-25% 6
Out-of-Home Residential Services	• Crisis residential/stabilization • Clinically Managed 24-Hour Care • Clinically Managed Medium Intensity Care • Adult Mental Health Residential • Adult Substance Abuse Residential • Children's Mental Health Residential Services • Youth Substance Abuse Residential Services • Therapeutic Foster Care	10-25% 6
Acute Intensive Services	• Mobile crisis services • Medically Monitored Intensive Inpatient • Peer based crisis services • Urgent care services • 23 hour crisis stabilization services • 24/7 crisis hotline services	10-25% 6
Prevention (Including Promotion)	• Screening, Brief Intervention and Referral to Treatment • Brief Motivational Interviews • Screening and Brief Intervention for Tobacco Cessation • Parent Training • Facilitated Referrals • Relapse Prevention /Wellness Recovery Support • Warm line	<10% 6
System improvement activities		N/A 6
Other		N/A 6

Footnotes:

The CMHSBG Table 5 above represents FY 2012 and 2013. Please note that the Division of Child Behavioral Health Services (DCBHS), within the New Jersey Department of Children and Families, does not receive federal funding from the Community Mental Health Services Block Grant. DCBHS services are funded primarily through federal matches to Medicaid and S-chip programs and funding allocated annually to DCF/DCBHS in the State budget.

III: Use of Block Grant Dollars for Block Grant Activities

Table 5 SAPT - Projected Expenditures for Treatment and Recovery Supports

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Start Year:

End Year:

Category	Service/Activity Example	Estimated Percent of Funds Distributed
Healthcare Home/Physical Health	- General and specialized outpatient medical services - Acute Primary Care - General Health Screens, Tests and Immunization - Comprehensive Care Management - Care coordination and health promotion - Comprehensive transitional care - Individual and Family Support - Referral to Community Services	<10% 6
Engagement Services	- Assessment - Specialized Evaluation (Psychological and neurological) - Services planning (includes crisis planning) - Consumer/Family Education - Outreach	N/A 6
Outpatient Services	- Individual evidence-based therapies - Group therapy - Family therapy - Multi-family therapy - Consultation to Caregivers	<10% 6
Medication Services	- Medication management - Pharmacotherapy (including MAT) - Laboratory services	10-25% 6
Community Support (Rehabilitative)	- Parent/Caregiver Support - Skill building (social, daily living, cognitive) - Case management - Behavior management - Supported employment - Permanent supported housing - Recovery housing - Therapeutic mentoring - Traditional healing services	<10% 6
Recovery Supports	- Peer Support - Recovery Support Coaching - Recovery Support Center Services - Supports for Self Directed Care	<10% 6
Other Supports (Habilitative)	- Personal care - Homemaker - Respite - Supported Education - Transportation - Assisted living services	N/A 6

- Recreational services
- Interactive Communication Technology Devices
- Trained behavioral health interpreters

Intensive Support Services

- Substance abuse intensive outpatient services
- Partial hospitalization
- Assertive community treatment
- Intensive home based treatment
- Multi-systemic therapy
- Intensive case management

<10% 6

Out-of-Home Residential Services

- Crisis residential/stabilization
- Clinically Managed 24-Hour Care
- Clinically Managed Medium Intensity Care
- Adult Mental Health Residential
- Adult Substance Abuse Residential
- Children's Mental Health Residential Services
- Youth Substance Abuse Residential Services
- Therapeutic Foster Care

26-50% 6

Acute Intensive Services

- Mobile crisis services
- Medically Monitored Intensive Inpatient
- Peer based crisis services
- Urgent care services
- 23 hour crisis stabilization services
- 24/7 crisis hotline services

N/A 6

Prevention (Including Promotion)

- Screening, Brief Intervention and Referral to Treatment
- Brief Motivational Interviews
- Screening and Brief Intervention for Tobacco Cessation
- Parent Training
- Facilitated Referrals
- Relapse Prevention /Wellness Recovery Support
- Warm line

26-50% 6

System improvement activities

N/A 6

Other

N/A 6

Footnotes:

The above Table 5 represents FFY2012 and 2013 for the SAPT BG.

III: Use of Block Grant Dollars for Block Grant Activities

Table 6 CMHS - Primary Prevention Planned Expenditures Checklist

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Start Year:

End Year:

Strategy	IOM Target	Block Grant FY 2012	Other Federal	State	Local	Other
Information Dissemination	Universal	\$0	\$0	\$0	\$0	\$0
Information Dissemination	Selective	\$0	\$0	\$0	\$0	\$0
Information Dissemination	Indicated	\$0	\$0	\$0	\$0	\$0
Information Dissemination	Unspecified	\$0	\$0	\$0	\$0	\$0
Information Dissemination	Total	\$0	\$0	\$0	\$0	\$0
Education	Universal	\$0	\$0	\$0	\$0	\$0
Education	Selective	\$0	\$0	\$0	\$0	\$0
Education	Indicated	\$0	\$0	\$0	\$0	\$0
Education	Unspecified	\$0	\$0	\$0	\$0	\$0
Education	Total	\$0	\$0	\$0	\$0	\$0
Alternatives	Universal	\$0	\$0	\$0	\$0	\$0
Alternatives	Selective	\$0	\$0	\$0	\$0	\$0
Alternatives	Indicated	\$0	\$0	\$0	\$0	\$0
Alternatives	Unspecified	\$0	\$0	\$0	\$0	\$0
Alternatives	Total	\$0	\$0	\$0	\$0	\$0
Problem Identification and Referral	Universal	\$0	\$0	\$0	\$0	\$0
Problem Identification and Referral	Selective	\$0	\$0	\$0	\$0	\$0
Problem Identification and Referral	Indicated	\$0	\$0	\$0	\$0	\$0
Problem Identification and Referral	Unspecified	\$0	\$0	\$0	\$0	\$0
Problem Identification and Referral	Total	\$0	\$0	\$0	\$0	\$0

Community-Based Process	Universal	\$0	\$0	\$0	\$0	\$0
Community-Based Process	Selective	\$0	\$0	\$0	\$0	\$0
Community-Based Process	Indicated	\$0	\$0	\$0	\$0	\$0
Community-Based Process	Unspecified	\$0	\$0	\$0	\$0	\$0
Community-Based Process	Total	\$0	\$0	\$0	\$0	\$0
Environmental	Universal	\$0	\$0	\$0	\$0	\$0
Environmental	Selective	\$0	\$0	\$0	\$0	\$0
Environmental	Indicated	\$0	\$0	\$0	\$0	\$0
Environmental	Unspecified	\$0	\$0	\$0	\$0	\$0
Environmental	Total	\$0	\$0	\$0	\$0	\$0
Section 1926 Tobacco	Universal	\$	\$	\$	\$	\$
Section 1926 Tobacco	Selective	\$	\$	\$	\$	\$
Section 1926 Tobacco	Indicated	\$	\$	\$	\$	\$
Section 1926 Tobacco	Unspecified	\$	\$	\$	\$	\$
Section 1926 Tobacco	Total	\$	\$	\$	\$	\$
Other	Universal	\$0	\$0	\$0	\$0	\$0
Other	Selective	\$0	\$0	\$0	\$0	\$0
Other	Indicated	\$0	\$0	\$0	\$0	\$0
Other	Unspecified	\$0	\$0	\$0	\$0	\$0
Other	Total	\$0	\$0	\$0	\$0	\$0

Footnotes:

For FY 2013, Table 6 for the CMHS BG is also anticipated to remain at zero (0).

III: Use of Block Grant Dollars for Block Grant Activities

Table 6 SAPT - Primary Prevention Planned Expenditures Checklist

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Start Year:

End Year:

Strategy	IOM Target	Block Grant FY 2012	Other Federal	State	Local	Other
Information Dissemination	Universal	\$214,828	\$313,950	\$629,814	\$	\$
Information Dissemination	Selective	\$322,242	\$104,650	\$247,220	\$	\$
Information Dissemination	Indicated	\$322,242	\$	\$64,820	\$	\$
Information Dissemination	Unspecified	\$	\$	\$	\$	\$
Information Dissemination	Total	\$859,312	\$418,600	\$941,854	\$	\$
Education	Universal	\$1,288,968	\$167,440	\$624,080	\$	\$
Education	Selective	\$1,611,210	\$41,860	\$647,700	\$	\$
Education	Indicated	\$2,470,520	\$	\$496,954	\$	\$
Education	Unspecified	\$	\$	\$	\$	\$
Education	Total	\$5,370,698	\$209,300	\$1,768,734	\$	\$
Alternatives	Universal	\$	\$	\$103,000	\$	\$
Alternatives	Selective	\$214,828	\$230,230	\$450,414	\$	\$
Alternatives	Indicated	\$214,828	\$83,720	\$105,014	\$	\$
Alternatives	Unspecified	\$	\$	\$	\$	\$
Alternatives	Total	\$429,656	\$313,950	\$658,428	\$	\$
Problem Identification and Referral	Universal	\$	\$	\$	\$	\$
Problem Identification and Referral	Selective	\$	\$	\$	\$	\$
Problem Identification and Referral	Indicated	\$322,242	\$	\$64,820	\$	\$
Problem Identification and Referral	Unspecified	\$	\$	\$	\$	\$
Problem Identification and Referral	Total	\$322,242	\$	\$64,820	\$	\$

Community-Based Process	Universal	\$107,414	\$	\$124,606	\$	\$
Community-Based Process	Selective	\$214,828	\$104,650	\$392,214	\$	\$
Community-Based Process	Indicated	\$322,242	\$	\$124,820	\$	\$
Community-Based Process	Unspecified	\$	\$	\$	\$	\$
Community-Based Process	Total	\$644,484	\$104,650	\$641,640	\$	\$
Environmental	Universal	\$2,685,349	\$627,900	\$1,855,164	\$	\$
Environmental	Selective	\$429,656	\$418,600	\$290,026	\$	\$
Environmental	Indicated	\$	\$	\$	\$	\$
Environmental	Unspecified	\$	\$	\$	\$	\$
Environmental	Total	\$3,115,005	\$1,046,500	\$2,145,190	\$	\$
Section 1926 Tobacco	Universal	\$	\$	\$	\$	\$
Section 1926 Tobacco	Selective	\$	\$	\$	\$	\$
Section 1926 Tobacco	Indicated	\$	\$	\$	\$	\$
Section 1926 Tobacco	Unspecified	\$	\$	\$	\$	\$
Section 1926 Tobacco	Total	\$	\$	\$	\$	\$
Other	Universal	\$	\$	\$	\$	\$
Other	Selective	\$	\$	\$	\$	\$
Other	Indicated	\$	\$	\$	\$	\$
Other	Unspecified	\$	\$	\$	\$	\$
Other	Total	\$	\$	\$	\$	\$

Footnotes:

The above Table 6 represents FFY2012 and 2013 for the SAPT BG.

III: Use of Block Grant Dollars for Block Grant Activities

Table 7 CMHS - Projected State Agency Expenditure Report

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Start Year: 2012

End Year: 2013

Date of State Expenditure Period From: 10/01/2011

Date of State Expenditure Period To: 09/30/2013

Activity	A. Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance Abuse Prevention and Treatment	\$	\$	\$	\$	\$	\$
2. Primary Prevention	\$	\$	\$	\$	\$	\$
3. Tuberculosis Services	\$	\$	\$	\$	\$	\$
4. HIV Early Intervention Services	\$	\$	\$	\$	\$	\$
5. State Hospital		\$	\$	\$	\$	\$
6. Other 24 Hour Care	\$769,158	\$161,464,000	\$	\$119,146,832	\$	\$
7. Ambulatory/Community Non-24 Hour Care	\$9,967,530	\$103,328,000	\$2,250,000	\$354,634,168	\$	\$
8. Administration (Excluding Program and Provider Level)	\$588,222	\$	\$226,701	\$16,449,000	\$	\$
9. Subtotal (Rows 1, 2, 3, 4, and 8)	\$588,222	\$	\$226,701	\$16,449,000	\$	\$
10. Subtotal (Rows 5, 6, 7, and 8)	\$11,324,910	\$264,792,000	\$2,476,701	\$490,230,000	\$	\$
11. Total	\$11,324,910	\$264,792,000	\$2,476,701	\$490,230,000	\$	\$

Footnotes:

This information is based on State FY 2012.

Line 8a includes \$566,246 for Administrative costs and \$21,976 for Planning Council planning activities for a total of \$588,222

For Adult Behavioral Health services herein, there are other resources supporting these programs not shown above because they are not appropriated to the SMHA.

For Child Behavioral Health services herein, Medical Assistance funding is directly appropriated to DCBHS, as such, expenditures above inclusive of those resources.

III: Use of Block Grant Dollars for Block Grant Activities

Table 7 SAPT - Projected State Agency Expenditure Report

Page 38 of the Application Guidance

Start Year: 2012

End Year: 2013

Date of State Expenditure Period From: 10/01/2011

Date of State Expenditure Period To: 09/30/2013

Activity	A. Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance Abuse Prevention and Treatment	\$31,664,326	\$	\$	\$211,410,340	\$4,322,906	\$
2. Primary Prevention	\$10,741,397	\$	\$2,093,000	\$6,220,666	\$	\$
3. Tuberculosis Services	\$	\$	\$	\$	\$	\$
4. HIV Early Intervention Services	\$2,334,291	\$	\$	\$	\$	\$
5. State Hospital		\$	\$	\$	\$	\$
6. Other 24 Hour Care	\$	\$	\$	\$	\$	\$
7. Ambulatory/Community Non-24 Hour Care	\$	\$	\$	\$	\$	\$
8. Administration (Excluding Program and Provider Level)	\$1,945,817	\$	\$	\$1,812,000	\$	\$
9. Subtotal (Rows 1, 2, 3, 4, and 8)	\$46,685,831	\$	\$2,093,000	\$219,443,006	\$4,322,906	\$
10. Subtotal (Rows 5, 6, 7, and 8)	\$1,945,817	\$	\$	\$1,812,000	\$	\$
11. Total	\$46,685,831	\$	\$2,093,000	\$219,443,006	\$4,322,906	\$

Footnotes:

The table above reflects FFY 2012

For FFY 2013, Table 7 for the SAPT BG remains the same except for the Other Federal Funds column currently reflecting \$2,093,000 will equal zero (0).

III: Use of Block Grant Dollars for Block Grant Activities

Table 8 Resource Development Planned Expenditure Checklist

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Start Year:

End Year:

Activity	A. Prevention-MH	B. Prevention-SA	C. Treatment-MH	D. Treatment-SA	E. Combined	F. Total
1. Planning, Coordination and Needs Assessment	\$	\$ 630,606	\$	\$ 1,504,654		\$2,135,260
2. Quality Assurance	\$	\$	\$	\$ 1,995,913		\$1,995,913
3. Training (Post-Employment)	\$	\$	\$	\$ 1,060,000		\$1,060,000
4. Education (Pre-Employment)	\$	\$	\$	\$	\$	\$
5. Program Development	\$	\$	\$	\$	\$	\$
6. Research and Evaluation	\$	\$ 526,201	\$	\$ 1,106,968		\$1,633,169
7. Information Systems	\$	\$ 101,284	\$	\$ 275,657		\$376,941
8. Total	\$	\$1,258,091	\$	\$5,943,192	\$	\$7,201,283

Footnotes:

For FY 2013, Table 8 for the SAPT BG is anticipated to remain the same.

For FY 2012 and 2013, Table 8 for CMHS BG is zero (0) across all fields.

IV: Narrative Plan

D. Activities that Support Individuals in Directing the Services

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Narrative Question:

SAMHSA firmly believes in the importance of individuals with mental and substance use disorders participating in choosing the services and supports they receive. To achieve this goal, individuals and their support systems must be able to access and direct their services and supports. Participant direction, often referred to as consumer direction or self direction, is a delivery mode through which a range of services and supports are planned, budgeted and directly controlled by an individual (with the help of representatives, if desired) based on the individual's needs and preferences that maximize independence and the ability to live in the setting of his/her choice. Participant-directed services should include a wide range of high-quality, culturally competent services based on acuity, disability, engagement levels and individual preferences. The range of services must be designed to incorporate the concepts of community integration and social inclusion. People with mental and substance use disorders should have ready access to information regarding available services, including the quality of the programs that offer these services. An individual and their supports must be afforded the choice to receive services and should have sufficient opportunities to select the individuals and agencies from which they receive these services. Person centered planning is the foundation of self-direction and must be made available to everyone. The principles of person centered planning are included at www.samhsa.gov/blockgrantapplication. Individuals must have opportunities for control over a flexible individual budget and authority to directly employ support workers, or to direct the worker through a shared employment model through an agency. People must have the supports necessary to be successful in self direction including financial management services and supports brokerage. In addition, individuals and families must have a primary decision-making role in planning and service delivery decisions. Caregivers can play an important role in the planning, monitoring and delivery of services and should be supported in these roles. In the section below, please address the following:

- Either summarize your State's policies on participant-directed services or attach a copy to the Block Grant application(s).
- What services for individuals and their support systems are self-directed?
- What participant-directed options do you have in your State?
- What percentage of individuals funded through the SMHA or SSA self direct their care?
- What supports does your State offer to assist individuals to self direct their care?

Footnotes:

D. Activities that Support Individuals in Directing their Service

The Single State Authority on Substance Abuse

At present the SSA does not have a formal policy on, or established process for, participant directed services. However, there are supports offered by the SSA to assist individuals to self-direct their care. The first example is the 211 Addictions Hotline. Consumers can call the hotline for help or information and are given the option of being screened using evidence-based tools for substance use disorders and an immediate level of care need. If they are interested in a referral, they are then given the option of three choices by the call specialist and also have the option of a “warm handoff”. In State Fiscal Year 2012, all substance abuse fee-for-service contracted providers are required to have an affiliation agreement in place with 211 to receive referrals through a warm hand-off process that screens the consumer for financial and program eligibility and links the consumer with the provider and first service. The SSA plans to use information collected from the Hotline to help streamline the referral and engagement process for those in need of services.

The SSA opened New Jersey's first Recovery Center at Eva's Village in Paterson, New Jersey during Recovery Month, September 2009 and its programs have continued to grow. The consumer-managed center, which operates 365 days a year, provides the following services for consumers in the local metropolitan area and surrounding communities: referrals to access assessment and treatment, peer support services, housing assistance, employment assistance, language assistance, self-help, childcare assistance, recreational activities, wellness classes of interest to the community, and advocacy activities in support of recovery. Additionally, the Recovery Center's participants and staff continue to take leadership roles in community-oriented recovery activities such as hosting the SSA's Citizen Advisory Council (CAC) Linkage Event in September 2010 and the nationally sponsored Recovery Walks in New York and Philadelphia.

There is also a planned project within the SSA to develop a Consumer Portal. This project derives from the SSA's goal to promote health literacy and empower consumers with information to be better able to make informed choices concerning their care. While the SSA has a website that is rich in reports and data, it is more tailored to the professional audience and not particularly “consumer friendly”. Concurrently, the SSA's CAC has identified the development of a consumer website as a key priority. Over the next two years the SSA and CAC will work collaboratively to develop the Consumer Portal in designing the structure and content for the site.

A third project under consideration by the SSA is to post all the Provider Performance Reports and the 360° Dashboard reports the SSA produces on its website. These reports contain information on outcomes for all levels of care within an agency and agency performance across key domains, respectively. In this way, consumers will be able to see if a substance abuse provider has good outcomes and if the provider falls above or below the State average on those outcomes and other performance indicators by service.

These projects align with SAMHSA's objective that consumers should have ready access to information regarding available services, including the quality of the programs that offer these services, and should have sufficient opportunities to select the agencies from which they receive

these services. The SSA's CAC is developing other projects related to its strategic priority to provide consumers with information to support their informed decision-making.

The State Mental Health Authority

The SMHA currently funds and sponsors a variety of support services that are peer-driven and self-directed in both community settings and at the State's five psychiatric hospitals. The SMHA recognizes the value of these services as they promote positive self-care and self-monitoring of one's physical health through health screenings, and the assumption of personal responsibility for one's own life and health. The SMHA strongly encourages and supports consumers to assume full responsibility for their own care and treatment. These services are directly controlled by the consumer based on individuals' strengths, and the maximization of personal choice in treatment planning and decision-making.

The SMHA currently has a policy that addresses self-directed care. An Administrative Bulletin was developed to promote the empowerment of consumers and to give consumers the opportunity to direct their own care. Administrative Bulletin 3:37 (see http://www.state.nj.us/humanservices/dmhs/info/notices/adminbulletins/3_37.pdf) on Psychiatric Advanced Directives (PADs) was issued to provide the opportunity to execute desired informed decision-making with regard to the care and treatment that a consumer receives. PADs are a useful tool for consumers to direct their own services. Examples of treatment decisions that are communicated in a PAD are those regarding administration of psychotropic medications as well as the standard of care a person receives or does not receive at a treatment facility. This document becomes a permanent record in the patients' chart, which can be revoked or amended by legal authority.

In addition, the SMHA is fortunate to sponsor The Institute for Wellness and Recovery Initiatives out of New Jersey's premier consumer-operated service provider organization, which enjoys a national reputation for promoting self-directed care. They offer training and resources that promote the overall wellness of the mental health consumer population. The Institute has provided national leadership for reducing mortality and morbidity of consumers through the provision of health screenings and self-care initiatives. The Institute offers regularly scheduled workshops to address the domains of wellness to include physical, mental, emotional, environmental, social, spiritual and financial aspects of a consumer's recovery. The Institute also produces a nationally-recognized newsletter on a monthly basis and each year sponsors the Annual Wellness Conference that is attended by hundreds of consumers, providers, family members and advocates. The Wellness Conference is highly successful and consistently focuses on all of the wellness domains.

On a State hospital level, person-centered treatment planning, on-grounds self-help centers, shared decision-making and Illness Management and Recovery services are offered. Each hospital also has a patient government and peer specialist at the hospital to advocate on behalf of inpatient consumers.

Each State hospital also offers programs on medication self-monitoring whereby consumers have the ability to manage their own psychotropic medications in preparation for discharge. Staff has

also been trained in person centered treatment planning where consumers set their own goals and choose appropriate interventions to be and stay well. Particular attention has been given to the harmful effects of psychotropic medications. The State hospitals provide medication fact sheets and an instrument for creating the opportunity for consumers to self-report medication side effects to their prescribing doctor and to report interactions and other issues that affect individuals' health and well-being.

The SMHA recently partnered with the University of Medicine and Dentistry of New Jersey (UMDNJ) to develop a cardio metabolic screening/self-monitoring tool to assist consumers with shared decision-making. The tool is highly useful in helping prepare for medication appointments, report side-effects of the medications and express concerns one has in their overall wellness and recovery. The tool was developed in FY12 and will soon be implemented in the community and as well as the state hospitals.

The SMHA remains committed to creating opportunities for consumers to direct their own care as well as the provision of consumer-operated services, supports and interventions. In FY '11 the SMHA allocated \$8.7 million dollars towards consumer-operated services that promote self-directed care, self-monitoring of physical health issues and the attainment of a life-style that is based in wellness and recovery. Although DMHAS does not currently collect specific data on the percentage of individuals funded through the State Mental Health Authority who direct their own care, staff are currently working on a Quality Assurance Initiative that would mandate agencies to collect this data beginning sometime in FY 2012 or 2013.

In addition, the Statewide Consumer Advisory Committee (SCAC) is a diverse group of emerging leaders throughout the state who are experiencing recovery in their own lives. They are committed to having open, honest and compelling discussions with the leadership of the DMHAS around what a recovery and wellness-oriented system is about and what it is not. SCAC has been greatly instrumental in working with the DMHAS on many aspects of the Transformation including focus groups to identify outcomes and other elements of service delivery. In addition, SCAC members have been used as consultants for subcommittee work, as trainers and for curriculum development for specialized DMHAS-sponsored initiatives, and as advisors for proposal reviews. The SCAC has been integrally involved in the completion of Federal Mental Health Block Grant consumer satisfaction surveys, and also makes recommendations back to the SMHA on all issues affecting the quality of life of consumers living in New Jersey from housing to medication co-pays to access to employment-related services.

The SCAC meets one time per month in each of the three regions of the state. SCAC meetings are frequently used to provide important input in to specific DMHAS-sponsored projects and initiatives. Members of the DMHAS' Management Team are frequent visitors to SCAC meetings where they provide updates and just listen to concerns, issues and ideas of consumers who are vested in transforming our mental health system.

The Division of Child Behavioral Health Services (DCBHS)

The Division of Child Behavioral Health Services (DCBHS), within the Department of Children and Families (DCF), is the single state agency that provides contracted services to children, youth and young adults with emotional and behavioral health care challenges and their families across multiple child-serving systems. DCBHS was created to coordinate and expand existing services and to develop new community services to help youth and their families recognize their strengths and plan services to meet their needs. DCBHS views children and their families as full partners in the development of their Individual Service Plans (ISP) and in assessing progress toward their own outcomes. DCBHS provides leadership in the coordination of the development of services and coordination of services for individual youth and families by providing case management care coordination at the level needed by each family.

DCBHS is committed to providing services based on the needs of the child, youth or young adult and their family in community-based, family-centered environment. DCBHS services are coordinated through one entity, the Contracted System Administrator (CSA, PerformCare) and are based on a single, strength-based ISP developed with the family for the child, young adult and their family in a community based, family-centered environment.

The principles inherent in this new system of care required the system to adhere to a core set of values:

- Provide a System of Care that is:
 - Child-centered and family-focused with the needs of the child and the family dictating the services received and the intensity of care coordination.
 - Based on individualized care plans using an integrated wraparound system of care that incorporates both formal and informal services and supports.
 - Community-based, with the locus of services as well as management and decision-making responsibilities resting at the community level.
 - Culturally competent, with agencies, programs and services that are responsive to the cultural, racial and ethnic differences of the populations they serve.
 - Provided in the least restrictive environment and support the youth in remaining at home, in school, and in their community.
- Provide an expanded array of formal and informal services.
- Provide Individualized Service Planning (ISP):
 - ISPs are developed around the needs of the child
 - Formal and informal services are part of the ISP
- Families are partners in treatment:
 - Engage families as active participants at all levels of planning, organization and service delivery
 - Build on child, youth and young adult and family strengths and assure the family perspective throughout the entire treatment process from development of the ISP to implementation
 - All services shall be designed to meet a family's needs for accessibility and shall be respectful of the family's rights and responsibilities
- Provide Culturally Competent Services
 - Assure that the child, youth or young adult and family needs and strengths are defined culturally

- All services must address cultural competency and language appropriate needs at the community and family level
- Deliver services consistent with the community's cultural strengths and values
- Provide Screening and Assessment Services
 - Develop common screening and assessment protocols that are used across various child-serving agencies and systems to ensure the creation of comprehensive service plans
 - The protocols shall be used to evaluate and screen the whole child from the point of access for risk and clinical need
 - The use of uniform screening and assessment tools will ensure consistency in the criteria used to develop ISPs

All families may request behavioral health services at any time. A Biopsychosocial Assessment, which includes a Needs Assessment, is administered at intake to all youth and their families accessing DCBHS services. These assessments collect information needed for treatment planning and represent a baseline of the needs of the youth and their family at intake into the system. A Strengths and Needs Assessment (SNA) is administered at 90-day intervals throughout treatment. The SNA indicates the changes in youth and family needs during treatment and provides information needed to make decisions on revisions to the ISP and intensity of service. Youth and their families are fully involved in this process.

Youth and their families are engaged as active participants at all levels of planning, organization and service delivery. Family choice in provider agency is offered. The PerformCare webpage (<http://www.performcarenj.org/>) contains useful information for families, youth and system of care providers. A Youth and Family Guide is available in both English and Spanish. It is here that parents and caregivers can learn how to obtain services and what can be expected when calling PerformCare. A resource page is available as well as information on how families can file a complaint.

All services and supports are planned, delivered, and directed with the youth and family's full participation.

DCBHS offers the following supports to assist individuals to self-direct care.

Family Support Organizations

Most fundamental to DCBHS is its emphasis on the family or caregiver as playing a central role in the health and well being of children, youth and young adults. DCBHS is committed to providing behavioral health services based on the needs of the child and family in a family-centered, team driven, community-based environment.

DCBHS involves families throughout the planning and any service delivery process in order to ensure a System of Care that is family-friendly and culturally competent, values and promotes the advice and recommendations of the family, and one which provides them the tools and support needed to create successful life experiences for their children with emotional and behavioral problems. One of the key partners in the System, unique to New Jersey, are the

Family Support Organizations (FSO). FSOs are private, non-profit, county-based organizations, funded by DCBHS, and run by families of children with emotional and behavioral challenges.

Each FSO is designed to provide a perspective that is uniquely family oriented through peer mentorship, education and advocacy, information/referral and the hosting of peer support groups. The FSOs act as guides for professionals and as direct peer support to families whose children are enrolled in local Care Management Organizations (CMO) and Unified Care Management (UCM) entities.

Working closely with care managers, family support partners hired by the FSOs provide guidance and support to families whose children have the most complex needs. Family support partners are individuals with experiences as caregivers to children with behavioral and emotional challenges who provide a unique opportunity to offer support and guidance to families receiving CMO or UCM services. Family support partners are present at Child Family Team Meetings for families who request their assistance, helping to ensure ISPs are supportive of family needs and true to the family's values, beliefs and concerns. Additionally, family support partners are available to assist families during critical situations such as the hospitalization of a child or admission to an out of home treatment setting.

The administration of DCBHS as well as the DCBHS Service Line Coordinator for Unified Care Management/Care Management Organization meet on a monthly basis with the FSO Directors.

Youth Partnerships

The Youth Partnerships are a network of advocacy groups run for and by youth who have behavioral or mental health challenges under the supervision of a Youth Coach. Housed within CMO/UCM Family Support Organizations, the Youth Partnerships have independent missions and budgets. The primary goals of the Youth Partnerships include advocating for youth who are coping with mental illness, educating their communities to eradicate the stigma associated with mental illness, and removing the barriers that young people face in obtaining resources for wellness. Most Youth Partnerships meet at least once a week and also plan additional trips and community service activities.

The NJ Alliance for Family Support Organizations stepped forward to support some statewide planning and technical assistance for Youth Coaches across the state. These coordination opportunities also allowed the Youth Partnerships to collaboratively plan a statewide youth conference, the first of which was held in the summer of 2008.

DCBHS Youth Development Council

The DCBHS Division Director met with the statewide planning group of youth and Youth Coaches in the spring of 2009. The feedback from that group of youth leaders and advocates made clear a desire and readiness to more meaningfully incorporate authentic youth voice and roles within the structure of the Youth Partnerships and other avenues throughout the system. The Youth Development Council was formed in the summer of 2009 in response to that clear

message, with intent to engage a core group in outlining a plan and process for such involvement.

As a short-term group with the specific purpose of developing a plan for meaningful and authentic youth involvement for DCBHS, the Youth Development Council created a mission statement for the DCBHS to embrace in order to move the plan forward. It is a mission for the Division and its system partners, and will serve as a guiding document for a standing Youth Council that reports directly to and holds accountable the Division Director. The guiding document outlines specific values and principles for the work of engaging youth, as well as provides core concepts essential to any type of youth development and offers guidance on creating a continued community dialogue to reduce the stigma of youth with mental health challenges. The core concepts of the plan address developmental readiness of the existing service system; mutual accountability between administrators, service providers and youth; elimination of stigma; provision of adequate training/preparation to implement the provisions of the Strategic Plan; action planning; increased ownership of the individual care/service plan; community involvement and governance. This guiding document is the first step of DCBHS toward systemically shaping the system of care to proactively combat stigma and most ambitiously, immunize youth against it.

Consistent elements of the stated missions of the local Youth Partnerships are:

- Educate communities about mental health issues facing young people;
- Eliminate stigma by advocating for one another in the community;
- Empower youth as self-advocates; and
- Foster connections between youth to support, educate, and advocate for and with one another.

Taking up these themes, the Youth Development Council advised DCBHS to adopt the following Youth Development mission statement:

The Division of Child Behavioral Health Services will support youth who receive mental health services as full partners in the development, oversight, and delivery of all levels of care. The Division will ensure, through its management and monitoring functions of the service delivery system, that youth are decision-makers in their own care, empowered as self-advocates, and supported as a community of advocates with distinct voice. Youth Voice will be routinely and meaningfully sought by DCBHS. The Division will demonstrate, through policy and practice, its accountability to meaningful and authentic youth involvement.

DCF and DCBHS support that full participation of youth in directing the mental health care systems helps to combat stigma and isolation; creates opportunities for our youth to develop a stronger sense of belonging, purpose, and self-esteem; and ensures that we remain honest and focused in our work. The benefits of youth development reach beyond the individual: the entire system profits when youth are given opportunities to make authentic contributions to quality of care.

Implementation of the plan was initiated in the spring of 2010. The Youth Development Council is currently in the process of developing Council by-laws, collaborating with the New Jersey

University of Medicine and Dentistry/University Behavioral Health Care on the development of a youth leadership-training curriculum and planning its 3rd annual Youth Conference. The Youth Development Council will have representation on the State Mental Health Planning Council and was the recipient of the 2010 New Jersey Governor's Council on Mental Health Stigma Ambassador Award, which recognizes individuals and organizations in New Jersey that have made outstanding contributions to the effort to raise mental health awareness and combat mental health stigma.

The full text of the Youth Development Council Guiding Document can be accessed at: http://www.state.nj.us/dcf/behavioral/YCguidingdoc10_28_09.pdf

IV: Narrative Plan

E. Data and Information Technology

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Narrative Question:

Regardless of financing or reimbursement strategy used, unique client-level encounter data should be collected and reported for specific services that are purchased with Block Grant funds. Such service tracking and reporting is required by SAMHSA to be reported in the aggregate. Universal prevention and other non-service-based activities (e.g. education/training) must be able to be reported describing the numbers and types of individuals impacted by the described activities. States should to complete the service utilization Table 5 in the Reporting Section of the Application. States should provide information on the number of unduplicated individuals by each service purchased with Block Grant Funds rather than to provide information on specific individuals served with Block Grant funds. In addition, States should provide expenditures for each service identified in the matrix. If the State is currently unable to provide unique client-level data for any part of its behavioral health system, SAMHSA is requesting the State to describe in the space below its plan, process, resources needed and timeline for developing such capacity. States should respond to the following:

- List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provide information on one or more of the following:
 - Provider characteristics
 - Client enrollment, demographics, and characteristics
 - Admission, assessment, and discharge
 - Services provided, including type, amount, and individual service provider
 - Prescription drug utilization
- As applicable, for each of these systems, please answer the following:
 - For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?
 - Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?
 - Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?
 - Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?
 - Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?
- As applicable, please answer the following:
 - Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?
 - Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?
 - Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?
 - Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?
 - Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?

In addition to the questions above, please provide any information regarding your State's current efforts to assist providers with developing and using Electronic Health Records.

Footnotes:

E. Data and Information Technology

The Single State Authority on Substance Abuse

Information Systems Maintained by the SSA

Overview. The SSA has several key information systems, described below, that provide information on: 1) provider characteristics, 2) client enrollment, demographics, and characteristics, 3) admission, assessment, and discharge and 4) services provided, including type, amount, and individual service provider.

NJ-SAMS. The New Jersey Substance Abuse Monitoring System (NJ-SAMS) was developed and implemented by the SSA to be a real-time, web-based substance abuse treatment data collection and reporting system. The system is used by all licensed substance abuse treatment providers in New Jersey, regardless of whether or not they contract with the SSA. It collects basic demographic, financial, clinical and service information on all clients enrolled and served in New Jersey's substance abuse treatment system. In 2010 there were approximately 72,000 admissions to treatment. The system consists of numerous modules and contains all the clinical assessments providers are required to complete. There are approximately 346 providers reporting on NJ-SAMS, representing 491 sites; approximately 4,056 users are password-registered.

The NJ-SAMS website is hosted by the Rutgers University Computer Center under a Memorandum of Agreement with the SSA. It is a secure web-based system designed to collect confidential health information and is HIPAA and 42CFR compliant. Providers reporting on NJ-SAMS require access to the internet in order to provide client information to the SSA. It runs on Microsoft SQL Server 2008; all new additions to NJ-SAMS are programmed within the .NET framework.

NJ-SAMS was developed over time under the initial auspices of the Center for Substance Abuse Treatment (CSAT). The purpose was to develop the State's capacity to use web-based information technology for the collection and reporting of data necessary to meet Federal Performance Partnership Grant (PPG) and the GPRA reporting requirements. It was piloted in October 2002, gradually phased in over time, and by July 2005 all providers were required to use NJ-SAMS for reporting. NJ-SAMS was developed in response to the need for: timelier reporting on substance abuse treatment episodes, better monitoring of client outcomes, quality improvement, better client placement, and tracking of treatment through the continuum of care. The NJ-SAMS includes a modified version of the Addiction Severity Index, as well as additional modules that can collect further information on client care and needs. The system is capable of producing the CSAT National Outcome Measures (NOMs) and generates the data needed for Provider Performance Reports which are distributed to all providers. Due to its flexible design, additional data elements or modules can be easily added to meet any new Federal reporting requirements or other treatment system considerations. Currently there are 24 modules within NJ-SAMS and three additional modules are planned. The newest additions are the DAS Income Eligibility (DASIE) module, the Prior-Authorization Module which was designed to interface with the SSA's third-party Fiscal Agent FFS Billing System, an Extension Request Module to

approve continuing treatment for all fee-for-service initiatives, a Child Protection Substance Abuse Initiative (CPSAI) Module for use by the Division of Youth and Family Services, and a Vivitrol Module to support all the data collection needs for a Vivitrol Pilot study that was launched in July 2011. Also being planned is a Drug Court Module for use by the Administrative Office of the Courts.

At the present time our unique client-level encounter data are collected and reported for services that may have different payors,(e.g., Drug Court, Work First NJ, Chapter 51, Self Pay, Private Insurance, etc). and are identified through the item on funding source in the Admission module in NJ-SAMS. However, we do not have a separate category for “Federal Block Grant”. This is currently subsumed under the category for “DAS Slot Contract”. Last year 72 providers received block grant funds; of these 28 received block grant funding only. The other 44 received a combination of block grant and other State funds. While it would be simple to report client level data for the 28 block grant funded only agencies, significant resources would be needed to be invested to get this level of detail for the other 44 agencies. This would require modification to the SSA’s Contract Information Management System (CIMS) to include a Block Grant budget category, modification to NJ-SAMS to include this option and training to providers on utilizing this category in future reporting to the SSA.

POMS. The Prevention Outcomes Management System (POMS) was designed to collect basic process and demographic information, as well as outcome data, about substance abuse prevention services provided in New Jersey. POMS data include the type of service, target audience, group and curriculum information, dates the service was performed, applicable CSAP strategy and domain, and outcome measures in the individual/peer, family and school domains based on CSAP’s core measures. The POMS collects data on the number and demographics of people served by education and training activities. Those are the domain-based programs and they serve selective and indicated populations. The information from POMS is used for Federal Block Grant reporting.

Numerous reports are included in the system. It is web-based and was developed and tested in-house over a six-month period during CY 2009. Focus groups were held for providers and staff in May and June 2009, and their feedback was incorporated into the system. All New Jersey substance abuse prevention providers that receive SSA contracts are required to use the system and were trained on it in July, which then went live on August 3, 2009. There are 35 providers reporting on POMS with 145 password-registered users.

Currently information about universal strategies (i.e., environmental strategies) is not collected on POMS, which is one of the modifications to be made over the next year. The SSA has applied for a Strategic Prevention Enhancement (SPE) grant from SAMHSA to seek financial assistance with this effort to add an environmental factors module to the system.

CIMS. The Contract Information Management System (CIMS) is a web-based, paperless contract processing system developed in C# in a .NET environment. When fully evolved, it will follow a contract through its entire life span from the initial RFP through the latest contract renewal, modification, and Report of Expenditures. Provider agencies are able to complete and submit all of their contract actions through CIMS at any location that has internet access. CIMS went live

July 1, 2010 for renewal contracts which included the electronic submission of the Annex B (budget). On January 1, 2011 the system went live for the Annex A and Programmatic Requirements.

The four main principles areas CIMS was designed to address are:

- ensure compliance with DHS contracting policies
- provide more accountability for the utilization of state funds
- improve transparency and tracking of SSA contracting
- develop a more efficient process for submitting, reviewing and approving contract documents

GEMS. The Guest and Emergency Medication System (GEMS) is a centralized, web-based .NET computer information system created by the SSA. The purpose of GEMS is to serve as both a guest dosing and disaster response system for opioid treatment programs (OTPs). It assists clients who are unable to obtain treatment at their home OTPs either due to a disaster or more routine service discontinuity or needing to travel to a different geographic location that is not easily accessible from the Home agency. During such instances, it is critical that clients are able to obtain needed medication. For this to occur, guest OTPs must have access to limited, but specific, information about each client to provide a safe and accurate dose. GEMS ultimate function is to provide this information, under appropriate restrictions, when needed due to emergency, other service disruption or guest access.

GEMS can interface with an OTP's third party clinical management methadone dosing software systems through an upload process to eliminate additional data entry regarding dosage and take home privileges. The OTP determines how frequently it will upload the information. It can also be used directly as the dosing information system for those agencies that do not have a third party software system. In the event that a client cannot reach his/her home clinic for treatment, another clinic, with the client's consent, will be able to securely access the needed dosing information from GEMS. Additionally, GEMS has been designed to interface with the New Jersey Substance Abuse Monitoring System (NJ-SAMS), which is the SSA's client administrative data system. When an OTP admits a client, key data fields will automatically transfer from NJ-SAMS to GEMS. GEMS will also interface with the Federal D-ATM emergency dosing system in the event of a federally declared disaster in New Jersey.

CSC Billing System. The Fiscal Agent Billing system contract was awarded to the Computer Sciences Corporation (CSC) through an open competitive bid process handled by Treasury's Division of Purchase and Property. The CSC system is a web-based billing system for all of the SSA's fee-for-service (FFS) initiatives: Drug Court, MAP-SPB, MAP-DOC, SJI, MATI, DUII and the Co-Occurring Network. The amount of funding dedicated to these initiatives is approximately \$40 million. All providers that participate in these networks must submit their claims through the CSC system for payment. Detailed service data is input which includes the CPT code. This system went live July 1, 2010.

CSC and the SSA have developed an automated interface with NJ-SAMS to link services data reported in NJ-SAMS which correspond to the claim for payment. This link includes service provider fields, services paid elements (service code, units, dates of service, amount, etc.) and client identifier elements. CSC confirms all information prior to paying any bill and verifies all requests for services through the NJ-SAMS Prior-Authorization Module. Approximately 3,500 claims are processed per month. CSC reimburses and/or notifies the agency of claim status within 10 working days of receipt of the bill for all clients. In addition, all the CSC billing data tables, approximately 76, are transferred to NJ-SAMS on a nightly basis.

The CSC System also tracks services rendered to each beneficiary by specific service on the prior authorization and maintains a record of amounts reimbursed by Medicaid and those not reimbursed by Medicaid.

IDP Data System. The current Intoxicated Driving Program (IDP) Data System is a Fox Pro 2.6a database LAN application used to manage and report the Division's IDP class scheduling related information. It was operational before 1997 and has been modified extensively over the years. The system allows users to enter client, DUI violations and suspension data. It also produces class rosters for Intoxicated Driver Resource Centers (IDRCs), client form letters and management reports, and provides data for the microfiche imaging process. Because the system is antiquated and the software is no longer supported, continuation of this existing system presents a critical risk to the SSA. As a result, the system is being redesigned into a web-based .NET application which will be completed in August 2011. There are approximately 400,000 client records and 500,000 violations in the system. All data has been successfully transferred to our web-server using our VPN connection and was imported into the new system. Because the new system uses the same technology and platform as the IDRC Data System, a scripting feature will be added that will allow the automatic transfer of class schedule data between the IDP system and the IDRC system, which is currently accomplished through a file extract and upload process.

IDRC Data System. The Intoxicated Driver Resource Center (IDRC) Data Management System was developed to transfer information electronically from the State Intoxicated Driving Program (IDP) to the 21 County and three Regional IDRCs and from these IDRCs to their affiliated treatment providers and back again. The IDP receives data on all (30,000 or more) intoxicated driving convictions from the Administrative Office of the Courts. Clients are scheduled to attend 12-hour County-based IDRCs or 48-hour programs based on their sentencing and county of residence. The IDP is responsible for sending information back to the State Motor Vehicle Commission regarding these drivers' compliance or non-compliance with Statute 39:4:50.

Before 2008, all class rosters were printed and mailed to the IDRCs. Information regarding compliance was done through the mail and fax. If a client was sent to a treatment provider for further assessment and treatment, the referral was made and the paperwork was mailed to the agency. This is all done electronically with the implementation of the IDRC Data Management System. Since all IDRC Affiliated Providers are required to submit admission, discharge and assessment information to the NJ-SAMS, the IDRC referrals are "linked" and can be tracked, easing the burden of hard-copy tracking of clients, making follow-up phone calls to see if a client

showed up to the treatment agency or not, and making reporting of client status instantaneous. The IDP can track client outcomes through the intervention (conviction), screening (IDRC), assessment and treatment (Treatment Agency) and discharge process.

QAMS. The Quality Assurance Monitoring (QAMS) system will support the collection, analysis, and reporting of individual agency and system-wide adherence to contract requirements as identified during annual program monitoring and site review visits. It includes both a standardized tool for recording and scoring agency adherence to specific contract requirements at the time of each site visit, as well as a mechanism for calculating scores for compliance within and across agencies over time. The system supports the production of dashboard reports for the Division's 360° contract review process and data-driven program performance evaluation. The system will be architected to operate on a PC tablet with touch screen technology. After monitors complete their paperless survey, the data will be transferred to a master database at the SSA. Since the system will use a provider identifier, information from QAMS can easily be linked to CIMS and NJ-SAMS.

Prescription Drug Utilization

In New Jersey the SSA is not the responsible entity for maintaining prescription drug information. That authority belongs with the Division of Consumer Affairs (DCA) within the Office of the Attorney General. The contract for New Jersey's prescription monitoring program (PMP) was awarded to Optimum Technology from Ohio. Pharmacies will be required to report information about prescriptions dispensed for Schedules II, III, IV and V controlled substances and Human Growth Hormone (HGH) in outpatient settings. The first mandatory data reporting period covers 9/1/11 to 9/15/11. This program is intended to monitor, prevent and detect the diversion and abuse of prescription controlled substances and to identify patients for possible treatment. One of the SSA's challenges in the coming year will be to try to coordinate with DCA and receive reports from the system in order to better understand the extent of this problem in New Jersey and help inform the development of prevention and treatment strategies regarding the abuse of prescription medication.

SAMHSA Additional IT Questions

For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?

For provider information, providers are required to include their Federal Tax ID, Inventory of Substance Abuse Treatment Services (I-SATS) number or New Jersey Site License number, depending upon the application. The federally assigned I-SATS number is entered into NJ-SAMS and its related modules, CIMS and POMS. The Federal tax ID appears in CIMS, the Prior Authorization interface to the CSC Billing system and POMS. The Site License number is included in NJ-SAMS.

Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?

Yes, a Site License number is also included in NJ-SAMS for aggregation at particular sites within an agency.

Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?

Yes, the SSA client information system (NJ-SAMS) utilizes a Unique Client Identifier that allows for unduplicated counts and the ability to aggregate services by level of care. In addition there is an ID Combo Identifier that allows us to track an entire episode of care for the client which includes all events, i.e., all level of care changes within that episode.

Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?

For the SSA there is an encounter module that was developed in NJ-SAMS to capture this level of detail for clients enrolled in the Medication Assisted Treatment Initiative (MATI) which involves mobile medication units. Individual services, date, number of units and provider identity are captured. In addition, the CSC Billing System captures this level of detail on the SSA Fee-for-Service initiatives: Drug Court (DC), Department of Corrections (DOC)-Mutual Agreement Program (MAP), State Parole Board (SPB)-MAP, South Jersey Initiative (SJI), Driving Under the Influence Initiative (DUII), Medication Assisted Treatment Initiative (MATI), and the Co-Occurring Network. The amount of funding dedicated to these initiatives is approximately \$40 million.

Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?

The CSC Billing system uses CPT codes for services rendered. NJ-SAMS uses DSM-IV codes for psychiatric diagnoses. The SSA is planning to incorporate ICD-10 codes for physical conditions which are currently text fields in our Bio-psychosocial Assessment Module.

Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?

The Department of Human Services has a Shared Data Warehouse (SDW) in which Medicaid and the SSA participate. The SSA is able to link its client records with Medicaid claims data in order to provide aggregate Medicaid provider information. The social security number is the primary key used along with other demographic data. A commercial product that utilizes a “deterministic matching” algorithm provides this capability for the SDW.

Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?

The SSA linked Medicaid data are used to produce reports on an as needed basis.

Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?

The SSA's information technology unit has not yet been included in regular meetings with Medicaid, other State agencies or the State's HIT Coordinator to discuss system interoperability, electronic health records, Federal IT requirements or similar issues; however, mental health staff have participated in the Electronic Healthcare Records Working Group . Senior staff from the SSA participates in the State's HIT Privacy and Security Working Group.

Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?

In January 2011, New Jersey was awarded \$11,408,594 as part of the Office of the National Coordinator for Health IT (ONC) State HIE Cooperative Agreement Program (<http://statehieresources.org/state-plans/>). The overall purpose of this program and New Jersey's related grant funding is to facilitate and expand the secure, statewide electronic movement and use of health information among organizations according to nationally recognized standards.

New Jersey's SSA has not yet been included in the development of the statewide health information exchange; however, we anticipate participation in these efforts as a result of the merger with the SMHA. New Jersey's SMHA is involved in the development of the statewide health information exchange, although initial implementation efforts are focused on enhancing the State's regional health information exchange organization capabilities, establishing the New Jersey Health Information Network (NJHIN), and defining the legal and financial sustainability frameworks for the entire health IT ecosystem. The SMHA will become more heavily involved as the State has more fully defined its technology infrastructure and more detailed plans are made to include health data from State data sources such as the Division of Mental Health and Addiction Services, Division of Medical Assistance and Health Services (Medicaid), and Department of Health and Senior Services (public health).

Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?

Yes, NJ Medicaid is in the process of updating/re-procuring a number of IT systems. They are already in the DDI (Design, Development, Implementation) of a new eligibility system called CASS. In addition, they are in the RFP development stage of an MMIS Re-procurement. As part of that effort, NJ Medicaid hosted 70+ MITA sessions that included all their sister Divisions, and additional requirements meetings beyond that.

New Jersey's Division of Medical Assistance and Health Services (Medicaid) has numerous IT system improvements in progress that include, but are not limited to:

- MMIS Replacement – Procurement and implementation of a new Medicaid Management Information System (MMIS) to support claims processing, information retrieval, and overall administration of the Medicaid program.

- Master Client Index (MCI) – A project intended to resolve duplicate records within and link recipients between New Jersey’s Medicaid program, and the Department of Health and Senior Services’ Immunization and Blood Lead Screening Registries.
- Version 5010 and NCPDP D.0 – Adoption of the new HIPAA standards for electronic healthcare and pharmacy claims.
- ICD-10 – Adoption of the new standard for clinical diagnosis and procedure codes.
- Consolidated Assistance Support System (CASS) – A project to integrate eligibility systems between Medicaid and the Division of Family Development programs.

NJ Medicaid is focused on the issues of data interoperability and Federal IT data standards, including the CMS Seven Conditions and Standards recently released. They are looking forward to continuing discussions with DMHAS to be sure they are covering all the needs of the Medicaid enterprise, especially as the Department is taking steps toward integrating behavioral health into some form of managed care.

While the SSA has not been included in efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standard until now, we anticipate participation in these efforts as a result of the merger with the SMHA as it is partnering with Medicaid and the Office of the New Jersey Health IT Coordinator on interoperability of behavioral health IT data in alignment with Federal IT data standards.

In addition to the questions above, please provide any information regarding your State’s current efforts to assist providers with developing and using Electronic Health Records.

New Jersey’s efforts to assist healthcare providers with the implementation and use of certified Electronic Health Records is led by the New Jersey Health Information Technology Extension Center (NJ-HITEC). NJ-HITEC was awarded \$23,048,351 by ONC as a part of the Regional Extension Center (REC) program. NJ-HITEC offers technical assistance, guidance, and information on best practices to healthcare providers in support their efforts to demonstrate meaningful use of Electronic Health Records (EHRs). Over 2,200+ healthcare providers are members of NJ-HITEC as of July 2011, and NJ-HITEC plans to reach 5,000 members by April 2012. More information on NJ-HITEC and its services can be found at: <http://www.njhitec.org/>.

The SSA does not directly assist providers with developing agency specific EHRs. The SSA is trying to position its client information system (NJ-SAMS) to serve as an EHR for those agencies that are unable to afford a third party solution and will be requesting technical assistance from SAMHSA for this purpose.

Identify the barriers that your State would encounter when moving to an encounter/claims based approach to payment.

The SSA does not envision any significant barriers when moving to an encounter/claims based approach to payment. In FY 2009 there was an Encounter Module programmed into NJ-SAMS for use by the providers that were participating in the Mobile Medication project. Providers were required to enter all encounters with clients, i.e., the actual service and the number of units. In FY 2010 the SSA launched its fee-for-service billing system. The contract was awarded to the

Computer Sciences Corporation (CSC) through an open competitive bid process handled by Treasury's Division of Purchase and Property. The CSC system is a web-based billing system for all of the SSA's fee-for-service (FFS) initiatives: Drug Court, MAP-SPB, MAP-DOC, SJI, MATI, DUII and the Co-Occurring Network. The amount of funding dedicated to these initiatives is approximately \$40 million. All providers who are participants in these networks must submit their claims through the CSC system for payment. CSC reimburses and/or notifies the agency of claim status within 10 working days of receipt of the bill for all clients. Approximately 3,500 claims are processed per month. In summary, the SSA's providers are accustomed to submitting claims for payment and have had this experience now for over one year.

The State Mental Health Authority

The SMHA currently uses several databases to track consumers and utilization management. In this section we will first describe the existing data infrastructure, and then discuss plans for updating its capacity for tracking client level data. This section will conclude with discussions of: linkages to Medicaid data, statewide health information exchanges & electronic health records (HITs/EHRs), and needs for technical assistance.

Unified Services Transaction Form (USTF): The USTF database is an electronic client registry originally developed in 1978 (and revised in FY 1990). It still serves as a primary source for populating the URS data tables. Within the USTF, electronic records are completed when a person is admitted into a program, terminated from a program, or transferred within a program. Currently USTF data is entered at each agency site, and then submitted electronically as text (.txt) files to the SMHA on a quarterly basis. The data collected by the SMHA is then uploaded into a data warehouse within the New Jersey Department of Treasury's Office of Information Technology (OIT), who consolidates an entire year of USTF data on a CD. The USTF data is submitted to the SMHA from a large array of approximately 120 different service providers with varying degrees of technical skill. In FY 2010 there were approximately 460,000 records—with each record containing the potential for almost 50 separate data fields, which is capable of capturing client data on: demographics, service enrollment/discharge, and Global Level of Functioning (GLOF) assessment. Information from this database is used to fulfill federal reporting requirements for data that is required to be submitted for the Community Mental Health Block Grant, Data Infrastructure Grant, URS Data Tables, National Outcomes Measures (NOMs), and other data requests.

Quarterly Contracted Monthly Report (QCMR) Database: The QCMR collects quarterly, cumulative, program-specific data from each of the service providers contracted by the SMHA. This data protocol has been in existence at the SMHA since the 1980's. A primary function of the QCMR is to measure contracted program commitments, relative to actual quarterly outcomes (in terms of a myriad of units, such as numbers of consumers served, face-to-face contacts, etc). Top-performing and under-performing outliers can be identified with the QCMR. The QCMR is utilized for planning purposes and to fulfill federal reporting requirements for data that is required to be submitted for the Community Mental Health Block Grant, Data Infrastructure Grant, URS Data Tables, NOMs, and other numerous data requests that are received, and reports that are generated on a regular basis. The QCMR also provides data for determining cost-per-

unit (of service) analyses in order to observe and compare provider efficiency. QCMR is a critical tool for performance-based contracting—and as such, is integral to the Wellness and Recovery goal of expanding data-driven decision making. Approximately 120 separate agencies provide QCMR data on roughly 630 separate program elements on a quarterly basis. QCMR data is aggregated on a provider-by-provider, and program-by-program basis; it does not provide client-specific information. The QCMR emphasizes agency/program process rather than consumer outcomes. The QCMR gives the SMHA the opportunity to observe service levels (e.g., how many consumers received how many units of service) but this system is not able (nor designed) to ascertain how many resources were provided to specific consumers.

Systems Review Committee (SRC) Datasets: Since the late 1980's each county convenes Systems Review Committee meetings for the purposes of sharing local (county-specific) information to stakeholders and the general public. To gain a systems-wide view across all 21 counties, administrators of contracted Short Term Care Facilities (STCFs) and Designated Screening Centers (DSCs) compile data on a one-page monthly MS-Excel spreadsheet. This data is then submitted to the SMHA central office for data scrubbing and aggregation into regional and statewide data. This data is aggregated and not client specific. Admissions, discharges, referral sources and referrals for subsequent treatment are documented as aggregate data, however client level data is not available (i.e. demographics). SRC data is helpful for: comparing system flow among agencies, identifying service gaps, and identifying efficiencies. Unfortunately SRC data is self-reported by agency and is not linked to any other independent nor corroborating dataset. Currently, the FY 2011 SRC dataset documents over 61k admissions episodes to DSCs and 12.7k admissions to STCFs.

Oracle Hospital Census Database: This extensive data base is used at all five of New Jersey's state psychiatric hospitals to keep track of client admission episodes, demographic profile, clinical progress, dietary needs, medications, discharge preferences, legal status, and other factors. This dataset contains comprehensive data on all state hospital consumers. The average census of the five state hospitals was 1,788 in FY 2011, including Ann Klein Forensic Center. The average number of admissions for these five facilities was 2,331 in FY 2011 and the average number of discharges was 2,336 in FY 2011.

The use and prescription of medications at the state hospitals is to be tracked through Physicians Order Entry System (POES), a stand-alone application that interfaces with Oracle, through a shared unique client i.d. POES is undergoing final testing/assessment at Greystone Park Psychiatric Hospital, and it will be expanded to the other state hospitals by the end of FY 2012. See below for a detailed description of the POES.

Client Specific Reporting: New Jersey is currently attempting to use its Data Infrastructure Grant (DIG) funds to significantly improve its ability to collect unique client level data (CLD). Table 1 (below) addresses the SMHA's current capacity to provide CLD, and illustrates the need for dramatic improvement.

The Physician's Order Entry System (POES) application was originally designed and written within the Central Office. It was deployed to Greystone Park Psychiatric Hospital (GPPH) in September 2009. The primary purpose of this application was to enable physicians to

electronically submit medication orders and to track the current and historical medications administered to patients.

After two years of use, POES holds the records of over 250,000 medication orders, 1,500 patient allergies and SADR events, 2,700 patient diet orders, 2,300 seclusion restraint orders, spanning 1,600 distinct consumers. POES manages all medications prescribed to 100% of our active patient population (approximately 450 patients per day). In addition, patient movements (locations and outside reasons – like Brief Visits, Medical/Surgical visits, etc), Seclusion/Restraint Orders, Diet Orders, Allergies, (suspected adverse drug reaction) SADR's, patient diagnosis, are all managed by POES.

Under the direction of the GPPH POES development team, over 88 new releases of POES have been successfully implemented with strong user acceptance, as each new build has brought meaningful change to patient care and to improving our clinical processes. Upcoming releases include Oracle integration, preferred drug list management, and the Medication Administration Record (MAR). Once these features are turned on, there is nothing technical that would prevent POES from being implemented at other State Hospitals.

MEDITRAK is an electronic repository of client visit data to the State hospitals. It contains separate but linked modules on individual clients and episodes of care. MEDITRAK facilitates submission of consumer claims for reimbursement. MEDITRAK has been modified slightly at each State hospital due to the slightly different administrative needs at each of New Jersey's five psychiatric inpatient facilities. In order to improve data integrity and uniformity, these data structures will be consolidated with an improved data structure which is currently under development. The Medicare Billing System (MBS) is functionally similar to MEDITRAK but is improved due to standardized structure, and its direct linkage to an ancillary patient billing records database (the Client Banking System (CBS)).

The QCMR and SRC databases maintain aggregate data reported from provider agencies, therefore the questions below from the application guidance that relate to NPI, billing, client level data, etc., will not be discussed in the table below for these databases as they are not applicable.

- As applicable, for each of these systems, please answer the following:
 - o For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?
 - o Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?
 - o Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?
 - o Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?
 - o Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPSC codes)?

Table 1. Existing SMHA Databases and Client-Level Reporting

	USTF	MEDITRAK (State Hospital Only)	Oracle Hospital Census Database (State Hospital Only)
Are providers required to obtain national provider identifiers?	n/a ¹	Yes	No
Does system collect & Record national provider identifiers?	n/a ¹	No ⁴	n/a
Does system employ any other method of unique provider identification that provides ability to aggregate service or other information by provider?	n/a ¹	Yes	No
System uses unique client i.d. that allows for unduplicated count of clients?	Yes	Yes	Yes
System able to aggregate services by client?	Yes	Yes	n/a
Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?	No	Yes	No ²
Does the system comply with Federal data standards in the following areas (use of ICD-10 codes)?	No ³	No	No ³
Does the system comply with Federal data standards in the following areas (use of CPT/HCPCS codes)?	Yes	Yes	Yes

NOTES for Table 1:

¹ – The USTF is a de-identified client level database which does not collect national provider identifiers (NPI); this system is not utilized for billing purposes.

² – Oracle Hospital Census contains limited client level data on dates and types of service. More specific client-level service and provider data is found in the MEDITRAK database.

³ – The SMHA is planning on making this compliant with ICD-10 in the future.

⁴ – The current MEDITRAK system does not provide the ability to collect this information, however the Medicare Billing System—which will be implemented at all NJ State hospitals in SFY 2012, will be capable of managing this data.

Linkage to Medicaid Data

Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non- Medicaid provider information?

The current data infrastructure in New Jersey does not permit expedient linkage between our current client-based mental health data base (USTF) with the state Medicaid recipient/claims data. Medicaid provides a shared data warehouse where the SMHA can look up client records for Medicaid claims.

Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?

The SMHA routinely produces reports using Medicaid claims data to help ensure that our contracted providers are correctly, accurately and appropriately billing the New Jersey Division of Medical Assistance and Health Services (NJ Medicaid).

Does your State's IT Division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?

True interdepartmental collaboration among relevant State entities (e.g., NJ Office of Information Technology, NJ Medicaid, the SMHA) is still in its early stages, so at this point, meetings around the topic of system interoperability, EHRs and Federal IT requirements occur on an 'as-needed' basis, but may be increasing in the future. In December 2010, the SMHA began sending four representatives to participate in the Statewide Electronic Healthcare Records Workgroup. Membership of this workgroup includes representatives of other State agencies including: NJ Medicaid, Division of Military and Veterans Affairs, Department of Corrections, Office of Information Technology, Department of Human Services, Health Information Technology, Department of Health and Senior Services, and the Division of Developmental Disabilities. This workgroup researched and evaluated vendor products, explored unique requirements of each Department/Division, considered data exchange/transmission issues (and requirements), identified implementation and hosting methods, identified potential funding resources and formulated 'next steps'. On July 1, 2011 the recommendations from this committee were put forth to the State Health Information Technology Coordinator.

Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?

Under the American Recovery and Reinvestment Act (ARRA) of 2009, New Jersey was awarded \$11,408,594 in federal funds over the next four years to fund infrastructure projects for creating regional Health Information Exchanges (HIEs) and Electronic Health Records (EHRs). This funding award moves the State closer to the national goal of achieving interoperable electronic health records transfer capability by the year 2014. This will allow hospital providers, and health insurance companies to share electronic medical records in real time in secure networks.

The New Jersey Health Information Network (see this link for the RFP http://www.state.nj.us/treasury/purchase/pdf/NJHIN_RFI_2011-07-01.pdf) is intended to facilitate the creation and use of a robust and secure statewide interoperable state information infrastructure that will provide all stakeholders with health and healthcare and which will also provide a gateway to the national health information network (NwHIN). New Jersey HIN will provide access to a variety of State databases including the Medicaid Management Information

System (MMIS), the Immunization Registry, Blood Lead Screening Registry and the Vital Statistics Registry.

Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?

The Division of Medical Assistance and Health Services (New Jersey Medicaid) is undertaking three major initiatives to improve its IT system (HIT Operational Plan or view it at http://www.nj.gov/health/bc/documents/hitc10/hit_operational_plan_onc.pdf: the Master Patient Index (MPI), the NJ Enterprise Service Bus (ESB), and a pilot for Federally Qualified Health Centers (FQHCs) to access NJ Medicaid data directly from the New Jersey Medicaid Management Information System (MMIS). These systems provide the baseline for the New Jersey Health Information Technology framework.

New Jersey has a Health Information Technology Commission that oversees interoperability, and devises fundamental methods and technologies that facilitate secure access and exchange of health information. For more information on New Jersey's health information technology efforts please see the following website <http://www.nj.gov/health/bc/hitc.shtml>.

Please see the discussion above regarding the SMHAs participation in the Statewide Electronic Healthcare Records Workgroup. In addition, the SMHA has been working on the development of a web-based, client-level database which is described further below.

Provide information regarding your State's current efforts to assist providers with developing and using Electronic Health Records.

New Jersey Health Information Technology Extension Center (NJ-HITEC) (see http://www.njhitec.org/about_us.html) is an affiliate of the New Jersey Institute of Technology, and is responsible for the dissemination of information on strategies and best practices necessary in the selection, implementation and use of EHR technology. HITEC provides a range of supports (live trainings, web-based forums) for a wide variety of stakeholders (hospitals, primary care providers, IT professionals) for the purpose of improving the quality and value of healthcare through improved data sharing.

Identify the barriers that your State would encounter when moving to an encounter/claims based approach to payment.

If the State of New Jersey moved to an encounter/claims-based approach to payment, the SMHA would likely encounter barriers, including but not limited to IT, programmatic, and financial resources, etc. for implementation. The SMHA is seeking technical assistance in this area as outlined in Section K of this application.

If the State is currently unable to provide unique client-level data for any part of its behavioral health system, SAMHSA is requesting the State to describe in the space below its plan, process, resources needed and timeline for developing such capacity.

The SMHA's goal is to plan, develop and implement a web-based comprehensive client registry and tracking system to support the SMHA's transformation into a recovery oriented service organization. The primary goal is to implement highly integrated and effective information and reporting system that will be used as the single entry point for all data from all the service providers into the SMHA database. This effort will be in accordance with recent NASMHPD/NRI's guidelines (NRI 2011).

The SMHA is in process of building a comprehensive system which integrates data collection from its contracted service providers and aims to consolidate all client admissions, terminations, discharges, transfers, client assessment, service use, hospitalization, fiscal, and contract management data into one centralized tracking and reporting application by applying an enterprise design that is consistent with a service oriented architecture that supports the sharing of business process, technical services, and common data. This redesign will further enable the SMHA to comply with federally and statutorily mandated reporting requirements and allow providers and purchasers of services to use the reported data as decision support.

The design plan includes the following functional and system architectural objectives:

- Convert all the existing applications (USTF, QCMR, PACT etc.), which are in Access databases into a more secure and scalable SQL server database.
- Allow integrating data across multiple programs supported by the SMHA, which supports comprehensive care plan automation and care data integration.
- New design will be implemented in a scalable architecture to allow for growth in respect to the number of users and number of simultaneous connections.
- Capability to provide open standards interfaces in order to integrate into other organizational systems.
- Provide standard data interface for uploading client demographic and service information from the service providers who have their internal applications. This interface will accommodate service providers existing applications.
- Provide interface to enter contract and fiscal information of the service providers which includes contract approval and renewal and will also track, report performance and outcomes of the service providers based on budgeted and actual expenditure data.
- Provide a reporting module which will support federally and statutorily mandated reporting requirements.
- New design will allow integrating State Hospital Census database application with the web-based client level database. This will enable post discharge electronic client specific data back and forth to community service providers and also from service providers to the Census database.
- System will be HIPAA compliant, historical data entry audit trail throughout the system and User-controlled access. Data transfer between the user site and system will be encrypted using SSL technology and Users will access to this web based system through user ID's and passwords.
- New design plan includes working with DHS on firewall security, backup, disaster response and recovery.

The SMHA will be able to determine how many consumers received how many units of service in each program. This will help enhance current evidence based practice initiatives. Client level reporting in the State will be managed at one central editing point. In terms of the current databases, the PACT Client Specific QCMR will be replaced by the web-based client level database and will have more quality controls and front end edits built into it. The new database will build upon this concept and combine that with client level and program outcome data. This database will also enable the SMHA to track the movement of consumers in its residential programs as well as track the vacancies in these programs, thus enhancing the discharge planning process in the state hospitals. Provider agencies will be able to pull their own status data from a new secured web-based system. This will facilitate tracking and editing and control of ongoing contractual obligations and also support the enhanced recovery of any Medicaid funds not currently tracked or recovered. The ability to track and monitor performance of programs is key especially where Performance Based Contracting (PBC) has been implemented - such as in PACT.

The timeline for this project is to employ 2.5 programmers by mid-August. These individuals will work on the design which has already been created by SMHA staff. The Data Planner and an IT Professional from the SMHA will attend the technical training hosted by NASMHPD/NRI to ensure that the changes made or those that are planned by the SMHA comports with federal recommendations for CLD.

Bibliography for SMHA

National Association of State Mental Health Program Directors (NASMHPD) National Research Institute, 2011 *Reporting of the Mental Health National Outcome Measures Using Client Level Data: Instruction Manual, Draft Version 1.1*. Prepared for SAMHSA/CMHS. NASMHPD Research Institute, Inc., Falls Church, VA.

The Division of Child Behavioral Health Services (DCBHS)

Contracted System Administrator

The Division of Child Behavioral Health Services (DCBHS) utilizes a Contracted System Administrator (CSA) to support care coordination, utilization management, quality management, and information management for the statewide system of care. The CSA creates a virtual single point of processing that registers, tracks and coordinates care for all New Jersey children who are screened into the system at any level. Through the creation of a single electronic record the CSA provides DCBHS, the case management entities and other system partners with the information needed to manage the Individual Service Planning process toward child and family satisfaction, quality outcomes, and cost effectiveness. The CSA provides data to DCBHS and providers through production and AdHoc reporting services. The CSA acts as an agent of state government contracted by and accountable to DCBHS to manage services. The CSA is not risk based and has no incentive to restrict care.

In May 2009, the Department of Children and Families (DCF) and DCBHS announced the award of the CSA RFP to PerformCare, LLC, an AmeriHealth Mercy Company. PerformCare's

programs include Medicaid risk and non-risk, Medicare Advantage, and varied commercial insurance programs totaling over 4 million covered lives. PerformCare's mission is the foundation upon which they build all of their programs and enables them to meet the special medical, pharmaceutical, and behavioral health needs of vulnerable populations, while satisfying complex state and federal requirements. PerformCare's programs are sensitive to the multiplicity of needs in the diverse regions and populations they serve.

The contract with PerformCare is for a five-year period effective September 8, 2009, with a possible extension for two additional years. This award was the culmination of a long and arduous process. Two years prior, DCF/DCBHS held public forums and stakeholder meetings to better understand what the community needed and wanted from a CSA. As the RFP was being developed, national experts, family members, and advocates served as editors and advisors. Family members, community providers, and advocates participated in the review of the proposals and offered valuable information to the Evaluation Committee. Throughout the process, the Office of Information Technology and Treasury served as critical partners in this endeavor.

Functions of PerformCare include:

- Providing 24-hour, seven-day-a-week customer service/call center support;
- Coordinating access to services for all children, youth and young adults;
- Facilitating access to specialized services for children, youth and young adults;
- Providing DYFS dedicated staff to facilitate call center support and triage of youth and their families involved with the Child Welfare system;
- Providing care coordination, utilization management, and outlier management to ensure children and their families receive appropriate treatment for an appropriate length of time;
- Establishes access to same quality of services across the state;
- Identifying the different intensity of services given by providers and assists DCF to adjust reimbursement rates to reflect these differences;
- Reviewing children, youth and young adults receiving treatment in psychiatric hospitals to assure appropriate discharge planning and after care services are in place so that they are linked to a community network of care;
- Reporting on the effectiveness of services and child and family satisfaction; and
- Implementing a complaints, reconsiderations and appeals process; and
- Providing quality and outcomes management and a system measurement program that supports DCF/DCBHS' goal to promote best practices and assists the state in assuring compliance with state and federal guidelines; and
- Interfaces with Medicaid and other State systems to ensure that services are authorized and providers are paid regardless of whether a child is Medicaid/NJ FamilyCare eligible or not.

These administrative services are supported through a highly innovative and customized Management Information System (MIS) solution called CYBER (Children and Youth Behavioral Health Electronic Record), which provides a number of enhancements to the previous CSA. Embedded in CYBER are YouthLink and Outcomes Management. Outcomes Management is a comprehensive child focused set of tools and reports that track and disseminates data gathered

through the comprehensive assessment tools, allowing DCBHS to track outcomes, use of Evidence Based Practices (EBP) and to more fully manage performance and effectiveness of service delivery. YouthLink identifies youth referred for out of home treatment services, and allows for their appropriate placement by accurately matching the intensity of service (IOS) needs, provider information and program capacity. YouthLink shows a Provider Queue that displays automated referrals and referrals that are assigned by the out of home provider. In addition, referral requests are displayed that match a providers' IOS or higher. The census displays a list of current admissions and complete admission history for youth within a facility.

Another feature of YouthLink is the Geo Map. This is a map of New Jersey that shows all the out of home treatment facilities by location using color-coded flags. A color key that represents each type of IOS is located on the right of the map. The Child's home or location is indicated by the address in CYBER. When considering a placement for a youth, the system calculates the youth's location and distance from a facility. Each flag will also display the name, address, contact information, number of beds, and the number of beds available in real time for each out of home location. The Geo Map is being expanded to include other types of providers that serve children including BA-IIC, CCIS, CMO, FFT, MRSS, MST, PHP, UCM and YCMs.

PerformCare leverages multiple corporate and local communication systems. They are fully supported by all available AmeriHealth Mercy communication systems including an integrated phone and data network, e-mail and intranet desktop solutions, tele- and video- and web-conferencing capabilities, and a best of breed information system to support their daily work.

PerformCare utilizes multiple methods for ensuring the accuracy of information given, proper call transfer, and timely response to calls requiring follow up. These methods include auditing of calls, supervision, training, use of satisfaction surveys from families and providers, meeting forums with providers, and use of internal reporting.

PerformCare systematically monitors a random sampling of calls handled by Member Services staff for assessing accuracy of information given and proper transfer and other performance indicators through auditing activities. Findings are used to track, trend, and report monthly performance at both individual and organization-wide levels. The Quality Improvement Department is responsible for monitoring and reporting functions. Specific quotas for number of calls audited are established. For the first 3 months of employment for a new hire, 3-5 calls per week are monitored. The numbers of calls audited are then reduced to 3-5 calls per month upon determination of consistent satisfactory performance. Satisfactory performance is determined based upon 90% compliance. If a MS staff has less than satisfactory ratings the frequency of monitoring will remain or resume at 3-5 per week until such time the MS staff has 4 consecutive weeks of satisfactory performance. The MS staff receives a monthly report about their individual performance. The MS Manager reviews audit findings with staff and addresses performance concerns through regularly scheduled supervision. .

The MS Manager regularly conducts audits as a method for supervision and monitoring staff performance. Additionally, members of the senior management team may monitor calls on an ad hoc basis. The MS Manager meets weekly with Member Services staff at a department level during which time quality improvement findings are reviewed, changes or refined processes are

presented and instructions are given during which time there is open dialogue for feedback, discussion, and understanding. The MS Manager meets with staff on a one to one basis for supervision to address strengths and areas for development. She is also located directly on the call center floor where she can directly observe call center performance activity and serve as an immediate resource for information or consultation when a MSR requires support.

PerformCare prioritizes use of ongoing training for instruction and education regarding new or revised policies and procedures ensuring that staff receives accurate complete information on a timely basis and that they are able to apply this new information.

Satisfaction surveys are also utilized to elicit feedback from callers, which include the performance indicator of accuracy of information provided. Multiple types of surveys are used. For families calling PerformCare the Quality Department telephones recent callers inquiring about their experience with the Call Center. Providers are given the opportunity to complete an electronic survey upon completion of a customer service request. Focused surveys are also administered to address specific needs, for example, an annual survey was administered for the Division of Youth & Family Services (DYFS) to measure satisfaction about the specialized DYFS dedicated unit operated by the CSA.

PerformCare holds numerous meeting forums with provider service lines statewide to both communicate new information but also to elicit feedback about CSA performance and operations for purposes of continuous improvement.

Additional enhancements to the CSA include:

- Increased outcomes management and outlier capacity, using newly developed tools available to every level of service delivery (Division Director and DCBHS staff through provider agencies and case management entities);
- Provider access to Data Dashboards;
- Enhanced reporting capacity and easy access to data and information by users through a web based application and the tools it provides;
- Simplification and easier navigation of electronic service plans; and
- Tracking eligibility to ensure more children gain access to public health insurance and ensure New Jersey maximizes federal dollars.

Daily communication and bi-weekly meetings with PerformCare continue as new CYBER features and fixes and enhancements to existing features are released. DCBHS maintains a “CYBER Update Corner” on its web page (<http://www.state.nj.us/dcf/behavioral/>) to keep users apprised of CYBER updates. Additionally, WebEx and Power Point trainings on functionality are available on the Cyber Update Corner.

The CYBER application can be accessed from the PerformCare webpage at: <http://www.performcarenj.org/>. The website also contains useful information for families, youth and system of care providers. A Youth and Family Guide is available in both English and Spanish. It is here that parents and caregivers can learn how to obtain services and what can be expected when calling PerformCare. A resource page is available as well as information on how families can file a complaint. Clinical criteria for each of the service lines (including CMO-

UCM, Mobile Response, Youth Case Management, Family Functional Therapy, Multisystemic Therapy, Partial Hospitalization, Group Homes, Psychiatric Community Residence, Residential Treatment Center and Treatment Homes) are posted. PerformCare uses the webpage as a means of providing reference guides, CYBER release notes, and training resources to help providers better understand how to navigate the electronic record.

DCBHS and the CSA will continue to improve and enhance the CSA program design and functions based upon the valuable feedback received from users, families, and providers.

A PowerPoint presentation, “The Division of Child Behavioral Health 10 Years of System of Care Implementation: *Letting the Data Tell the Story*,” can be accessed at:
<http://www.state.nj.us/dcf/home/childdata/behavioral/DCBHS10yrReview.pdf>

DCF CARES - The Department of Children and Families Consolidated Analytical Reporting System

DCBHS, in conjunction with the New Jersey Office of Information Technology (OIT), has implemented a comprehensive data warehouse reporting solution that will meet the immediate data reporting needs of the DCBHS while laying an integration foundation to meet future integrated enterprise data information needs of the Department of Children and Families. DCF is using the services of the Data Management Services (DMS) unit of the New Jersey OIT and the data architecture components of the New Jersey Common Information Architecture (NJCIA) to meet these objectives. The NJCIA provides design patterns, methodologies, technologies, reference data, and data facilities to achieve data integration.

In the past, DCBHS reporting approached was limited to receiving data via predefined data marts from PerformCare’s CYBER and loading that data into a Microsoft Access database so reports could be produced. Perform Care’s data was transformed, cleansed, formatted and loaded into a Microsoft Access database. This database was used to produce analytical reports. Some of these reports require extensive pre-processing to transform the data into the appropriate report format.

The DCF CARES data warehouse solution provides a more flexible and user-friendly reporting approach. It standardizes the data transformations and improves overall report performance. It allows DCBHS and DCF to incorporate other data sources from within and outside of DCF into the solution. Most outside data sources are within other agencies in the Health and Social Services affinity group (line of business), such as various divisions within the New Jersey DHS.

DCF CARES is being implemented in two phases:

The first phase, Initial Reporting (IR), which is currently implemented, deployed BusinessObjects (BO) as a reporting tool against the data currently in DCBHS’ Microsoft Access database. This data is hosted in an Oracle database. For DCBHS this is considered an independent data mart (not supplied through an enterprise data warehouse environment). The creation of an independent data mart is permitted as an interim solution during an enterprise data warehouse development effort.

The second track, the Consolidated Analytical Reporting Services (CAREs), will create an enterprise DCF normalized data warehouse (integrated data store) for all social services data along with data marts (published data) as necessary to meet reporting needs. These data marts will be dependent, conforming data marts. They will be supplied from the enterprise data warehouse and will use conforming (standardized) reference data across data marts.

Data marts and BO universes will be created for each unique reporting need community/reporting need. Users may have different summary requirements or may need to see data aggregated in different ways. A data mart provides a user with the data in the form required, while other users have data marts in the form that they require. Because all data marts are sourced from the integrated data in the data warehouse, the answers generated across data marts will be consistent.

The DCF CAREs track is the first step in a comprehensive data initiative compatible with and complementary to NJ-SPIRIT, the current DCF Child Welfare data system.

IV: Narrative Plan

F. Quality Improvement Reporting

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Narrative Question:

SAMHSA expects States to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures that will describe the health of the mental health and addiction systems. These measures should be based on valid and reliable data. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, reflect their evidence of effectiveness. The State's CQI process should also track programmatic improvements; and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to critical incidents, complaints and grievances. In an attachment, please submit your State's current CQI plan.

Footnotes:

F. Quality Improvement Reporting

The Division of Addiction Services (the SSA) and the Division of Mental Health Services (the SMHA) were formally merged on paper in July 2010 into the Division of Mental Health and Addiction Services (DMHAS). The newly merged division continues to plan to physically co-locate and merge/combine administrative and programmatic functions. Part of this initial planning includes an integrated approach to quality assurance that is informed by current processes for the SSA and the SMHA as well as the SAMHSA framework which will serve as a guidance document to develop a DMHAS-wide quality assurance and performance improvement strategy. Current quality improvement strategies are described separately below for the SSA and SMHA, and attached are the current Continuous Quality Improvement Plans.

The Single State Authority on Substance Abuse

The SSA bases the administrative operations and delivery of services for consumers with substance use disorders on principles of continuous quality improvement and total quality management through a systemic, data-driven approach to improved service delivery and achievement of future results. It has developed and implemented three critical processes based on reliable and valid data to identify and track critical outcomes and performance measure that describe the effectiveness of the system, continuously measure the effectiveness of services and ensure, whenever possible, that services reflect the evidence of their effectiveness. These three processes are dynamically related, mutually informing, and incorporate some of the same client outcome and agency and systems performance data to identify opportunities for agency and systemic improvements that promote improved client outcomes. In addition to the processes described below, DMHAS implements the attached CQI Plan to monitor contracted agency performance and respond to critical incidents, complaints, and grievances.

Provider Performance Reports

The SSA developed the “Provider Performance Reports” for all addiction treatment provider agencies funded by the SSA. The report includes: 1) statewide treatment data for all agencies, 2) admission and discharge data by modality for each specific agency, and 3) NOMS data for each modality an agency provides in comparison to statewide averages and peers. The outcomes in these reports include: abstinence from drug and alcohol use, increased employment, decreased criminal justice involvement, decrease in homelessness, and increased retention in substance abuse treatment. A measure on the percentage of clients successfully completing their treatment plan is also included. These reports are issued for the fiscal and calendar year. In addition, County aggregate performance reports are produced that provide Local Advisory Councils on Alcoholism and Drug Abuse (LACADAs) with profiles of the strengths and weaknesses of local systems of care.

“360°” Contract Review Process

The “360° Contract Review” provides Division leadership, management, program, fiscal, and support staff within the SSA the opportunity to conduct a thorough, integrated, and multidimensional review of all contracts for the purchase of substance abuse prevention, treatment, and recovery support services. In 2008, the SSA developed and implemented a 360° process format for substance abuse treatment and prevention contracts that supports both individual contract and cross-systems performance assessment. This format includes a data

display and narrative analysis of key data elements and indicators for each provider contracted for the same service or deliverable. The display facilitates the identification of “outliers” as well as trends across programs. This format renders a comprehensive understanding of system-wide performance strengths and concerns that may require corrective action or technical assistance, as well as identifies utilization and other program trends that inform future planning and funding decisions. This process has been evolving and refined over the last 4 years. Initially, each unit within the SSA was responsible for compiling relevant unit-specific fiscal, program, licensure, and performance information on each contracted agency into a single report that included a summary of the services purchased by modality (level of care) and spending plan, the contract deliverables, program monitoring and licensure survey reports, complaints and reportable events deficiency reports, and plans of correction, and program performance data, including utilization and program-specific outcomes data displayed against statewide outcomes for the same measures. While these initial reviews invited close scrutiny of individual agencies, several systems-wide questions emerged as a result of these agency-specific reviews, including:

- To what extent are services purchased in response to identified needs?
- Are contract requirements for similar services uniform and consistent across agencies?
- What does individual agency performance data mean in relation to data for other agencies?

The systems-level questions that arose from a complete cycle of agency-specific reviews indicated that organizing the reviews around systemic structures would allow agency-specific issues to emerge and be addressed in the course of the reviews but also identify opportunities to implement systemic improvements. For example, a 360° review by modality or level of care might result in a recommendation to revise the Annex A requirements for intensity and type of services to be provided to insure consistency across programs. It might also reveal outliers in performance measures, including utilization, that were not identified in individual agencies reviews. The information presentation was reorganized so that contracts across agencies with common deliverables could be reviewed concurrently.

While the Annex A reviews include many of the same data elements that were included in the agency reviews, the information is organized and presented across agencies. Each review includes a “Dashboard Report” that captures and displays key program, fiscal, licensure, and quality assurance (contract monitoring, performance, and critical incident) indicators. The package also includes a set of standard narrative questions intended to elicit information about the quality, performance, and need for services, as well as other issues of concern across modalities and with specific agencies. The complete review package includes supporting documentation and attachments from each additions unit. At the time of the review, key decisions concerning systemic questions (i.e., should a service be contracted through slots or fee-for-service reimbursement? Are evidence-based practices a contract requirement? Does the contract promote the most appropriate service for the target population? Do the service requirements promote a client-centered, recovery-oriented approach to care?) are discussed and strategies for re-procurement, including realignment of contract deliverables and purchasing strategies, are developed. Individual agency performance issues are also identified and corrective action steps are formulated to address deficiencies.

The Dashboard Report has become an essential addiction services management tool that includes critical performance indicators in the domains of licensing, contracting, fiscal, outcomes, and consumer satisfaction. The SSA is presently defining standardized measurable targets and severity threshold for each indicators that clearly display areas of systemic and agency performance strength and weakness, and planning to develop a web-based monitoring tool that will populate the dashboard indicators for specific domains. In addition to use of the Dashboard Report within the 360° contract review process to evaluate individual agency and system performance and support consistent decision-making regarding contractual and licensure actions, the SSA intends to share this information with those high-risk agencies as part of its corrective action process and to produce a version of the reports for public distribution.

NIATx Capacity Building Program

Because of its belief in the promise of the process improvement approach to improve access, engagement, retention, and consumer outcomes, in 2009 the SSA engaged NIATx to deliver the learning collaborative model to selected contracted substance use disorder treatment agencies in New Jersey. The agencies were selected through a competitive application process which required each agency to conduct and document a walk-through. Ten agencies were selected to participate in the NIATx Quality Improvement Capacity Building Program and were coached in the NIATx process improvement model. The goal of the NIATx Quality Improvement Capacity Building Program is to develop a core group of treatment agencies and staff that can provide leadership and serve as mentors for other NJ substance abuse treatment agencies that wish to improve performance and attain meaningful, client-centered treatment outcomes. DMHAS also participated and implemented its own walk-through and change projects. Within six months of the program completion, two of the agency Change Leaders and one DMHAS staff were trained as NIATx coaches, and two of the participant agencies, in collaboration with DMHAS, planned and delivered a one-day NIATx conference to the statewide provider community .

In 2009, the SSA initiated its first addictions performance-based contract. Through a competitive bidding process, residential treatment providers were contracted to provide treatment services to Drug Court participants. The contract includes an opportunity to earn incentives for meeting length of stay targets that are correlated with program engagement and retention. These targets were identified through a survival analysis of program encounter data. Contracted providers are required to participate in NIATx in order to improve their attainment of the performance targets and report data.

In 2010, the SSA received support from the Nicholson Foundation to extend the NIATx Quality Improvement Capacity Building Program. Two additional learning collaboratives were launched. One collaborative invited fee-for-service contracted providers to participate in program to implement the NIATx Process Improvement Model build their business systems and fully participate in third-party billing. Agencies were able to initiate change projects to implement and /or improve third-party billing systems and learn skills to develop a business practice dissemination plan. The second collaborative targeted agencies providing outpatient services for child-welfare-involved consumers and provided an opportunity for these agencies to improve their processes related to engagement and retention for this priority population. These collaboratives were led by Coaches trained in the first collaborative. The SSA has continued to implement change projects related to improve its contract monitoring procedures and practices.

The next change planned change project includes incorporating consumer input into contract monitoring site visits.

In 2010 the SSA used the NIATx rapid cycle change project to design a uniform Plan of Correction (PoC) format for use by all funded agencies. The aim was to ensure that PoC's are being completed in a uniform and consistent way and reviewed in the same manner. The areas identified as needing to be in an acceptable PoC were: 1) Identifying citation; 2) Plan of Correction; 3) Measurability; 4) Person(s) responsible; 5) Implementation date; and 6) Estimated completion/compliance. The PoC template was originally piloted on 10 agencies and it was compared to their 2009 PoC's. The findings are as follows:

- 2009 PoC's findings:
 - 53% of the 2009 PoC's were fully and accurately completed.
 - 7 of 10 clearly listed the PoC
 - 9 of 10 listed of PoC for the citation
 - 6 of 10 PoC's were measurable
 - 4 of 10 name the staff responsible
 - 0 of 10 indicated an implementation date
 - 2 of 10 indicated a completion/compliance date
 - Monitor's not reviewing PoC's in a uniformed consistent manner
- 2010 PoC's findings:
 - 97% of the 2010 PoC's were fully and accurately completed.
 - 10 of 10 clearly listed the PoC
 - 10 of 10 listed of PoC for the citation
 - 3 of 10 PoC's were measurable*
 - 10 of 10 name the staff responsible
 - 10 of 10 indicated an implementation date
 - 10 of 10 indicated a completion/compliance date
 - Monitor's reviewed PoC's in a uniformed consistent manner

*3 agencies partially answered the Measurability question.

The Final Results were that 97% of the PoC's that were submitted on the new template were acceptable at first submission vs. 53% in 2009.

Quality Assurance Monitoring System (QAMS)

The QAMS system will support the collection, analysis, and reporting of individual agency and system-wide adherence to contract requirements as identified during annual program monitoring and site review visits. It includes both a standardized tool for recording and scoring agency adherence to specific contract requirements at the time of each site visit, as well as a mechanism for calculating scores for compliance within and across agencies over time. The system will interface with the planned system to produce dashboard reports for the 360° contract review process and data-driven program performance evaluation. QAMS will be architected to operate on a PC tablet with touch screen technology. After monitors complete their paperless survey, the data will be transferred to a master web-based database at the SSA.

The State Mental Health Authority

The SMHA does not have a continuous quality improvement plan; however, there are processes that are tracked at the State psychiatric hospitals and several clinical initiatives that the SMHA is working on with the hospitals and community. Each hospital has a Quality Plan that is developed every year.

NJ State hospitals are expected to incorporate recovery principles into every policy and program. As providers of inpatient mental health services, State psychiatric hospitals recognize that they are one important step in the continuum of care toward the recovery of the individuals we serve. The five psychiatric hospitals support the Substance Abuse and Mental Health Services Administration (SAMHSA) National Consensus Statement on Mental Health Recovery: “Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.”

The State psychiatric hospitals utilize the following guiding principles to support the treatment and recovery of persons with severe and persistent mental illness:

- Leadership provides structure, accountability, resources, and services to support staff and facilitate patient recovery through a foundation of a caring and therapeutic relationship;
- Planning, implementation and provision of integrated, patient driven, recovery-focused treatment;
- Provision of strengths based, individualized, person centered care, encouraging patient involvement and peer support;
- Provision of a culture of nonviolence and safety, focused on mutual patient and staff respect;
- Hope, empowerment, empathy, and compassion are central to the hospital achieving its mission.

The primary goal of the Performance Improvement Program is to continually and systematically plan, design, measure, assess and improve performance of hospital-wide key functions and processes relative to patient care. To achieve this goal, the quality plans strive to:

- Incorporate quality planning throughout the facilities;
- Provide a systematic mechanism for the facilities’ individuals, departments and committees to function collaboratively in their efforts toward performance improvement;
- Provide for hospital-wide programs that assures the facilities design processes (with special emphasis on design of new or revisions in established services) well and systematically measure, assess and improve its individual performance to achieve optimal patient health outcomes in a collaborative, cross-departmental, interdisciplinary approach. These processes include mechanisms to assess the needs and expectations of the patients and their families, staff and others;
- Focus upon what is performed and how well it is performed. To facilitate this goal, emphasis is placed upon “dimensions of performance”. The dimensions of performance include:

- Efficacy of the procedure or treatment in relation to the patient's condition;
- Appropriateness of a specific test, procedure or service to meet the patient's needs;
- Availability of a needed test, procedure, treatment or service to the patient who needs it;
- Timeliness with which a needed test, procedure, treatment or service is provided to the patient;
- Effectiveness with which tests, procedures, treatment and services are provided;
- Continuity of the services provided to the patient with respect to other services, practitioners, providers and over time;
- Safety of the patient (and others) to whom the services are provided;
- Efficiency with which services are provided
- Respect and caring with which services are provided.

Initiatives at the State Psychiatric Hospitals

1. **Core Measures – Hospital Based Inpatient Psychiatric Services (HBIPS)** - HBIPS is a major, national leadership effort to improve quality, safety, and performance of hospital-based inpatient psychiatric services through the collaboration of hospitals, physicians, and consumers. Measures are collected and data is sent to the NASMHPD Research Institute, Inc. (NRI), which then forwards it on to the Joint Commission. NRI is a subdivision of the National Association of State Mental Health Program Directors (NASMHPD). All free-standing psychiatric facilities were required to begin reporting this data to the Joint Commission beginning January 1, 2011. Aggregate data is reviewed and outliers are assessed and corrective actions taken to increase scores.
2. **Inpatient Consumer Survey** - As a recovery-oriented system, the hospitals strive to be inclusive and collaborative as well as to instill hope to patients. As expressed in the SMHA Transformation Statement, each participant in the mental health system -- patients, primary support persons, hospital staff, and community providers -- is empowered and holds distinct and valuable knowledge and experience. One way of gathering this information is through an inpatient consumer survey originally started as one of the performance measures collected for NRI. The hospitals have revised the form somewhat and this data will begin to be entered into the Division's database some time in August of 2011. Aggregate data is reviewed, outliers are assessed, and corrective actions taken to improve scores. Data is collected in the following areas:
 - Patient Perception of Outcome of Care
 - Patient Perception of Dignity
 - Patient Perception of Rights
 - Patient Perception of Participation in Treatment
 - Patient Perception of the Facility Environment
3. **Assaults (Patient-to-Patient and Patient-to-Staff)** - State psychiatric hospitals collect data on patient-to-staff and patient-to-patient assaults. The purpose is to provide data

about the incidence of patient-to-patient and patient-to-staff/other assaults at each hospital in order to facilitate performance improvement activities. This data is aggregated and analyzed, looking for patterns and trends, and actions implemented in attempt to decrease violence. Individual cases of assault may need to be thoroughly analyzed in order to develop changes in a patient's treatment plan. Each hospital has a systematic process for reviewing monthly assault data

4. **Falls-** Falls are a major concern in health-care-settings because they can lead to serious injury or worsen health problems. A Falls Risk Assessment is completed, at a minimum, on each patient on admission, whenever there is a fall (un-witnessed or witnessed), yearly, and when falls precautions are ordered. Every hospital has a "Falls Committee" which is responsible for reviewing each and every patient fall, aggregating and intensely analyzing the data. Falls Risk Assessments are completed per Hospital Policy. For patients at high risk for falls, interventions are listed in the patient's treatment plan and implemented as per the plan.
5. **Grievances/Complaints** - Each hospital has a policy related to addressing patient complaints or grievances. Patient complaints are addressed by hospital policy. Patient grievances are addressed per hospital time frames.
6. **Evidence-based Treatment Interventions (training/programming)** - Illness Management and Recovery (IMR) and Dialectical Behavior Therapy (DBT) are groups run by hospital staff trained and supervised by on-site university consultants. Data is collected about the number of staff trained, the number of individual and groups sessions held, the Consumer Perception of Outcome of IMR groups and the percentage of IMR groups that have an average fidelity score of five (5).
7. **Family Monitoring Programs** - Unannounced visits by family members to review environment and therapeutic activities are made periodically and findings reported to the hospital administration. The hospital addresses findings from family monitoring within 20 days. Hospitals meet at least quarterly with their family monitoring groups.

Quality Improvement and Management Initiatives at the SMHA

1. **Patient Services Compliance Unit Site (PSCU) Visits** - The PSCU conducts announced and unannounced site visits at each state hospital related to abuse and neglect reporting and monitoring, clinical and direct care staffing, therapeutic programming, environment of care, special levels of observation, and other aspects which the Assistant Commissioner deems appropriate. Reports are sent to the facility for corrective action plans as necessary and completion of these plans are monitored by PSCU.
2. **PSCU Hotline Calls Related to Allegations of Abuse, Neglect, Mistreatment, Exploitation and Professional Misconduct** - Data regarding telephone calls received on the PSCU hotline is entered into a database and compared with the Unusual Incident Reporting Management System (UIRMS) at the end of each month. This reconciliation process ensures that, as appropriate, calls to the hotline receive a corresponding incident

report and investigation. Outliers are brought to the attention of the specific hospital for follow-up. UIRMS allegations of abuse, neglect, mistreatment, exploitation and professional misconduct are also reviewed each month for closure to the incident report. These are closed as substantiated, unsubstantiated, or unfounded. There is follow-up with a particular hospital if there are any questions with a case closed as unsubstantiated or unfounded. Data is tracked and shared with the hospitals. Cases of professional misconduct that are substantiated are tracked for reporting to the appropriate licensing board.

3. **Patient Safety Act Root Cause Analysis** - Any hospital sentinel event that falls under The Patient Safety Act requires completion of a root cause analysis by the respective hospital. The SMHA Patient Safety Act Oversight Committee reviews each root cause analysis. Patient Safety Act events are reported within 24 hours of the event. Root Cause Analysis is received by the Division within 45 days. Root Cause Analyses are deemed thorough and credible upon review.
4. **Centralized Admissions** - Centralized Admissions was designed to serve as the clearing house and triage center for potential admissions to State psychiatric hospitals. In addition, for those persons not appropriate for admission to a State psychiatric hospital, the Centralized Admissions Unit diverts admissions to a least restrictive setting. Patients are appropriately medically cleared for admission in a timely manner. All referrals are addressed the same day of receipt. Patients are triaged in a timely manner. Referrals from ERs are addressed within 24 hours.
5. **Clinical Initiatives** - The Medical Director's Office in conjunction with the Office of Quality Management has prioritized the following clinical initiatives with each of the state psychiatric hospitals:
 - **Polypharmacy** - Decrease the use of antipsychotic medication in each of the following categories by 10%:
 - **Special Levels of Observation (Use of 1:1)** Reduce the use of 1:1 to critical behavioral situations
 - **Metabolic Syndrome** Ensure that treatment is being provided to patients with abnormal metabolic syndrome indices. Decrease the % of patients with diagnosed metabolic syndrome

The Division of Child Behavioral Health Services (DCBHS)

Continuous Quality Improvement Processes Implemented by the Contracted System Administrator

PerformCare's CQI process first identifies key quality care and performance indicators and initiatives, both within the CSA and with individual providers in the service delivery network. Many of these indicators and initiatives are defined by contract and later enhanced as programs mature. This provides a framework for all QI/UM and Outlier Management activities using a balanced and well-integrated quality, cost, and risk perspective. Under every identified

goal/objective (called Strategic CQI Initiatives), there are multiple indicators (Dimensions of Performance) that form the basis of an annual PerformCare QI/UM and Outlier Management Program Description and Work Plan. The Work Plan outlines specific measures and reports that are monitored, evaluated, and then used to determine if quality initiatives are needed. A consistent structure and philosophy guides all of PerformCare's CQI efforts and is apparent within the Quality and Outcomes Management and Systems Measurement Program (QOMSMP) described below. Depicting the order of process graphically, PerformCare QI/UM and outlier management activities are structured as follows:

QOMSMP Strategic CQI Initiatives



Organization of QI/UM and Outlier Management Program Description, Work Plan, and Annual Program Evaluation



Organization of the QI/UM Committee Agendas, Minutes, Actions, and Reports



Organization of Responses to Requests for QI/UM Summaries from Stakeholders

The success of the QI/UM Committee is measured by the ability of PerformCare staff to administer systematic QI/UM policies and procedures, monitor and evaluate treatment delivered to children/youth/young adults and families according to predetermined standards, and ensure CQI.

The QI/UM Committee systematically monitors and evaluates the quality and safety of clinical care and service delivery by PerformCare's Care Coordinators/DYFS Care Coordinators and Member Services Specialists as well as service providers. Quality of care is defined as the degree to which health care services for children/youth/young adults and/or their families increase the likelihood of desired health outcomes that are consistent with current professional knowledge. When a quality of care issue is identified through a routine call, complaint, reconsideration, appeal, or during the course of a CSA care coordination review, it is brought to the attention of the Clinical Manager or Director. The Clinical Manager or Director works with the reporter to determine priority and follow up needs. Non-urgent items are sent for review to the Quality of Care Council (QOCC) that meets regularly. The QOCC consists of the Medical Director, Clinical Manager or Director, and Director of Quality Improvement or designees. This group reviews the information and determines next steps as well as generates a report for the QI/UM Committee.

The following 10 Strategic CQI Initiatives serve as starting guideposts to provide a focus for all QI/UM and outlier management activities in the New Jersey System of Care.

1. **Access** – The degree to which appropriate care and services are accessible and obtainable to meet the child's/youth's/young adult's and family's needs.
2. **Appropriateness** – The degree to which the care and services provided are relevant to the child's/youth's/young adult's and family's clinical needs, given the current state of knowledge of best and promising practices, evidence-based care, and available resources.
3. **Competency** – The degree to which providers and PerformCare staff adhere to

- professional and/or organizational standards of care and practice.
4. **Child and Family Involvement** – The degree to which children/youth/young adults and families have an active role in the program.
 5. **Continuity and Care Coordination** – The degree to which needed healthcare services for a child/youth/young adult or specified population are coordinated across levels of service intensity, organizations, child-serving systems, and across the coordination of physical and behavioral health systems.
 6. **Diversity and Cultural Competency** – The degree to which providers and PerformCare staff understand and demonstrate respect for differences among cultural and ethnic groups that affect service delivery and clinical care.
 7. **Outcomes and Efficacy** – The degree to which a treatment or service improves health status.
 8. **Prevention and Community Outreach** – The degree to which PerformCare services promote health, prevent deterioration of emotional and behavioral health difficulties, and educate the community.
 9. **Safety** – The degree to which risks of adverse outcome are reduced for children/youth/young adults, families, and others, including the service provider.
 10. **Service Excellence** – The degree to which PerformCare meets established service standards and produces customer, provider, and child/youth/young adult and family satisfaction.

The framework for the activities of the QI/UM Committee is based on the Define/Measure/Analyze/Improve/Control (DMAIC) plan. This plan is defined as follows:

Define: Define the problem and costs/benefits to be realized.



Measure: Establish measurement with objective quality indicators and data.



Analyze: Analyze collected data, root causes, and processes.



Improve: Implement system interventions to achieve improvement.



Control: Develop ongoing monitoring to sustain gains and control processes.

A. Quality and Outcomes Management and System Measurement

PerformCare, as the CSA, is committed to offering the highest quality of services by actively exploring and taking action on opportunities for improvement. As areas of improvement are identified, PerformCare will implement new or different practices to achieve the goal of utilizing a data-driven system. Such improvements will increase efficiency, accuracy, timeliness, accountability, communication, and satisfaction by all users of CSA services. More specifically, the QI/UM and Outlier Management Programs monitor:

- Call center performance in answering calls: PerformCare will monitor all phone statistics and submit reports to the Director of Quality Improvement for review in QI/UM meetings.
- Child/youth/young adult and family/caregiver satisfaction: Satisfaction is a key indicator that services are or are not working for the people using the system. PerformCare will work with DCF/DCBHS to implement existing satisfaction measurement tools or review and determine most appropriate tools.
- Reliability and timeliness of service delivery: Though an authorization is approved by PerformCare, it is only through this monitoring that the company truly knows what is occurring in service delivery. Data like this assists Care Coordinators/DYFS Care Coordinators in the re-authorization process and understanding the speed or lack thereof in outcomes and functional improvement.
- Decision making process: Timeliness and consistency.
- Service utilization: This includes trends, outliers, length of stay by service and by provider, racial and ethnic disparities, and disproportionality. This data is used to assist in the assignment of Enhanced Care Coordination and to explore the disparity and disproportionate use of services by certain groups as well. Sharing this information in the QI/UM Committee allows members to have the opportunity for input. It also enhances discussion with DCF/DCBHS to help design the intervention and monitoring through a CAP.
- Network adequacy: Information regarding timely access to services wait times and partial service delivery assists the PerformCare and DCF/DCBHS to address network issues. The MIS can produce geo-mapping technology that allows for the determination of what type of service line is inadequate, as well as where the inadequacies lie. The QI/UM Committee and/or DCF/DCBHS will continue to monitor reported inadequacy through a CAP.
- Costs of services provided: This can be outlined by type, average cost per child/youth/young adult, and in aggregate.
- Outcomes measurement: The positive attainment of outcomes by service line and system-wide, including clinical and functional outcomes and system-wide outcomes such as OOH services.

CAPs

Written CAPs include specific action(s) taken or to be taken, timeframes for initiation and completion, person(s) responsible, and follow-up activities to be implemented to ensure effectiveness of the action. CAPs may include additional staff and system partner training, technical assistance, and revisions in or development of new policies and procedures. The effectiveness of CAPs requires continual monitoring and evaluation to identify measurable changes and improvements. Measuring and evaluating CQI efforts helps to ensure:

- measurable improvement of the desired change,
- that improvement is maintained over a specified time period,
- that improvement in the quality of treatment and/or service is continually reflected in daily operations,
- that improvements continually meet the requirements of the standards outlined in the

- action plan, and
- that there is supporting documentation of the required outcomes and improvements.

PerformCare, through the QI/UM and Outlier Management programs and regular monitoring, develops CAPs anytime performance standards are not met. These CAPs are submitted to DCF/DCBHS for review and feedback, and performance improvement is monitored by supervisors and through the QI/UM Committee.

B. Delegation of Quality Improvement and Utilization Management Program Activities

PerformCare does not delegate any QI/UM and Outlier Management Program activities. In the event that PerformCare delegates any of these functions to another entity, such as a subcontractor, the QI/UM Committee will ensure the following:

- There is a written description of the delegated activities. This description will include the delegate's accountability for these activities and the frequency of reporting to the QI/UM Committee.
- PerformCare's program has written policies and procedures monitoring and evaluating implementation of delegated functions and verifying the quality of care provided.
- There is evidence of continuous ongoing evaluation of delegated activities including approval of the entity's annual QI/UM and Outlier Management Program Description and Work Plan and regular specified reports.

C. The Quality Improvement/Utilization Management (QI/UM) Committee

The QI/UM Committee is established to provide administrative oversight of the QI/UM and Outlier Management Program and as carried out by the Work Plan. The Work Plan is a document developed and updated at least annually to identify the specific indicators, measures, and timeframes of the QI/UM and Outlier Management Program for that year.

The QI/UM Committee assesses pertinent utilization and trended data to ensure that appropriate care and interventions will be implemented along with assessing organizational functions for improvements. The QI/UM Committee assures that the QI/UM and Outlier Management Program seizes opportunities for clinical and service improvement by embedding the principles of CQI into the process and then implements the change necessary to improve outcomes. The principal responsibility of the QI/UM Committee is to monitor the utilization and quality of both clinical and non-clinical services offered to the children/youth/young adults and their families served by the CSA.

The QI/UM Committee meets on a minimum of a quarterly basis. Committee meetings are internal to PerformCare and will focus on monitoring internal processes and post go-live implementation activities. The Medical Director serves as PerformCare's designated behavioral healthcare practitioner and co-chairs the QI/UM Committee. The Director of Quality Improvement serves as Chair. Committees generally operate by consensus, but sufficient representation by voting members must be present to vote on resolutions or actions. Sufficient

representation is defined as a quorum and occurs when two-thirds of voting members are in attendance.

The QI/UM Committee may add, as appropriate and in consultation with DCF/DCBHS, to its ad hoc membership by including other necessary members such as PerformCare management and line staff, providers, family members (including priority population representatives), and others. Ad hoc members are approved by the Committee Chair prior to attending meetings and are non-voting, but are subject to the same committee rules as voting members. The QI/UM Committee is comprised of representatives from all of the service delivery components of the organization including administration, care coordination, and member services. Interested healthcare practitioner representatives may attend and participate in the committee meetings, with an emphasis on improvements in clinical behavioral health care and service. Under the direction of DCF/DCBHS, the QI/UM Committee may include youth, young adults, families, providers, and other stakeholders.

PerformCare solicits and supports provider participation in the QI/UM process through opportunities for provider participation in provider-specific meetings, trainings, and ongoing communication in the course of normal operations. The standing membership of the QI/UM Committee includes the following:

Voting Members

- Chair: PerformCare Medical Director or physician designee.
- Co-Chair: PerformCare Director of Quality Improvement.
- PerformCare Clinical Manager or Director.
- Possible external DYFS and DCF/DCBHS representatives, providers, child/youth/young adult and family stakeholders are to be determined under the direction of DCF/DCBHS

Consistent with PerformCare's commitment to CQI, the Director of Quality Improvement, in consultation with the Medical Director and under the direction of the QI/UM Committee, formulates the QI/UM and Outlier Management Program Description and Work Plan for the upcoming year. The contents of the program include:

- goals and objectives for the upcoming year;
- program scope;
- specification of indicators to be monitored in the coming year, including a brief outline of the methodology, timeline, and party(ies) responsible for monitoring each indicator;
- an outline of scheduled projects and activities designed to address issues identified through evaluation of the previous year's report, including the quality and safety of clinical care and quality of service;
- timeframe within which each activity is to be achieved;
- identification of priority areas of program focus, including variables to be explored through focused Performance Improvement Projects (PIPs); and
- planned evaluation of the QI/UM and Outlier Management Program.

The QI/UM Committee fulfills its purpose through the following activities:

- Annual review, revision, and approval of all policies and procedures.

- Annual review, approval, and implementation of the QI/UM and Outlier Management Program Description, Work Plan, and Program Evaluation.
- Analysis and evaluation of the results of QI/UM activities, quality indicators, current goals, and recommended modifications to the Work Plan. This monitoring includes reviewing data and reports to identify trends and any necessary organizational corrective action(s).
- Ensuring practitioner participation in the QI/UM and Outlier Management Program through planning, design, implementation, or review.
- Monitoring the implementation and effectiveness of remedial/corrective actions.
- Determining the need for PIPs beyond standardized monitoring and evaluation.
- Monitoring implementation and review findings of these PIPs.
- Reporting to the PerformCare Board of Directors and DCF/DCBHS conclusions and necessary actions and follow-up as appropriate to meet the goals of the QI/UM and Outlier Management Program.
- Submitting a QI/UM and Outlier Management Annual Program Description to the PerformCare Board of Directors and DCF/DCBHS for recommendations regarding any necessary changes to the program.

The QI/UM Committee meets at least quarterly to accomplish the annual goals and oversee, coordinate, implement, evaluate, and modify the Work Plan.

1. Documentation

The QI/UM Committee protocol for documenting activities, findings, recommendations, and actions is as follows:

- All meetings and activities of the QI/UM Committee are documented using committee minutes and a written agenda. Minutes are typed, reviewed, dated, and signed by the committee chair/co-chair, and distributed to committee members. Final adopted documents (including reports that are adopted with or without changes) are provided to the QI/UM Committee after the monthly meetings.
- Minutes follow a consistent format that identifies:
 - topics discussed;
 - findings, supporting data, documentation, and recommendation(s) for problem resolution, service/system enhancements, and opportunities for improvement; and
 - a written action plan to include specific action(s) taken or to be taken, timeframes for initiation and completion, person(s) responsible, and follow up activities to be implemented to ensure effectiveness of above action.
- Minutes of the previous meeting are reviewed, amended as needed, and approved as the first order of business in the next consecutive meeting.
- Committee meeting minutes, reports, summaries, reviews, monitoring/evaluative data, and any other documentation and information (in part or complete) are confidential and proprietary in nature. Distribution is made according to an established approved distribution list. All committee members (standing and ad hoc), participants, and/or observers on a regular or ad hoc basis are required to sign a statement agreeing to abide by all standards, rules, regulations, and guidelines regarding confidentiality and the handling of proprietary information.

2. Accountability to the Governing Body

The QI/UM Committee is assigned oversight responsibilities for the QI/UM and Outlier Management Program by the PerformCare Board of Directors. The PerformCare Board of Directors reviews and approves the QI/UM and Outlier Management Program Description on an annual basis. Prior to implementation, the Program Description and Work Plan are also submitted to DCF/DCBHS for review and approval annually, no later than January 30 of each calendar year. The QI/UM Committee provides administrative direction and direct oversight for all processes and activities of the QI/UM and Outlier Management Program. The QI/UM Committee is accountable to the PerformCare Board of Directors and DCF/DCBHS. The QI/UM Committee is actively involved in the design, development, and implementation of the QI/UM and Outlier Management Program and the monitoring and evaluation of all quality improvement activities.

3. Medical Director as Designated Practitioner

Responsibility for medical policy pertaining to the quality of behavioral health care is assigned to the PerformCare Medical Director. The Medical Director is the designated behavioral healthcare practitioner with overall oversight of the QI/UM and Outlier Management Program. The Medical Director, who is a Board Certified Psychiatrist, is an active participant in the QI/UM Committee. The Medical Director oversees clinical activities and provides clinical supervision/consultation of all personnel. The Medical Director retains the final authority for recommendations for professional clinical review of credentials, medical necessity, and appropriateness or quality of care.

4. Annual Work Plan

The QI/UM Committee provides oversight approval of the QI/UM and Outlier Management Program Description, Work Plan, and Annual Program Evaluation. All three documents are developed by the QI/UM Committee and annually evaluated and approved by the PerformCare Board of Directors and DCF/DCBHS. As a CQI document, the Work Plan evolves and changes as new issues develop and revised priorities are established to monitor care and service quality. The content of the Work Plan will change annually in response to the changing needs of the organization, children/youth/young adults and their families, and other customers. Continuous evaluation and reporting by the QI/UM Committee, entities, and/or individuals will identify the necessity for adding new information or adjusting the existing information during the program year. The continuous review and analysis of information serves to improve quality of outcomes, services, clinical care coordination, and reinforces PerformCare's commitment to quality.

The Work Plan identifies specific data collection procedures and on-going evaluation of clinical and administrative functions. Data is used to review progress towards implementation and accomplishment of QI/UM and Outlier Management Program goals and objectives; identify problems for resolution; determine effectiveness of remedial/corrective actions; modify services/systems within the organization; and re-evaluate performance standards and thresholds

to ensure the implementation of a continuous quality improvement process throughout the clinical, administrative, and operational functions.

As part of the Work Plan, PIPs may be identified during the course of the year that can have a favorable effect on health outcomes and child/youth/young adult and family satisfaction. If identified, the NCQA Quality Improvement Activity format or other agreed upon mechanism will be used to develop measurements and interventions that will be reported to the QI/UM Committee. These projects may include Quality Planning, Quality Improvement, and Quality Control/Measurement activities focused on:

1. measurement of performance, using objective quality indicators,
2. implementation of system interventions to achieve improvement in quality, and
3. evaluation and initiation of activities for increasing and sustaining improvement.

Certain areas are targeted for PIPs. Projects include activities focused on:

- performance measurement, using objective quality indicators to be monitored with an emphasis on indicators that provide efficient, accurate, and reliable means of monitoring quality of services and treatment in targeted areas;
- identification of research methodology, reporting mechanisms, and timeframes for data collection for each PIP;
- appropriate data collection methods, including scheduled audits, focused studies (i.e., studies by population, diagnostic group, or service type), standardized outcomes measurement, and routine analysis of treatment-generated data;
- comparison of PerformCare's performance data with benchmarking data, professional standards, and internal baseline data to establish performance thresholds and guidelines;
- analysis of collected data for root causes, barriers to improvement, and to identify opportunities for intervention and improvement;
- development and implementation of system interventions to achieve improvement;
- evaluation of improvement activities to ensure that identified problem areas are effectively addressed; and
- provision of ongoing evaluation to PerformCare, DCF/DCBHS, DYFS, and other system partners as appropriate.

5. Annual Program Evaluation

During the fourth quarter of each year, the Director of Quality Improvement begins the process of preparing an annual summary and evaluation regarding the quality and effectiveness of improvement activities from the previous year. The outcomes and results of all quality improvement activities will be summarized and reported annually in the QI/UM and Outlier Management Annual Program Evaluation. The Program Description and Work Plan are submitted for approval no later than January 30 of each calendar year. This report evaluates the continuity and effectiveness of the QI/UM and Outlier Management Program for the previous year. The contents of the report include:

- a description of completed and ongoing QI/UM and outlier management activities that address the quality and safety of clinical care and quality of service;
- analysis of the results and summaries of QI/UM and outlier management initiatives, including barrier analysis and interventions;

- trending of clinical and administrative quality and safety of clinical care and quality of service indicators and performance data, including aggregate data on utilization and inter-rater reliability documentation;
- areas of deficiency/corrective action recommendations;
- progress towards and achievement of Work Plan annual goals and objectives; and
- evaluation of overall effectiveness and continuity of the QI/UM and Outlier Management Program.

6. Resources

Guided by the QI/UM and Outlier Management Program Description and the annual Program Evaluation, PerformCare is committed to continuous evaluation and analysis of outcome and performance information. The review and analysis of process and outcome data is critical to identifying and resolving QI/UM issues that affect all aspects of the organization and its operations. This quality improvement initiative is a shared responsibility, requiring commitment from not only across departments but by all staff. However, particular PerformCare staff members are charged with the responsibility of overseeing daily QI/UM activities to meet the goals of the program.

Administrative responsibility for the QI/UM and Outlier Management Program is assigned to the PerformCare Director of Quality Improvement who works in consultation with the Medical Director or other qualified appointee. The Director of Quality Improvement is responsible for ensuring there are adequate resources to operate the QI/UM and Outlier Management Program. To this end, the Director of Quality Improvement, in coordination with the Chief Executive Officer and Chief Financial Officer, is responsible for the development and submission of an annual budget. The budget includes provisions for sufficient material resources, adequate staffing, and the provision for necessary education, experience, and/or training to effectively carry out QI/UM and Outlier Management Program activities. PerformCare works to ensure the availability of sufficient staff, data sources, and analytical resources to complete all program activities in a competent and timely manner. In addition, PerformCare has designated staff with statistical expertise that has the ability to design sound studies, apply statistical analysis of data, and derive meaning from the statistical analysis.

9. PerformCare Care Coordination and UM Monitoring Process

PerformCare's New Jersey QI/UM and Outlier Management Program includes clearly defined processes to manage mental health care utilization for children/youth/young adults involved in the System of Care. The program includes procedures to evaluate medical necessity criteria information sources, clinical appropriateness, and review and determination processes for behavioral health services. The QI/UM and Outlier Management Program provides the operational structure and processes necessary by which utilization decisions are made so that DCF/DCBHS and PerformCare can continuously evaluate program effectiveness and quality.

The goal of the QI/UM and Outlier Management Program is to determine the appropriate intensity of service for children/youth/young adults accessing behavioral health services and

evaluating the continuity, effectiveness, and quality of care. The QI/UM and Outlier Management Program for New Jersey centers on the following critical elements:

- utilization management services;
- single telephonic point of access;
- focused, outcome-oriented care for children/youth/young adults and their families/caregivers;
- utilization of cost-effective, least restrictive care;
- detection of over- and under-utilization;
- timeliness of UM decision-making, including initial assessment for service needs and continued stay; and
- consistency of UM decision-making based on DCF/DCBHS guidelines, policy, and medical necessity criteria including a comparison of actual decisions to DCF/DCBHS established algorithms for referral.

Ongoing monitoring of care coordination and continuity of care is one of PerformCare's Strategic Clinical Quality Improvement Initiatives and is incorporated into the QI/UM and Outlier Management Program Description and Work Plan. Coordination and continuity of care is defined as:

The degree to which needed healthcare and other services for an enrollee or specified population are coordinated across levels of care, across organizations, and across care of physical and behavioral health services. Treatment services and supports are coordinated on both the local system level and on an individual child/youth/young adult and family basis in order to reduce fragmentation and to improve efficiency and effectiveness with service delivery. Coordination includes linkages with children/youth/young adults, families, advocates, and professionals at every level of the System of Care. Care Coordinators/DYFS Care Coordinators are accountable for facilitating this coordination and to monitor appropriate performance based on established standards of practice.

Monitoring activities related to coordination of care include, but are not limited to, tracking and reporting on the following:

- readmission rates;
- coordination efforts with the DDD;
- coordination efforts with DYFS; and
- coordination efforts with Family Courts and the Juvenile Justice Commission.

Data is collected from a variety of sources, including:

- assessment and UM and authorization data from PerformCare's MIS,
- outcomes data
- Care Coordinator/DYFS Care Coordinator documentation audits and inter-rater reliability studies,
- retrospective (post-utilization) reviews, and
- outlier management data.

10. Review of Information Management Decision Support (IMDS) Tools, Medical Necessity, and Level of Need Criteria

The IMDS tools, medical necessity, and level of need criteria (DCF/DCBHS approved criteria), review guidelines, and standards are reviewed and evaluated on an ongoing basis by the Medical Director under the direction of DCF/DCBHS, its designated committees, and in consultation with the QI/UM Committee and other identified professionals. A formal review of all IMDS tools, medical necessity, and level of need criteria guidelines and standards is completed on an annual basis to ensure criteria remain relevant, valid, and consistent with the literature pertaining to the determination of medical necessity. The medical necessity and level of need criteria is also formally reviewed and approved annually by the QI/UM Committee.

By applying IMDS tools, medical necessity, and level of need criteria, the Care Coordinator/DYFS Care Coordinator determines the following:

- The child/youth/young adult is receiving services in the least restrictive, least intensive, and most clinically appropriate level of service intensity required by his/her emotional and/or behavioral challenges and level of function.
- Current and requested treatment and ancillary services are consistent with the child's/youth's/young adult's clinical stability, complexity, and severity of symptoms.
- The child/youth/young adult is responding or can reasonably be expected to respond to the prescribed plan of treatment.
- Behavioral healthcare services continue to meet medical necessity.

While medical necessity criteria assists in establishing the intensity and mix of services most suited to the child/youth/young adult and family's condition, the criteria does not provide for specific individualized services. For this reason, PerformCare includes the assessment of the appropriateness of services and quality of care beyond the mere intensity of service. The PerformCare Medical Director and clinical team utilize best practice standards and clinical practice guidelines in assessing evaluations and provider practices.

The Director of Quality Improvement, in collaboration with the QI/UM Committee and Medical Director, ensures data interpretation and the use of medical necessity criteria are informed by best practices in the field of behavioral health. Current research in the field, clinical practice guidelines published by relevant professional organizations (i.e., American Medical Association, American Psychiatric Association), and guidelines established by licensing and accrediting bodies will be referred to in the development of recommendations for enhancements to medical necessity criteria and practice standards.

11. Complaints, Reconsiderations, and Appeals

The ability to effectively manage complaints, reconsiderations, and appeals for children/youth/young adults and their families in service is essential to the provision of

uninterrupted care and the ability of the child/youth/young adult to achieve stated treatment goals. Effective care coordination should minimize the need for extensive complaints as it is the responsibility of PerformCare to not only assure its own staff is responding effectively, but also to provide the appropriate training and expertise needed in the provider community to minimize the need for such complaints. PerformCare has established guidelines and a uniform process to resolve complaints, reconsiderations, and appeals in full compliance with all mandates, such as Medicaid-related procedures, including Fair Hearings and External Reviews. These processes include multiple review levels, as necessary, all designed to assure that children/youth/young adults and families are receiving the right services at the right time to achieve stated goals.

Documentation regarding each initial complaint and subsequent resolution captures data that demonstrates PerformCare's actions, the actions of the provider as reported, and the ability to monitor quality, focusing on:

- number and type of complaints, reconsiderations, or appeals received;
- timely decision-making and action plans;
- timely and accurate notification of resolution to all parties; and
- final outcomes of complaints, reconsiderations, or appeals (upheld, overturned, withdrawn, or pending status).

The QI/UM Committee monitors required timelines for resolution of complaints, reconsiderations, and appeals. All PerformCare staff understands that children/youth/young adults and their families are entitled to the best possible services from all entities within the System of Care and strive to reach timely resolutions. The family burden often experienced of managing complex issues should not be exacerbated by unresolved complaints. Any complaint related to quality of care or care coordination is documented and addressed by the Clinical Manager or Director. PerformCare ensures the determination and assurance of continuation rights (continuing current services) during the complaints, reconsiderations, and appeals processes.

Required data for every complaint is captured in the MIS that allows for reporting and monitoring of each complaint, reconsideration, and appeal until resolution. The MIS provides for real-time data analysis; monitoring the status of any complaint, reconsideration, or appeal at any time during the process; and accurate reporting of this information to all required parties including DCF/DCBHS. The recovery of all gathered information inclusive of that related to complaints, reconsiderations, and appeals is managed through a redundant, multifaceted backup system that ensures the integrity of the data. Backup media is stored on and off-site (in two separate off-site locations) and is readily available for restoring the data in a timely manner should the need arise. Additionally, backup servers are maintained on and off-site in a replicated arrangement assuring that information is obtainable in a near online state should the need arise.

Information about complaints, reconsiderations, and appeals processes (including clear and concise policies and procedures) are widely distributed through multiple channels including:

- the Youth and Family Guide,
- family and provider orientations and training, and
- the PerformCare web site.

In addition, PerformCare staff is required to verbally advise each child/youth/young adult and his/her family/caregiver of their rights and responsibilities should resolution of any complaint, reconsideration, and/or appeal be a suspension of the requested service level. Staff is trained to use language and terminology appropriate to the understanding of the child/youth/young adult and family when explaining the process. Staff is also trained to offer information about Family Support Partners and other peer resources should the family/caregiver be interested in obtaining such assistance. All employees, regardless of position, receive training on complaints, reconsiderations, and appeals policies and procedures during initial orientation. Refresher training is provided at least annually. Compliance documentation and other complaint, reconsideration, or appeal information will be available as required. Monthly compliance reporting is reviewed by the QI/UM Committee and Corporate Compliance Committee to assure that multiple departments are monitoring the company's performance. The Director of Quality Improvement is responsible for the implementation and management of complaints, reconsiderations, and appeals in conjunction with the Clinical Manager or Director.

A. Complaints

A parent/legal guardian, young adult, emancipated minor, or authorized representative may file a complaint. The complaint is referred to the Community Outreach Liaison who logs the relevant complaint information into the database. The Quality Improvement Coordinator verifies with the parent/legal guardian, young adult, emancipated minor, or authorized representative whether or not s/he first attempted complaint resolution through the local level process. If not, s/he is encouraged to seek local level complaint resolution first. If s/he tried local level complaint resolution or s/he insists upon complaint resolution through PerformCare, the Quality Improvement Coordinator Community Outreach Liaison proceeds with complaint resolution. If the complaint is of a sensitive nature or requires expertise in a given area, the complaint is referred to a supervisor or a staff member with expertise in the subject matter. If the complaint is regarding service quality, the complaint is brought to the attention of the Director of Quality Improvement and Clinical Manager or Director for intervention who will initiate the quality of care committee review process.

Resolution for complaints is completed within 5 business days from receipt of the complaint. A letter is sent to the parent/legal guardian, young adult, emancipated minor, or authorized representative and provider within 48 hours of this decision. If the parent/legal guardian, young adult, emancipated minor, or authorized representative does not accept the first attempt at complaint resolution, the appeal process is followed. All information collected for the processing of the complaint is documented in the complaints/reconsiderations/appeals database.

B. Reconsiderations

Any parent/legal guardian, young adult, emancipated minor, or authorized representative of a parent/legal guardian, young adult, or emancipated minor may request a reconsideration of a level of care determination when notified of that action. The reconsideration is referred to the Quality Improvement Coordinator who logs the relevant information into the database. The Quality Improvement Coordinator verifies with the parent/legal guardian, young adult, emancipated minor, or authorized representative if s/he first attempted resolution through the

local level process. If not, s/he is encouraged to seek local level resolution first. If s/he tried local level resolution or s/he insists upon resolution through PerformCare, the Quality Improvement Coordinator proceeds with reconsideration and coordinates the process as follows:

- review by the Clinical Manager or Director is completed;
- review by the Medical Director is completed;
- the first attempt at resolution of the reconsideration is within 5 business days of the reconsideration request;
- if the parent/legal guardian, young adult, emancipated minor, or authorized representative does not accept the first attempt at resolution, the appeal process is followed;
- until the reconsideration/appeal is finalized, the intensity of service prior to reconsideration will be continued;
- when the resolution is finalized, appropriate services are authorized and all documentation regarding the reconsideration is entered into the database;
- a letter is sent to the parent/legal guardian, young adult, emancipated minor, or authorized representative and provider within 48 hours of this decision;
- all information collected for the processing of the reconsideration is documented in the complaints/reconsiderations/appeals database.

C. Appeals

Any parent/legal guardian, young adult, emancipated minor, or authorized representative of a parent/legal guardian, young adult, or emancipated minor may request an appeal of the resolution regarding a level of care reconsideration. If the appeal is regarding a level of care determination then, until the appeal is finalized, the level of care prior to reconsideration/appeal is continued.

For individuals eligible for Medicaid and Medicaid-administered health benefits programs including, but not limited to, NJ FamilyCare-Children's Program Plan A, NJ KidCare, Medicaid Special Eligibility, Medicaid Only, Medically Needy, and Special Medicaid Programs for the Aged, Blind and Disabled, appeals are conducted in accordance with the Medicaid Fair Hearing procedures set forth in N.J.A.C. 10:49, et seq. For individuals eligible for NJ FamilyCare-Children's Program Plan B, C, or D, appeals are conducted in accordance with the grievances and appeals procedures set forth in N.J.A.C. 10:79-6.5, et seq. For individuals not eligible for Medicaid, NJ FamilyCare, or any other Medicaid-administered health benefits program, appeals are conducted in accordance with the dispute resolution procedures as follows:

- The request must be made within 30 days of notice of the resolution or within 30 days of learning that the resolution notice was not received.
- If these timeframes are not met, the appeal request may be denied.
- The parent/legal guardian, young adult, emancipated minor, or authorized representative of a parent/legal guardian, young adult, or emancipated minor must submit a written request for an appeal and must include the following:
 - name and address of person filing the appeal,
 - name and address of the individual receiving services,
 - a brief statement of the matter under appeal,
 - a list of involved parties and /or potential witnesses, and
 - any information that would support the request.

- The DCF/DCBHS Director or designee conducts a record and document review in lieu of having the parties present unless the DCF/DCBHS Director or designee determines that an in-person meeting or teleconference is necessary.
- Within 30 days of the receipt of the written request and at least 5 business days prior to the review, DCF/DCBHS sends the parent/legal guardian, young adult, emancipated minor, or authorized representative written notification of whether the review will be in person, telephonic, or a record review. The notice includes the issues to be considered and the method in which the review will be conducted (in-person meeting, document review, or telephone meeting), and includes the time and location of the review if it is a meeting.
- The appeal process (whether in-person, telephonic, or a record review) is completed within 60 days from the date the written request for an appeal was received.
- A postponement request for the review will be granted only for good cause and includes the parent's/legal guardian's, young adult's, emancipated minor's, or authorized representative's need for additional time to provide necessary information.
- Unless delayed for reasons beyond the control of the parent/legal guardian, young adult, emancipated minor, or authorized representative, a failure to appear for the scheduled review is considered as a withdrawal of the appeal.
- When the outcome of an appeal will have a direct impact on the child/youth/young adult, the DCF/DCBHS determines whether, and in what manner, the child's/youth's/young adult's position on the appeal will be ascertained and the nature of his/her participation in the appeal process.
- Prior to the review, the DCF/DCBHS Director or designee conducting the appeal, at his/her discretion, may consult with the staff members who have information related to the issue being appealed.
- The appeal review includes the following:
 - summary of the factual basis for DCF/DCBHS action;
 - the relevant rules and policy;
 - a review of the information gathered through the prior consultation with staff, information presented orally or in writing by witnesses, supporters, or representatives; and
 - questions asked during the appeal process.

The DCF/DCBHS Director or designee conducting the appeal makes a decision based on the record and the information presented at the appeal or during consultation with other staff. DCF/DCBHS forwards written notification of the decision of the appeal to the parent/legal guardian, young adult, emancipated minor, or authorized representative within 30 days of the completion of the appeal. The notification shall include notice of whether the parent/legal guardian, young adult, emancipated minor, or authorized representative has the right or opportunity to appeal further and directions on how to initiate this process and whom to contact.

DCF/DCBHS may deny any appeal opportunity that has not been exercised in accordance with established timeframes except in cases where the parent/legal guardian, young adult, emancipated minor, or authorized representative was delayed for reasons beyond his/her control.

If the parent/legal guardian, young adult, emancipated minor, or authorized representative does not request further dispute resolution within 20 days of notification of the appeal decision, or is ineligible for further dispute resolution, the appeal decision will be considered final. All actions taken during the appeal process are fully documented in the complaints/reconsiderations/appeals database.

12. Auditing and Audit Reviews

A. Financial

PerformCare will have an independent financial audit performed annually and submitted to the State within 120 days of the end of PerformCare's fiscal year.

B. Information System

PerformCare will conduct an annual or periodic examination of the controls within its Information Technology (IT) infrastructure.

C. Operational

PerformCare will have an independent operational audit of CSA operations performed annually.

D. General

PerformCare complies with all state and federal audit review requirements or requests. DCF/DCBHS may conduct its own audits whenever it chooses and PerformCare cooperates in facilitating access to the facility and system at any time, with or without prior notice, to state, federal, or other personnel authorized by DCF/DCBHS for site inspections, audits, or other purposes. These authorized personnel have unlimited access to all systems, records and areas, and personnel of PerformCare.

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IV: Narrative Plan

G. Consultation With Tribes

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Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it is to engage in regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have Tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues. For the context of the Block Grants, SAMHSA views consultation as a government to government interaction and should be distinguished from input provided by individual Tribal members or services provided for Tribal members whether on or off Tribal lands. Therefore, the interaction should include elected officials of the Tribe or their designee. SAMHSA is requesting that States provide a description of how they consulted with Tribes in their State. This description should indicate how concerns of the Tribes were addressed in the State Block Grant plan(s). States shall not require any Tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for Tribal members on Tribal lands.

Footnotes:

G. Consultation with Tribes

New Jersey does not have any federally recognized tribes.

IV: Narrative Plan

H. Service Management Strategies

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Narrative Question:

SAMHSA, similar to other public and private payers of behavioral health services, seeks to ensure that services purchased under the Block Grants are provided to individuals in the right scope, amount and duration. These payers have employed a variety of methods to assure appropriate utilization of services. These strategies include using data to identify trends in over and underutilization that would benefit from service management strategies. These strategies also include using empirically based clinical criteria and staff for admission, continuing stay and discharge decisions for certain services. While some Block Grant funded services and activities are not amenable (e.g. prevention activities or crisis services), many direct services are managed by other purchasers.

In the space below, please describe:

1. The processes that your State will employ over the next planning period to identify trends in over/underutilization of SABG or MHBG funded services
2. The strategies that your State will deploy to address these utilization issues
3. The intended results of your State's utilization management strategies
4. The resources needed to implement utilization management strategies
5. The proposed timeframes for implementing these strategies

Footnotes:

H. Service Management Strategies

Development of an Administrative Services Organization

Future strategies for utilization management include implementation of an Administrative Services Organization (ASO) for behavioral health services which is being proposed to CMS as one component of New Jersey's Medicaid Global Waiver Application. It is anticipated that as of January 1, 2013, behavioral health services for Medicaid-eligible adults and children will be delivered through a managed care model. DHS will issue a Request for Proposals (RFP) for these services in SFY 2012.

Prior to the ASO being operational, the DMHAS will undertake a series of tasks in addition to developing the RFP including:

- Working with Division of Medical Assistance and Health Services (DMAHS) to promote integration of services with HMO's or the highest cost members (top 5%) across the two systems including data-sharing
- Working with health homes and accountable care organizations to promote integration
- Fully integrating addiction and mental health services within a single division
- Completing a State hospital closure and transition residents to the community consistent with the division's Olmstead plan. DMHAS will see to utilize Money Follows the Person for patients leaving the State and county hospital system
- Engage stakeholders in improving the community infrastructure including the network of providers and emergency department triage
- Develop screening tools to identify adults that will be serviced through HMOs
- Seek enhanced federal matching funds for integration of physical and behavioral health at community behavioral health provider sites allowed under Section 2703 of the Accountable Care Act
- Rebalance behavioral health provider rates to incentivize more cost-effective care.

Tasks to be performed by the successful applicant once the contract is in place include:

- Developing and conduct a uniform assessment of all adults seeking treatment that includes diagnosis and functional status to identify the most "at-risk" population for long-term behavioral health service needs
- Conducting predictive modeling
- Managing inpatient admissions for private and public psychiatric care and perform continued-stay reviews
- Recommend and implement prior authorization requirements approved by DHS
- Building a provider network focuses on network adequacy for community-based care
- Perform all unitization management foundations
- Assisting resident's transition to the community from State hospitals that are closed
- Identifying individuals meeting the State's definition of serious mental illness
- Recommending rate revisions to promote community behavioral health capacity
- Paying claims
- Providing member access services including on-line and toll free number with appropriate languages available.

- Designing and recommending a member rewards program
- Providing behavioral health supports for individuals with intellectual and developmental disabilities and providing training for direct care workers who must manage behavioral health issues
- Implementing programs to promote integration of behavioral health and physical health.

The Single State Authority on Substance Abuse

The SSA will ensure that all treatment services funded through SAPTBG funds will employ the American Society of Addiction Medicine Patient Placement Criteria, 2nd Edition, Revised (ASAM PPC-2R) to determine placement in the most appropriate and least restrictive level of care that provides for client safety and to support uniform and consistent admission, continuing stay, and discharge decisions. Additionally, the SSA will ensure that that all SAPTBG funded agencies utilization does not fall below 90 percent of funded capacity. The utilization requirement for all other slot funded agencies is 95 percent. The SSA currently utilizes the following three accountability mechanisms to ensure that patient placement criteria are consistently implemented and that funded capacity is maintained: 1) collection and review of the New Jersey Substance Abuse Monitoring System (NJ-SAMS) data; 2) review of client placement, including intensity and duration of services as documented in site visit monitoring reports prepared by Addiction Program Management Officers (APMOs); and 3) review of agency client rosters. Each of these three mechanisms is briefly described below.

NJ-SAMS: The SSA requires all agencies receiving contract funds for substance use disorder treatment services to perform real-time documentation in NJ-SAMS of each agency's client admission and discharge dates and level of care placement based on the ASAM-PPC-2R criteria. An electronic version of the Level of Care Index (LOCI) is available in NJSAMS to support decision-making. NJ-SAMS also provides a client roster for each funded program component reflecting admission and discharge dates.

MONITORING SITE VISITS AND REPORTS: SSA staff will record and review information collected during the on-site agency monitoring visits to determine if the PPC 2-R are implemented consistently and uniformly, if the funded agency is meeting capacity utilization targets, and if the agency is adhering to access and service delivery requirements for priority and all populations. APMOs conduct on-site visits to all funded substance abuse treatment agencies at least annually by calendar year. During each visit, APMOs will review files, confirm that priority treatment to pregnant women and IVDA are being provided, and document the active number of clients as a means of verifying the real-time occupancy/service capacity. These utilization findings of each visit will be placed in the respective addiction services provider file. If deficiencies in the administration of the ASAM PPC-2R are noted, the agency is cited and required to submit and implement a Plan of Correction (POC). If the service capacity falls below their funded level of service contained within the contract specifications, the provider is also cited and the agency will be required to submit and implement a POC to increase its utilization. The SSA also has a provision within the requirements section of each contract that agencies providing treatment to IVDA to ensure that these entities: 1) admit all individuals who request and are determined to be in need of treatment for intravenous drug abuse within 14 days of their request; or, 2) make interim services available to the individuals within 48 hours of the request,

and should the individual actively remain on the waiting list, admit the clients within 120 days. When at full capacity, programs maintain a waiting list for each client who cannot be admitted to treatment within 14 days. The waiting list, at a minimum, has: 1) the date of placement on the waiting list, 2) unique client identifying number, 3) categorical priority status for admission, 4) record of provision of interim services by type and date, 5) record of weekly contact between client and entity, and 6) date and reason for removal from the waiting list.

CLIENT ROSTER: The SSA requires all of its contractors to maintain current monthly client rosters showing the number of active clients in treatment. The roster provides information on each client including: a client identifier, gender, family income, date of admission, date of discharge and funding source. The roster helps ensure that contractors are targeting indigent clients as well as serving at least the minimum number of clients supported by the addiction services contract. These rosters are compared with NJ-SAMS admission and discharge data and reviewed by APMOs who conduct the site visits as well as review the annual contract renewal application. The APMOs calculate service utilization for all funded treatment slots by agency and funded component on a monthly basis and enter it into a utilization service day chart. Each funded agency has its own utilization service day chart that is maintained and updated on a monthly basis by the APMO. A master utilization chart of all agencies is compiled and updated on a regular basis and maintained by the monitoring unit supervisor. The master utilization chart shows monthly utilization and average utilization for 3, 6, 9, and 12-month periods. The chart is reviewed by the senior SSA staff at least every six months to determine if additional individual agency or system-wide action needs to be taken. The SSA will continue to determine the status of each SAPTGB funded agency and cite those that fall below the required 90 percent capacity and cite all other slot funded agencies that fall below 95 percent. The programs that are operating at 100 percent occupancy will not cited as they are providing services at full capacity and no corrective action will be required. Programs with occupancy levels that fall below 90 and/or 95 percent will be notified and instructed to expand outreach and other activities to increase occupancy levels to greater than 90/95 percent of funded capacity. Any programs found to be below contracted matrix may be required to submit client rosters, either weekly or bi-weekly, to their APMO until the client service has increased to the minimum funded level. According to the SSA Hybrid Contract Policy (see attached policy), programs that fall under capacity for at least three consecutive months may potentially be placed on a Cost Reimbursement payment schedule for the number of slots that are not being utilized. The programs will remain on this schedule of payment for at least six months and/or until their level of occupancy has increased.

The State Mental Health Authority

The SMHA and SSA are participating with the State Medicaid authority in an effort to secure a global Medicaid waiver for the State of New Jersey. The waiver envisions, among other things, engaging one or more entities that would manage adult and child MH/SA Medicaid and non-Medicaid services for the public MH/SA system in New Jersey, including services supported with Block Grant funds. The targeted date for commencement of system management, as of the drafting of this application, is January 1, 2013. The RFP and ensuing contract for service management will contain requirements for utilization management. The State is evaluating the extent to which the engaged provider(s) may be placed at financial risk, or to the extent a non-

risk model is selected, what financial incentives can be applied to assure achievement of the State's policy objectives. The objectives of service management are to assure the application of the optimal mix of services at the right time to achieve the clinical objectives at the least cost. The cost of employing a managing entity has not yet been determined.

The Division of Child Behavioral Health Services (DCBHS)

The Division of Child Behavioral Health Services' (DCBHS) Utilization Management Processes are implemented by PerformCare, the Division's Contracted System Administrator (CSA). PerformCare's UM program is designed to ensure that children/youth/young adults and families receive the right services at the right time for the right length of time and that behavioral health services are individualized and incorporated into the overall service and permanency plans for children/youth/young adults involved in multiple service systems. PerformCare accomplishes this through the following mechanisms:

- having a customized UM program for the CSA based on unique local, regional, and programmatic needs;
- employing licensed clinical staff available 24 hours/day, 7 days/week with specific experience and training focused on the population being served;
- holding initial and ongoing training regarding program requirements;
- incorporating evidence-based practices and clinical practice guidelines that promote resiliency in children/youth/young adults and families into the review process;
- promoting family-centered, strengths-based, culturally competent planning, and community-based services, natural supports, and active care coordination; and
- using the MIS to capture accurate, real-time data for analysis and identification of opportunities for improvement.

Care Coordinators, DYFS Care Coordinators, the Medical Director, and other professional PerformCare staff participate in determining when a child's/youth's/young adult's situation necessitates services. Providers submit an ISP based on a thorough initial and ongoing clinical assessment of the child's/youth's/young adult's and family's needs. The ISP must represent an appropriate intensity, combination, duration, and frequency of services most clinically appropriate to the child's/youth's/young adult's and family's needs and have a reasonable likelihood of success of stabilizing and/or improving the child's/youth/young adult's ability to remain in his/her home, school, or other community setting or to transition from intensive services to community-based services. The proposed services must be within the scope of privileges of the requesting provider's credentials and service setting. The ISP is reviewed by the Care Coordinators, DYFS Care Coordinators, and the Medical Director, when indicated, to ensure consistency with the child's/youth's/young adult's history; presenting problems; DSM-IV-TR diagnoses; strengths and needs; requirements for comprehensive, coordinated, integrated services; and adherence to best practice standards and clinical practice guidelines. Efforts are made to obtain all necessary information and consultation with the treating provider as appropriate throughout the UM process by the Care Coordinators, DYFS Care Coordinators, and Medical Director.

The PerformCare UM process includes the initiation of the triage and referral process; service

authorization process; clinical supervision and determinations; and special UM processes and monitors. Information is collected and analyzed during these processes as described further below.

Service Authorization Process

Medically necessary, timely services are essential to the goals of safety and the provision of quality care and delivery of services at the most appropriate intensity of service. Initial and continued care authorization reviews are carried out by the PerformCare Care Coordinator/DYFS Care Coordinator. Services subject to prior authorization, concurrent, joint care, and discharge review are determined in collaboration with DCF/DCBHS. Reviews are conducted through documentation review of the electronic medical record, telephonically, or through retrospective reviews. The review process is based on several sources of data and information, including, but not limited to:

- provider documentation in the electronic medical record describing written plans for behavioral healthcare services;
- discussion between Care Coordinator/DYFS Care Coordinator and provider during telephonic review;
- information reviewed by the Care Coordinator/DYFS Care Coordinator which includes:
 - Initial assessment using DCF/DCBHS standardized tools
 - DSM-IV-TR Diagnoses
 - ISP
 - Diagnostic Formulation
 - Biopsychosocial Assessment
 - Documentation of Initial Services
 - Current Clinical Presentation
 - Continuing Service Planning and Discharge Planning
 - Current Progress Notes and Medical and Psychiatric Treatment
 - Documentation of Service Integration with Primary Care Physician, other treating providers, agencies involved with the child/youth/young adult and family, and community resources.
- Application of DCF/DCBHS-approved medical necessity criteria

Services that are approved by DCF/DCBHS or its designee - after a thorough review of clinical information submitted directly to DCF/DCBHS - include OOH treatment for Intensive Intermediate Units, Detention Alternative Programs, Psychiatric Community Residences, Specialty Services, and Emergency Diagnostic Reception Units. These services do not require a clinical review by PerformCare's Care Coordinators. Member Services Specialists complete the registration process and the services are automatically authorized. PerformCare is responsible for tracking and reporting utilization related to these services. Initial reviews for Intensive Residential Treatment Services are completed by DCF/DCBHS and Joint Care Reviews are completed by PerformCare.

Individual/group/family therapy, psychological testing, psychiatric evaluation, and medication management and monitoring do not require authorization, unless covered by 3560 coverage. Providers submit claims to Molina for payment purposes.

All services are subject to monitoring for over- and under-utilization and outlier management by the QI/UM Committee.

PerformCare may also collaborate with DCF/DCBHS to develop criteria based on data analysis for parameter-driven authorizations aimed at:

- identifying children/youth/young adults who require intensive care coordination and utilization review, and
- identifying children/youth/young adults for whom utilization review can be less frequent or eliminated, and subject to retrospective review and data analysis only.

Authorization Standards/Levels of Urgency and Review Types

Each service authorization has an associated level of urgency as well as performance standards for referral and authorization. Those standards are determined by DCBHS. Attached are the tables for “Service Authorization Standards Based on Level of Urgency” and “Service Authorization Types.”

Clinical Supervision and Determinations

The Medical Director has accountability for clinical supervision; oversees the utilization management review process for determination of medical necessity for behavioral healthcare services; and monitors intensity of service determinations through the application of inter-rater reliability. As part of the role of the Medical Director, quality of care issues are closely monitored and addressed internally with Care Coordinators/DYFS Care Coordinators, and externally with providers as indicated. Physician-to-Physician consultations are determined by the Medical Director to ensure appropriate care and follow-up. The Medical Director provides clinical expertise to all Care Coordinators/DYFS Care Coordinators in which case consultations are completed on a regular basis for oversight and guidance.

All determination decisions are made by qualified behavioral health professionals to include the Medical Director, and licensed Care Coordinators/DYFS Care Coordinators. Only a board-certified or board-eligible psychiatrist (the Medical Director) can render a determination for denials, reductions, or terminations of inpatient services or alternatives to inpatient services. However, other licensed qualified practitioners may make denial, reduction, or termination decisions for other types of services. The Medical Director is the identified licensed behavioral health professional charged with overseeing all clinical and UM aspects of the QI/UM and Outlier Management Programs.

PerformCare ensures that service authorizations allow for access to services at a lower level of need than assessed need, so that access to less intensive care does not require additional review and authorization. There are times when the desired level of service is not immediately available,

but a lower intensity of service is desired by the family or caregiver of a child/youth/young adult who has been assessed. Care Coordinators/DYFS Care Coordinators receive training in accessing an alternative intensity of service while continuing to work to arrange for a higher intensity of service as soon as possible. In some situations, sequential changes in service intensity will not be advantageous for the child/youth/young adult or family and should be avoided. The reasons for a decision to admit a child/youth/young adult to a lower intensity of service other than his/her assessed need is documented and followed by repeated evaluations. For accurate reporting purposes, providers complete an online notification of the less intensive services accessed. In addition, ISPs and progress notes for each unit of service are documented in the child's/youth's/young adult's individual electronic medical record to support New Jersey Medicaid's submissions to the Centers for Medicare and Medicaid Services.

Special UM Processes and Monitors

1. Outlier Management

The goal of outlier management is to identify statistical, programmatic, and clinical outliers using data-driven analysis to make recommendations for interventions aimed at improving services for individual children/youth/young adults and families and system-wide service delivery enhancement and improvements. PerformCare's outlier management activities are integrated into its QI/UM processes. PerformCare incorporates into its outlier management approach circumstances, criteria, and flags to serve as predictors of unfavorable children/youth/young adults and family experiences or, at a minimum, conditions and circumstances that are determined likely to significantly challenge their progress in meeting personal goals.

Data used in outlier management includes, but is not limited to:

- access to services for routine, urgent, significant, and emergent care
- MRSS data, including the caller declining services when MRSS is the recommended disposition
- evaluations, assessments, and other services
- utilization by service intensity type
- readmission rates by level of service intensity and average length of stay
- denial and adverse incident data
- complaints, reconsiderations, and appeals data
- claims data
- provider network geo-access data
- results of Tier II OOH consultations
- "red flagged" Joint Care Reviews
- Youth Link data
- Outcomes data
- outcomes management tool data

This data is then trended using valid and reliable statistical methodologies to identify outliers and develop targeted interventions. Interventions may include, but are not limited to:

- referring individual children/youth/young adults and families to Enhanced Care Coordination
- more frequent physician consultation
- more frequent utilization review
- revision to PerformCare policies and procedures
- developing and providing targeted internal and/or external training
- developing and monitoring Performance Improvement Projects (PIPs) or Corrective Action Plans (CAPs)
- under the direction of DCF/DCBHS, providing targeted technical assistance to providers, DYFS, Care/Case Management entities, and others
- collaborating with DCBHS to develop plans for service expansion

These interventions may focus on specific groups or areas such as:

- age groups
- gender
- diagnostic categories
- co-occurring, developmental disability, substance use, medical and/or behavioral health diagnoses
- geographic variations in service utilization and/or quality
- provider agency-specific variations in service utilization and/or quality
- intensity of service specific-groups, for example, frequent users of MRSS , frequent referrals to screening centers/psychiatric emergency services, frequent users of OOH treatment settings
- children/youth/young adults who have been in OOH/residential treatment settings for more than 12 months

2. Over- and Under-Utilization

Data used to monitor over- and under-utilization includes penetration rates by eligibility category and service types, access to services, average length of stay and readmission rates by service type, services delivered compared to those prescribed, county-specific trends, provider-specific trends along with comparison data, quality of care issues, utilization for priority populations (i.e. children/youth/young adults in out-of-state placements, awaiting behavioral health services in the juvenile detention center, awaiting behavioral health services in a secure inpatient unit, and/or involved with the DYFS system), number of children/youth/young adults with co-occurring mental health and substance abuse disorders, complaint volume and trends, and other additional data.

Quality control is engaged to ensure that continued stay medical necessity is met for the current level of service intensity or to plan discharge or transition to appropriate services, and to ensure that children/youth/young adults move through the continuum of services appropriately. Care Coordinators'/DYFS Care Coordinators' review progress focusing on development of a comprehensive biopsychosocial assessment; defined service goals and strategies targeted at specific issues and symptoms; identification of existing natural supports and those targeted for

development; quality of care concerns; long- and short-term goals; measurable objectives with reasonable timeframes; realistic treatment expectations consistent with child/youth/young adult and family goals and choice; specific, appropriate discharge planning with scheduled and coordinated aftercare; evidence of family-centered planning and child/youth/young adult and family participation in treatment and aftercare; appropriate treatment of co-morbid disorders; and update on admission symptoms and progress or lack of progress made to date and how services decisions reflect this. Care Coordinator/DYFS Care Coordinator reviews may be more or less frequent depending upon each individual and family's unique needs, strengths, and progress.

3. Utilization Management for DYFS Populations

PerformCare's dedicated unit of DYFS Care Coordinators performs the UM functions for children/youth/young adults involved in the DYFS system. PerformCare's DYFS-dedicated unit carries out all information and referral, and initial, continued stay, joint care, discharge, and expedited reviews for children/youth/young adults in the DYFS system, based on the child's/youth's/young adult's and family's unique and individualized needs. Children/youth/young adults and families involved in the DYFS system require additional supports, collaboration, and coordination due to the complexity of needs and involvement in multiple service systems. DYFS Care Coordinators collaborate to facilitate resolution of any barriers to effective services and access based on federal and New Jersey timeframes, New Jersey Special Education regulations, and evidence-based practices. DYFS Care Coordinators and the DYFS Care Coordinator Supervisor work directly with DYFS case workers and Team Leads in their respective regions.

4. Retrospective Reviews

Retrospective (post-discharge) reviews are performed on a random sampling of cases or according to targeted criteria from specific intensities of services. Responsibility for such reviews falls to the Director of Quality Improvement and the QI/UM Committee. Records are selected for retrospective review quarterly. Such reviews assist in the evaluation of treatment plan and ISP effectiveness, effectiveness of the authorization and concurrent review processes, and assist in the identification of any program or system development needs. Records may be identified through random sampling methodology, the outlier management process, evaluation of authorization data, complaint and grievance data, critical incident data, and other data such as an eligible child/youth/young adult receiving services with no authorization.

Retrospective reviews may also be conducted based upon provider utilization patterns (i.e., over- and under-utilization of authorized services). Retrospective review does not result in the non-certification of previously authorized care, unless it is conclusively determined that the information initially provided to obtain authorization was substantially inaccurate (such as in the case of fraud).

Clinical standards for care as outlined in New Jersey Master Business Rules, DCBHS Clinical Criteria, policies, regulations, and guidelines have been accepted as established criteria by PerformCare and are the standard by which all retrospective reviews are conducted. Results of

retrospective reviews are submitted to DCF/DCBHS along with recommendations for improvement, which may include CAPs or PIPs identified through the reviews if necessary.

IV: Narrative Plan

I. State Dashboards (Table 10)

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Narrative Question:

An important change to the administration of the MHBG and SABG is the creation of State dashboards on key performance indicators. SAMHSA is considering developing an incentive program for States/Territories based on a set of state-specific and national dashboard indicators. National dashboard indicators will be based on outcome and performance measures that will be developed by SAMHSA in FY 2011. For FY 2012, States should identify a set of state-specific performance measures for this incentive program. These state-specific performance indicators proposed by a State for their dashboard must be from the planning section on page 26. These performance indicators were developed by the State to determine if the goals for each priority area. For instance, a state may propose to increase the number of youth that receive addiction treatment in 2013 by X%. The state could use this indicator for their dashboard.

In addition, SAMHSA will identify several national indicators to supplement the state specific measures for the incentive program. The State, in consultation with SAMHSA, will establish a baseline in the first year of the planning cycle and identify the thresholds for performance in the subsequent year. The State will also propose the instrument used to measure the change in performance for the subsequent year. The State dashboards will be used to determine if States receive an incentive based on performance. SAMHSA is considering a variety of incentive options for this dashboard program.

Plan Year:

Priority	Performance Indicator	Selected
Pregnant Women/Women with Children	Increase number of pregnant women or women with children receiving substance abuse treatment in 2013 by 5%.	☐
Intravenous Drug Users	Increase the number of opiate dependent individuals including, IVDUs, who obtain MAT in combination with other treatment modalities by 5%.	☒
Tuberculosis	Increase the percent of clients being tested for TB to 95% by 2013.	☐
HIV	Increase the number of agencies engaged in the Rapid HIV Testing Initiative in 2013 by 30%.	☐
Adolescents with Substance Use Disorders	Increase the number of adolescents receiving substance abuse treatment in 2013 by 5%	☐
Intoxicated Drivers	A 5% increase in DUII clients receiving ambulatory substance abuse treatment in FY 2013.	☒
Supportive Housing	The number of consumers served by Supportive Housing will increase by 7% in SFY 2012 (relative to the projected 2011 estimate) and will increase by 5% in SFY 2013 (relative to the projected 2011 estimate).	☒
Access to Mental Health Services in the Community for Adults	In SFY 2012 an additional 2% consumers with SMI will be served, and an additional 3% in SFY 2013. In SFY 2012 an additional 2% consumers with and without SMI, will be served and will be increased to 3% in SFY 2013.	☒
Supported Employment	The SMHA has requested that the 22 SE providers self evaluate their programs using SE Fidelity Scale Total: SFY 2012 – 90, SFY 2013– 95.	☒
Older Adults	20% increase in staff knowledge of behavioral crisis management in older adults with SMI-- measured in staff pre & post training tests. 7% admissions decrease to state non-forensic psychiatric hospitals of people aged >55. SFY2013 goal is 15% decrease.	☐
Intensive Family Support Services (IFSS)	Baseline data will be aggregated on the current proportion of minority families enrolled in IFSS, forming the basis of the 2013 performance indicator target. Relevant data on demographic/racial composition of its member families will be assessed annually.	☒

Access to Community-based Mental Health Services for Children, Youth and Young Adults	In SFY 2012 DCBHS will serve an additional 2% (X) of children, youth and young adults with and without SED, relative to the number served in SFY 2011 (27,550). In SFY 2013 this value will be and additional 3% (X) of the SFY 2011 number.	b
In-State, Community-based Specialty Services to Children, Youth and Young Adults	At the close of SFY 2011, nine youth continued to receive services in an out of state treatment setting. Four youth require treatment services for deaf/hard of hearing; two youth require MI/DD services; and two youth await child welfare permanency plans.	b
Youth Suicide	The number of school personnel trained during SFY 2012 will serve as baseline. SFY 2013 will use the same database to measure a specified percentage of change.	e
Youth Suicide	The number of individuals trained during SFY 2012 will serve as baseline. SFY 2013 will use the same database to measure a specified percentage of change.	e
Mental Health Outpatient Services for Youth	The number of Outpatient services slots available statewide and the number of children, youth and young adults receiving Outpatient services at close of SFY 2012 will serve as baseline. SFY 2013 will use the same database to measure a specified % change	e
Justice Involved Services	In SFY 2012 there will be 250 consumers successfully diverted, with reduced days in jail. In SFY 2013 this number will be increased to 275.	e

Footnotes:

I. State Dashboards

Rationale

Intravenous Drug Users. There is a need to increase the use of medication assisted treatment (MAT) which is an effective evidence-based practice for treating opiate-addicted individuals, and in particular, IVDUs. Opiate addiction is a medical disorder that can be treated effectively with medication and counseling. Also, the use of Mobile Medication vans in New Jersey has provided this population with easier access to treatment.

Intoxicated Drivers. There is a need to draw more indigent DUI offenders into less restrictive and less costly treatment settings, such as outpatient, rather than residential, treatment, and begin to use medication assisted treatment, such as Vivitrol. Increased treatment for this population will also help protect public safety.

Supportive Housing. In the wake of endemic housing shortages faced by New Jersey's mentally ill and recently recovered, as well as addictions consumers, it is incumbent on the SSA and SMHA to increase the opportunities for community based housing for those at risk of homelessness. New Jersey embraces 'Housing First' principles and Supportive Housing as an EBP.

Increase Access to Services. In order to safeguard the mental health, promote the wellness and facilitate the recovery of New Jersey's residents with mental illness, the SMHA must be optimally accessible.

Supported Employment. In order to facilitate the complete recovery and long-term wellness of current (and recent) mental health consumers, the SMHA must attempt to facilitate employment opportunities for consumers with and recovering from mental illness.

Minority Enrollment in IFSS. As mental illness affects all demographic segments of New Jersey (and their families), the SMHA must enhance participation in Family Support Service Programs across the spectrum of the state's ethnic, cultural and linguistic groups.

Increase access to community-based services for children, youth and young adults with mental/behavioral health care challenges and children, youth and young adults with serious emotional disturbance (SED). In order to safeguard the mental health, promote the wellness, and facilitate the recovery of New Jersey's children, youth and young adults with mental/behavioral health challenges, the DCBHS System of Care must be optimally accessible.

Increase the availability of in-state community-based specialty services for children, youth and young adults with specialized treatment needs. DCBHS Specialized Residential Treatment Services Unit (SRTU), through comprehensive record review, analysis, and monitoring of out of home treatment utilization, identified gaps in services to particular youth with specialized treatment needs who have required out-of-state treatment due to a lack of available in-state, community-based services.

IV: Narrative Plan

J. Suicide Prevention

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Narrative Question:

In September of 2010, U.S. Health and Human Services Secretary Kathleen Sebelius and Defense Secretary Robert Gates launched the National Action Alliance for Suicide Prevention. Among the initial priority considerations for the newly formed Action Alliance is updating and advancing the National Strategy for Suicide Prevention, developing approaches to constructively engage and educate the public, and examining ways to target high-risk populations. SAMHSA is encouraged by the number of States that have developed and implemented plans and strategies that address suicide. However, many States have either not developed this plan or have not updated their plan to reflect populations that may be most at risk of suicide including America's service men and women -- Active Duty, National Guard, Reserve, Veterans -- and their families. As an attachment to the Block Grant application(s), please provide the most recent copy of your State's suicide prevention plan. If your State does not have a suicide prevention plan or if it has not been updated in the past three years please describe when your State will create or update your plan.

Footnotes:

J. Suicide Prevention

The Governor's Council on Mental Health Stigma has been working with a variety of community partners on suicide prevention efforts, utilizing our "A Community Effort" model for public awareness and education. "A Community Effort" is based on a philosophy of community connectedness, connecting all the audiences in the community in prevention efforts. "A Community Effort" public awareness campaigns target audiences that include Individuals and Families, Youth, Educators and Students, Employer and Employees, Veterans and Military, Law Enforcement, Multicultural Communities, Communities of Faith and Providers. "A Community Effort" aims at stigma by sending the message that "we all have mental health."

Specifically in regard to youth, the Council is represented on the Monmouth County Suicide Task Force and Monmouth County Emergency Response Committee. Through both of these endeavors, the Council utilizes "A Community Effort" to "market" prevention and break down the "silos" that exist not only in Monmouth County but across the State.

The Council has also facilitated a partnership with the New Jersey Council of County Colleges to create the first ever statewide Mental Health Awareness Day at all 19 New Jersey Community Colleges, to premier this coming October 6, 2011. This is part of an already existing partnership with Bergen, Cumberland, Mercer, and Sussex Community Colleges, as well as work with Ramapo and Felician Colleges and Princeton University.

The Council is working with the New Jersey Youth Development Council to create a public awareness campaign in the youth voice. The Youth Development Council comprises youth who have been through New Jersey's systems of care. Part of the goal of the Youth Development Council is to strengthen and elevate the youth voice to inform systems of care and engage peers in awareness and prevention. The Council will also be working with the New Jersey Department of Children and Families on an initiative to provide information and resources to pediatricians, pediatric nurses and families receiving treatment at pediatric offices. Two members of the Youth Development Council are also part of the New Jersey Mental Health Planning Council.

Division of Child Behavioral Health Services (DCBHS) Enhanced Suicide Prevention Strategies

The following are administered under the auspices of the Department of Children and Families (DCF).

- **The Youth Suicide Prevention Advisory Council** was formed under legislation signed into law in January 2004. The 17 members of the Council meet monthly to examine existing needs and services and make recommendations to the DCF for youth suicide reporting, prevention and intervention. The Council also advises DCF on the content of informational materials to be made available to persons who report attempted or completed suicides. Along with the Council, DCF works to develop and publicize public awareness campaigns on youth suicide prevention and intervention, and to compile data of reported attempted and completed suicides by youths in the State, without identifying any individuals involved. A report by DCF is also issued annually to the council, the Governor and the Legislature containing a summary of the data compiled by the division

that includes aggregate demographic information about youths who attempt or complete suicide. The enabling legislation charges the Youth Suicide Prevention Advisory Council with making formal recommendations to DCF for the development of the New Jersey Youth Suicide Prevention Plan, which outlines the goals, rationale, objectives and strategies for increasing the prevention effort throughout the state.

In March 2011, the DCF released their Youth Suicide Prevention Plan 2011-2014. A PDF of this plan is attached to this application and can be viewed at <http://www.state.nj.us/dcf/behavioral/prevention/preventionplan.pdf>

- **The Traumatic Loss Coalitions for Youth Program** at UMDNJ-University Behavioral HealthCare is an interactive, statewide network that offers collaboration and support to professionals working with school-age youth. In 1999 the Traumatic Loss Coalitions for Youth Program (TLC) was created to establish TLCs in each of New Jersey's 21 counties and to provide ongoing technical assistance to communities in crisis. The dual mission of the TLC is excellence in suicide prevention and trauma response assistance to schools following unfortunate losses due to suicide, homicide, accident and illness. This is accomplished through county, regional and statewide conferences, training, consultation, onsite traumatic loss response, and technical assistance. The purpose is to ensure that those working with youth from a variety of disciplines and programs have up-to-date knowledge about mental health issues, suicide prevention, traumatic grief, and resiliency enhancement. Since its inception, the TLC has trained thousands of individuals throughout the state with the purpose of saving lives and promoting post trauma healing and resiliency for the youth of New Jersey.

The DCF DCBHS funds the TLC. It has operated as a county-based collaborative since the year 2000 with a TLC Coordinator in each county. These county Coordinators provide meetings throughout the year bringing together school personnel, mental health clinicians, juvenile justice personnel, law enforcement officials, social service agencies, child welfare workers and many others who work closely with youth. The meetings are effective forums for reviewing traumatic loss events, identifying service needs, and providing professional development through the inclusion of an educational component. Speakers for the educational component are experts in topics related to the needs of youth. The Coordinators often collaborate with other agencies in their respective counties to co-sponsor workshops and conferences focused on issues pertinent to the mental health of the youth.

The Coordinators also work within their counties to direct a Lead Response Team (LRT) to assist schools when needed following a traumatic loss event, or as in the case of several counties, support the director of an existing team. Post Traumatic Stress Management (PTSM) training is provided for members of these teams.

The Traumatic Loss Coalitions for Youth Program has created an expanding statewide network that effectively works to prevent suicide and promote healing and resiliency in the aftermath of traumatic loss. The TLC secured funding from the American Foundation for Suicide Prevention to produce two (2) videos for school districts to be used by the

school's mental health staff as a teaching tool. Since the majority of suicides are caused by untreated or inadequately treated depression, it is AFSP's hope that by teaching adolescents to recognize the signs of depression in themselves and others, suicide deaths among teenagers will decrease. The teen version, "More Than Sad" is a sensitive and accurate portrayal of teen depression and is a wonderful resource for schools and other community agencies, programs and groups. It is appropriate to show to teenagers as well as adults who work closely with them.

The second video, "More Than Sad: A Guide to Preventing Teen Suicide," became available in September 2009. This DVD was created for Educators (and other adults working with youth). It covers the causes of youth suicide, warning signs to look for and how to get a student to the help they need. Vignettes of real teachers talking about real students communicates key messages that include paying close attention to any observed behavioral changes in their students, speaking to those students, and referring those who may be suffering from a mental disorder to a nurse or school counselor.

Together these materials provide a comprehensive suicide prevention resource that can be used by on-site, licensed personnel to conduct faculty training to fulfill the professional development requirement, per N.J.S.A. 18A:6-112. A complete listing of programs and supports provided by the TLC can be accessed at: <http://ubhc.umdny.edu/btri/TLC.htm>

TLC programs and services support DCF's goals and objectives outlined in the New Jersey Youth Suicide Prevention Plan. DCBHS has partnered with the Traumatic Loss Coalition for Youth Program in applying for the Garrett Lee Smith State/Tribal Youth Suicide Prevention Grant. The grant opportunity was announced on December 28, 2010 and the grant proposal was submitted on February 16, 2011. The purpose of this grant program is to build on the foundation of prior suicide prevention efforts in order to support states and tribes in development and implementing statewide or tribal youth suicide prevention and early intervention strategies, grounded in public/private collaboration among youth-serving institutions and other child and youth supporting organizations. TLC was the lead agency in the development of the grant application. In coordination with partnering agencies the TLC prepared the grant application to CMHS to secure funding to formalize the existing processes and available resources to implement successful suicide prevention and intervention strategies including evidence-based practices and best-practice models. The New Jersey Youth Suicide Prevention Plan is a required element of the grant application. DCBHS role in this project is supportive in nature. Grant awards have not yet been announced.

- **2nd Floor – New Jersey's Youth Helpline/Suicide Hotline** is available 24-hours a day, seven days a week to youth and young adults ages 10-24 to help find solutions to the problems they face at home, school, or play.

Youth can either call the helpline/hotline, 1-888-222-2228, or access the interactive Web site www.2NDFLOOR.org. The helpline/hotline is supervised at all times by a mental health professional. Youth are provided with relevant and appropriate linkages to information and services to address their social, emotional, and physical needs. Calls to

the 2NDFLOOR youth helpline/hotline are anonymous and confidential except in life-threatening situations. 2nd Floor was recently certified by the American Association of Suicidology as a statewide suicide hotline.

- **Provision of Training to Emergency Mental Health Responders:** In regard to development of staffing resources, the DCBHS funds the Technical Assistance Center through University Behavioral Health Care of the University of Medicine and Dentistry of New Jersey to provide training statewide.

DCBHS, through the UMDNJ Training contract, offers training to all emergency mental health service providers free of charge. The following courses are available on a regularly scheduled basis throughout the year:

- Risk Assessment and Mental Health
- Crisis Assessment for Parents and Caregivers
- Crisis Cycle
- Developing and Managing the Family Crisis Plan
- Safety Issues Working in the Community
- Youth Behavior, Diagnosis and Intervention Strategies
- Risk Assessment and Mental Health
- Domestic Violence: An Introduction to Domestic Violence
- Working with Challenging and Aggressive Adolescent Behaviors
- MRSS Orientation – Crisis Response Protocol (Day One)
- MRSS Orientation – Crisis Assessment Tool (CAT) and Developing the Individualized Crisis Plan (ICP)
- MRSS Orientation – Crisis Response Protocol (Day 2)
- Understanding Child Abuse and Mandatory Reporting Laws

IV: Narrative Plan

K. Technical Assistance Needs

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Narrative Question:

Please describe the data and technical assistance needs identified by the State during the process of developing this plan that will be needed or helpful to implement the proposed plan. The technical assistance needs identified may include the needs of State, providers, other systems, persons receiving services, persons in recovery, or their families. The State should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

Footnotes:

K. Technical Assistance Needs

The Single State Authority on Substance Abuse

One area of potential technical assistance is ICT. In surveying SSA providers about their use of ICT it became apparent that many providers did not know much about this area and were interested in learning how these technologies could be helpful. The SSA is interested in the use of e-therapy in our more rural locations where there is limited access to transportation. Also, the SSA would like to understand how professional liability, security, confidentiality and reimbursement issues are addressed. Another area the SSA would like to learn more about is how these technologies can be used to increase client engagement and retention.

A second area of technical assistance would be on how to position the SSA's client reporting system (NJ-SAMS) to serve as an Electronic Health Record (EHR) for those agencies unable to afford third party systems. The SSA is currently exploring the addition of a Treatment Plan module to the system and the SSA would be interested in learning what additional elements would be required to make the existing system compatible as an EHR.

The State Mental Health Authority

The SMHA would benefit from technical assistance in the following areas:

1. Implementation of an Electronic Health Record (EHR)
2. Development/Implementation of a Personal Health Record (PHR)
3. Implementation of Interactive Communication Technologies (ICTs) such as e-apps and telemedicine.
4. Implementation of Health Homes/utilization of Information Technology to monitor outcomes.
5. Assistance with the development of modules for inclusion in the Web-based Client Level Database that will include the following:
 - New client level data requirements in accordance with the DIGs Client Level Data Specifications issued by NASMHPD-NRI and subsequent reporting requirements
 - URS data tables/National Outcome Measures (NOMS)
 - EBP Outcome Measures
 - EBP Fidelity Scales to be automated for community providers to enable the SMHA to monitor fidelity to the model for the EBP programs that are funded.
6. The provider community and consumer stakeholders have been advocating to the SMHA for the development and implementation of such a web-based, client-level database for several years. The SMHA and its providers request technical assistance in integrating the new SMHA web-based client level database with the myriad data structures found in the provider community.

7. Systems Integration (i.e., Health Information Exchange, State Medicaid Master-Patient Index).
8. Best practices on incorporating ASO requirements with existing state data structures.
9. The SMHA has a computerized physician's order entry system (CPOE) that is currently in use at one of New Jersey's state psychiatric hospitals; the SMHA would like technical assistance for providing compliance with the meaningful use standards.
10. The SMHA will require technical assistance in moving to an encounter/claims based approach to payment.

It is noteworthy that the SMHA has been working with the Statewide Electronic Health Records Workgroup, in evaluating the suitability of several vendor-based solutions for an EHR. The SMHA continues to utilize Data Infrastructure Grant (DIG) funding to launch the development of the aforementioned web-based, client-level database. The SMHA will continue to pursue these and other strategies to meet its technical needs, with or without additional assistance from outside parties.

The Division of Child Behavioral Health Services (DCBHS)

During the process of developing this State Plan DCBHS identified the following Technical Assistance needs:

1. Technical assistance in the provision of evidence-based treatment options for youth with co-occurring mental illness/developmental disabilities.

DCBHS developed a comprehensive, organized DD/MI training curriculum and technical assistance program in coordination with the University of Medicine and Dentistry-University Behavioral Health Care that provides that assists DCBHS, system partners, DDD, community providers, family members, and other stakeholders in working effectively with the dually diagnosed population. The training curriculum includes:

- Parent/Caregivers Strategies for Shaping Behavior & Implementing a Behavioral Plan of Care for Youth with both Developmental Disabilities and Mental Health Challenges;
- Understanding Youth with Co-Occurring Developmental Disabilities and Mental Health Challenges;
- Assessment, Diagnosis & Psychotherapy for Youth with Intellectual Disabilities;
- Developing an Individualized Education Program (IEP) for Achievement (includes expanded focus on youth with developmental disabilities & mental health challenges);
- Developmental Tasks of Childhood and Adolescence; and
- Supporting Youth with Co-Occurring Developmental Disabilities and Mental Health Challenges.

Despite this robust curriculum, technical assistance on the provision of evidence-based treatment options for this population is limited.

2. Technical assistance on the provision of in state, community-based and/or in-home mental/behavioral health services for youth who are deaf or hard of hearing.

DCBHS recognizes that the provision of out of home treatment services for youth with mental/behavioral health challenges who are deaf present a serious challenge and have resulted in youth being referred out of state to receive appropriate treatment. Key DCBHS administrators met with administrators of the DHS Division of Deaf and Hard of Hearing to discuss the following: the development of an in state residential program specifically for youth with mental/behavioral health challenges who are deaf; supports and services that could be provided to existing in-state residential treatment facilities, including group homes and treatment homes and the provision of community-based and in-home services.

IV: Narrative Plan

L. Involvement of Individuals and Families

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Narrative Question:

The State must support and help strengthen existing consumer and family networks, recovery organizations and community peer advocacy organizations in expanding self advocacy, self-help programs, support networks, and recovery-oriented services. There are many activities that State SMHAs and SSAs can undertake to engage these individuals and families. In the space below, States should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the State mental health and substance abuse treatment system. In completing this response, State should consider the following questions:

- How are individuals in recovery and family members utilized in the development and implementation of recovery oriented services (including therapeutic mentors, recovery coaches and or peer specialists)?
- Does the State conduct ongoing training and technical assistance for child, adult and family mentors; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and help develop the skills necessary to match goals with services and to advocate for individual and family needs?
- Does the State sponsor meetings that specifically identify individual and family members? issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
- How are individuals and family members presented with opportunities to proactively engage and participate in treatment planning, shared decision making, and the behavioral health service delivery system?
- How does the State support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Footnotes:

L. Involvement of Individuals and Families

The Single State Authority on Substance Abuse

The Division of Mental Health and Addiction Services (DMHAS) contracts with 2-1-1 for an addictions hotline. Individuals seeking substance abuse treatment, as well as family members and significant others who may be exploring treatment options, can call the 2-1-1-hotline. Staff is trained and available (24/7) to engage and assist callers to access substance abuse treatment. Data collected from these calls are used for the expansion of the referral and engagement process for those in need of substance abuse services. Additionally, 2-1-1 provides information regarding all self-help groups to consumers seeking access to meetings throughout the state.

The SSA's Citizens' Advisory Council (CAC) is comprised of consumers representing the voices of New Jersey residents at risk for, struggling with, or otherwise affected by the chronic disease of addiction. The CAC supports education, prevention, intervention, treatment, and recovery from addictive disorders and the elimination of associated stigma. The CAC meets monthly, represents the voice of addictions consumers, and provides guidance and recommendations to the SSA regarding recovery oriented service delivery in furthering its mission to strengthen and expand recovery services by linking the Division with consumers and advocating for needs and interests of individuals, families, and communities. The CAC identifies policy and program priorities, researches and takes official positions on relevant issues of concern to consumers, and provides consumer representation and input on the Division of Mental Health and Addiction Services merger planning committee. The CAC provides Linkage Events to inform individuals, family members and significant others about important policies, programs and other issues specific to the individuals in recovery and their families. The Linkage Events build two-way communication with consumers/consumer advocates and the SSA.

The Recovery Mentor certification was established in 2004 as part of the SSA's federal Access to Recovery grant (New Jersey Access Initiative) to provide wrap-around services to individuals with substance abuse problems. The Recovery Mentor's primary role was to work one-on-one with clients as they transition from addiction to a sober life in the community. The SSA developed a 30-hour training which focused on the Recovery Mentor's role, basic communications skills, case management, and administrative responsibilities. Mentors were required to possess a minimum of two (2) years' sobriety or have a family member who was affected by substance abuse. Several hundred individuals were trained and approximately 150 Recovery Mentors were hired by faith-based, community-based, and licensed substance abuse treatment providers. The program was overwhelmingly successful, but unfortunately was dismantled in 2008 when funding was depleted.

The Recovery Mentor certification is now available through the Addiction Professionals Certification Board of New Jersey. Individuals must complete 72 hours of addiction training and 2,000 experience hours in a pre-approved facility. As the Division of Mental Health and Addiction Services works to integrate mental health and substance abuse services, the need to utilize Recovery Mentors remains crucial to sustained client wellness. With the advent of healthcare reform, Recovery Mentor services are expected to be reimbursable, and accordingly the Division plans to include Recovery Mentors as part of a recovery oriented system of care.

At the SSA's Recovery Center at Eva's Village, all the services are specific to the needs of the individuals. Services can include referrals to recovery oriented treatment, peer support, interpreter services, access to housing, employment assistance and child care. Wellness activities support recovery and include recreational activities and self help advocacy. In addition, the Recovery Coach is a new role that functions between the professional and the sponsor. Recovery Coaches are consumers who have made significant progress in their personal development and are experientially credentialed and trained as peer specialists to assist others to achieve their recovery goals. Recovery Coaches are from the community and trained in cultural competence to ensure sensitivity to the needs of the individual and the family members. Recovery Coaches work with individuals across multiple pathways of recovery, provide outreach to the community, link people to professional treatment and to communities of recovery, and provide long-term, stage-appropriate recovery education and support that meet the individual and family needs. The Recovery Coach assist consumers to develop their Recovery Plan. The Recovery Plan assists the individual to identify goals within nine life domains: recovery from use/abuse; living and financial independence; employment, and education; relationships and social support, medical health, leisure and recreation, independence from legal problems and institutions; and spirituality and mental wellness. Recovery Coaches are trained to assist the individual to identify goals and strengths, skills and resources. Families are encouraged and welcome to participate. Together, they identify barriers and problems, and develop plans to utilize strengths and skills to remove the barriers with a goal of overall family wellness.

The Advisory Committee to the Alcoholism and Drug Abuse Program for the Deaf, Hard of Hearing and Disabled meets on a quarterly basis to ensure quality substance abuse treatment services are provided to individuals identified as Deaf, hard of hearing or disabled in the community. The Committee is comprised of individuals from statewide disability, substance abuse and social service providers, including five (5) State staff in addition to five (5) members who are identified as Deaf, Hard of hearing or disabled and two (2) public members with an interest in substance and co-existing disabilities.

The SSA has a contract with an agency to offer communication access to individuals who are Deaf and/or hard of hearing via interpreter services or Communication Assisted Realtime Translation (CART) services at up to eight (8) recovery support meeting groups held weekly statewide (this includes AA, NA, sober house meetings, etc.)

The SSA is currently involved in a Technical Assistance (TA) project with CSAT to develop a recovery oriented treatment plan. Originally the SSA request was focused on assistance to develop an automated treatment plan, but the need to move away from the traditional symptom/pathology based approach to a more strength based, recovery oriented approach became more apparent as the TA was further developed. The SSA consultant provided examples and New York's model was chosen. Key to this approach is the use of concurrent documentation where both the consumer and clinician work together at the same time to develop the progress note. Also, the treatment plan focuses on meaningful life goals for the consumer and the steps necessary to attain those goals. This recovery-oriented treatment planning approach was presented to the SSA's Professional Advisory Committee and several members participated in an all day workshop with the consultant to learn more. Currently, one outpatient and one residential

substance abuse treatment providers are now participating in a pilot to test this approach. The consultant will be preparing a final report to submit to CSAT and the SSA will be planning for the next steps.

The State Mental Health Authority

New Jersey is proud of its commitment to provide highly innovative and effective consumer-operated services, supports and interventions. DMHAS currently funds and sponsors thirty-three consumer-operated self-help centers statewide, including three (3) centers on the grounds of our state hospitals. These centers are highly effective at providing high quality peer-directed services and supports that promote one's personal wellness and recovery. In fact, New Jersey has taken a national leadership role in the provision of peer-based services that provide needed support and opportunities for living well in the community by creating new opportunities to develop healthy relationships, regain hope, work towards personal respect, dignity and compassion as well as develop a more personally meaningful life. They also provide non-stigmatizing environments where individuals can share a common concern or similar life experience. They offer the opportunity to socialize, share struggles, strengths and challenges within trusting, safe environments.

Community-based services provide an opportunity for consumers to serve as peer mentors for other adults with serious mental illness. These services focus on the domains of wellness through peer-based counseling and coaching. Examples of these services include consumer-operated/peer-based self-help centers, wellness coaching, consumer-parent support, advocates, dual recovery groups, self-help groups, advanced self-advocacy plans, supported socialization, Wellness Recovery Action Plans (WRAPs) and Psychiatric Advanced Directives (PADs).

Peer-operated services have demonstrated great success in empowering consumers to accept personal responsibility for their own care and treatment. New Jersey has paid particular attention to assist consumers with their physical health needs through the CHOICES Program, the Hearts and Minds Program and peer wellness coaching.

The DMHAS remains committed to creating opportunities for consumers to direct their own care as well as the provision of consumer-operated services, supports and interventions. In FY '11 the SMHA allocated \$8.7 million dollars towards consumer-operated services that promote self-directed care, self-monitoring of physical health issues and the attainment of a life-style that is based in wellness and recovery.

Consumer Recovery Support Programs:

- Wellness Recovery Action Plans
- Psychiatric Advance Directives
- Peer Wellness Coaching
- CHOICES (tobacco cessation program)
- 100 Pioneers Program (Program to assist consumers with substance abuse and mental health issues around best practices for smoking cessation).
- Peer-run self-help centers

- Peer-run self-help groups (Dual Recovery Anonymous, women's groups, men's groups, walking clubs, etc.)
- Peer-delivered Illness Management and Recovery (IMR)
- Hearts & Minds Program (a consumer-managed wellness program)
- Financial Literacy Program
- Individual Development Accounts
- Consumer-run Transportation Services
- Peer Recovery Operated WarmLine
- Peer Outreach Support Teams (POST)
- Consumer Connections training program
- In Our Own Voice (Consumer Recovery Speaker Program)
- NAMI Connection (Consumer Support Groups)

Statewide Consumer Advisory Committee (SCAC)

The Statewide Consumer Advisory Committee (SCAC) is a diverse group of emerging leaders throughout the state who are experiencing recovery in their own lives. They are committed to having open, honest and compelling discussions with the leadership of the DMHAS around what a recovery and wellness-oriented system is about and what it is not. SCAC has been greatly instrumental in working with the DMHAS on many aspects of the Transformation including focus groups to identify outcomes and other elements of service delivery. In addition, SCAC members have been used as consultants for subcommittee work, as trainers and for curriculum development for specialized DMHAS-sponsored initiatives, and as advisors for proposal reviews. The SCAC has been integrally involved in the completion of Federal Mental Health Block Grant consumer satisfaction surveys, and also makes recommendations back to the SMHA on all issues affecting the quality of life of consumers living in New Jersey from housing to medication co-pays to access to employment-related services.

The SCAC meets one time per month in each of the three regions of the state. SCAC meetings are frequently used to provide important input in to specific DMHAS-sponsored projects and initiatives. Members of the DMHAS' Management Team are frequent visitors to SCAC meetings where they provide updates and just listen to concerns, issues and ideas of consumers who are vested in transforming our mental health system.

Family Involvement and Services with the SMHA

Families continue to fulfill an important role in the planning and development of mental health services for consumers, their family members and significant others. The SMHA has designated the New Jersey Chapter of the National Alliance on Mental Illness (NAMI NJ) to administer the State Family Support Services Plan for Families of Persons with a Serious Mental Illness. This Plan, which is reviewed and revised annually, identifies the needs, goals and family priorities for the provision of family support services as well as recommending strategies for outreach and coordinated delivery of support services. The SMHA closely monitors the implementation of the State Family Support Services Plan via quarterly reports and other documentation which conveys the activity of the three regional family working groups as well as the statewide family working group.

Intensive Family Support Services Programs

Intensive Family Support Services (IFSS) Programs are funded by the SMHA in each of New Jersey's twenty-one counties. These programs, which encompass the DMHAS Wellness and Recovery philosophy, enhance family functioning by providing the family with a greater knowledge about mental illness, treatment options, the mental health system and skills useful in managing and reducing symptomatic behaviors of the member with a serious mental illness. Families involved in IFSS also learn patterns of communication and levels of environmental stimulation which have been demonstrated to reduce the number of psychiatric crises and hospitalizations. Services offered include psycho education groups, family support groups, single family consultation, respite activities and referral/service linkage. Services are delivered in the family home, at the agency or at other sites in the community convenient to individual family members.

Each IFSS Program receives input and feedback from family members via a variety of mechanisms including but not limited to participation on Advisory Boards, Family Satisfaction Surveys, Service Preference Forms, Level of Concern Survey's and suggestion boxes.

The NAMI NJ is contracted with the SMHA to facilitate TA initiatives directed toward improving the knowledge and skills of IFSS staff. Toward this end, the NAMI NJ identifies TA priorities and develops a TA plan which includes up to four training initiatives presented by knowledgeable consultants per year. In State Fiscal Year 2011, training initiatives were "Building Resiliency: Learning to Bounce back from Adversity", "Intentional Peer Support" and "What Families Need To Know About Substance Abuse."

The IFSS Programs have created a workgroup which meets on a quarterly basis. A representative from the SMHA and the NAMI NJ is in attendance. These meetings allow for the opportunity to update program status, share information regarding upcoming events, problem solve, provide support with respect to challenging situations and cases and gain information about new state funded initiatives.

Family Recovery Support Programs:

New Jersey identifies families as consumers and an integral part of the wellness and recovery continuum of care in NJ. There are a number of programs that are operated and/or intended for use for individuals whose family members are involved in the NJ mental health system. Some of these include:

- Family to Family Education- a peer family education program designed to foster learning, healing and empowerment among families of individuals with serious mental illness
- Anti-Stigma campaigns – designed to combat hurtful and negative stereotypes perpetuated about people with mental illness and about serious mental illnesses.
- Educating the Educators - a program developed by NAMI NJ to enlighten and inform educators about mental illness and present practical tools to help motivate children with social and emotion disorders.
- Every Mind Matters – a mental illness education program targeted to children in grades 5-9.
- Law Enforcement Education – NJ NAMI members can be called upon to teach a basic class in mental illness awareness for NJ law enforcement officers. In addition, NAMI NJ

created the police training film called *The Community I Service* that is now being used by 61 NJ police departments as well as in 25 other states and parts of Canada as part of their training curriculum.

- Multicultural Outreach – NAMI NJ has several self help groups and tools that are specific to the context of families from various cultures affected by serious mental illness. These include:
 - SAMHAJ (South Asian Mental Health Awareness in Jersey)
 - CAMHOP-NJ (Chinese American Mental Health Outreach Program in New Jersey)
 - NAMI NJ En Espanol
 - AACT-NOW (African American Community Takes New Outreach Worldwide)
 - The film *Documenting Our Presence: Multicultural Experiences of Mental Illness*

Other Family Involvement

Administrative Bulletin 4:12 (attached) “Professional Collaboration with Families of Adult Clients Hospitalized in New Jersey State Psychiatric Hospitals” was enacted by the Division of Mental Health Services in 1996. This document directed that families be encouraged to become active participants in the treatment and discharge planning process for their family member with a serious mental illness. It also specified that families be made aware of significant events involving their loved one while in the hospital.

Administrative Bulletin 4:12 also instructed that a family advisory group be established for each state hospital excluding the Forensic Psychiatric Hospital. As a result, Concerned Family Groups were formed and commenced conducting monitoring visits of the hospital in their catchment area. Observations and recommendations were conveyed to hospital administration including the Chief Executive Officer via quarterly meetings. In State Fiscal Year 2011, additional family monitors were recruited and they as well as veteran or established family monitors received training regarding new family monitoring documentation which has undergone several revisions. Family monitors were also asked to comment and provide feedback on the document which permits uniform monitoring of both hospital programming and environment. Thus, it paves the way for family monitors to visit and tour the hospital of their choice regardless of the location. It is expected that family monitoring will continue with renewed vigor and spirit in State Fiscal Year 2012 and continue in 2013.

Additionally, families are key participants in the Office of Mental Health Licensing tri-annual site reviews and families serve and play an integral role in each of the twenty-one county Mental Health Advisory boards which meet on a monthly basis.

The combined New Jersey Community Mental Health Citizen’s Advisory Board and the Community Mental Health Planning Council consist of more than 50% of their membership as family and consumers. This Council is actively recruiting consumers and family members of individuals in recovery with co-occurring and addiction disorders to enhance membership and to be more aligned with the changes at the Federal level as well as the State level with the merger of the State’s Divisions of Mental Health and Addiction Services in July 2010.

Consumer and Family Involvement with Patient Services Compliance Unit (PSCU) Site Visits

During State Fiscal Year 2011 (7/1/10 – 6/30/11), PSCU conducted five (5) three-day site visits. One consumer and one family member served as adjunct surveyors to each site visit. The adjuncts serve as full PSCU team members in every aspect of the site review with the exception of medical record review. They are also involved in the exit summation with the hospital leadership staff at the end of the site visit as well as the tallying of data for the report. The protocols used involve the topics on therapeutic programming, unit observations, environment of care, patient and staff interviews and staff deployment.

For Fiscal Year 7/1/11 – 6/30/12, PSCU plans on having approximately the same number of site visits (one 3-day site visit per hospital per calendar year) and consumer and family involvement. However, with the closure of Hagedorn Psychiatric Hospital, this particular site visit may not occur at this facility. In addition, we plan on developing and assessing competencies related to conducting site visits, data aggregation and report writing, exit summations and interpersonal interactions.

Multicultural Services Advisory Committee (MSAC)

The Multicultural Services Advisory Committee (MSAC) was formed in 1981 to address issues of quality and quantity in the development and delivery of culturally competent mental health services, and to advocate for policies, programs and legislation that impact the mental health delivery system. It is composed of diverse representation of consumers, providers, families and stakeholders who are committed to cultural and linguistic competency in mental health. MSAC provides a structure through which the mental health needs of New Jersey's multicultural population is communicated within the SMHA, and ensures that cultural competency be a critical aspect in the planning and implementation of an effective system of care.

The mission of the MSAC is to address issues of quality and quantity in mental health services and staffing, and to develop a recovery oriented service delivery system which promotes education and best practice strategies that are appropriate to the lifestyles, special needs and strengths of New Jersey's diverse minority and cultural groups. The MSAC, under the auspices of the SMHA, ensures that mental health services are culturally sensitive, culturally competent and accessible in a language understood by the consumers and families. MSAC supports the consumer's journey to wellness and recovery through the provision of stigma-free mental health services that are culturally and linguistically competent. By partnering with mental health providers, consumers and their families in the planning, development and implementation of culturally and linguistically effective services, disparities and stigma that exist within New Jersey's mental health delivery system will be eliminated.

IV: Narrative Plan

M. Use of Technology

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Narrative Question:

Interactive Communication Technologies (ICTs) are being more frequently used to deliver various health care services. ICTs are also being used by individuals to report health information and outcomes. ICT include but are not limited to: text messaging, etherapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, case manager support and guidance, telemedicine. In the space below, please describe:

- a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?
- b. What specific applications of ICTs does the State plan to promote over the next two years?
- c. What incentives is the State planning to put in place to encourage their use?
- d. What support systems does the State plan to provide to encourage their use?
- e. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?
- f. How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?
- g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?
- h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?

Footnotes:

M. Use of Technology

In order to better understand the use of ICT among substance abuse prevention and treatment providers, the SSA sent a brief web-based survey to all providers. Responses were received from 130 providers. Results of the survey indicated that some providers (30) are using ICT. Most use ICT for text messaging and outreach, followed by recovery tools, emotional support, case management support and prompts. Some are using it for appointment reminders, confirmation, telemedicine and social media (Facebook, Twitter) for information dissemination. Telemedicine is being used to evaluate/screen psychiatric patients and for commitment hearings.

a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?

The SSA employs other strategies (e.g., peer support, follow-up phone calls) to support recovery rather than leveraging ICT for this purpose. The SMHA is anticipating that the use of ICTs will increase upon the implementation of the Electronic Health Record and the web-based, client-level database. This is an area where technical assistance is requested by both the SSA and SMHA.

The SMHA has allowed several provider agencies to conduct telemedicine in several Designated Screening Centers. Telemedicine is permitted by providers who have obtained written waivers to do so from the SMHA. The increased affordability of telemedicine makes it attractive in locales where traditional medical settings are cost-prohibitive. Currently telemedicine is conducted primarily in central New Jersey (e.g., Warren, Mercer and Middlesex Counties), and the southern region (e.g., Gloucester, and Camden Counties).

For DCBHS, DCF's "Transitions for Youth (TFY)" is a multifaceted statewide initiative that utilizes a positive youth development framework to address the complex needs of youth transitioning to adulthood, particularly those who are aging out of foster care or who were involved with New Jersey's juvenile justice or behavioral health systems. TFY is funded primarily through the Department of Children and Families' Office of Adolescent Practice and Permanency (OAPP) and is coordinated by the Center for Nonprofit Management and Governance, The School of Social Work at Rutgers, The State University of New Jersey. The goal of this initiative is to ensure that youth develop essential skills and competencies in education, employment, daily living, decision-making, and interpersonal communication. All TFY programs are rooted in best practices and integrate Positive Youth Development, a model for improving outcomes for youth by addressing the following domains: housing stability; improved academic functioning; job-readiness skills; financial literacy; emotional regulation and physical wellness; and peer, adult and community partnerships. TFY utilizes the following ICT: Facebook at <http://www.facebook.com/pages/Transitions-for-Youth/202831964660>; YouTube at <http://www.youtube.com/user/TransitionsForYouth1?feature=mhum>; and flickR at <http://www.flickr.com/groups/1498471@N25/>.

The New Jersey Statewide youth helpline/hotline, 2NDFLOOR, is available 24-hours a day, seven days a week to youth and young adults ages 10-24 to help find solutions to the problems they face at home, school, or play. Youth can either call the helpline/hotline, 1-888-222-2228, or

access the interactive Web site www.2NDFLOOR.org. An interactive message board is available for youth who have questions and concerns but are not yet ready to place a phone call to the helpline. The helpline/hotline is supervised at all times by a mental health professional. Youth are provided with relevant and appropriate linkages to information and services to address their social, emotional, and physical needs. Calls to the 2NDFLOOR youth helpline/hotline are anonymous and confidential except in life-threatening situations. The American Association of Suicidology recently certified 2NDFLOOR as a statewide suicide hotline. 2NDFLOOR utilizes the following ICT: <http://www.facebook.com/2ndflooryouthhelpline>; and YouTube at http://www.youtube.com/watch?v=eL8yP7_Qy6I.

b. What specific application of ICTs does the State plan to promote over the next two years?

The SSA would like to explore the use of e-therapy in rural areas where access to substance abuse treatment is limited. A discussion on the use of e-therapy was held with the SSA's Professional Advisory Committee about one year ago and was acknowledged as an area needing further exploration. Also, New Jersey was awarded a Strategic Prevention Framework State Incentive Grant (SPF SIG) several years ago. Several of the grantees had plans to use social media as part of their prevention strategy. The SSA is interested in ICT as a means of information dissemination and promoting health literacy over the next few years.

Within the next two years, the SMHA envisions the implementation of Personal Health Records (PHRs), the use of e-apps, and exploring new uses of telemedicine.

DCBHS is exploring its options in this area of technology.

c. What incentives is the State planning to put in place to encourage their use?

The SSA does not provide incentives for ICT use nor is planning to do so in the near future, due to limited funding availability.

The SMHA does not provide incentives for the use of ICTs at this time. There are some provider agencies that have begun to develop/implement ICTs; one of these agencies recently was awarded the Primary and Behavioral Healthcare Integration Grant, and recently applied for the Supplement for that Grant (Primary and Behavioral Healthcare Integration Grant for Health Information Technology).

DCBHS has not yet explored providing incentives for the use of ICT.

d. What support system does the State plan to provide to encourage their use?

The SSA is always available to provide technical assistance to its providers when rolling out new initiatives. It makes frequent use of webinar technology to educate providers and eliminating the need for travel and securing meeting space.

The SMHA intends to develop a fully-interactive component of its website to facilitate the use of interactive technologies among its service providers. This will present one interface for ease of use and sharing program services data for providing enhanced services and care coordination for consumers.

DCBHS has not yet explored supports to encourage the use of ICTs within the Children's System of Care.

e. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?

The SSA has concerns regarding the security of these technologies and potential liability issues for clinicians who utilize e-therapy. Appropriate privacy protection must be incorporated into the design of the ICT, particularly when dealing with consumers who have substance use disorders. Since most SSA clients are indigent, many may lack easy access to the internet or cell phones. This barrier is also noted by the SSA's Citizens Advisory Council (CAC).

SSA providers surveyed have also identified a variety of barriers in the use of this technology. Some do not use ICT to communicate with clients due to concerns about information security and confidentiality. Others identified lack of funding to hire appropriate technology staff or acquiring the needed equipment. Lack of reimbursement for services such as e-psychiatry and telemedicine were seen as obstacles. Agencies were also restricted by system firewalls or county policies and procedures. Other barriers are clients' phone numbers change or are disconnected, if an answering machine picks up, there is no confirmation, clients are charged for cell phone and texting minutes, and lack of knowledge by providers about how to use these systems. This is an area requiring further education.

The SMHA may face the following barriers during its implementation of ICT strategies: inadequate funding necessary for the development and maintenance of related ICT technology (e.g., personnel costs related to the development of such technologies and hardware expenditures) and complications arising from the interface of a myriad of unrelated data structures.

Funding to implement exploration and wide-scale implementation of ICTs is not available to DCBHS at this time.

f. How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?

The SSA and SMHA will be looking closely at the use of ICTs as it moves towards the development of Behavioral Health Homes to support integration of services and for monitoring consumer and provider outcomes.

The planned development of the ICTs identified above will be developed and utilized by the SMHA upon the implementation of the EHR and web-based, client-level database.

These areas have not yet been explored by DCBHS.

g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?

At present, the SSA will not use ICT for collecting data for program evaluation at both the client and provider levels since there are existing web-based client and provider level reporting systems that are used by the SSA for this purpose.

As stated above, the SMHA currently plans to use ICTs to monitor both consumer and client level outcomes in all of its funded programs.

These areas have not yet been explored by DCBHS.

h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?

If the SSA were to move in this direction, it would want to assess the effectiveness of this technology in reducing no shows and improving client engagement and retention.

Although the SMHA will institute formal evaluation protocols closer to the final implementation of ICTs, the following indicators for evaluating the use and efficacy of ICTs may include: improved no-show rates for community services, decreased hospital readmission rates, and improved health and behavioral health outcomes.

These areas have not yet been explored by DCBHS.

IV: Narrative Plan

N. Support of State Partners

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Narrative Question:

The success of a State's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, education and other State and local governmental entities. States should identify these partners in the space below and describe the roles they will play in assisting the State to implement the priorities identified in the plan. In addition, the State should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the State education authority(ies); the State Medicaid agency; the State entity(ies) responsible for health insurance and health information exchanges (if applicable); the State adult and juvenile correctional authority(ies); the State public health authority, (including the maternal and child health agency); and the State child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan. This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The State Department of Justice that will work with the State and local judicial system to develop policies and programs that address the needs of individuals with mental and substance use disorders that come into contact with the criminal and juvenile justice systems; promote strategies for appropriate diversion and alternatives to incarceration; provide screening and treatment; and implement transition services for those individuals reentering the community.
- The State Education Agency examining current regulations, policies, programs, and key data-points in local school districts to ensure that children are safe; supported in their social-emotional development; exposed to initiatives that target risk and protective actors for mental and substance use disorders; and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The State Child Welfare/Human Services Department, in response to State Child and Family Services Reviews, working with local child welfare agencies to address the trauma, and mental and substance use disorders in these families that often put their children at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system.

Footnotes:

N. Support of State Partners

Joint SSA and SMHA Partnerships with Other State Partners

New Jersey has been fortunate to have several Health Homes initiatives that have developed at the grass roots level. Two New Jersey providers are implementing SAMSHA-funded Behavioral Health Home Pilots. In addition, the Nicholson Foundation, through a public-private partnership, has provided funding to two FQHCs to implement health homes providing integrated behavioral health care. New Jersey DMHAS and the Division of Medical Assistance and Health Services (Medicaid) have been at the table to help these efforts overcome obstacles created by the current regulatory and funding mechanisms.

New Jersey's Medicaid Waiver Application includes a proposal under Section 2703 of the ACA to include Health Homes as part of its Medicaid State Plan, thereby becoming eligible to receive additional Federal funds (90/10 match) for Health Home services in the first two years after implementation. This component of the waiver includes provisions for Behavioral Health Homes (BHHs) for people with severe mental illness, addictions and one other chronic condition, or co-occurring mental health and addiction disorders.

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

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

Staff from DMHAS are part of a team that continues to meet after a 2010 Returning Service Members, Veterans, and Their Family Members Policy Academy conducted by SAMHSA. The New Jersey Veteran Enhancement Team Coalition (VETC) is comprised of DHS representatives from DMHAS, Medicaid, Department of Military and Veterans Affairs (DMAVA), Veterans Service Organizations, Department of Law and Public Safety, Department of Labor, Office of the Attorney General, the Governor's Council on Alcoholism and Drug Abuse, New Jersey Veterans Administration, New Jersey Army National Guard, and other stakeholders. The VETC is charged to develop a strategic plan including five priority areas that was submitted to SAMHSA and to the Governor's Office. Staff from DMHAS are assigned to co-chair the workgroup focusing on the priorities to identify existing exemplary service in New Jersey; integrate, expand, enhance the service delivery system; and coordinate/expand outreach and engagement strategies that work to assist veterans and their families regarding mental health and

substance use disorders. The New Jersey Team has established a number of goals, one of which is the Office of the Attorney General/DMHAS Veterans Pilot in Atlantic County. A draft Executive Order is working its way through the Governor's Office to officially establish the Veterans Services Enhancement Team.

The Chief Justice created an Interbranch Advisory Committee on Mental Health Initiatives. This appointed group is looking at ways that the New Jersey Court system can collaborate and increase access to needed mental health and co-occurring services for defendants with mental illness. Three DMHAS representatives were officially appointed to this Interagency Committee.

The AOC established an official Drug Court Advisory Committee to review the current drug court system and ways to improve referrals and participation. Three DMHAS staff members were appointed by the AOC to this committee.

The Single State Authority on Substance Abuse

A Memorandum of Agreement (MOA) will continue to be executed between the New Jersey State Parole Board (NJSPB) and the SSA to purchase, within a fee-for-service network, community-based residential beds for NJSPB parolees under the Mutual Agreement Program (MAP). A similar verbal agreement will continue between the New Jersey Department of Corrections (NJDOC) and the SSA to purchase, within a fee-for-service network, community-based residential beds for NJDOC inmates. Data collected from assessments performed for NJDOC clients will be utilized to determine if any additional services or levels of care should be added to the NJDOC array of services. Data collected will also be used to inform program improvements and in provider monitoring. See attached MOA.

The Cooperative Agreement with the Administrative Office of the Courts (AOC) will be maintained to fund a full continuum of treatment services for adult offenders who are deemed legally eligible for Drug Court. State funding appropriated to the AOC for this purpose will be transferred to the SSA, which is responsible for implementing and managing the statewide network of treatment services in coordination with the AOC and participating Superior Court vicinages. Enhanced services will be maintained as funding permits, including: medication, psychiatric/psychological evaluations, medication monitoring, physical exams, transportation, counselor appearances, partial care, pregnant women and children's services, co-occurring integrated services, methadone, and methadone intensive outpatient services.

An agreement with the Juvenile Justice Commission (JJC) will be continued. The agreement defines the provision of substance abuse treatment services for juveniles involved in the justice system and under the JJC's custody and care. Funding transferred by JJC supplements a SSA State appropriation. The SSA is working to convert funding for contracted beds serving JJC referred youth into fee-for-service. See attached MOA.

Additionally, the SSA will coordinate its efforts with those of the Department of Children and Families (DCF). This collaboration will continue to markedly enhance the capacity of both Divisions' abilities to provide more effective and far-reaching services while minimizing unnecessary service duplication. As part of the Child Welfare Reform, the DCF will continue to

provide funding to the SSA through 2013 to support an initiative for gender specific treatment with specialized services in all modalities of care to women with dependent children and parents who are at risk of losing custody of their young children due to the abuse or neglect of these children resulting from, or aggravated by their substance abuse. See attached MOA.

It is expected that the National Center on Substance Abuse and Child Welfare will continue to provide technical assistance to the SSA, DCF's Division of Youth and Family Services (DYFS) and AOC through the In-Depth Technical Assistance (IDTA) grant to improve outcomes for children and families involved with child welfare, substance abuse and the courts. The SSA, DYFS and AOC will continue to work together through this grant to facilitate systems change and move towards having a shared role in achieving safety, permanency, and well being outcomes for substance abusing families. IDTA will also help to improve cross system training and workforce development capacity to more effectively address the co-occurrence of substance abuse and child maltreatment. The SSA and DCF will utilize the work from the IDTA and its own needs assessment to convert many of its slot funded women's services to a fee-for-service network that will include a wide array of gender specific treatment and recovery support services. See attached letter.

The Department of Children and Families (DCF) Division of Youth and Family Services (DYFS) and Department of Human Services (DHS) Division of Mental Health and Addiction Services (DMHAS) are collaborating to develop permanent supportive housing for homeless women with children involved with child welfare and in substance abuse treatment. At the invitation of the New York State Office of Alcoholism and Substance Abuse Services (OASAS) and New York City Child Protective Services, staff from both Divisions visited several permanent supportive housing models in New York City. The Divisions are interested in replicating the Corporation for Supportive Housing (CSH) Keeping Families Together (KFT) initiative that is currently in New York City. This initiative integrates and enhances units of permanent supportive housing for women with children. Services are designed to prevent further child welfare involvement and enhance family functioning. CSH has been granted funding through the Robert Wood Johnson Foundation for a planning grant to further develop and refine the KFT initiative and work with DMHAS and DYFS on the planning process and to assist the Divisions with the actual implementation. See attached letter regarding the agreement.

The SSA will continue to execute an MOA with UMDNJ- Robert Wood Johnson Medical School, Department of Pathology and Laboratory Medicine to provide directorship and oversight ensuring HIV rapid testing for clients in an estimated 30-50 licensed substance abuse treatment agencies statewide. These funds will be used as part of the HIV/EIS set-aside. All other HIV diagnostic services, aside from testing, will be contracted with Public Health and Environmental Laboratories. See attached MOA's.

The Alcohol and Drug Abuse Program for the Deaf, Hard-of-Hearing and Disabled and a Program Advisory Committee was established pursuant to PL 1995, c.318 (NJSA 26:2B-36 to 39), and continues to meet on a quarterly basis to ensure quality substance abuse treatment services are provided to individuals identified as Deaf, hard of hearing or disabled in the community. The Committee is comprised of individuals from statewide disability, substance abuse and social service providers, including five (5) State representative from the Division of

Disability Services, Division of Deaf and Hard of Hearing, Division of Vocational Rehabilitation Services, the Developmental Disabilities Council and the Governor's Council on Alcoholism and Drug Abuse, in addition to five (5) members who are identified as Deaf, Hard of hearing or disabled and two (2) public members with an interest in substance abuse and co-existing disabilities. Staff from the SSA coordinate the meeting.

The SSA will continue to coordinate with the Department of Education (DOE) to develop school health goals and priorities. The primary focus of this interdepartmental group will be to reduce risky behaviors and promote adoption of health enhancing behaviors. Additionally, the SSA will continue to collaborate with the DOE in identifying and creating survey instruments that can be jointly used to collect data required by both entities, and to coordinate schedules for administering student surveys so as to minimize duplication of data collection efforts. See attached MOA.

The SSA will continue to establish relationships with Federally Qualified Health Centers throughout the State to implement SBIRT programs as well as deliver primary prevention programming in those settings. See attached letter of support from the New Jersey Primary Care Association on the SSA's recent application for a SBIRT grant.

Since 2006, the New Jersey State Epidemiological Outcomes Workgroup (SEOW) has met to collect and organize multiple sources of data to guide relevant and effective substance abuse prevention strategies. The purpose is to develop and support a statewide, cross-system, data-driven alcohol, tobacco, and other drug prevention prioritization, implementation and evaluation infrastructure, which will guide and support communities across New Jersey. The SEOW is comprised of government and community agency-based experts in the field of substance abuse. The members come from diverse entities, including universities, research institutions, government agencies, and private organizations. All have extensive experience working with substance-related data. Organizations/institutions that are represented on the SEOW include: Childhood Drinking Coalition, County Alcohol and Drug Directors Association, the SSA, Department of Education, Department of Health and Senior Services, Division of Highway Traffic Safety, Drug Enforcement Administration, Governor's Council on Alcoholism and Drug Abuse, Juvenile Justice Commission, New Jersey State Police, New Jersey Prevention Network, Princeton House Behavioral Health, Rowan University, and Rutgers University.

In August of 2010, DMHAS convened an Addiction Prevention Strategic Planning Committee for the purpose of developing a five-year prevention strategic plan. The purpose of the DMHAS Addiction Prevention Strategic Plan is to focus statewide prevention efforts on specific data-driven priorities for which measurable change can be achieved at the state and community levels. The Strategic Planning committee included community stakeholders and State government partners, including the Alcoholic Beverage Control, Division of Child Behavioral Health Services, DYFS, Division of Developmental Disabilities. In conducting its work, the planning committee formed needs assessment, capacity, and planning sub-committees to analyze existing data on addictions in the state population and current prevention resources. These data provided the foundation for identifying and selecting statewide prevention priorities. See attached invitation letter.

The State Mental Health Authority

State agency representation on the Community Mental Health Planning Council includes the following: Division of Mental Health and Addiction Services, NJ State Medicaid, Department of Corrections, Juvenile Justice Commission, State Housing Authority (New Jersey Housing and Mortgage Finance Agency-NJHMFA), Department of Vocational Rehabilitation, Division of Family Development (Social Services), and the Department of Education. Some of the consumer and family members are representatives of consumer advocacy groups, including National Alliance on Mental Illness in New Jersey (NAMI-NJ), County Family Support Organizations, Self Help Centers, Youth Development Council, Statewide Consumer Advisory Committees (SCAC), and various other New Jersey Partners.

The SMHA has a number of formal and informal partnerships with the criminal justice system:

Office of the Attorney General

DMHAS has two MOU's with the Office of the Attorney General (OAG); one moves \$50,000 from the OAG to DMHAS to support our joint CIT Center for Excellence. The second MOU creates a pilot Prosecutor Diversion program in Atlantic County for military members and veterans who become entangled in the criminal justice system and who have behavioral health issues.

Administrative Office of the Courts (AOC) /Judiciary

The DMHAS was an instrumental in assisting the AOC to establish a Veteran's Assistance Initiative which is a formal referral system for military service members and veterans who come before the court or are in jail. The referral goes from the court to the New Jersey Department of Military and Veterans Affairs so that the service member can get services if desired. DMHAS can also supplement and/or assist.

The Division of Probation created and advisory committee for its demonstration project of special mental health probation officers (MHPO's). A DMHAS representative was appointed this group assisted with the training of the 30 MHPO's and has been troubleshooting the collaboration between the local mental health system and probation office.

State Parole Board (SPB)

While there are no written MOU's or advisory committee memberships, DMHAS has collaborated with SPB in jointly submitting three Bureau of Justice Assistance Grants which were unfortunately not funded. There is also regular dialogue and collaboration to gains access for parolees to mental health services

DMHAS is an official partner in the SPB's new Veterans Assistance Project.

Department of Corrections

While no formal agreement exists, DOC and DMHAS work together to get access to mental health services for ex-offenders

Department of Labor and Workforce Development (DLWD); Division of Vocational Rehabilitation Services (DVRS)

DVRS and DMHAS jointly fund 22 Supported Employment programs for people with psychiatric disabilities. The joint collaboration has been going on for 23 years. DMHAS and DVRS currently have an interagency contract to braid funding for this service. The contracting mechanism will be converted to an MOU starting 10/1/11.

The Division of Child Behavioral Health Services (DCBHS)

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

Clinical Consultants report to DYFS Area Offices four days per week and serve as liaisons, joined from the wraparound perspective, who translate system of care principles and values into case practice and planning and assist in the coordination of behavioral health services for youth involved in the child welfare system. The CMO/UCM Clinical Consultant is a jointly owned and administered position between the CMO/UCM and DYFS. Clinical Consultants translate clinical information into user-friendly language identify mental health concerns regarding youth involved in the child welfare system and propose interventions to address underlying issues. Clinical Consultants serve as an advocate for youth in permanency and discharge planning, speaking on a clinical level with PerformCare and provider agencies and facilitating communication between case management entities. Clinical Consultants are required to be Master's level clinician's licensed by the New Jersey Board of Marriage and Family Therapists or Board of Social Work Examiners.

DCF Transitions for Youth Initiative

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

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

A complete description of the programs and supports available through TFY can be accessed at: <http://www.transitionsforyouth.org/index.aspx>.

DCF Division of Prevention and Community Partnerships (DPCP)

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

culturally competent, strength based and family-centered, with a strong emphasis on primary child abuse prevention. DPCP's programs include but are not limited to:

- **Family Success Centers**
New Jersey now has one of the country's only statewide systems of publicly supported Family Success Centers. These centers are neighborhood-based gathering places where any community resident can find family support, information and services. The purpose of the Family Success Center is to enrich the lives of children by making families and neighborhoods stronger. There is no cost to access services provided by Family Success Centers. Some of the services include: employment, information and referral, parent education, health care, parent-child activities, home visiting, life skills training, advocacy and housing.
- **PALS Programs (PEACE: A Learned Solution)**
DPCP oversees PALS programs in counties for children who have witnessed domestic violence. PALS is an intensive program that provides counseling and creative arts therapy for children who have witnessed domestic violence. The program serves children primarily aged four to twelve.
- **Outreach to At-Risk Youth**
Outreach to At-Risk Youth is an initiative designed to prevent crime and deter gang involvement by providing enhanced recreational, vocational, educational, outreach or supportive services to youth, ages 13 to 18, with the option to serve youth until age 21. Programs are located in communities with demonstrated high crime and gang violence.
- **Home Visitation Program**
The Home Visitation Program provides services to families challenged by complex health related and/or social problems. This program focuses on young families who are at risk for abuse and neglect with primary prevention and early intervention services for pregnant women and children up to age five.
- **Strengthening Families through Early Care and Education**
The Strengthening Families Initiative (NJ SFI) is an approach to preventing child abuse and neglect by strengthening families through early care and education. The Center for the Study of Social Policy developed the Strengthening Families through Early Care and Education Framework. The fundamental principle is that certain protective factors contribute towards family resiliency and strength. Early Care and Education Centers play a prominent role in building these protective factors among the families they serve. Through seven key strategies, centers become well positioned to help families build these protective factors that have proven to be effective in preventing child abuse and neglect.
- **School Based Youth Services Program (SBYSP)**
SBYSP sites are located in each of the 21 counties in or near schools in urban, rural and suburban communities. The programs are open to all youth ages 10 -19 enrolled in the school that is home to the SBYSP, and provide services before, during and after school and throughout the summer. Major services include: mental health and family services; health services; substance abuse counseling; employment services; pregnancy prevention programs; learning support services; referrals to community-based services; and recreation.
- **Prevention of Juvenile Delinquency Programs (PJDs)**
PJDs provide healthy alternatives for youth who have had trouble with the law, in conjunction with the Stationhouse Adjustment regulations of the New Jersey Department

of Law and Public Safety and has increased the State's capacity to address the complex needs of school-aged children.

- **Adolescent Pregnancy Prevention Initiative**
The Adolescent Pregnancy Prevention Initiative uses education, counseling and health services to reduce the birth rate among teens in high school. Any youth, at-risk or not, enrolled in the school that is home to the APPI program is eligible for services. Risk factors include sexual abuse or neglect at home, low school achievement, poverty, substance abuse or living in a home where siblings or relatives gave birth during their teen years. Referrals can come from peers, family members, guidance counselors, or foster families. Students also may enroll themselves.
- **Family Empowerment Program (FEP)**
FEP is a unique intervention program that targets students and families with intergenerational distress related to substance abuse. It provides a comprehensive intervention that integrates direct family system and adolescent development services with school and community resources. Related issues include substance abuse, mental health, academic performance and attendance, violence, gangs and juvenile justice involvement. The goal of the program is to maintain the student in school, while facilitating positive change that reduces risk factors in both student and family.

Collaboration with the New Jersey Juvenile Justice Commission (JJC)

DCF and its Divisions have established cooperative relationships with the Juvenile Justice Commission (JJC). In December 2004, the Department signed a Memorandum of Understanding with the JJC that outlines a distinct process by which youth in the JJC can be referred directly into the Children's Behavior Health System before being discharged from a JJC facility. Representation from both DYFS and DCBHS participate in the JJC and Annie E. Casey Foundation driven Juvenile Detention Alternative Initiative (JDAI) in order to collaborate on developing alternatives to detention and to reduce the number of youth going into detention. Both systems participate in each other's planning process and in case review process.

The JJC is responsible for operating State services and sanctions for juveniles and for developing a statewide plan for the effective provision of juvenile justice services and sanctions at the state, county and local levels. To emphasize New Jersey's commitment to provide coordinated quality services and appropriate sanctions for youthful offenders while ensuring the public's safety, the JJC established the State/Community Partnership Grant Program. These Partnership Grants provide funding to teach county for services to reduce detention overcrowding, to provide treatment for sex offenders, to increase disposition options, and to provide aftercare to youth and their families.

Special Case Review Committee (SCRC)

The Special Case Review Committee (SCRC) reviews those juveniles, both male and female, who present multi-system needs/issues and the need for special attention or advocacy. Included are: those who appear to have developmental disabilities for possible referral to the Division of Developmental Disabilities (DDD); those who need placement by the Department of Children and Families (DCF), Division of Youth and Family Services (DYFS) due to court orders for diversion or aftercare, special presenting problems, and/or homelessness; and those who are being referred or are accepted by the DCF DCBHS.

The Office of Special Needs oversees the SCRC, in terms of intra- and inter-agency planning. It is chaired by the Special Needs Assistant. Members include representatives from the DYFS Central, Middlesex, Union and Camden offices, the JJC Juvenile Parole and Transitional Services (JP & TS) Pre-Release Teams, Regional Court Liaisons/designees, the JJC Child Study Teams, JJC community residential homes, and the New Jersey Training School at Jamesburg (NJTS), Juvenile Medium Security Facility (JMSF), and the Juvenile Female Secure Care and Intake Facility (Hayes Unit) Social Services Departments.

Meetings are held twice a month, for northern and southern regional cases respectively. Referrals are primarily made from the Reception and Program Review committees, from the Reception and Assessment Center (RAC), the New Jersey Training School (NJTS), and Juvenile Female Secure Care and Intake Facility. However, youth may be referred by any source identifying a special need for advocacy and planning, including the Institutional Classification Committees, JP & TS staff, court liaisons and supervisors and program staff.

In addition to this population of JJC/DYFS involved juveniles, DYFS maintains an existing Memoranda of Understanding (MOU) with JJC. This MOU stipulates that DYFS has the responsibility to plan for any homeless juvenile pending discharge from JJC. The Special Needs Review Committee will identify those juveniles and make referrals to DYFS via State Centralized Screening (SCR) when appropriate for homeless juveniles not known to DYFS or those juveniles whose DYFS cases are closed. In cases where a juvenile with an open DYFS case is pending discharge and known to be homeless, it is expected that the DYFS worker is already engaged in permanency plans.

When JJC juveniles have permanency and treatment needs that require the intervention of DCBHS, the JJC Special Needs Review Committee will work with DCBHS and DYFS to make appropriate referrals prior to time of discharge. In circumstances where DCBHS is unable to facilitate a timely permanency plan in accordance with mandatory release dates, DYFS will be expected to effectuate the most appropriate contingency plan until such time that a more feasible plan is developed. CMO and YCM involvement are inclusive in this agreement when appropriate.

Collaboration with Juvenile Detention Centers

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

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

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

DHS Dual Diagnosis Task Force released its report, *Collaborating to Provide Services and Supports for Children and Adults with Co-Occurring Developmental Disabilities and Mental Health/Behavior Disorders*, on October 10, 2008. Task Force membership is comprised of individuals with developmental disabilities, family members, advocates, service providers, professionals, state officials and representatives. Leadership from DDD, DMHAS and DCBHS respectively pledged their support and expressed their commitment to bring about change to efficiently and effectively serve the dually diagnosed population. The Task Force makes recommendations for system and service change which are cognizant of the difficult economic climate and its impact on implementation, focusing on identifying opportunities to maximize existing resources to make incremental changes. An Executive Oversight Board was convened to manage the implementation plan to ensure that the vision for system change is achieved. The Task Force re-convened in SFY 2010 to continue its work and is now creating a plan for implementing the most important recommendations outlined in the report, which include:

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

DCBHS will continue to increase the availability of services and supports to youth with co-occurring developmental disabilities and mental health/behavioral challenges and their families. DCBHS administration will continue to meet with DDD administration to develop collaborative services for youth with mental/behavioral health challenges who function in the lower ranges of developmental disability.

Transition of Aging Out Youth to the Adult Mental Health System

DCBHS and DMHAS continued their effort in long-term joint planning for easing the transition of aging-out youth who need to move from the child system to the adult mental health system. Guidelines for the pilot were developed as well as “The Tool” to document information and inform participants.

DCBHS and the SMHA established relationships amongst the DCBHS case management organizations, the SMHA program analysts and the SMHA service providers. Over the last year multiple meetings were held in the pilot counties of Burlington, Middlesex, Monmouth and Ocean.

Successful outcomes from this collaboration include: understanding the language of each system; education of DCBHS system partners about services offered by the SMHA; preparation of youth to seamlessly transition from the child serving system to the adult system; identification of gaps in services as well as the development of services to fill those gaps.

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

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

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

- Regional School and Institutional programs for DCF clients. Each of the Office of Education's eighteen Regional Schools offers individualized, comprehensive year-round programs designed to meet the educational and psychological needs of students with moderate and severe cognitive impairments. Multiple disabilities, autism, behavioral or emotional disturbances and other disabilities that cannot be served in the public school system. In addition to their educational program, children receive child study, clinical and rehabilitative services.
- Project TEACH (Teen Education and Child Health) is an alternative, year-round education program for pregnant or parenting teens. Project TEACH services students at risk of school failure.
- Transition Education Center (TEC) is an alternative year-round program designed to meet the needs of an array of "at-risk" students who are referred because of their involvement with the juvenile justice system. The TEC program provides a comprehensive educational program which provides the at risk adolescent with the skills needed to create a positive life for themselves in order to promote their successful reintegration to future school, work and/or community endeavors.
- Technology for Life and Learning Center (TLLC) assists students with disorders that affect their ability to communicate. The TLLC provides two distinct programs: Augmentative and Alternative Communication (AAC) and Assistive Technology Educational Achievement Models (ATEAM). Both provide diagnostic and intervention services to enable student to become proficient users of assistive technology tools/strategies, thereby increasing their function in identified areas.

Cooperation with the New Jersey Department of Education (DOE)

Recognizing the importance of the educational community in a youth's life, the Department has undertaken several strategies to coordinate services for troubled youth with the State DOE. As part of the restructuring of the New Jersey child welfare system, the DCF has targeted several areas of cooperation with DOE to improve the lives and access to education for youth in the child welfare system. These activities have been expanded to include all youth who are accessing mental health services through DCBHS. Goals have been set which assure all youth in out-of-home settings are registered for school within 3 days of movement to a new setting/residence. A roundtable co-hosted by DCF and DOE in May 2007 established a work group to develop and implement Memoranda of Understandings of the supports and services the two departments will provide to youth who are admitted into an out-of-home setting. While primarily focused on youth in the child welfare system, the MOUs are applicable to all DCF youth. One of the two committees established as a result of the roundtable will focus on youth, special education and the impact on the education system of youth who are placed into an out of district school community as a result of the DCF service plan for that youth.

Additionally, DCBHS is represented on the DOE Office of Educational Support Service's interagency work group to study and take actions on the issues of student absences and truancy. The purpose of the workgroup is to continue the work of previous statewide groups organized to study and manage issues, concerns, practices and recommendations regarding student unexcused absences and truancy. Emphasis is placed on assessing and addressing the effects of existing statutes and regulations on absences and truancy and on examining and advancing the effectiveness of courts, school, human services agencies and other resources in addressing truancy cases.

DCF agreed to participate and forwarded a letter of support as one of the State partner agencies in the DOE's application to the United States Department of Education for the Building State Capacity for Preventing Youth Substance Abuse and Violence Program Grant Competition. DCBHS will continue its collaboration with DOE and serve as the DCF point of contact for this project.

IV: Narrative Plan

O. State Behavioral Health Advisory Council

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Narrative Question:

Each State is required to establish and maintain a State advisory council for services for individuals with a mental disorder. SAMHSA strongly encourages States to expand and use the same council to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders as well. In addition to the duties specified under the MHBG, a primary duty of this newly formed behavioral health advisory council would be to advise, consult with and make recommendations to SMHAs and SSAs regarding their activities. The council must participate in the development of the Mental Health Block Grant State plan and is encouraged to participate in monitoring, reviewing and evaluating the adequacy of services for individuals with substance abuse disorders as well as individuals with mental disorders within the State.

Please complete the following forms regarding the membership of your State's advisory council. The first form is a list of the Advisory Council for your State. The second form is a description of each member of the behavioral health advisory council.

Footnotes:

O. State Behavioral Health Advisory Council

Prior to the enactment of the Federal mandate governing State Planning Councils, the New Jersey Community Mental Health Services Act (10:37-2.1), Chapter 37, established the New Jersey Mental Health Planning Council (hereinafter the Planning Council) as the *State Community Mental Health Citizen's Advisory Board*. Subchapter 2 of the Act describes the requirements for membership, function, power to establish committees and scope of authority. In 2003, the Planning Council updated its bylaws, with assistance from the DMHAS' legal counsel, to ensure the Planning Council's composition, purpose, principles and mission were in accordance with the federal requirements for Planning Councils. Legal Counsel meets annually with the Planning Council to facilitate compliance with the State Uniform Ethics Code and to address questions regarding legal mandates of the Planning Council.

Membership:

Members of the Community Mental Health Citizen's Advisory Board are appointed by the Governor of New Jersey. Planning Council members are appointed by Assistant Commissioner of the New Jersey Division of Mental Health and Addiction Services (DMHAS). The Advisory Board and the Planning Council function together as the New Jersey Community Mental Health Planning Council. The Planning Council's membership is geographically representative of the State, and reflects the diversity of the State. A mandated minimum of 50% of the members of the Planning Council are mental health consumers, family members of adults with serious mental illnesses (SMI), family members of children with severe emotional disturbances (SED) or other non-state or provider members.

In light of the merger of the State's Addiction and Mental Health Service Divisions in Fiscal Year 2011 and new recommendations from SAMHSA, the Planning Council is in the process of including individuals and families in recovery for co-occurring and substance use disorders as well as addiction providers. The current membership has some individuals in recovery for co-occurring disorders and a few providers who provide both mental health and addiction services. The SSA recently implemented a Citizen's Advisory Council (CAC) that consists of consumers of addiction services, individuals in substance abuse recovery, and family members. A few members from the CAC are also being asked to participate in the Planning Council.

Additionally, the Planning Council has representation from mental health providers, local and nongovernmental agencies, State agencies and other major stakeholders concerned with the provision and need for services, planning, operation, funding, and use of mental health services and related services. A number of provider agency Planning Council representatives are consumer/survivors, giving consumers an even greater participation than reflected in the Planning Council Membership Composition Chart. Many of the Planning Council representatives are actively involved in other Councils, Committees or Advocacy activities throughout the State. These unique qualities of the Planning Council foster interagency collaboration, coordination of services, and alliances with other Councils and Committees. Council members have noted the good working relationships between consumers, family members, advocacy groups, and other agencies such as NAMI-NJ, the Mental Health Association of NJ, the County Mental Health Administrators, DMAHS and other State Agencies.

Role:

The Planning Council serves in an advisory capacity to the DMHAS and is charged with the responsibility of advocating for adults with serious mental illness and children with severe emotional disturbances for community mental health services throughout the State. The role of the Planning Council is to fulfill a federal mandate to review state plans and submit any recommended modifications to the Community Mental Health Block Grant and participate in the planning for this joint application. Planning Council members monitor, review, and evaluate periodically the allocation and adequacy of mental health services and began including addiction services in the process in FY 2011.

Highlights of Planning Council Activities for FY 2011:

- Since October 2010, the Planning Council received monthly updates regarding the merger of the Division of Addiction Services and the Division of Mental Health Services and the activities of the Merger Advisory Committee by two members who sit on that Committee and various DMHAS staff
- A presentation by disability Rights New Jersey regarding the Involuntary Medication Treatment Litigation
- An update on the Acute Care Task Force Report
- Updates regarding children services and the use of Children Crisis Intervention Services (CCIS)
- Information about new developments in mental health community services
- Presentation from the Governor's Council on Mental Health Stigma and the efforts to address stigma about addiction services into this Council
- FY 2012 proposed and approved budget and the impact on the service system.
- Information regarding the Primary Care and Behavioral Care Integration Task Force
- Information regarding older adult mental health services in New Jersey
- Beginning in May 2011, the Planning Council began receiving information and monthly updates from Council members who are participating in the Advisory Committee on Implementing Involuntary Outpatient Commitment in New Jersey
- Information presented to the Council about the submission of the State's Projects for Assistance in Transition from Homelessness (PATH) Grant
- Updates regarding the Dual Diagnosis Developmental Disabled and Mental Illness Task Force Report and recommendations.
- In June 2011, the Council received the link to SAMHSA's new Block Grant Application Guidance and information proposed in the application was discussed with the Council
- Information on data collection used in the Substance Abuse Prevention and Treatment Grant was presented to the Council
- Information presented to the Council regarding New Jersey's Medicaid Comprehensive Waiver, the implementation of an Administrative Services Organization and changes in the system with the approval of the Community Support Services Plan
- Update regarding Olmstead in New Jersey as well as Nationally from NJ's Olmstead Settlement Consultant, Marti Knisley

Subcommittee Activities:

A number of subcommittees have been meeting this past year. The committees include:

Olmstead Advisory Committee - This Committee meets regularly to monitor the implementation of The Home to Recovery CEPP Plan and Olmstead Settlement. The Co-Chair of this Subcommittee also participates in the Olmstead Oversight Committee.

Membership, Nomination and Election - This Subcommittee has been updating Council member information and focusing their efforts in the following areas:

- Reviewing Planning Council member attendance records
- Removing absent Council members according to the bylaws
- Replacing retired/resigned State agency representatives of Planning Council
- Filling consumer/family/provider Planning Council vacancies
- Overseeing the nomination and election of Planning Council officers

Mental Health Block Grant - The Block Grant Subcommittee monitored the Block Grant application for FY 2011 and the planning for the FY 2012 joint Mental Health and Substance Abuse Treatment Block Grant as it was being developed with the new changes.

The Wellness and Recovery Transformation Action Plan (WRTAP) Review Subcommittee - This newly formed Subcommittee met five (5) times in FY 2011 to review the State's WRTAP that ended in December 2010. However, the group has been on hiatus since the State is in the process of evaluating their progress in the WRTAP and is working on a summary of the goals met and plans for moving forward as a joint Division.

Identified Strengths of the State's SSA, SMHA and Children's System of Care (CSOC)

- Expansion and continued recognition of the value of consumer driven services.
- The cooperation of the State's Medicaid agency with the DMHAS and the CSOC.
- Beginning the integration of mental health and addiction services through the newly formed Division of Mental Health and Addiction Services.
- Consumers and family members who are also Planning Council members involved in various levels of State planning including the Implementation of Involuntary Outpatient Committee, Early Intervention Services, review of RFPs, and licensing reviews.
- Increased funding for Early Intervention Services, Residential Services and Intensive Outpatient Treatment Support Services.
- Implementation of a Procedure for registering and accessing Psychiatric Advanced Directives
- The Approval of the State Plan Amendment of Community Support Services that will enhance the use of peers in the service system.
- The broad composition of the State's Behavioral Health Planning Council and the commitment of the Membership to improving care for people with mental illness and addiction disorders in New Jersey.

Identified Weaknesses of the State's SSA, SMHA and Children's System of Care (CSOC)

- The lack of data infrastructure to adequately report client level data in the mental health system.
- Budget reductions to the community legal service programs that provide services to individual with mental health disorders may decrease consumer's ability to access legal services.
- Despite this consistent use of supportive employment services in the State, the unemployment rate for consumers with SPMI has been remained at 90%. Access to the few supported employments slots in the state is limited due to a cumbersome, ineffective referral process and by programs that do not provide pre-vocational and readiness services that prepare consumers to pursue competitive work opportunities commensurate with their employment choices, skills and financial needs.
- New Jersey's mental health advocacy organizations have called repeatedly for increased funds to build more and better Supported Employment programs; however, this critical recovery domain remains unfunded.
- Challenges of integrating primary care and behavioral health care.
- Lack of coordinated services for aging-in youth into the adult systems
- Long waits in emergency rooms for proper levels of care, particularly with children and adolescents.
- Insufficient workforce development for providers, especially about co-occurring disorders.
- Education is needed for consumers, families and providers about accessing emergency services.
- There is not a web based interactive registry of Psychiatric Advanced Directives as planned in the original Advanced Directive Legislation.

Recommendation for approval of the Combined Block Grant Application for New Jersey

The Council has met on a monthly basis throughout the past year with a focus on being informed and advised of the integration of the former Division of Mental Health Services and Division of Addiction Services into the newly merged DMHAS. Therefore, a Joint Block Grant submission is the most suitable choice for New Jersey for this Block Grant Application. The Council has had the opportunity to review the new guidelines and provide input regarding the Joint Block Grant Application. With the use of Survey Monkey and WebBGas Citizen's log in, the Planning Council members have had the opportunity to review and comment on the Joint Block Grant Application prior to submission. A letter of endorsement for the combined Mental Health and Substance Abuse Prevention and Treatment Block Grant for 2012-2013 has been submitted to SAMHSA and is included in the Attachments of this document

IV: Narrative Plan

Table 11 List of Advisory Council Members

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Start Year:

End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Jacob Bucher	Individuals in Recovery (from Mental Illness and Addictions)	Collaborative Support Programs of NJ, Inc.	11 Spring Street Freehold, NJ 07728 PH: 732-780-1175	jbucher@cspnj.org
* Winifred Chain	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	National Alliance on Mental Illness of NJ (NAMI)	21 Gatesway Drive Lumberton, NJ 08048	winifredchain@yahoo.com
Lisa Negron	Individuals in Recovery (from Mental Illness and Addictions)	Self Help Center, Brighter Day	2747 Hooper Avenue, #3-9 Brick, NJ 08723 PH: 732-677-0656	lnegron@cspnj.org
* Jesus Castro	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		50 Hillman Street Paterson, NJ 07522 PH: 973-841-3354	thetiano@hotmail.com
Joseph Delany	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		467 Harwick Court Piscataway, NJ 08854 PH: 732-827-2446	jdelaney@voa-gny.org
Karen Vogel-Romance	Providers	Jersey Shore Med. Ctr.	1945 Corlies Avenue Neptune, NJ 07752 PH: 732-776-3747	kvogue@comcast.net
Helen Williams	Individuals in Recovery (from Mental Illness and Addictions)	Collaborative Support Programs of NJ	2100 East State Street Extension Trenton, NJ 08629 PH: 609-816-2439	hwilliams@cspnj.org

Annette Wright	Providers	COMHCO	408 Sussex Street Paterson, NJ 07503 PH: 973-778-8810	COMHCO@aol.com
Damyanti Aurora	Providers	Project Live	465-475 Broadway Newark, NJ 07104 PH: 973-481-1211	daurora@projectlive.org
Leah Barhash	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		5 Roosevelt Pl-2L Montclair, NJ 07042	lbarhash@yahoo.com
Donna Best	State Employees	New Jersey Department of Education	PO Box 500 Trenton, NJ 08625-0500 PH: 609-984-1286	Donna.best@doe.state.nj.us
Rose Brown	Providers	New Jersey Association of Clinical Case Management	100 Route 46, Building C Mountain Lakes, NJ 07046 PH: 973-334-3496	rbrown@mhamorris.org
Karen Carroll	State Employees	NJ Department of Labor, Vocational Rehabilitation, DVRS	PO Box 398 Trenton, NJ 08625-0398 PH: 609-292-4967	Karen.carroll@dol.state.nj.us
Patricia Dana	State Employees	Medicaid	2 Riverside Drive, 1 Port Center, Suite 401 Camden, NJ 08103 PH: 856-614-2869	Patricia.dana@dhs.state.nj.us
Mary Ditri	Providers	NJ Hospital Association	760 Alexander Road, PO Box 1 Princeton, NJ 08543 PH: 609-275-4279	mditri@njha.com
* Maryanne Evanko	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	NJ Department of Children and Families	10 Quakerbridge Plaza Mercerville, NJ 08619 PH: 609-588-3165	Maryanne.evanko@dcf.state.nj.us
Angel Gambone	Individuals in Recovery (from Mental Illness and Addictions)	Independent Survivors	103 E. Somerdale Somerdale, NJ 08083 PH: 609-506-7987	angelgambone@yahoo.com

Alice Garcia	State Employees	NJ Juvenile Justice Commission	PO Box 107 Trenton, NJ 08625 PH: 609-943-5274	Alice.garcia@njjjc.org
Marilyn Goldstein	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	National Alliance on Mentally Illness of NJ (NAMI)	410 Hawthorne Court Flemington, NJ 08822	marmatgold@comcast.net
Joseph Gutstein	Individuals in Recovery (from Mental Illness and Addictions)		770 Anderson Avenue, Apt 10A Cliffside Park, NJ 07010	Joeg@nj.rr.com
Renee Ingram	State Employees	NJ Department of Human Services	PO Box 716 Trenton, NJ 08625 PH: 609-588-2155	Renee.ingram@dhs.state.nj.us
Barbara Johnston	Providers	Mental Health Association in New Jersey	88 Pompton Avenue Verona, NJ 07044 PH: 973-571-4100	bjohnston@mhanj.org
Herbert Kaldany	State Employees	New Jersey Department of Corrections	PO Box 863 Trenton, NJ 08625-0863 PH: 609-984-4102	Herbert.kaldany@doc.state.nj.us
Michael Jones	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	Family Member Nami-Ocean County	PO Box 1436 Toms River, NJ 08754 PH: 732-380-9400	j.michael.jones@l3com.com
Phillip Lubitz	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	National Alliance on Mental Illness of NJ (NAMI)	1562 Route 130 North North Brunswick, NJ 08902 PH: 732-940-0991	plubitz@naminj.org
Shannon Brennan	State Employees	NJ Association of County Mental Health Admin.	202 Mansfield Street Belvedere , NJ 07823 PH: 908-475-6092	sbrennan@co.warren.nj.us
Patricia Matthews	State Employees	NJ DHSS, Div of Aging and Community Services	PO Box 807 Trenton, NJ 08625-0807 PH: 609-633-0411	Patricia.matthews@doh.state.nj.us

Suzanne Mills	Individuals in Recovery (from Mental Illness and Addictions)		98 Hanover Street, Apt. 3 Pemberton, NJ 08068	smills@drenk.org
Ed Murphy	Providers	Supportive Housing Assoc/Alternatives	15 Alden Street Cranford, NJ 07016 PH: 908-931-1131	edmurphy@shanj.org
Robin Nighland	State Employees	NJ Department of Human Services	PO Box 362 Trenton, NJ 08625-0362 PH: 609-292-5760	Robin.nighland@dhs.state.nj.us
* Hazeline Pilgrim	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	Family Support Organization of Essex County	60 Evergreen Place, Suite 412 East Orange, NJ 07018 PH: 973-395-1595	pilgrimh@fsoec.org
Jim Romer	Providers	Monmouth Medical Center	300 Second Avenue Long Branch, NJ 07740 PH: 732-923-6999	JRomer@SBHCS.com
* Marilee Ryan	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		PO Bo 3096 Trenton, NJ 08619	Marileemcryan1@aol.com
Regina Sessoms	Individuals in Recovery (from Mental Illness and Addictions)	Self Help Center, Brighter Day	2747 Hooper Avenue, #3-2 Brick, NJ 08723 PH: 723-262-3905	RSESSOMS@comcast.net
Kelly Smith	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	Mental Health Association of Monmouth County	119 Avenue at the Commons Shrewsbury, NJ 07702 PH: 732-542-6422	ksmith@mentalhealthmonmouth.org
Robin Weiss	Individuals in Recovery (from Mental Illness and Addictions)	Consumer Provider Association of NJ	920 Bentley Road Lindenwold, NJ 08021 PH: 856-956-6380	s.robin.weiss@gmail.com

Debra Wentz	Providers	New Jersey Association of Mental Health and Addictions Agencies, Inc.	3575 Quakerbridge Road, Suite 102 Trenton, NJ 08619 PH: 609-838-5488	dwentz@njamhaa.org
Marie Verna	Individuals in Recovery (from Mental Illness and Addictions)	UMDNJ/UBHC	151 Cemtenial Avenue Piscataway, NJ 08854 PH: 732-235-9289	vernamd@umdnj.edu
Bruce Blumenthal	State Employees	NJ Housing Mortgage and Finance Agency	637 South Clinton Avenue Trenton, NJ 08611 PH: 609-278-7449	Bblumenthal@NJHMFA.state.nj.us

Footnotes:

*Parents or Caregivers of Children or Youth with Behavioral Health Problems

IV: Narrative Plan

Table 12 Behavioral Health Advisory Council Composition by Type of Member

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Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	39	
Individuals in Recovery (from Mental Illness and Addictions)	9	
Family Members of Individuals in Recovery (from Mental Illness and Addictions)	11	
Vacancies (Individuals and Family Members)	0	
Others (Not State employees or providers)	0	
Total Individuals in Recovery, Family Members & Others	20	51.28%
State Employees	10	
Providers	9	
Leading State Experts	0	
Federally Recognized Tribe Representatives	0	
Vacancies	0	
Total State Employees & Providers	19	48.72%

Footnotes:

IV: Narrative Plan

P. Comment On The State Plan

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Narrative Question:

SAMHSA statute requires that, as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State plan. States should make the plan public in such a manner as to facilitate comment from any person (including Federal or other public agencies) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary. In the section below, States should describe their efforts and procedures to obtain public comment on the plan in this section.

Footnotes:

P. Comment on State Plan

New Jersey Mental Health Planning Council

The 2012-2013 Community Mental Health and Substance Abuse Prevention and Treatment Joint Block Grant Application was reviewed by the public on August 17, 2011 at the New Jersey Mental Health Planning Council Meeting. The Planning Council is comprised of members who are representative of a comprehensive cross section of mental health consumers, addiction consumers, State staff, and mental health provider agencies. Notice of this meeting was sent to the Newark Star Ledger, Asbury Park Press, The Times (Trenton), Bergen Record, The Press (Pleasantville), and The Courier-Post (Cherry Hill). A Block Grant Subcommittee within the New Jersey Mental Health Planning Council reviewed and commented on the Plan as it was developed and reported its findings, comments and recommendations to Planning Council members at the May 11, 2011, June 8, 2011, July 13, 2011, and August 17, 2011 meetings which were also made open to the public via meeting notices in the above publications. Members had the opportunity to review and comment on the Plan. Members were also provided the WebBGAS information for the Citizen's log in to be able to view the application and submit comments to DMHAS at DMHAS@state.nj.us or via mail to DMHAS, 50 East State Street, PO Box 727, Trenton, NJ, 08625-0727

Public Notices

A public notice regarding the availability of the Community Mental Health and Substance Abuse Prevention and Treatment Application was published on the New Jersey Department of Human Services website on August 10, 2011 to facilitate public access and comment. Also, it was sent out to the DMHAS providers' email list serve and posted on the SSA's NJ-SAMS data collection system announcement page.

On August 10 and 11, 2011, DMHAS published a Notice of Solicitation of Comment simultaneously in the Newark Star Ledger, Asbury Park Press, The Times (Trenton), Bergen Record, The Press (Pleasantville), and The Courier-Post (Cherry Hill), which specified that DMHAS is making available to the public the draft Community Mental Health and Substance Abuse Prevention and Treatment Plan Block Grant Application. The notice specified the procedure for acquiring the WebBGAS website address, Citizen Log in information to be able to view the application. Comments can be submitted to DMHAS at DMHAS@dhs.state.nj.us or via mail to DMHAS, 50 East State Street, PO Box 727, Trenton, NJ, 08625-0727.

Presentations

SSA staff presented an overview of the draft Community Mental Health and Substance Abuse Prevention and Treatment application on April 26, 2011 to the Addictions Sub-Committee of the New Jersey Association of Mental Health and Addiction Agencies. This overview outlined changes to the application.

On June 8, 2011, SSA staff presented an overview of the Substance Abuse Prevention and Treatment Block Grant requirements, populations, and data collection tools for needs assessment to the Mental Health Planning Council.

DMHAS staff presented an overview of the draft Community Mental Health and Substance Abuse Prevention and Treatment Application on July 21, 2011 at a joint meeting of the New Jersey County Alcohol and Drug Directors and the New Jersey Association of County Mental Health Administrators. This overview outlined the new application and provided information on how to submit public comment.

DMHAS provided a PowerPoint overview of the new application to SSA's Professional Advisory Committee (PAC) on August 1, 2011. The PAC is comprised of members who are representative of a comprehensive cross section of addictions providers.

Public Viewing

Furthermore, DMHAS utilized the public viewing function of the Block Grant Web Application System. Those requesting to view and comment on the draft Community Mental Health and Substance Abuse Prevention and Treatment Application were given the website address, username, and password to view the Plan as it is drafted and posted online, as were the Mental Health Planning Council members during the meeting described above.

The completed Joint Block Grant Application was electronically submitted through SAMHSA's WebBGAS website and will be posted on the DMHAS website which is accessible to the public after September 1, 2011. Comments received by DMHAS about this submission will be compiled and used to guide the future planning efforts.

**DEPARTMENT OF CHILDREN AND FAMILIES
DIVISION OF CHILD BEHAVIORAL HEALTH SERVICES**

Effective Date: August 1, 2008 Policy & Procedure: DCBHS-20

Date Issued: July 31, 2008

Title: Procedures for Dispute Resolution, Administrative Review and Appeal

I. Purpose

The purpose of this policy is to describe the Division of Child Behavioral Health Services (DCBHS) dispute resolution policies and procedures for level of care determinations for children, youth and young adults receiving services through DCBHS.

II. Scope

This policy is limited to the dispute resolution procedures for individuals not eligible for Medicaid, NJ FamilyCare or any other Medicaid administered health benefits program. For individuals eligible for Medicaid and Medicaid administered health benefits programs including, but not limited to, NJ FamilyCare, NJ KidCare, Medicaid Special Eligibility, Medicaid Only, Medically Needy, and Special Medicaid Programs for the Aged, Blind and Disabled, appeals are conducted in accordance with N.J.A.C. 10:49, et seq.

III. Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Agency decision" means any decision of the Division subject to further appeal made as the result of a level of care determination, denial, reduction or suspension of service and which is not a final agency decision.

"Agency review" means an examination of a Division action that is conducted by the Division Director or his or her designee through a record and document review or by examining relevant records and documents and either convening a meeting of the relevant parties to the Division action under dispute or conducting a telephone conference.

"Appeal" means a request made by an authorized person within established timeframes for modification or reversal of a Division action or an agency decision. General complaints shall not be considered appeals.

"Appellant" means the authorized person who is requesting a reversal or modification of a Division action or an agency decision.

"Authorized person" means:

1. The parent or guardian of a minor receiving services from or applying for services of the Division;
2. An authorized representative of a parent or guardian of a minor receiving services or applying for services of the Division. Written verification of status as an authorized representative from the parent or guardian of the minor authorizing representation shall be required;
3. An emancipated minor receiving services from or applying for services of the Division;

4. An authorized representative of an emancipated minor receiving services or applying for services of the Division. Written verification of status as an authorized representative from the emancipated minor authorizing representation shall be required;

5. A young adult receiving services from or applying for services of the Division

6. An authorized representative of a young adult receiving services or applying for services of the Division. Written verification of status as an authorized representative from the young adult authorizing representation shall be required; or

7. An attorney, if written verification of the client/attorney relationship is provided.

"Business days" means the five working days of a week other than Saturday, Sunday and legal holidays.

"Division" means the Division of Child Behavioral Health Services within the Department of Children and Families.

"Division action" means a decision, plan or conduct by a Division representative within the scope of the individual's official duties, which may result in a contested case as specified in N.J.A.C. 10:6-1.2, but does not include an "agency decision" or a personnel action.

“Final agency decision” means:

1. A final decision by the Division Director or his or her designee pursuant to N.J.S.A. 9:3A-6 that adopts, rejects or modifies an initial decision by an administrative law judge;
2. An initial decision by an administrative law judge that becomes a final agency decision by operation of N.J.S.A. 52:14B-10; or
3. A Division action that becomes a “final agency decision” when the appellant does not choose to exercise his or her right to further dispute resolution.

“Involved parties” means the representative of the appellant, the Division and/or CSA and the service provider.

“Level of care determination” means a decision regarding the level and type of service that is determined to be clinically necessary.

"Record and document review" means a type of agency review, conducted by the Division Director or his or her designee, of the relevant documents and records related to a Division action under dispute.

IV. Procedures related to agency reviews

A. A request for an agency review shall be made in accordance with the criteria established within this policy.

B. Any person noticed of a Division action and entitled to appeal that Division action may request an agency review within 30 days of notice of that Division action, or within 30 days of learning of the Division action if notice was not received. If an individual fails to submit a request for an agency review within the time limits for

requesting an agency review as established in this policy, DCBHS may deny the agency review.

C. The appellant shall submit a written request for an agency review to the Director, Division of Child Behavioral Health Services, P.O. Box 717, Trenton, New Jersey 08625-0717.

D. The request for an agency review shall be in writing and shall contain all of the following:

1. Name and address of appellant;
2. Name and address of child, youth, or young adult receiving services through DCBHS, if the request for an agency review is made by the child, youth or young adult's legal guardian or authorized representative;
3. A brief statement of the matter under agency review;
4. A list of involved parties and/or potential witnesses, if known;
5. Reference to the law, rule, regulation or policy alleged to be violated, if known; and,
6. Any information the appellant believes would support the request for an agency review.

E. The Director or his or her designee shall conduct a record and document review in lieu of having the parties present unless the Director or his or her designee determines that an in person meeting or telephone conference is necessary.

F. Within 30 days of receipt of the written request for an agency review, and at least five business days prior to the agency review, the Division shall send the appellant written notification of whether the agency review shall be in person meeting, telephonic, or a record and document review. The notification shall indicate the issues

to be considered. If the review is to be conducted in person or via telephone, the notification shall include the time and location of the agency review.

G. The agency review process, whether in person, telephonic, or a record and document review, shall be completed no more than 60 days from the date the Division received the written request for an agency review.

H. The Division shall grant a request for postponement of an agency review only for good cause, which shall include the appellant's need for additional time to provide necessary information. The Division shall consider that an appellant has withdrawn his or her request for an agency review when the Division has not granted a postponement and the appellant:

1. Does not appear at the scheduled agency review, unless such failure is due to unavoidable causes; or

2. Does not provide the agreed upon information for the agency review within the agreed upon time limit, unless delayed for reasons beyond the appellant's control or for other good reason.

I. Participation in an agency review shall be in accordance with N.J.A.C. 10:6-1.5(e).

J. The Division shall determine whether and in what manner the child or youth's position on the matters at issue shall be ascertained and the nature of the child or youth's participation in the agency review where the outcome of the agency review shall have a direct impact on the child or children.

K. Prior to the agency review, the Division Director or his or her designee conducting the agency review, at his or her discretion, may consult with Division staff members who have information related to the issue being appealed.

L. The agency review shall include a summary of the factual basis for the Division action, in accordance with N.J.A.C. 1:1-8.2(a)5, the relevant rules and policy, a review of information gathered through prior consultation with staff, information presented orally or in writing by the appellant, information presented orally or in writing by witnesses, supporters or representatives for both the Division and the appellant, and questions asked and answered in the course of the agency review.

M. The Division Director or his or her designee conducting the agency review shall make an agency decision based on the record and the information presented at the agency review or during any consultation with other Division representatives.

N. The Division shall forward written notification of the agency decision concerning the agency review to the appellant within 30 business days of the completion of the agency review process and shall include notice of whether the appellant has a right or opportunity to appeal further and, if so, notice of the procedures for initiating further appeals, including the name, address and telephone number of the person to whom a request for further appeal is made.

O. The Division may deem waived any appeal opportunity that has not been exercised in accordance with the time frames specified in this policy, except that the Division shall not deny an appeal where the request for an appeal was delayed for reasons beyond the appellant's control.

P. If the appellant does not request further dispute resolution within 20 business days of notification of the agency decision, or is not eligible for further dispute resolution when material facts are in dispute, the agency decision shall be considered the final agency decision.



Nadezhda Robinson, Ph.D., Director
Division of Child Behavioral Health Services

DEPARTMENT OF HUMAN SERVICES
OFFICE OF CHILDREN'S SERVICES
DIVISION OF CHILD BEHAVIORAL HEALTH SERVICES

Effective Date: May 1, 2006

Policy and Procedure: # DCBHS-013

Date Issued: April 20, 2006

- I. SUBJECT:** Reporting Unusual Incidents to the Division of Child Behavioral Health Services (DCBHS)
- II. PURPOSE:** To ensure that unusual incidents, as defined in this policy, are promptly reported and tracked in accordance with Department of Human Services (DHS) and DCBHS policy.
- III. AUTHORITY:** There are various statutory authorities governing the reporting of incidents and investigations related to service recipient care. The most commonly referenced are:

N.J.S.A. 9:6-8.10	N.J.S.A. 30:11B-1 et seq.
N.J.S.A. 30:1-12.1	N.J.A.C. 10:37-6-108
N.J.S.A. 30:4-160	N.J.A.C. 10:37-9.9(B)3
N.J.S.A. 9:6-8.10	N.J.S.A. 52:27g-7.1(a)
N.J.S.A. 26:2H-12.23	
N.J.A.C. 8:57-1.3	
P.L. 1997 Chapter 70	
DHS Administrative Order 2:05	
DHS Administrative Order 2:05 Addendum	

- IV. SCOPE:** This policy and procedure applies to all DCBHS and DCBHS-related entities including, but not limited to: the Contracted Systems Administrator (CSA), Care Management Organizations, Youth Case Management Agencies, Mobile Response Stabilization Services, Family Support Organizations, Residential treatment providers, community-based service providers certified by DCBHS and agencies under contract with DCBHS.

- V. POLICIES:** DHS-operated facilities, institutions, schools and programs shall report unusual incidents and submit subsequent follow-up reports directly to DHS in accordance with DHS Administrative Order 2:05, "Unusual Incident Reporting and Management System (UIRMS)."

Community-based service providers certified by DCBHS and community-based programs or services contracted, regulated, licensed or subject to investigation by DHS or its Divisions, Bureaus, Offices or Commissions, shall report unusual

incidents and submit subsequent follow-up reports in accordance with this policy and the requirements of the Addendum to DHS Administrative Order 2:05, "Community Reporting: Unusual Incident Reporting and Management System.

The first duty of individuals involved is to ensure the health and safety of the child/youth/young adult. Unusual incidents shall be reported as quickly as safety allows; however, it is the responsibility of all employees of DCBHS, DCBHS-related entities, community-based service providers certified by DCBHS and agencies under contract with DCBHS to report unusual incidents within the time frames established within this policy.

For entities covered by the Scope of this policy, in addition to the reporting requirements of DHS and DCBHS, all reporting required by New Jersey statute and regulation shall be made to the appropriate agencies.

New Jersey statute (N.J.S.A. 9:6-8.10 et seq.) requires that:

Any person having reasonable cause to believe that a child has been subjected to child abuse and/or neglect or acts of child abuse and/or neglect is obligated to report this information to the Division of Youth and Family Services (DYFS) State Central Registry (SCR), also referred to as "Centralized Screening", at:

1-877-NJ ABUSE (1-877-652-2873)

or

1-800-792-8610

Failure to report an unusual incident to DHS, DCBHS and/or appropriate authorities or failure to cooperate in an investigation may result in corrective action being taken.

Appropriate law enforcement authorities shall be advised of any suspected criminal activities.

For DCBHS staff, in addition to the reporting requirements of this policy, incidents that meet the criteria for the Comprehensive Child Abuse/Prevention and Treatment Act (CCAPTA, N.J.S.A. 9:6-8.83 et seq.) shall be reported, followed-up and reviewed in accordance with DHS CCAPTA Critical Incident Notification and Review Procedures.

In accordance with DHS Administrative Order 1:50, Centralized Police Operations, it is the responsibility of the Chief Executive Officer or other persons in charge at each

DHS operated facility, to promptly alert police personnel to any criminal acts, violations of the law, or suspicious acts or incidents that may infringe upon the orderly and proper administration of the facility. (See DHS Administrative Order 2:05 Attachment C for categories that are required to be reported to Human Services Police).

The child's parent shall be informed of all unusual incidents that are child-specific, unless contraindicated.

Where the parent of the child is not the legal guardian, the legal guardian shall be informed of all unusual incidents that are child-specific.

The child's caregiver shall be informed of all unusual incidents that are child-specific, unless contra-indicated.

DCBHS shall review all reports of unusual incidents and the corrective action plans to prevent their reoccurrence. DCBHS and/or DHS may require subsequent actions by any entity covered by the scope of this policy to address the issues reviewed.

DCBHS shall maintain each Unusual Incident Report (UIR) in accordance with the State Record Retention Schedules and State and Federal confidentiality laws, including, but not limited to, the Federal Health Information Portability and Accountability Act (HIPAA, 42 USC 1301 et seq.).

VI. GENERAL STANDARDS:

A. DEFINITIONS:

The following terms, when used in this policy, shall have the meanings as indicated below:

1. The definitions of **abuse and neglect** are divided into two sections.
2. Section 1 definitions apply to DCBHS service recipients' ages 18 to 21 years.
3. Section 2 definitions, as codified in N.J.S.A. 9:6-8.21, apply to DCBHS service recipients less than age 18 and the Institutional Abuse Investigation Unit (IAIU) only.
4. Section 3 definitions apply to all reporting entities.

Section 1: Abuse/Neglect Definitions for DCBHS Service Recipients ages 18 to 21 years

Physical Abuse

As defined in Administrative Order 4:08, Supplement 1, refers to a physical act directed at a service recipient by a DHS employee, volunteer, intern, or consultant/contractor of a type that could tend to cause pain, injury, anguish, and/or suffering. Such acts include but are not limited to the service recipient being kicked, pinched, bitten, punched, slapped, hit, pushed, dragged, and/or struck with a thrown or held object.

Sexual Abuse

Acts or attempted acts such as rape, exposure of genital body parts, sexual molestation, sexual exploitation, or inappropriate touching of an individual by a DHS employee, volunteer, intern, or consultant/contractor. Any form of sexual contact or activity between a DHS employee, volunteer, or intern and a service recipient is abuse, regardless of whether the service recipient gives consent or the employee, volunteer, or intern is on or off duty.

Verbal/Psychological Abuse/Mistreatment

Any verbal or non-verbal acts or omissions by a DHS employee, volunteer, intern, or consultant/contractor which inflicts emotional harm, mental distress, invocation of fear and/or humiliation, intimidation, degradation, or demeaning a service recipient. Examples include, but are not limited to: teasing, bullying, ignoring need, favoritism, verbal assault, or use of racial slurs, or intimidating gestures (i.e., shaking a fist at a service recipient).

Neglect

The failure of a caregiver (person responsible for the service recipient's welfare) to provide the needed services and supports to ensure the health, safety, and welfare of the service recipient. These supports and services may or may not be defined in the service recipient's plan or otherwise required by law or regulation. This includes acts that are intentional, unintentional, or careless regardless of the incidence of harm. Examples include, but are not limited to, the failure to provide needed care such as shelter, food, clothing, supervision, personal hygiene, medical care, and protection from health and safety hazards.

Exploitation

Any willful, unjust, or improper use of a service recipient or his/her property/funds, for the benefit or advantage of another; condoning and/or encouraging the exploitation of a service recipient by another person. Examples of exploitation include, but are not limited to, appropriating, borrowing, or taking without authorization, personal property/funds belonging to a service recipient, or requiring him/her to perform functions/activities that are normally conducted by staff or are solely for the staff's convenience.

Section 2: Abuse/Neglect Definitions for DCBHS for a child less than 18 years of age and IAIU Only

Child Physical Abuse

As defined in N.J.S.A. 9:6-8.21, means a child less than 18 years of age whose guardian (or person responsible for the child's welfare—i.e., staff person or person

having his custody and control) inflicts or allows to be inflicted, physical injury by other than accidental means which causes or creates a substantial risk of death, serious/protracted disfigurement, protracted impairment of physical health, protracted loss or impairment of the function of a bodily organ, or a substantial or ongoing risk of physical injury or harm; or a child upon whom excessive physical restraint has been used under circumstances which do not indicate that the child's behavior is harmful to himself, others, or property.

Child Sexual Abuse

As defined in N.J.S.A. 9:6-8.21, means a child less than 18 years of age whose guardian (or person responsible for the child's welfare—i.e., staff person or person having his custody and control) commits or allows to be committed, an act of sexual abuse against the child. Examples include, but are not limited to, ambiguous or unambiguous verbal statements with sexual connotations or denotations, non-genital or genital contact involving touching, fondling, or kissing, and sexual exploitation.

Child Emotional Abuse

As defined in N.J.S.A. 9:6-8.21, means a child less than 18 years of age whose guardian (or person responsible for the child's welfare - i.e., staff person or person having his custody and control) inflicts or allows to be inflicted, emotional injury (harm), or mental injury (harm), by other than accidental means, which causes or creates protracted impairment of emotional health or a substantial or ongoing risk of emotional injury (harm). Emotional abuse also includes a child who is in an institution and (a) has been placed there inappropriately for a continued period of time with the knowledge that the placement has resulted or may continue to result in harm to the child's mental or physical well being or (b) who has been willfully isolated from ordinary social contact under circumstances which indicate emotional or social deprivation.

Child Neglect

As defined in N.J.S.A. 9:6-8.21, means a child less than 18 years of age whose physical, mental, or emotional condition has been impaired or is in imminent danger of becoming impaired as the result of the failure of his guardian (or person responsible for the child's welfare- i.e., staff person or person having his custody and control) to exercise a minimum degree of care in supplying the child with adequate food, clothing, shelter, education, medical care, or in providing the child with proper supervision or guardianship, or by willfully isolating the child under circumstances which indicate emotional or social deprivation, or by the continued inappropriate placement of a child in an institution with the knowledge that the placement has resulted or may continue to result in harm to the child's physical, emotional, or mental well-being by other than accidental means.

SECTION 3: Other Definitions

Assault - Physical

Act of touching or striking a victim's body to cause physical harm, which may or may not result in actual injury. The acts perpetrated under the physical assault category could occur between two service recipients, staff to staff, "other" to service recipient or staff, or service recipient to staff or "others." When staff persons charged with the responsibility of supervising or providing direct care

physically strikes a service recipient, the incident is always categorized as abuse and must be reported as such.

Assault - Sexual

Incidents of nonconsensual sexual activity involving penetration, such as vaginal and anal intercourse; the insertion of a hand, finger, or object into the anus or vagina; or cunnilingus and fellatio. (Also see sexual contact definition.)
Reference: NJ Criminal Code - NJSA 2C:14-1

Contraband

Possession or use of an item(s) by a service recipient or an employee that has been designated by the service provider as having the potential to pose danger or harm to others. Examples include, but are not limited to, weapons (commercially manufactured or hand-made) used for offensive or defensive purposes; illegal items such as CDS (Controlled Dangerous Substances) or fireworks; alcohol (for service recipients under the age of 21, with a Mentally Ill Chemical Abuse (MICA) diagnosis, or with potential for pharmacological reaction); or other items identified by the service provider, including, but not limited to, coffee, matches, and aerosol sprays.

Consultant/ Contractor

Refers to a person or company that provides services for DHS facilities on a regular or occasional basis. Examples include, but are not limited to, environmental remediation companies, HVAC repair persons, pharmaceutical delivery service, and medical specialists who come to the facilities to provide care for service recipients (i.e., podiatrist). Consultant/contractors are not DHS employees.

Continuous Quality Improvement Unit (CQI Unit), DCBHS

Refers to the unit within DCBHS which provides continuous quality improvement and quality assurance programs and methodologies for services provided to children enrolled in DCBHS and their families.

Criminal Activity

Refers to the alleged activity of a service recipient, employee, or service provider meeting the thresholds of NJ Criminal Statutes Title 2C, specifically N.J.S.A. 2C: 43-1, the Grading of Offenses (i.e., disorderly persons, aggravated assault) or N.J.S.A. 2C: 24-7 & 8- Neglect of the Elderly and the Disabled. These alleged activities could result in physical injury to another person or damage/loss of property belonging to the State, a service recipient or an employee). [See Attachment ___ for reporting levels.]

Criminal Status

Refers to a service recipient with a criminal status of **Not Guilty by Reason of Insanity (NGRI)** or pursuant to **State v. Krol (KROL)** (68 N.J. 236 (1975)); **Incompetent to Stand Trial (IST)**; **Detainer** (a service recipient originally in the legal custody of a correctional facility found to be in need of mental health services); or **Megan's Law** (sex offender). [See definition of Megan's Law Sex Offender].

Danielle's Law

Refers to the requirement of staff at a facility for persons with developmental disabilities or a facility for persons with traumatic brain injury, who works directly with persons with developmental disabilities or traumatic brain injury, to call the 911 emergency telephone service for assistance in the event of a life-threatening emergency at the facility, and to report that call to the Department. Life-threatening emergency means a situation in which a prudent person could reasonably believe that immediate intervention is necessary to protect the life of a service recipient, or to protect the lives of other persons at the facility or agency, from an immediate threat or actual occurrence of a potentially fatal injury, impairment to bodily functions or dysfunction of a bodily organ or part.

Death - Unexpected

Death of a service recipient that was not medically anticipated. Examples include suicide, homicide and/or unanticipated death due to unforeseen circumstances/complications. Example: A healthy individual goes into the hospital for a routine procedure, develops complications and succumbs to the complications two weeks later.

Death - Expected

Death of a service recipient with a recent (six months or less) medical prognosis of probable or imminent expiration. [See Attachment ___ for reporting levels.]

Elopement

Refers to the act of a service recipient with criminal status, leaving the grounds of a facility without authorization and who cannot be located after a diligent and reasonable search of two hours (for a minor under the age of 18 search time is one hour). For service recipients with no criminal status, see "Walk away" definition. Incident reports are required for all occurrences regardless of when an SR is located. [See Attachment ___ for reporting levels.]

Employee

Refers to a full-time or part-time employee, volunteer, or student intern of the Department of Human Services.

Entered in Error

Refers to an Unusual Incident Report that has been entered in error into database.

Inappropriate Sexual Conduct

Refers to the act of a service recipient exposing him/herself to another person or masturbating in a public setting. No physical contact between the service recipient and the other person. [See also Sexual Contact].

Injury

Injury refers to the accidental, self-inflicted, or intentional damage to the body by an external force. Levels of injury will be categorized as follows:

a. **No injury**

Lacking any evidence of injury and/or no complaint of pain as determined by staff assessing the situation and, if possible, as described by the service recipient.

b. Minor injury

Refers to an injury that requires no treatment beyond basic first aid administered by a medical professional or service provider. Examples of minor injuries include, but are not limited to, bruises and abrasions.

c. Moderate injury

Refers to an injury that requires treatment beyond basic first aid and can only be performed by a medical professional at a physician's office, at a hospital emergency room, or by facility physicians. Examples of moderate injuries include, but are not limited to, a laceration requiring sutures or a human bite breaking the skin, injury around the eye such as bruising, swelling or lacerations.

d. Major injury

Refers to an injury that requires treatment that can only be performed at a hospital facility and may or may not include admission to the hospital for additional treatment or observation. Examples of major injuries include, but are not limited to, skull fractures, injuries to the eye (excluding the area around the eye), and broken bones requiring setting and casting. (See Attachment A for reporting levels.)

Due to the subjective nature of this issue there may be some overlapping of categories. Diagnostic tests including, but not limited to, x-rays, may be needed to rule out injuries of a more significant level. In all circumstances the location and extent of the injury should be taken into careful consideration during the initial assessment by the service provider or facility medical personnel before selecting the injury level.

Media Interest

Refers to media (TV, radio) or journalistic (newspaper, magazine/book) attention that has been or is likely to be generated or intensified regarding any reportable incident involving the Department, Divisions, and their service recipients or employees. Said media interest may or may not have an impact on daily facility operations. Media interest replaces the previous "newsworthy" category and can apply to any type of reportable incident. Examples: "Fire, Media Interest" or "Death, Media Interest".

Medical

Medical refers to any incident concerned with choking, disease/illness, or errors in medical treatment and/or the administration of medication categorized as follows:

a. Choking

Means an incident that occurs during swallowing that requires the assistance of another person for relief, as in the application of an abdominal thrust or suctioning.

- b. **Disease**
Refers to the outbreak of a communicable illness that could impact the health, safety, or operation of a facility or program or a single incident of illness reportable to the Department of Health and Senior Services. Reference: N.J.A.C. 8:57-1.3
- c. **Medication/Treatment Error**
Refers to any deviation from prescribed orders that results in, or has the potential to result in, serious effects that require medical intervention as determined by a qualified medical professional (physician, pharmacist). These incidents may involve errors in medical treatment or errors in the administration of medication.

Megan's Law Sex Offender

Refers to any person convicted, adjudicated delinquent, or acquitted by reason of insanity of designated sex offenses pursuant to N.J.S.A. 2C:7-2b. Refer to AO 3:06, Department of Human Services Implementation of Megan's Law.

Operational Incidents

This category consists of a wide variety of incidents that significantly impact or could potentially affect the general health, safety, and welfare of DHS service recipients or impacts on the daily operation of the facility or program. Examples include, but are not limited to, fires, environmental issues, damage to state or service recipient property, and staff shortages. (See individual sub-category definitions below.)

- a. **Destruction/Damage to State, Service Recipient, or Employee Property**
Refers to an accidental or willful act, perpetrated by any person that damages or destroys state or personal property rendering the item unusable. The incident may or may not impact on service recipient care or facility operations. [Also see Theft/Loss category.]
- b. **State Property**
Examples include, but are not limited to, equipment (vehicle, laptop computer, tools,) or property (structural or land).
- c. **Service Recipient Property**
Examples include, but are not limited to, television, stereo, camera, and clothing. Incidents involving money will be handled under the Theft/Loss category.
- d. **Employee or Other's Property**
Examples include, but are not limited to jewelry, clothing, cell phone, automobile tires, and equipment/tools. (Also see Theft/Loss category.)
- e. **Discharged Service Recipient**
Refers to a service recipient who has been discharged/released/transferred from a DHS facility for six months

or less and is now residing in the community (group, boarding, nursing, or own home).

f. **Environmental**

Refers to incidents involving spills or illegal dumping of toxic substances on state property or other incidents impacting on air or water quality.

g. **Fire**

1. **Major event**

Refers to an incident resulting in damage, which renders a facility, or part thereof, unusable or resulting in injuries to staff or service recipients.

2. **Moderate event**

Refers to incidents requiring outside assistance to extinguish or contain.

3. **Minor event**

Refers to incidents that were extinguished or contained utilizing facility staff. [See Attachment __ for reporting levels.]

h. **Mass disturbance**

Refers to an incident involving five or more people (service recipient or employee) that disrupts services or impacts on facility operations and may pose a threat to the life or safety of others. Example: riot.

i. **Operational breakdown**

Refers to any utility outage, which may cause a threat to life or safety and impact on facility operations. Examples: loss of electricity to all or part of the facility or loss of telephone service.

j. **Public Safety issue**

Refers to incidents such as natural disasters flood, hurricane, etc.), terrorist threats or the taking of hostages posing an immediate threat to the life and safety of service recipients and employees.

k. **Theft/Loss**

Refers to a willful or unexplainable incident, perpetrated by any person, resulting in State, service recipient, or employee property or monetary funds, being stolen or missing. (See Attachment A for reporting levels.)

l. **Unexpected Staff Shortages**

Refers to incidents resulting from an apparent job action or other situations that may pose a threat to life/safety or impact on facility operations.

m. **Other**

Refers to a person(s) who is not an employee or service recipient such as a visitor (family member or friend) or a consultant/contractor.

Patient Safety Act

Refers to those double coded incidents occurring in DMHS operated psychiatric hospitals that involve an adverse event that is a preventable event and results in death or loss of a body part, or disability or loss of bodily function lasting more than seven days or still present at the time of discharge from a health care facility.

Pica

Refers to the behavior of ingesting inedible substances or objects including, but not limited to soil, paint chips, batteries, or cigarette butts.

Reporting Authority

Refers to the person(s) at a facility/institution charged with the responsibility of submitting the incident report to UIRMS. Each Division utilizes different staff titles for this task. Example: DMHS - Risk Management Unit; DDD - Quality Assurance Coordinator.

Restraint Use

Refers to the restriction of an individual's freedom of movement either partially or totally by physical contact imposed by staff (Personal Control Technique), the application of a physical device (Mechanical Restraint) or through the use of medication (Chemical Restraint). Restraints are further defined as follows:

a. **Approved:**

Refers to restraints implemented with prior approval and written order, in accordance with the administrative regulations of the appropriate division, or as part of an approved behavior treatment plan.

b. **Unapproved:**

Refers to restraints implemented without prior approval/order or not in accordance with the administrative regulations of the appropriate division or without the existence of an approved behavior treatment plan.

Rights Violation

Any act or omission that deprives a service recipient of human or civil rights, including those rights which are specifically mandated under applicable regulations. Court ordered restrictions, clinically justified restrictions that are appropriately documented, or licensing regulations subject to a waiver are not considered rights violations within the meaning of this policy. Examples include, but are not limited to, unauthorized removal of personal property, refusal of access to the telephone, privacy violations, breach of confidentiality, or any failure to inform, respect, or assist a service recipient in exercising his or her rights.

Service Recipient -

Refers to a child (birth to 17 years of age) enrolled in DCBHS or a young adult (18 to 21 years of age), who had been receiving mental/behavioral health services under DCBHS (formerly the Partnership for Children) prior to becoming 18 years of age, or who is currently receiving services in the child-serving system and who demonstrates a clinical need for the continuation of such services as part of the process of transitioning into the adult service system. This term replaces the previously used terms of consumer, patient, or client.

Sexual Contact

Refers to the intentional, nonconsensual touching of the victim's breast, genital, or anal area, over or under clothing, with the purpose of sexual arousal and/or gratification of the perpetrator. **Any act perpetrated by staff upon/involving a service recipient is considered abuse and must be reported as such.** (Also see **Assault: Sexual.**) Reference: N.J.S.A. Criminal Code 2C:14-1.

Suicide Attempt

Refers to an attempt to intentionally kill one's self regardless if the act resulted in injury. (See Attachment A for reporting levels.)

Unusual Incident

An occurrence involving the care, supervision, or actions of a service recipient that is adverse in nature or has the potential to have an adverse impact on the health, safety, and welfare of the service recipient or others. Unusual incidents also include situations occurring with DHS staff or contractors or affecting the operations of a facility/institution/school. Examples include, but are not limited to, allegations of abuse and neglect, service recipient to service recipient assault, and medication errors. An unusual incident may also involve the conduct of employees (while on- or off-duty) or others who may come in contact with service recipients who reside in DHS operated facilities, regardless of the place of occurrence of the incident. Examples include, but are not limited to, a service recipient receiving medical care in a local hospital or an incident occurring while service recipient is on brief visit.

Unusual Incident Report Coordinator (UIR Coordinator), DCBHS

An individual assigned by the Director, DCBHS or his or her designee to carry out the unusual incident reporting system.

Walk away (No Criminal Status)

Refers to the act of a service recipient who leaves the grounds of a facility without authorization and who can not be located after a diligent and reasonable search of two hours **(for minors under the age of 18 search time is one hour.)** This incident category applies to service recipients who:

- a. May be considered dangerous to self or others but have no prior documented criminal status.
- b. Are under age 18 or over age 60,
- c. May be at-risk due to disability (medical or cognitive); or

- B. In accordance with DHS Administrative Order 2:05, all facilities, institutions, schools, and programs that are operated by a respective Division, Office, or Commission of DHS shall report unusual incidents directly to DHS utilizing the Unusual Incident Reporting & Management System (UIRMS).
- C. Community-based service providers certified by DCBHS and agencies under contract with DCBHS shall submit reports of unusual incidents and subsequent follow-up reports on incident report forms designated by DCBHS.
- D. The Director, DCBHS or his or her designee shall identify certain staff that is available both during and after business hours, to serve as the UIR Coordinator, DCBHS.
- E. Entities covered by the Scope of this policy shall have internal policies and procedures for:
 - 1. The initial reporting of unusual incidents,
 - 2. Follow-up investigation of unusual incidents,
 - 3. Follow-up reporting of unusual incidents, and
 - 4. Notification of the child's parent or legal guardian and caregiver of all child-specific unusual incidents, unless contraindicated.
- F. Each service provider certified by DCBHS and agency under contract with DCBHS shall identify an individual who has overall responsibility for incident management.
- G. The results of a service provider or agency investigation and the follow-up UIR report shall be provided to the UIR Coordinator, DCBHS within established timeframes.
- H. The Director, DCBHS or his or her designee reserve the right to initiate an internal investigation of an unusual incident at his or her discretion.
- I. Accidents involving State vehicles in which there is no personal injury shall be reported according to Treasury Circular 3-87 and are not addressed in this policy and procedure.

VII. PROCEDURES:

- A. Unusual incidents shall be categorized as follows:
 - a. For community-based programs or services contracted, regulated, licensed or subject to investigation by DHS or its Divisions, Bureaus, Offices or Commissions, unusual incidents shall be categorized as described in Appendix A of this policy.

- b. For all facilities, institutions, schools and programs that are operated by a respective Division, Office, or Commission of DHS unusual incidents shall be categorized as described in Appendix B of this policy. (Appendix B of this policy is the DHS-DCBHS UIRMS Incident Category List.)
- B. **ALL** medication errors require, at a minimum, a consultation by a medical professional (i.e. physician, pharmacist) other than the individual(s) involved the medication error.
 - 1. Documentation of this consultation and the condition of the child/youth/young adult shall be made in the child's/youth's/young adult's medical chart.
 - 2. Where medical intervention is required, documentation of the intervention and the condition of the child/youth/young adult shall be made in the child's/youth's/young adult's chart.
- C. Service providers certified by DCBHS and agencies under contract with DCBHS shall verbally report unusual incidents to DCBHS in accordance section VII. F. 1 of this policy.
- D. Service providers certified by DCBHS and agencies under contract with DCBHS shall submit written reports to the UIR Coordinator, DCBHS in accordance with sections VII. G. 1 through 3 of this policy.
- E. Telephone Notification
 - 1. **IMMEDIATE:**
 - a. Community A+ level incidents shall be reported immediately by telephone to the UIR Coordinator, DCBHS.
 - b. DHS-operated institution, facility, school and program A+ and A level incidents shall be reported immediately by telephone to the UIR Coordinator, DCBHS.
 - c. The UIR Coordinator, DCBHS shall immediately notify the Director, DCBHS or his or her designee by telephone of each A+ and A level incident.
 - d. Immediately upon notification that an A+ level incident has occurred, the Director, DCBHS or his or her designee shall notify the Deputy Commissioner, Office of Children's Services, the DHS Office of Public Information and appropriate DHS personnel or their designees of the incident, regardless of the hour of the day, by telephone.
 - 2. Telephone notification is not required for B and C level incidents.

G. Written Notification: Via Email, Fax or Hard Copy

1. A+ Level Incidents - Information regarding A+ level incidents occurring during normal business hours shall be submitted in writing to the UIR Coordinator, DCBHS on the DCBHS Initial report form immediately after obtaining the details required to complete the initial incident report. Submission of an A+ level UIRs shall not be delayed if information is unknown. Missing information shall be submitted as soon as possible via a follow-up incident report.

A+ level incidents occurring after normal business hours shall be submitted in writing to the UIR Coordinator, DCBHS as soon as possible on the next business day. Following weekends and holidays, the submission of A+ level UIRs shall be made a priority.

2. A Level Incidents - Information regarding an A level incident occurring during regular business hours shall be submitted by the end of that working day to the UIR Coordinator, DCBHS utilizing the DCBHS Initial Report Form. Submission of an A level incident shall not be delayed if information is unknown. Information shall be submitted as soon as possible via a follow-up incident report.

A level incidents occurring after normal business hours shall be submitted in writing to UIR Coordinator, DCBHS as soon as possible on the next business day.

3. B Level Incidents - Information regarding B level incidents shall be submitted to the UIR Coordinator, DCBHS, in writing by the end of the next working day utilizing the DCBHS Initial Report Form.

4. C Level Incidents - For DHS-operated institutions, facilities, schools and programs, information regarding C level incidents must be submitted to DHS via UIRMS on a quarterly basis.

- H. The UIR Coordinator, DCBHS shall develop a system for logging, tracking and filing UIRS. The coordinator's review, at a minimum, shall indicate a DCBHS review of the incident report, level of reporting, actions needed, actions taken, and administrative and regulatory notifications.

- I. The UIR Coordinator, DCBHS shall monitor compliance with time frames of initial and incident follow-up reports.

- J. Follow-Up Reporting for all A+, A, and B Level Incidents shall be submitted to the UIR Coordinator, DCBHS utilizing the DCBHS Follow-Up Report Form when:

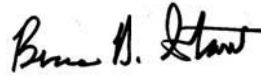
1. Additional critical information becomes available, particularly when the reporting category of the incident was an A+ or is being upgraded from an A level incident to an A+ level incident,
2. An internal investigation is completed, or

The incident is considered closed.

3. Where none of the above has occurred by the **30th calendar day** after the report of the initial incident, a follow-up report shall be submitted to the UIR Coordinator, DCBHS to document the reason(s) for the delay.
 4. Follow-up reporting shall occur at **45 calendar day** intervals until the incident is closed.
- K. Closing Criteria - All of the following criteria shall be met for an incident to be closed:
1. A thorough investigation and/or evaluation of the incident by an objective party has been completed in accordance with applicable statutory, regulatory, and/or policy-related timeframes.
 2. An objective conclusion, known as the finding, is formulated based upon the corroboration of evidence and facts. There are two types of findings:
 - a. Substantiated: There is a preponderance of credible evidence that the allegation or situation is true and/or occurred.
 - b. Unfounded: There is no credible evidence, information or facts to support the allegation or situation is true and/or occurred.
 3. Recommendation(s) are made that delineate the scope of the required corrective action plan, identify those individuals responsible for carrying out the plan, and designate timeframes for the plan's implementation to prevent reoccurrences of the incident.
 4. All relevant facts, conclusions, and recommendations are presented to the administration of the DHS-operated institution, facility, school or program, DCBHS, and DHS as applicable.
- L. Any incident, once closed, may be re-opened by the administration of the facility, agency or service provider, DCBHS or DHS. Subsequent recommendations may be needed to address the issues reviewed.
- M. DHS shall exercise final discretion when the need for additional review is disputed.
- N. Where a DCBHS staff member receives a written or verbal report of an unusual incident from any source (anonymous or known), DCBHS staff shall:
1. At a minimum, obtain the following:
 - a. Child's name,

- b. Date of incident,
 - c. Agency/provider involved,
 - d. Nature of incident, and
 - e. Identity and telephone number of individual making verbal report (where available).
- 2. Inform the individual of his or her obligation to immediately report the incident to the SCR at 1-877-NJ ABUSE (1-877-652-2873) or 1-800-792-8610.
- 3. Inform the individual of his or her obligation to submit an initial UIR via fax or email to the UIR Coordinator, DCBHS. The DCBHS Initial UIR template is located on the DCBHS web-page. <http://www.state.nj.us/>
- 4. Where abuse or neglect is alleged contact the SCR, state that a verbal report of an unusual incident was received and provide all available information.
- 5. Via email, contact the UIR Coordinator, DCBHS and provide:
 - a. All information obtained within N.1 above,
 - b. Date and time DCBHS staff member reported the incident to SCR, and the
 - c. Identity and telephone number of the individual who will provide the written Initial UIR to DCBHS.
- O. The UIR Coordinator, DCBHS shall ensure that all applicable statutory and regulatory agencies are notified of the unusual incident, including but not limited to DYFS, DMHS, DDD, DMAHS (Medicaid) and DHS OPIA and Office of Licensing (OOL).
- P. As directed by the Director, DCBHS or his or her designee, the UIR Coordinator, DCBHS shall notify the CSA of UIRs regarding service providers certified by DCBHS and agencies under contract with DCBHS for the purpose of tracking and quality management.
- Q. In accordance with DCBHS CQI practices, all UIRs shall be reviewed by the CQI Unit, DCBHS for the purpose of tracking and quality management.
- R. At the discretion of the Director, DCBHS or his or her designee, UIRs shall be investigated by the CQI Unit, DCBHS and/or other DCBHS staff as assigned.
- S. Where, as the result of an investigation conducted by the CQI Unit, DCBHS and/or DSBHS staff, an adverse finding regarding an individual, service provider, or agency under contract with DCBHS is indicated, the final DCBHS investigative report shall be forwarded by the DCBHS UIR Coordinator to the appropriate regulatory and statutory authorities.

- T. At the discretion of the Assistant Director, DCBHS and/or his or her designee, the CQI Unit, DCBHS shall assist the regulatory authority with investigations and follow-up of plans of correction.
- U. At the discretion of the Assistant Director, DCBHS and/or his or her designee, where DCBHS becomes aware of an adverse regulatory or licensing action involving a service provider certified by DCBHS or agency under contract with DCBHS, the UIR Coordinator, DCBHS shall notify Systems Partners including, but not limited to, the CSA, CMO, YCM, MRSS and FSO.



Bruce D. Stout, Ph.D.
Director, Division of Child Behavioral Health
Services

SSA Continuous Quality Improvement Plan

The SSA relies on three formal routine mechanisms to continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, demonstrate evidence of effectiveness, and to respond to critical incidents, complaints and grievances: Service Contract Monitoring, the Program Improvement Committee (PIC), and the Contract Coordinating Committee.

A) Service Contract Monitoring and Reporting

The SSA conducts at least one formal contract monitoring site visit annually per calendar year for all prevention, treatment, and recovery support service contracts. More frequent reviews are conducted on an as needed basis for agencies identified by the PIC as needing additional technical assistance or monitoring in response to identified deficiencies, technical assistance needs, or special contract requirements.

The SSA notifies a contracted agency in writing at least one week in advance of a scheduled site visit (site visits can be unannounced). Prior to the site visit, Addiction Programmatic Monitoring Officers (APMOs) review the most recent listing of agency personnel and reviews the last monitoring site visit report for renewal contracts to ensure follow-up for any previous citations is incorporated into the upcoming review. Once onsite, the APMO tours the facility, reviews relevant components of the policy and procedure manual and individual client files, if appropriate for the contracted service, for compliance with contractual agreements, Federal Block grant requirements, and licensure requirements. Each review is conducted and recorded using a standardized Annual Site Visit Monitoring Review Form as a guide. The Site Visit Monitoring Form is used to document adherence or non-adherence to contract deliverables, service requirements, service levels, and contracted outcomes. The APMO selects a random sample of client files from the active client roster for a detailed review of requirements including use of placement criteria, treatment planning and progress documentation, and delivery of specific client services. Rosters are reviewed to monitor utilization for slot-funded services. Fee-for-service claims reports are compared to individual client records. At the conclusion of the site review, the APMO conducts an exit conference with agency representatives.

The Annual Site Visit Monitoring Review Form addresses a minimum of five issues: Facility, Staff, Treatment or Service Records, Quality Assurance, Specialized Services, and Other Contract-Specific requirements. Facility questions pertain to the facility's interior and exterior appearances, facility accessibility, and the proper posting of licenses and certificates. Staff questions pertain to personnel policies, staff meetings and training, and staff certification. Treatment Record questions pertain to the counselors' procedures, availability of medical and clinical services, the client roster, and maintenance of client files for treatment services; for prevention and recovery support services, this section of the monitoring form documents fulfillment of other specific contract deliverables and requirements. Quality Assurance questions pertain to the agency's Quality Assurance plan and quality of care, and to contract-specific performance targets. Specialized Services questions pertain to child care, transportation and gender specific treatment. Other questions pertain to management and administrative matters.

During the annual site visit the APMO will notify the Monitoring Unit Supervisor immediately if he/she finds that the clients and/or staff are at immediate risk due to life safety concerns such as lack of facility maintenance; construction being done on site, or other possible dangers, including numerous citations for contractual or licensure non-compliance or other issues of concern. The Monitoring Unit Supervisor immediately notifies the appropriate SSA Senior Staff so that a determination can be made regarding the need for immediate and appropriate actions. Such findings are also reported to the Program Improvement Committee (PIC) for resolution.

After the site visit has been completed, which can take anywhere between 1-5 days depending on the agency size and their funded treatment modalities, the APMO then completes the Annual Site Monitoring Review Form and cover letter. The APMO then gives a copy to the Monitoring Unit Supervisor for review prior to mailing it to the agency. The Monitoring Unit Supervisor reviews the findings, if a finding is a serious and/or extreme violation of a contractual and/or licensure requirement, the Monitoring Unit Supervisor informs the SSA Senior Staff. The violations are then also reported to the PIC who may require agency representatives to come to DMHAS in Trenton to meet with program representatives regarding a required plan of correction and/or the frequency of monitoring may increase.

The Annual Site Visit Monitoring Review Form is currently being revised so that satisfaction or compliance of each contract requirement is given a quantitative score. Individual item scores will be weighted and aggregated to reflect agency performance and risk and these scores will be incorporated into the 360 Dashboard. This new tool will also include consumer feedback scores. It will be made available in an electronic format that facilitates data upload into a single database to support comparisons of performance over time and across agencies. A test version of the new tool will be available in November of 2011.

When an agency receives the site visit report, the agency is then required to respond with a plan of Corrections (PoC) if they were found to be out of compliance with the Annex A requirements. Once a PoC is received it is then reviewed by the APMO. The APMO will either accept the PoC or reject the PoC. If a PoC is rejected a letter goes out to the agency indicating what components of the submitted PoC were rejected and the agency must submit a new/revised PoC. The APMO will provide technical assistance and this process will continue until an acceptable PoC is submitted. If after several attempts for any reason an agency is unable to submit an acceptable PoC, the monitoring unit supervisor is notified by the APMO and the issue will be brought to PIC for review and discussion.

B) Program Improvement Committee (PIC)

The SSA maintains a Program Improvement Committee (PIC) to review reportable events, consumer complaints, monitoring and/or licensure citations. The PIC is convened on a bi-weekly basis. It is chaired by the Addiction Services Quality Assurance Coordinator of the Complaint and Reportable Event Management Unit (CREMU) or designee; with respective staff (also known as committee members) from applicable units/offices within Addiction Services participating as needed. Staff attending the PIC are: 1) responsible for completing any assignments or for following up on issues as identified and decided upon at the PIC, 2) updating the committee on the progress or resolution of the issue at the next meeting or sooner as assigned, and 3) responsible for ensuring a substitute or designee attends the PIC if a committee

member is unable to attend. Each committee member is responsible for briefing the substitute/designee regarding any applicable issues so an update(s) may be provided to the PIC. Minutes are taken at each PIC meeting and distributed at the next meeting.

Staff from the CREMU are responsible for notifying the PIC immediately via email during normal business hours of any Reportable Event received. The Quality Assurance Coordinator is responsible for verbally reporting and updating the PIC on the status of all Reportable Events received by the CREMU.

The following topics are discussed at PIC: 1) all reportable events received by the SSA 2) All complaints received at the SSA that indicate potential or substantiated health, life and safety deficiencies; 3) any CREMU investigation results that indicate life and health safety issues; 4) all CREMU complaints or investigative results that indicate licensure noncompliance (such as a facility licensed within the past year with multiple deficiencies, operating without a license, providing services over licensed capacity, or with numerous deficient areas indicating a need for a full survey, 5) all monitoring unit findings that indicate serious and persistent contract noncompliance; 6) all findings that indicate egregious network contract/fee for service/agreement noncompliance; 7) any facility that is found to have repeated noncompliance with a contract requirement, licensure regulation or SSA network agreement; 8) any agency (facility/program) that does not submit a plan of correction for regulatory or contract citations, or does not implement the applicable corrective action plan; and 9) any CREMU investigation results that indicate possible contract noncompliance.

When a member or attendee wishes to introduce a topic, the following procedures apply: 1) consensus is reached by the members as to whether the issue is to be addressed at PIC; 2) the topic will be discussed for approximately three minutes, at which time a course of action is decided on and recorded in the written minutes; 3) in those instances in which a topic requires a lengthy discussion, a senior addiction management staff will direct that the issue be addressed at a dedicated meeting. Such direction includes who should attend the dedicated meeting and identification of the staff person responsible for scheduling the dedicated meeting. A decision will be made whether to keep the issue open for updates to PIC, or whether the issue may be closed to PIC.

The following are issues that must be brought to the attention of the Division Assistant Commissioner: 1) any life and health safety issues that are not immediately rectified by the agency (facility/program); 2) any topic as identified in B. 1-8 above; 3) circumstances in which legal advice is needed or legal action is involved; 4) any other issue as decided by the committee or at the discretion of the senior addiction management staff.

C) Contract Coordinating Committee

The Contract Coordinating Committee was established to convene fiscal and programmatic unit staff to discuss fiscal and programmatic issues and/or concerns pertaining to contractual requirements and contractual processes to ensure continuity and consistency of fiscal and programmatic management activities. The meeting is held on a bi-weekly basis and is chaired by SSA senior staff. Items referred for consideration by the committee include: 1) time line for

contractual renewal applications; 2) contract modifications and revisions; 3) contract reductions; 4) agency utilization; 5) RFP start dates; 6) recoupment; and 7) audit findings.

When a member or attendee wishes to introduce a topic, the following procedures apply: 1) the member notifies the fiscal unit in advance so that the topic will be placed on the agenda; 2) the topic will be discussed for approximately 3- 10 minutes, at which time a course of action is decided; 3) follow-up actions are assigned and documented in meeting minutes; 4) in those instances in which a topic requires extended consideration a SSA senior staff member will direct that the issue be addressed at a dedicated meeting. Such direction includes who should attend the dedicated meeting and identification of the staff person responsible for scheduling the dedicated meeting.

Service Authorization Performance Standards Based on Level of Urgency

	Service	Emergent (within 1 hour)	Urgent (within 1 calendar day)	Significant (within 3 business days)	Routine (within 5 business days)
1.	MRSS				
	▪ Initial Dispatch	X			
	▪ Stabilization Management Services		X		
	▪ Discharge Review				X
2.	CCIS Referrals for OOH Treatment		X		
3.	OOH Treatment:				
	▪ Intensity of Service Determination		X		
	▪ JCR				X
	▪ TJCR/DJCR				X
	▪ Tier II Consultation			X	
4.	CMO/YCM/UCM:				
	▪ Initial Review			X	
	▪ Continued Stay Review				X
	▪ Discharge Review				X
5.	14-day Plan (initial referral & authorization)		X		
6.	Partial Hospital (all review types)		X		
7.	IIC/BA (all review types)				X
8.	MST (all review types)				X
9.	FFT (all review types)				X

Service Authorization Types

	Service	Registration Only	SRTU Review	CSA Review
1.	MRSS:			
	▪ Initial Dispatch			X
	▪ Stabilization Management Services			X
2.	Children's Crisis Intervention Services (CCIS)	X		
4.	Intensive Residential Treatment Services (IRTS)		X	X (continued stay)
5.	Out of Home (OOH) Treatment Settings:			
	▪ Treatment Home (TH)			Intensity of service determination, JCR, TJCR, DJCR review
	▪ Group Home (GH)			Intensity of service determination, JCR, TJCR, DJCR review
	▪ Residential Treatment Center (RTC)			Intensity of service determination, JCR, TJCR, DJCR review
	▪ Psychiatric Community Residence (PCR)		X	
	▪ Specialty Services (SPEC)		X	
	▪ EDRU		X	
	▪ DAP		X	
6.	Case Management:			
	▪ Care Management Organization (CMO)			X
	▪ Youth Case Management (YCM)			X
	▪ Unified Care Management (UCM)			X
7.	14-day Plans			
8.	Partial Hospitalization			X
9.	Intensive In-Community Services/Behavioral Assistance (IIC/BA)			X
11.	Multi-Systemic Therapy (MST)			X
12.	Functional Family Therapy (FFT)			X
13.	Flex Fund Services			X

**SFY 2011 MEMORANDUM OF UNDERSTANDING (MOU)
BETWEEN
THE DIVISION OF YOUTH AND FAMILY SERVICES (DYFS)
AND
THE DIVISION OF ADDICTION SERVICES (DAS)
FOR
DYFS CHILD WELFARE (CW) SUBSTANCE ABUSE SERVICES**

WHEREAS, the Division of Youth and Family Services (hereafter referred to as DYFS) in partnership with the Division of Addiction Services (hereafter referred to as DAS) recognize the need to promote and provide coordinated enhanced child welfare substance abuse treatment services for residential, intensive outpatient, outpatient and methadone maintenance for children and families who have an open child welfare case with DYFS, and

WHEREAS, the DYFS and DAS agree that enhanced treatment services shall include, but shall not be limited to substance abuse screening, assessment, treatment planning with DYFS and coordination with the Child Protection Substance Abuse Initiative (CPSAI) that promote children's outcomes of safety, stability, permanency, wellbeing, and parents' outcomes of personal responsibility and transition to self-sufficiency, and

WHEREAS, the DYFS and DAS agree that the DYFS Child Welfare Substance Abuse Treatment Providers (CWSATP) shall use the same substance abuse assessment tools, which are based on American Society of Addiction Medicine (ASAM) criteria, to determine that DYFS involved families are placed in the appropriate level of treatment. The CPSAI and Work First New Jersey-Substance Abuse Initiative (WFNJ-SAI) vendors shall coordinate services with the DYFS CWSATP to maximize the utilization of enhanced residential and outpatient treatment slots and the fee-for-service Work First New Jersey Provider Network for residential and outpatient treatment, and

NOW, THEREFORE, THE PARTIES HERETO AGREE AS FOLLOWS:

- I) Under this agreement, the DYFS is the "Funding Agency" and the DAS is the "Service Provider Agency."
 - A) Obligations of the Funding Agency:
 - 1) Under this agreement, the Funding Agency shall provide \$13,753,335 for continuation funding and proposed expansion of current services.
 - (a) The DYFS portion shall not exceed \$13,753,335 for the period of July 1, 2010 to June 30, 2011 and payment is contingent upon the satisfactory delivery of services by the Provider Agency.

B) DYFS shall monitor the progress of the DAS obligations to ensure completion within the stated timelines in order for funds to be provided. All financial, programmatic, performance and other monitoring requirements are in accordance with previous agreements and the Expenditure Reporting Instructions and Program and Outcomes Reporting and MOU Monitoring (available upon request)

1) Payments shall be made to DAS in accordance with the provisions in Attachment A for the approved \$13,753,335 allocation for the continuation of existing DYFS Child Welfare Substance Abuse Services.

2) Funds shall be transferred from DYFS to DAS upon execution of this agreement.

C) DYFS Rights

1) Audit:

(a) The Funding Agency shall have the right at any time to audit all accounts and records maintained by the recipient of these funds. To effectuate this provision, the Funding Agency shall be afforded, during normal business hours access to all records and/or data of the Provider Agency indicated in Section III that pertain to this agreement. The provisions of this subparagraph shall continue for a period of seven years after the submission and acceptance of the financial and programmatic reports required under this agreement.

(b) The Grantee (Subgrantee) shall meet the standards prescribed by the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, dated June 9, 1987 and HIPAA. Staff shall receive training on confidentiality guidelines and its limits. As the "Funding Agency," DYFS has authority to evaluate and audit all recipients' records, as granted under the exclusions to the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, dated June 9, 1987 and HIPAA.

2) Reporting Requirements:

(a) Quarterly Program Utilization Reports shall be submitted by Christine Scalise, DAS Manager of Child Welfare and Targeted Populations Unit, to Tyrone Richardson, DYFS Statewide Manager for Child Welfare and Substance Abuse Services, Office of the Director.

(b) Quarterly Financial Reports must be submitted by John Rountree, Fiscal Services Unit, Division of Addiction Services, to DYFS within 20 days of

the end of each calendar quarter. These reports should be sent to the attention of Jim Dolan, Office of Budget and Revenue at the Department of Children and Families (DCF) Business Operations. A cover memo must be submitted by an authorized agency official along with the name and telephone number of the individual that completed the report.

- (c) Final Reports must be submitted by DAS to DYFS within 90 days of the end of this MOU.

II) Obligations and Rights of the Service Provider Agency

A) DAS shall ensure that the contracted Child Welfare agencies will provide:

- 1) Consultation with DYFS workers as needed to incorporate the treatment plan with the goals of the DYFS case plan.
- 2) Standardized substance abuse assessments, including urine drug screens, referral if needed to other appropriate levels of treatment.
- 3) Collaboration with referring provider for treatment coordination, and monitoring of treatment compliance in keeping with current case closing protocols.
- 4) Notification to DYFS 24 hours prior to discharge in services.
- 5) Transportation and support services.
- 6) Ongoing written and verbal case conferencing with DYFS staff.

III) Terms and Terminations

- A) This agreement may be terminated by either party with or without cause upon sixty (60) days in advance written notice.
- B) Subject to any rights of termination hereinafter set forth, this agreement shall become effective on July 1, 2010 and shall remain valid through June 30, 2011. Extensions of this agreement or changes in funding which impact the services provided require the approval of both DYFS and DAS.

IV) Principal Contacts

A) The principle contacts under this agreement for the Division of Youth and Family Services shall be:

1) Program Officer:

(a) Tyrone Richardson, Office of the Director for the Division of Youth and Family Services, 50 East State Street, CC# 900, P.O. Box 717, Trenton, NJ 08625-0717, Telephone 609-943-4206.

2) Fiscal Contact:

(a) Jim Dolan, Department of Children and Families, Business Operations, 50 East State Street, CC# 974, P.O. Box 717, Trenton, New Jersey 08625-0717, Telephone: 609-984-6967.

B) The principal contact for all notifications under this Agreement for Division of Addiction Services shall be:

1) Program Officer:

(a) Christine Scalise, Division of Addiction Services, 120 Stockton Street, 3rd Floor, P.O. Box 362, Trenton, N.J. 08625-0362, Telephone (609) 292-7293.

2) Fiscal Officer:

(a) Jose Gonzalez, Division of Addiction Services, Fiscal Services Unit, 120 Stockton Street, 3rd Floor, P.O. Box 362, Trenton, N.J. 08625-0362, Telephone (609) 984-3211.

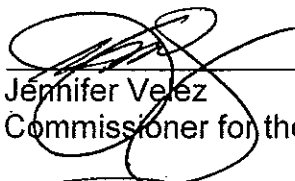
V) We the undersigned, consent to the contents of this agreement:

The New Jersey Department of Children and Families, Division of Youth and Family Services

Signature: Allison Blake Date: 6/18/10
Allison Blake, Ph.D., L.S.W.
Acting Commissioner for Department of Children and Families

Signature: Christine Mozes Date: 6.10.10
Christine M. Mozes, L.S.W.
Director for the Division of Youth and Family Services

The New Jersey Department of Human Services, Division of Addiction Services

Signature:  Date: 6/23/10
Jennifer Velez
Commissioner for the Department of Human Services

Signature:  Date: 6/22/10
Raquel Mazon-Jeffers
Director for the Division of Addiction Services



State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF ADDICTION SERVICES
PO Box 362
TRENTON NJ 08625-0362

JON S. CORZINE
Governor

JENNIFER VELEZ
Commissioner

RAQUEL MAZON JEFFERS
Director

January 26, 2009

Dear Provider:

I am writing to announce the enclosed Division of Addiction Services' (DAS) Hybrid Contract Policy.

The Hybrid Contract Policy has been developed to ensure the responsible use of limited public funds available for substance abuse treatment to maximize service availability. The Hybrid Contract Policy addresses the management of slot utilization at individual treatment agencies contracted by DAS, and affords agencies with a documented history of underutilization with an opportunity to successfully rectify problems of underutilization and maintain their level of contract funding. Should any particular agency have difficulty bringing their utilization up to the contracted level, this policy allows DAS to redirect the resources to best ensure the maximum level of client services.

The Hybrid Contract Policy is effective immediately for any agency that has already been placed on Hybrid status.

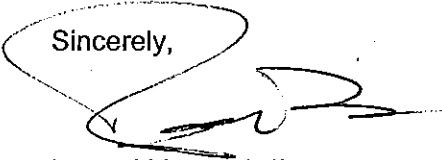
The policy applies to utilization in the DAS treatment contracts which are funded in a slot format. It does not apply to fee-for-service Letters of Agreement.

DAS is aware of your sincere dedication to provide excellent care to as many clients as possible. We are looking forward to a continued working relationship with you and your agency to provide quality care to as many substance abusers in New Jersey as possible. I am hopeful that the Hybrid Contract Policy will be received in the same light for which it was developed by DAS; that is, as an essential management instrument that identifies and provides sufficient advance notice of utilization deficiencies, thereby permitting agencies to address the areas of concern by instituting appropriate corrective measures.

As this policy impacts the areas of both utilization and fiscal, any questions you have may regarding contracts should be directed to Jose Gonzalez, DAS Assistant Director for Contract Operations and any questions you may have regarding client rosters/utilization should be directed to Kathy Goat-Delgado, Manager for the Contract Monitoring. Mr. Gonzalez may be reached at 609-984-6961 and Ms. Goat-Delgado may be reached at 609-292-0563.

Thank you for your attention to this matter.

Sincerely,



Raquel Mazon Jeffers
Director

**Department of Human Services
Division of Addiction Services
Administrative Services**

External Policy

Policy Number: AS012009

**SUBJECT: CRITERIA TO DETERMINE DESIGNATION AND HANDLING OF
HYBRID CONTRACTS**

I. PURPOSE

The purpose of this administrative bulletin is to establish procedures to designate a service or services within an Agency as a Hybrid Contract and to outline how such contracts will be evaluated and disposed of.

II. SCOPE

This policy shall be applicable to all components which contract with the Division of Addiction Services (DAS) for the purpose of providing substance abuse prevention and treatment services.

III. DEFINITIONS

In addition to the terms defined in the Glossary of the Department of Human Services (DHS) Contract Policy and Information Manual (CPIM), and the DHS Contract Reimbursement Manual (CRM), the policies referred to herein and the following terms, shall have these meanings:

Advance Payment means the contract payment methodology where the ceiling amount is prorated over the number of desired payment intervals in the contract term to determine the installment payment amount.

CPIM means the DHS Contract Policy and Information Manual describing provider payments and reimbursement criteria.

CRM means the DHS Contract Reimbursement Manual describing third party contacting policy.

DHS means the Department of Human Services.

DAS means the Division of Addiction Services.

Fee-For-Service (FFS) means payment methodology where a set fee is provided for each service unit delivered through a DAS Network Agreement with provider agencies, and/or a Letter of Agreement capping the payable amount.

Hybrid Contract means placing a portion of an Agency contract on a unit cost reimbursement method of payment, without altering the total value of the contract or the number of slots the Division has committed to reimbursing.

Performance means maintaining the standards and requirements as set forth in the contract's Annex A.

Plan of Correction means the set of actions developed by the agency in response to deficiencies identified by DAS.

Terms and Conditions means the rules and regulations as described in the DHS CPIM, the DHS CRM and the DHS Standard Language Document.

Unit Cost Reimbursement Method of Payment means the submission of an expenditure report and State of New Jersey payment voucher in order for a provider to be reimbursed for services provided on a unit cost basis only. Settlement is generally made at the end of the contract period based on utilization.

IV. POLICY

- A. The designation of Hybrid shall apply when DAS, based on Agency data submitted to DAS, determines that an Agency has not met the service utilization level for which it has contracted.
1. An Agency that has not met its service utilization level for at least **3 consecutive months or otherwise demonstrate a pervasive pattern of underutilization** will receive written notification from DAS that it will be placed on a Hybrid contract for the next 6 months.
 - a. The period of underutilization shall not be limited to the current contract, and may include consecutive periods prior to the current contract.
 2. Placement into Hybrid status alters the payment arrangement for those slots to a unit cost reimbursement method of payment but does not change the contract ceiling or the level of service being purchased from the Agency.
 3. Placement into a Hybrid status is a conditional form of contracting where the provider must achieve the contracted level of service.
 4. The Hybrid arrangement cannot last more than 8 months, and is not intended to be a long-term arrangement.
 5. An Agency which has a service or services designated as unit cost reimbursement shall:

- a. Be notified by certified mail to the Executive Director that it is being placed on Hybrid based on a determination of underutilization;
 - b. Have its contract modified to be effective no later than 60 days from the beginning of the next month after Hybrid status is determined to be applicable to reflect the designation of certain slots as unit cost reimbursement.
6. Payment and recoupment shall be based on the assumption that all slots must be filled before FFS is billed and payable unless otherwise specified in the notification letter, or other applicable policy.
7. The placement of a service or services into Hybrid status is independent of any other action by DAS such as a Request for Proposal, or POC for other reasons.
- B. It is the responsibility of the Agency to demonstrate compliance during each month it is on Hybrid status and at the end of the six-month period by submitting accurate reports for the entire service area (modality) across all funded services.
- C. DAS shall have up to 60 calendar days from the date of receipt of the month six utilization information to render and implement its decision, or to advise the Agency in writing that an extension of the Hybrid status is required.
- D. At the end of the six month period, DAS shall notify the Agency to advise them that their contract is being modified in as follows:
 1. Return all unit cost reimbursement slots to advance pay status;
 2. Eliminate all underutilized slots, redirecting these slots as DAS deems advisable
 - a. While DAS shall consider maintaining the slots within the same service, it may, based on its assessment, determine that other priorities may exist and dedicate the funds realized to other priorities with the written approval of the DHS Deputy Commissioner or designee.
- E. Renewals of contracts containing Hybrid payment status which are in the 60-day evaluation period shall be processed as Hybrid contracts until DAS has determined final status.
- F. This policy does not abrogate the rights of the Division under the Standard Language Document or any Terms of the Contract. DAS may convert services in whole or part into a Fee-For-Service network, at any time, regardless of utilization.
- G. An Agency shall have 100% of its unit cost reimbursement returned to Advance Payment contracted slots if:
 1. It reaches 95% LOS (combined slot and unit cost reimbursement) by month 5.

2. All actions must be in writing to the Agency.

V. UTILIZATION COMPLIANCE REVIEW MECHANISMS:

- A. As part of its customary and established contract monitoring process, DAS periodically reviews Agency's utilization patterns to ensure contract compliance. An Agency may be determined to be in non-compliance with its contract service utilization requirements through any of the following utilization compliance review mechanisms:
 1. Review of monthly rosters submitted by the Agency,
 2. Review of Agency data input on NJ-SAMS,
 3. Site visit report by DAS Monitoring Unit,
 4. DAS internal reviews,
 5. Contract Coordinating Meeting, and
 6. Other information as presented or available to DAS.
- B. Services which have 10 or fewer slots with underutilization may be moved to 100% unit cost reimbursement at the option of the Division of Addiction Services.
- C. Any services with 5 or fewer slots with underutilization will be placed 100% unit cost reimbursement.

VI. UTILIZATION METHODOLOGY

- A. DAS uses a uniform methodology to calculate actual utilization of contracted treatment slots for each modality that includes a) the number of clients served, b) the number of service days provided, and c) the number of face-to-face client contacts expected at each modality/ASAM level of care to ensure that all services rendered are accounted for. This methodology is applied to NJSAMS data as well as hard copy rosters.
- B. The formula for each modality/level of care is as follows:
 1. **Outpatient Psycho/social (ASAM PPC 2 Level I care)** – clients receiving this level of care are required at a minimum to have 4 face-to face contacts a month, or 4 days of service.
 - a. If a client appears as active in NJSAMS and on hard copy rosters for the entire month, the Agency is credited with 4 days of service for that slot, or full utilization of the slot for the month. If a client appears as active in NJSAMS

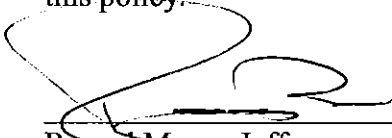
and on hard copy rosters for part of the month, the Agency is credited with one day of service for each full or partial week that the client is in treatment.

- b. Full utilization of the slot is realized for each 4 face-to face contacts or days of service each month.
2. **Partial Care (ASAM PPC 2 Level II.5 care)** – clients receiving this level of care are required at a minimum to have 20 face-to face contacts a month, or 20 days of service.
 - a. If a client appears as active in NJSAMS and on hard copy rosters for the entire month, the Agency is credited with 20 days of service for that slot, or full utilization of the slot for the month. If a client appears as active in NJSAMS and on hard copy rosters for part of the month, the Agency is credited with one day of service for each full or partial week that the client is in treatment.
 - b. Full utilization of the slot is realized for each 20 face-to face contacts or days of service each month.
3. **Intensive Outpatient and Methadone Intensive Outpatient (ASAM PPC 2 Level II.1 care)** – clients receiving this level of care are required at a minimum to have 13 face-to face contacts a month, or 13 days of service.
 - a. If a client appears as active in NJSAMS and on hard copy rosters for the entire month, the Agency is credited with 13 days of service for that slot, or full utilization of the slot for the month. If a client appears as active in NJSAMS and on hard copy rosters for part of the month, the Agency is credited with one day of service for each full or partial week that the client is in treatment.
 - b. Full utilization of the slot is realized for each 13 face-to face contacts or days of service each month.
4. **Methadone Maintenance (ASAM PPC 2 Level OMT)** – clients receiving this level of care are required at a minimum to have 26 face-to face contacts a month, or 26 days of service. It is understood that clients in higher phases of care may have fewer face-to-face contacts, however, they are still credited for the same number of service days as they are presumed to be actively on the clinic roster.
 - a. If a client appears as active in NJSAMS and on hard copy rosters for the entire month, the Agency is credited with 26 days of service for that slot, or full utilization of the slot for the month. If a client appears as active in NJSAMS and on hard copy rosters for part of the month, the Agency is credited with one day of service for each full or partial week that the client is in treatment.
 - b. Full utilization of the slot is realized for each 26 face-to face contacts or days of service each month.

5. **Residential Care: Long-term Residential (ASAM PPC 2 Level III.5 care); Short-term Residential (ASAM PPC 2 Level III.7 care); Halfway House (ASAM PPC 2 Level III.1 care); Sub-acute Residential Detox (ASAM PPC 2 Level III.7D care)** – clients receiving this level of care are required at a minimum to have 30 or 31 face-to face contacts a month, or 30 or 31 days of service.

- a. If a client appears as active in NJSAMS and on hard copy rosters for the entire month, the Agency is credited with 30 or 31 days of service for that slot, or full utilization of the slot for the month. If a client appears as active in NJSAMS and on hard copy rosters for part of the month, the Agency is credited with one day of service for each full or partial week that the client is in treatment.
- b. Full utilization of the slot is realized for each 30 or 31 face-to-face contacts or days of service each month.

VII. This policy is effective as of the date of signature; however, Agencies which have been in Hybrid status for 6 months prior to the effective date shall be immediately subject to action under this policy.



Raquel Mazon Jeffers
Director, Division of Addiction Services

1/26/09

Date

MEMORANDUM OF AGREEMENT

Between

**THE DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES (DMHAS)**

And

JUVENILE JUSTICE COMMISSION (JJC)

This Memorandum of Agreement (MOA) is made and entered between the Department of Human Services (DHS) Division of Mental Health and Addiction Services (DMHAS) and the Juvenile Justice Commission (JJC) for the purpose of administrating and funding forty-one (41) beds for certain juveniles involved in the Juvenile Justice System, including juveniles under the JJC's direct custody and care, at Integrity House, New Hope Foundation, and Newark Renaissance House.

WHEREAS the DHS/DMHAS and the JJC have enjoyed a long-standing relationship in administering American Society of Addiction Medicine (ASAM) Level III residential substance abuse treatment for certain juveniles involved in the Juvenile Justice System; and

WHEREAS the DHS/DMHAS has the statutory authority under N.J.S.A. 26:2B-12, et seq. and N.J.S.A. 26:2G-1; et seq. to provide treatment services for adjudicated juvenile offenders; and

WHEREAS the DHS/DMHAS finds it in the public interest to continue to work with the JJC to provide residential substance abuse treatment programming for juveniles involved in the Juvenile Justice System; and

WHEREAS the JJC, pursuant to N.J.S.A. 52:17B-169, et seq., is the single State Agency responsible for the operation of State services and sanctions for juveniles involved in the Juvenile Justice System;

THEREFORE, in consideration of the mutual understanding of the parties, and intending to be legally bound thereby, the parties agree as follows:

SECTION I

A. DURATION

This MOA shall be effective from July 1, 2010 through June 30, 2011.

B. TERMINATION

This MOA may be terminated by either party on sixty (60) days advanced written notice.

C. AMENDMENTS

Any provision of this MOA may be changed or modified by mutual consent of the parties. To be effective and binding, any change or modification must be in writing and signed by both parties.

D. PRINCIPAL CONTACTS

1. All notices, reports or correspondence to the JJC shall be sent to:
Program Management Officer:

Vicky Major, Administrator
JJC Office of Substance Abuse Administration
306 Burlington Street, 2nd Floor
P.O. Box 534
Bordentown, New Jersey 08505
609-324-6231
609-324-6101 (fax)

Fiscal Officer:

Sal Marcello, Chief Fiscal Officer
Juvenile Justice Commission
1001 Spruce Street
Trenton, New Jersey 08652
609-341-3024
609-943-4616 (fax)

2. All notices, reports or correspondence to DHS/DAS shall be sent to:
Program Management Officer:

Robin Nighland, Coordinator, Adolescent Services
Division of Addiction Services
120 S. Stockton Street
P.O. Box 362
Trenton, New Jersey 08625
609-984-5895
609-292-3816 (fax)

Fiscal Officer:

Jose Gonzalez, Director, Administrative Services
 Division of Addiction Services
 120 S. Stockton Street
 P.O. Box 362
 Trenton, New Jersey 08625
 609-984-0895
 609-292-1045 (fax)

3. A party may, during the term of this Agreement, designate another person to serve as a principal contact, and in that event, shall give reasonable advance written notice to the other party of any such change. The notice shall specify the name, title, address, telephone and fax number of the successor contact.

SECTION II**A. SCOPE OF THE AGREEMENT**

1. This Agreement covers the use of a total of forty-one (41) beds at the Integrity House, New Hope Foundation, and Newark Renaissance House Residential Substance Abuse Treatment Programs for use by certain juveniles involved in the Juvenile Justice System.

2. The JJC shall have priority access to eight (8) long-term care beds under this Agreement.

3. DHS/DMHAS shall notify the JJC immediately if one of the eight (8) JJC-funded beds becomes vacant. The JJC shall notify DHS/DMHAS within 48 hours whether it intends to use the bed for a JJC resident. If the JJC does not intend to use the vacant bed immediately, the DHS/DMHAS may make the bed available to other adolescents involved in the criminal justice system.

B. SOURCES OF FUNDING

1. A total of \$1,109,307 will be made available under this MOA for the forty-one (41) beds at Integrity House, New Hope Foundation, and Newark Renaissance at the rate of \$29,277 per bed annually.

2. The funding responsibility shall be divided as follows:

(a) \$964,491 will be provided by the DHS/DMHAS funding thirty-three (33) beds, and

(b) \$233,816 will be provided by the JJC funding eight (8) beds at Integrity House, Newark.

3. The JJC shall pay the full amount due under this Agreement to DHS/DMHAS within two weeks the Agreement's execution.

4. The terms of this Agreement are contingent on the availability of funds through the appropriation process.

5. For audit purposes, the recipients of these funds must be in compliance with State Circular Letter 04-04 OMB. The JJC shall have the right to audit any and all accounts and/or records maintained by DHS/DMHAS pertaining to these funds. To effectuate this provision, JJC shall be afforded, upon reasonable notice and during normal business hours, access to all records and/or data of DHS/DMHAS that pertain to this MOA. The provisions

of this subparagraph shall continue for a period of seven (7) years after the submission and acceptance of the financial and programmatic reports required under this MOA.

C. RESPONSIBILITIES OF THE JUVENILE JUSTICE COMMISSION

1. JJC shall identify juveniles appropriate for placement in the eight (8) beds funded by the JJC in accordance with the ASAM Level III criteria.
2. The JJC shall arrange for transportation of all JJC residential treatment referrals and shall facilitate the necessary sharing of resident information between the parties. Any and all costs to the JJC associated with this process shall be borne solely by the JJC.
3. The JJC shall be responsible for the removal and transportation of its juveniles upon discharge from the program.
4. The JJC shall provide payment for non-Medicaid eligible (as determined by the JJC) emergency medical/dental services provided to the juveniles on committed status upon receipt of a detailed billing statement from the medical service provider.
5. The JJC shall notify the DHS/DMHAS of any changes in the policies and procedures in its Standard Operating Procedure Manual for Private Substance Abuse Treatment Programs at least 2 weeks prior to the effective date of any changes. The JJC shall provide the DHS/DMHAS with copies of all modified policies and procedure.
6. The JJC will notify the DHS/DMHAS Complaints and Reportable Events Management Unit at 609-292-5760 and 1-877-712-1868, and Robin Nighland (Adolescent Coordinator) at 609-943-5895, immediately upon knowledge of a reportable event at Integrity House.
7. The JJC shall participate in an operational workgroup comprised of staff of DMHAS, JJC, and Integrity House, New Hope Foundation, and Newark Renaissance House on a bimonthly basis to explore the need for program changes or enhancements and discuss operational issues which might arise over the term of this Agreement.
8. The JJC shall, in coordination with DMHAS, conduct program monitoring site visits annually to ensure adherence to JJC policies and procedures.

D. RESPONSIBILITIES OF THE DEPARTMENT OF HUMAN SERVICES/DIVISION OF ADDITION SERVICES

1. The DHS/DMHAS shall contract with Integrity House New Hope Foundation and Newark Renaissance House for forty-one (41) substance abuse treatment beds through the established DHS/DMHAS Provider Service Contract process.
2. DHS/DMHAS staff shall conduct program monitoring site visits of Integrity House, New Hope Foundation, and Newark Renaissance House annually.
3. The DHS/DMHAS shall ensure that Integrity House, New Hope Foundation, and Newark Renaissance House comply with JJC disciplinary regulations as set forth in N.J.A.C. 13:101, et seq.
4. The DHS/DMHAS shall ensure that juveniles placed in Integrity House, New Hope Foundation, and Newark Renaissance House receives educational services as required by New Jersey State law.
5. The DHS/DMHAS shall require that its contract with Integrity House, New Hope Foundation, and Newark Renaissance House provides that any non-emergency medical/dental services needed by a JJC resident while residing at these providers shall be

provided by an approved Medicaid provider, and that transportation for those services is provided by Integrity House, New Hope Foundation, and Newark Renaissance House.

6. DHS/DMHAS shall lead the bimonthly operational workgroup meeting comprised of DHS/DMHAS, JJC, and Integrity House staff, New Hope Foundation staff, and Newark Renaissance staff to explore the need for program changes or enhancements and discuss operational issues which might arise over the term of this Agreement.

7. The DHS/DMHAS shall monitor the utilization of the forty-one (41) funded beds on a weekly basis with a utilization target of 100%, and shall inform the JJC of the utilization rate on a weekly basis.

8. The DHS/DMHAS program monitors shall visit Integrity House, New Hope Foundation, and Newark Renaissance House to assess the quality and frequency of treatment received by each referred client relative to that client's documented needs. The DHS/DMHAS monitors shall review program administration, staffing, and other aspects of the treatment program's operations consistent with the DHS/DMHAS review of all contracted substance abuse treatment programs.

9. The DHS/DMHAS Coordinator shall share DHS/DMHAS findings from the annual site visit reports, including utilization and/or programmatic deficiencies with the JJC in order to jointly develop and implement appropriate corrective action where necessary.

E. CONFIDENTIALITY

1. The data and records exchanged and/or developed over the course of this MOA shall be deemed confidential and shall be used solely for the purposes established by this Agreement.

2. JJC records (e.g., information concerning juveniles who have been adjudicated delinquent) are confidential pursuant to N.J.S.A. 2A:4A-60. DHS/DMHAS and its agents, representatives, and employees shall safeguard all confidential information, which may only be disclosed as provided by law and with the prior written consent of the JJC. DHS/DMHAS shall further ensure that Integrity House is aware of the confidential nature of JJC information and the obligation to safeguard any such information.

3. The parties further agree that all reasonable care shall be used to protect the confidentiality of information or data as required by the Health Insurance Portability and Accountability Act (HIPAA) and the Family Education Records Privacy Act of 1974 (FERPA).

F. NON-DISCRIMINATION

Neither party to this Agreement, nor any of its agents, representatives, or employees, shall discriminate on the basis of race, national origin, religion, creed, color, sex, age, veteran status, familial status, or sexual orientation or handicap in the performance of their obligations under this Agreement.

G. EFFECT OF INVALIDITY

If any of the provisions of this MOA are, or become invalid, to any extent, the other provisions of this MOA shall not be effected thereby. In the event of the invalidity of a provision, the parties agree to accept a provision that reflects as closely as possible the intention of the invalid provision.

The terms of this MOA have been read and understood by the persons whose signatures appear below. The parties agree to comply with the terms and conditions of the MOA set forth on the preceding pages. This MOA is the entire agreement between the parties with respect to the subject matter contained herein.

New Jersey Department of Human Services:



Raquel Mazon Jeffers, Director
Division of Addiction Services

Dated: _____

4/21/11

Juvenile Justice Commission:



Veleria Lawson
Executive Director

Dated: _____

4-26-11

Approved as to form:

Paula T. Dow
Attorney General of New Jersey

By: _____

Mary Beth Wood

Senior Deputy Attorney General

(Dated) _____

4/28/11



State of New Jersey

DEPARTMENT OF HEALTH AND SENIOR SERVICES

PO BOX 360
TRENTON, N.J. 08625-0360

www.nj.gov/health

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

POONAM ALAIGH, MD, MSHCPM, FACP
Commissioner

**MEMORANDUM OF AGREEMENT
BETWEEN**

**THE DEPARTMENT OF HUMAN SERVICES
DIVISION OF ADDICTION SERVICES
MANAGED CARE UNIT
(Hereafter DAS)**

AND

**THE DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF PUBLIC HEALTH AND ENVIRONMENTAL LABORATORIES
PUBLIC HEALTH LABORATORY SERVICES
(Hereafter PHEL)**

FOR

**NEW JERSEY SUBSTANCE ABUSE INITIATIVE
HIV SCREENING AND DIAGNOSTIC SERVICES FOR
HIV POSITIVE CLIENTS IN EARLY INTERVENTION PROGRAMS AT
DESIGNATED DRUG TREATMENT CENTERS**

WHEREAS the New Jersey Department of Human Services (DHS), Division of Addiction Services (DAS) and the New Jersey Department of Health and Senior Services (DHSS), Division of Public Health and Environmental Laboratories (PHEL), wish to provide HIV screening for clients in State funded drug treatment centers and diagnostic testing and services for positive HIV clients enrolled in HIV Early Intervention Programs (EIP) at designated drug treatment centers.

WHEREAS the DHSS has the statutory authority under NJSA 26:2G-5 to request that these services be provided in order to implement specialized programs pursuant to the Federal PHS Act, P.L. 102-321, to ensure the maintenance of HIV early intervention services for substance abusers.

NOW, THEREFORE, THE PARTIES HERETO AGREE AS FOLLOWS:

- I. Under this Agreement, the DAS is hereafter referred to as "the Funding Agency" and the PHEL is hereafter referred to as "the Service Provider Agency."

II. Obligations and Rights of the Funding Agency

A. DAS Obligations

All of the requirements of this section apply to the Funding Agency.

1. The DAS shall provide funding annually in an amount not to exceed \$50,000. Payment is contingent upon the satisfactory delivery of services as described herein in this MOA, Section III., A. Service Provider Obligations. Payment obligations, as well as reporting and monitoring requirements and other special conditions to this agreement, are contained in Attachment A incorporated herewith by reference. Payments shall be made for approved budget costs, contained in Attachment B, incorporated by reference.
2. The DAS shall monitor the progress of this project to ensure that services are being provided in accordance with Section III. A., which establishes the work products and deliverables which must be completed in order for funds to be provided and the timeliness for completion. All financial, performance and MOA monitoring requirements are contained in Attachment A, sections II, III and IV.
 - a. Furnish to PHEL and periodically update the names and addresses of all drug treatment centers (DTC) eligible to utilize these lab services.
 - b. Establish and modify, when necessary, the panel of diagnostic testing performed.
3. This section establishes all other obligations of the DAS.
4. In addition to the above, the DAS is required to abide by all general requirements contained in Sections IV and V of this Agreement.

B. DAS Rights

All of the rights outlined in this section are applicable to the DAS.

1. Audit

The DAS shall have the right at any time to audit any and all accounts and/or records maintained by the recipient of these funds. To effectuate this provision, the DAS shall be afforded, during normal business hours, access to all records and/or data of the service provider agency indicated in Section III which pertain to this Agreement. The provisions of this paragraph shall continue for a period of seven years after the submission and acceptance of the financial and programmatic reports required under this Agreement.

2. Work Product

All data, technical information, materials gathered, originated, developed, prepared, used or obtained in the performance of the requested services, including but not limited to, all papers, reports, surveys, plans, charts, records analyses or publications produced for or as a result of this Agreement shall bear an acknowledgement of the

support of the DAS. No work product produced utilizing funds or data obtained under this Agreement shall be released to the public without the prior written consent of the DAS. The DAS shall have the right to edit the work product and shall further have the right to add co-authorship or disclaimers as it, in its sole discretion, deems appropriate.

3. Equipment

All equipment acquired with funds from this Agreement shall be the property of PHEL, which agrees to maintain adequate insurance.

III. Obligations and Rights of Service Provider Agency

A. PHEL's Obligations

All of the requirements of this section apply to PHEL.

1. The PHEL shall provide services in accordance with Section III. A. 4 which establishes the work products and deliverables which this agency must perform, in accordance with the established timeframes established for each item in Section III. A. 5. The PHEL will adhere to the budget requirements as detailed in the approved cost proposal and as contained in Attachment B.
2. The PHEL shall be required to maintain primary instrument records for a period of two (2) years and requisitions and result reports for a period of five (5) years.
3. The PHEL shall be required to submit progress and final reports and state invoices in accordance with the requirements of Attachment A.
4. Services to be provided. In exchange for funding provided by the funding agency indicated in Section II. A., the PHEL agrees to perform the following:
 - a. Written instructions and, when necessary, consultation to the substance treatment providers on the procedures for laboratory samples. These instructions will be supplied in an initial mailing to the treatment providers, which will also contain initial supply of testing kits.
 - b. The PHEL shall perform the following lab tests, screening and confirmatory testing for the presence of HIV antibody in client serum or plasma.
5. Timeframe for Performance of Service Deliverables. This section contains the timetable for each of the services indicated in Section III., A. 4. With regard to this timetable, time of the essence. The PHEL agrees that the service deliverables indicated in Section III., A. 4 will be performed by corresponding date or time period indicated in Section III., A. 5.
 - a. Initial HIV screening results within one week after receipt of blood specimen, if applicable.
 - b. Other diagnostic test results will be sent to the treatment providers within four (4) business days following the receipt of specimens.

6. In addition to the above, the PHEL is required to abide by all general requirements contained in Sections IV. And V. of this Agreement.

B. PHEL's Rights

All of the rights of this section apply to PHEL.

1. PHEL has the right to expect that all drug treatment centers will handle sample collection and shipping in a manner consistent with the instructions supplies by PHEL.
2. PHEL has the right to expect proper use of supplies and mailers as per instructions.
3. PHEL has the right to expect proper notification in a timely manner when problems are identified such as requests for supplies or copies of missing reports.
4. PHEL has the right to expect prompt payment of that portion of the bills not in dispute.
5. PHEL has the right to charge for excessive use of mailers only after the site has been notified three times during the period of this agreement to bundle collections in mailers as instructed.

IV. General Provisions

A. Mandatory General Provisions

1. During the term of this Agreement, both parties shall comply with all Federal, State and Municipal Laws, Rules and Regulations generally applicable to the activities performed pursuant to this Agreement. The array of funds is based on the PHEL's submission and the DAS' acceptance to a Cost Proposal, which is incorporated herewith by reference to this Agreement.
2. Each party shall maintain accurate books and records of all disbursements, funds receives, funds spent and funds available as a result of this Agreement.
3. Each of the parties is an independent entity and neither party shall hold itself out as an agent, partner or representative of the other.
4. Failure by each party to exercise any right or demand performance of any obligations under this Agreement shall not be deemed a waiver of such right or obligation.
5. If any of the provisions of this Agreement are or become invalid to any extent, the other provisions of this Agreement shall not be affected thereby. In the event of the invalidity of a provision, the parties agree to accept a provision which reflects as closely as possible the intention of the invalid provision.

6. This Agreement may not be assigned without the prior written consent of the DHSS and DHS.
7. The laws of the State of New Jersey govern this Agreement.
8. This Agreement may be modified in accordance with the provisions of Attachment A., III.
9. PHEL will purchase the designated equipment and replacement reagents when the MOA is approved and funds are available. The replacement supplies are subject to the fiscal approval of Financial Services.

B. Operational General Provisions

1. The parties agree that all data resulting from this Agreement are to be considered confidential and shall be solely used for the purposes as outlined above. All parties are required to use reasonable care to protect the confidentiality of the data.

V. Terms and Termination

- A. Subject to any rights of termination hereinafter set forth, this Agreement shall begin October 1, 2010 and shall remain valid through September 30, 2011.
- B. This Agreement may be terminated by either party with or without cause upon thirty (30) days advance written notice.
- C. Notice of termination shall be delivered via U.S. mail; return receipt requested and shall be effective upon receipt. Notice shall be sent to the appropriate contact person identified at Section VI.
- D. Upon the issuance of notice of termination by the DAS or automatic termination under Section V., B. upon receipt of the DAS' notice of termination, all unexpended funds appropriated by the DAS to the PHEL in any account whatsoever shall be immediately returned to the DAS through the contact person identified at Section VI. Without any further assessment or expenditure except as specifically approved by the DAS in writing.

VI. Principal Contacts

The principal contacts for all notifications required or otherwise necessary under this Agreement shall be as follows.

For the Department of Human Services, Division of Addiction Services:

Program Management Officer

Adam Bucon, Program Coordinator
Office of Quality Assurance
Division of Addiction Services
P.O. Box 362
Trenton, NJ 08625-0362
(609) 984-3316
(609) 292-3816 – FAX

Fiscal Officer

Jose Gonzalez
Director, Administrative Services
Division of Addiction Services
P.O. Box 362
Trenton, NJ 08625-0362
(609) 984-6961
(609) 292-1045 – FAX

For the Department of Health and Senior Services, Division of Public Health and Environmental Laboratories:

Program Management Officer

Bruce Wolf
Chief, Virology Program
P.O. Box 360
Trenton, NJ 08625-360
(609) 984-2622
(609) 633-9601 – FAX

Fiscal Officer

Mauro Focarelli, Section Supervisor
Fiscal Resources
P.O. Box 360
Trenton, NJ 08625-360
(609) 292-4590
(609) 633-9601 – FAX

SIGNATURE PAGE

**MEMORANDUM OF AGREEMENT
BETWEEN**

**THE DEPARTMENT OF HUMAN SERVICES
DIVISION OF ADDICTION SERVICES
AND
THE DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF PUBLIC HEALTH AND ENVIRONMENTAL LABORATORIES
FOR
NEW JERSEY SUBSTANCE ABUSE INITIATIVE
HIV SCREENING AND DIAGNOSTIC SERVICES FOR
HIV POSITIVE CLIENTS IN EARLY INTERVENTION PROGRAMS AT
DESIGNATED DRUG TREATMENT CENTERS**

We, the undersigned, consent to the contents of this Agreement.

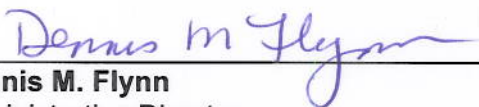
New Jersey Department of Human Services
Division of Addiction Services



Raquel Mazon Jeffers
Director

9/11/10
Date

New Jersey Department of Health and Senior Services
Division of Public Health and Environmental Laboratories



Dennis M. Flynn
Administrative Director

9/29/10
Date

Attachment A

Attachment A is hereby incorporated to and provide for additional provisions and conditions between the New Jersey Department of Health and Senior Services, Division of Public Health and Environmental Laboratories and the New Jersey Department of Human Services, Division of Addiction Services for a Memorandum of Agreement entitled, "HIV Screening and Diagnostic Services for Positive HIV Clients in Early Intervention Programs at Designated Drug Treatment Centers."

I. Method of Payment

Cost reimbursement payments shall be made by the Funding Agency on the following basis:

☒ Monthly

☐ Quarterly

☐ Lump Sum

☒ Based on submission of the monthly bill and listing of the tests conducted by PHEL for the DAS agencies.

II. Financial and Performance Reporting and MOA Monitoring

- A.
- A. Performance reports are not required. DAS will do a follow-up with substance abuse treatment providers every six months to ensure deliverables are being met by PHEL.
 - B. The DAS may require technical assistance meetings with the PHEL on the following basis:
☐ Initial ☐ Monthly ☐ Quarterly ☐ Final ☒ Other (Describe)

May request education for substance abuse treatment providers on sample collection and/or PHEL submission procedures.

III. Modifications to the Agreement

This document represents the entire Agreement between the parties and shall not be amended except by the express written consent of both parties, except as stated herein:

1. MOA extensions may be made to this Agreement. If allowed, approval may be granted by the Program Management Officer and Fiscal Officer identified in Section VI.
2. Budget revisions may be made to this Agreement. If allowed, approval may be granted by the Program Management Officer and Fiscal Office identified in Section VI.
3. Modifications to Subsection III of the MOA regarding service deliverables to be performed under Section III. A. may be made with the approval of the Program Management Officer identified in Section VI.

IV. Special Conditions (as applicable)

Laboratory testing prices are subject to annual inflationary increases.

V. Multi Year Agreements

This MOA is not a multi year Agreement.

Attachment B

Attachment B is hereby incorporated to and provides a description of the budget proposal for the Memorandum of Agreement between the New Jersey Department of Human Services, Division of Addiction Services (DAS) and the New Jersey Department of Health and Senior Services, Division of Public Health and Environmental Laboratories (PHEL) entitled "HIV Screening Diagnostic Services for Positive HIV Clients in Early Intervention Programs and at Designated Drug Treatment Centers."

The DAS shall reimburse PHEL according to the fee schedule attached. The maximum annual amount of this Agreement is \$50,000. No administrative expenses shall be allowed under this Memorandum of Agreement.

FEE SCHEDULE

Total Lab costs for all testing and equipment associated with the Early Intervention Project for the period of 10/1/10 to 9/30/11.

HIV Cost Per Test for 10/1/10 to 9/30/11: \$22.03

MEMORANDUM OF AGREEMENT

BETWEEN

**THE DEPARTMENT OF HUMAN SERVICES (DHS)
DIVISION OF ADDICTION SERVICES (DAS)**

AND

**THE DEPARTMENT OF EDUCATION (DOE)
DIVISION OF STUDENT SERVICES (DSS)**

Purpose

The Division of Addiction Services (DAS) and the Department of Education agree to implement a Student Health Survey on health behaviors in New Jersey high school students. Included in the survey items will be substance use questions and questions regarding factors protecting and posing risk to adolescent substance use. This will assist in prevention and treatment planning, community organization and coalition building and school planning via the New Jersey Student Health (High School) Survey.

Term

The agreement is in effect for the period September 1, 2010 through June 30, 2011.

Contracts Management

DOE shall be responsible for the management of the specific contract which is the subject of this Agreement including payments to survey administrators, contract modifications and report dissemination. In the event that contract services funded in part by this Agreement are disrupted or not delivered, for any significant period of time, it is the responsibility of DOE to notify DAS and modify the Agreement, as necessary.

Modification and/or Termination

This Agreement may be modified at any time, or terminated with 60 days' notice, by agreement of both parties, as evidenced by an exchange of correspondence or document signed by representatives of DAS and DOE.

Provision of Funding for Services

DAS shall make available the funding amount of \$50,000 to provide financial assistance for the implementation of the Student Health Survey no later than October 1, 2010. This payment will be a single credit transaction.

Planning for Collaboration

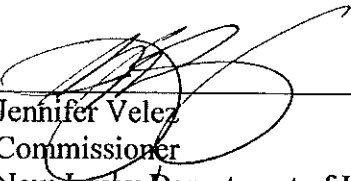
DAS and DOE agree to continually work cooperatively in order to improve survey, development, protocol, implementation and methods. A significant example of this interdivisional collaboration is the Interdepartmental Working Group on Student Surveys headed by DOE when planning to implement this survey. This workgroup consists of members from DOE, DAS, the Department of Health and The GCADA, the Department of Law and Public

Safety. The DOE has conducted this survey among public high school students every other year since 1993. To ensure data are collected on substance use and risk and protective factors valuable to Addiction Services planning and funding initiatives, DAS has been a part of the Interdepartmental Workgroup. The findings of this survey helps parents, schools, youth-serving agencies, including DAS maintain awareness of current trends among teens and provide feedback on the impact of large-scale programs to influence teen behavior.

DAS will be consulted on any issues concerning the addition, deletion or modification of questions related to substance use and risk and protective factors and agreement will be reached between both parties prior to inclusion in the Student Health Survey. DAS will also be provided with a draft copy of the final survey report for comment.

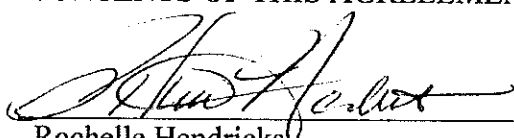
The final report for the 2011 Survey will be available in the Spring 2012.

WE, THE UNDERSIGNED, CONSENT TO THE CONTENTS OF THIS AGREEMENT.



Jennifer Velez
Commissioner
New Jersey Department of Human Services

Date



Rochelle Hendricks
Acting Commissioner
New Jersey Department of Education

Date

Attachment A

Budget - Shared Costs
FY 2010-11
New Jersey Student Health Survey

	<i>NJDOE</i>	<i>DAS</i>	<i>Total</i>
<i>2011 NJSHS</i>			
A. Recruit schools and administer survey - Personnel	\$83,277	\$35,300	\$118,577
B. Travel	\$7,700	\$3,300	\$11,000
C. School Incentives	\$16,100	\$6,900	\$23,000
D. Student Incentives	\$10,500	\$4,500	\$15,000
Subtotal, FY 2010-11	\$117,577	\$50,000.00	\$167,577



State of New Jersey

DEPARTMENT OF CHILDREN AND FAMILIES

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

ALLISON BLAKE, PH.D., L.S.W.
Acting Commissioner

June 8, 2010

Ms. Alison Recca-Ryan
Director
Corporation for Supportive Housing (CSH)
650 South Broad Street
Third Floor
Trenton, NJ 08611

Dear Ms. Ryan:

Please accept this letter of interest on behalf of the Department of Human Services (DHS) Division of Addiction Services (DAS) and the Department of Children and Families (DCF) Division of Youth and Family Services (DYFS).

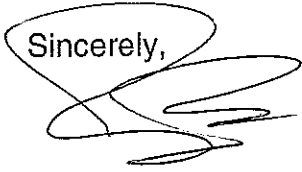
As you are aware, in September 2009, at the invitation of the New York State Office of Alcoholism and Substance Abuse Services (OASAS), New York City Child Protective Services, and CSH, staff from DYFS and DAS attended a facility tour and roundtable meetings of two agencies located in New York City that provide permanent supportive housing for women with children involved with child welfare and in substance abuse treatment. We were impressed with the Keeping Families Together (KFT) model that integrates and enhances units of permanent supportive housing for homeless child welfare involved families with histories of substance abuse, mental illness and multiple barriers to self sufficiency.

The Divisions are interested in receiving technical assistance from CSH on how to replicate the KFT Initiative that is currently in New York. As part of the planning process, staff from both Divisions and CSH should begin the next step of establishing a workgroup to explore funding options through a planning grant under Robert Wood Johnson Foundation.

Ms. Recca-Ryan
June 8, 2010
Page Two

Please contact Ms. Christine Scalise or Mr. Tyrone Richardson of your availability so that we can schedule time to meet as a workgroup. If you have any additional questions regarding our interest, Ms. Scalise can be reached at (609) 292-7293 or Christine.Scalise@dhs.state.nj.us and Mr. Richardson can be reached at (609) 943-4206 or Tyrone.Richardson@dcf.state.nj.us. Thank you in advance.

Sincerely,



Raquel Mazon Jeffers
Director
Division of Addiction Services



Christine M. Mozes, LSW
Director
Division of Youth and Family Services

C Kevin Martone, DHS
Robert Sebreen, DCF
Dave Sims, DYFS
Mollie Greene, DAS
Harry Reyes, DAS
Vicki Fresolone, DAS
Suzanne Borys, DAS
Chris Scalise, DAS
Tyrone Richardson, DYFS
Richard S. Cho, CSH



State of New Jersey

DEPARTMENT OF CHILDREN AND FAMILIES

JON S. CORZINE
Governor

KIMBERLY S. RICKETTS
Commissioner

Division of Youth and Family Services
PO Box 717
Trenton, NJ 08619

October 29, 2008

Nancy K. Young, Ph.D., Program Director
National Center on Substance Abuse and Child Welfare
4940 Irvine Boulevard, Suite 202
Irvine, California 92620

Dear Dr. Young:

The State of New Jersey's Department of Children and Families, Division of Youth and Family Services (DCF-DYFS), Department of Human Services, Division of Addiction Services (DHS-DAS), and Administrative Office of the Courts (AOC) are committed to developing and implementing a state-wide, coordinated plan to work with families who are involved with the child welfare system and affected by substance abuse disorders.

We will use current research and consultation to improve policy and practice leading to improved outcomes for children and their families. In developing and implementing this plan, we expect to assess each of our present policies and procedures. We will utilize consultation to arrive at a common vision, with shared values and principles that will govern our work together. While we are each dedicated to implementing best practice within our field, the assistance of the NCSACW to coordinate our work will make us more effective and allow us to operate from a common frame of reference.

An example of the collaboration among the three systems is the Child Protection Substance Abuse Initiative (CPSAI), a DYFS contracted program that has substance abuse counselors located at each DYFS Local Office. The CPSAI provides substance abuse assessments and referrals for families identified by caseworkers as having a substance use disorder. The parents are referred to the DAS licensed substance abuse treatment agencies that specialize in treating families involved with child welfare. Many of their cases are also actively involved in Family Court and are presented at the DYFS Child Welfare Substance Abuse Consortia. Our mutual goal is to improve cross systems communication and collaboration while promoting safety, stability, permanency and well being for the children and families with complex multi-service needs.

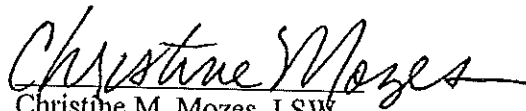
Nancy K. Young, Ph.D., Program Director
October 29, 2008
Page 2

Our designated Core Team members include mid to high level management staff who are decision makers and responsible for carrying out IDTA designated activities as well as engage their Directors to enact change.

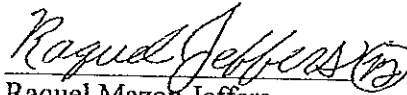
Finally, with this letter, we affirm our willingness to meet at least twice annually with the Core Team and the Consultant to provide oversight and support to the project. We are committed to a positive outcome and will include our other stakeholder partners in this work.

Thank you for your consideration. If you have any other questions, please feel free to contact our designated site liaison, Christine Scalise at (609) 292-7293 or Christine.scalise@dhs.state.nj.us.

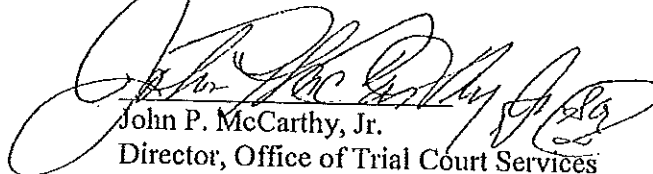
Sincerely,



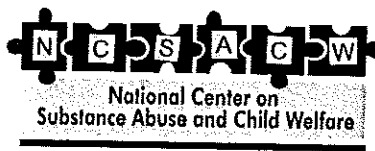
Christine M. Mozes, LSW
Director, Division of Youth and Family Services



Raquel Mazon Jeffers
Director, Division of Addiction Services



John P. McCarthy, Jr.
Director, Office of Trial Court Services



December 22, 2008

Christine M. Mozes, Director
Department of Children and Families
Division of Youth and Family Services
50 East State Street
P.O. Box 717
Trenton, New Jersey 08619

Raquel Mazon Jeffers, Director
New Jersey Department of Human Services
Division of Addiction Services
P.O. Box 362
Trenton, New Jersey 08625

John McCarthy, Jr., Esq.
Administrative Office of the Courts
Criminal Practice Division
PO Box 982
Trenton, New Jersey 08625

Christine Scalise, Women's Treatment Coordinator
New Jersey Department of Human Services, Addiction Services
P.O. Box 362
Trenton, New Jersey 08625

Dear Ms. Scalise,

I am pleased to inform you that the State of New Jersey has been selected to participate in the National Center on Substance Abuse and Child Welfare's (NCSACW) program of In-Depth Technical Assistance. We were pleased to learn about the efforts that you have underway and your thoughts on how technical assistance from the NCSACW can enhance your State's efforts. The reviewers recognized the strong commitments, relationships and history of work within your agencies to improve outcomes for families in the child welfare system and juvenile courts affected by substance use disorders.

In addition to New Jersey, the States of Arizona and California and the Seminole Tribe in Florida were selected for this 5th round of In-Depth Technical Assistance (IDTA). The NCSACW will be completing its fourth round of IDTA program this coming Spring 2009 with the States of Connecticut and Iowa, as well as Orange County, California and the Couer D'Alene Tribe in Idaho. Each of those sites as well as the jurisdictions participating in previous IDTA rounds have made great strides and provide many lessons that we hope to share with you. In addition to the direct resources from NCSACW, we will draw upon the expertise of our national partners and other Federal technical assistance resources.

Some Important Dates

We will be conducting an introductory cross-site webinar for Round 5 participants on Wednesday, February 18, 2009. This will be a three-hour interactive event (beginning at 10:00am PST) that will introduce site teams to one another and to the work of the NCSACW. Participants will have the opportunity to share their plans for the IDTA, exchange ideas, and brainstorm solutions for anticipated challenges.

An exciting opportunity for sites to learn in a peer-to-peer technical assistance meeting and to share experiences and lessons will be made available through a cross-site meeting scheduled for April 21 – 23, 2009, in Sacramento, California. NCSACW will sponsor five members from your site team to join us for that technical assistance event. Additional team members are welcome to participate at the site's own expense. We expect that attendees will be present for the entire 3-day meeting, so please ensure that this date is calendared as soon as possible for your site representatives. We would appreciate having the names and contact information for the team members that will be attending the Sacramento meeting by March 2nd, so that NCSACW staff can be in touch with each of them to arrange their travel logistics.

The technical assistance in the months preceding the April cross-site meeting will focus on refining your site's objectives, defining the priority population for the IDTA, and establishing the baseline information necessary to support your team's development of a scope of work and detailed work plan covering the period of the IDTA project. The scope of work will detail the products and major deliverables, as well as the commitment of resources from NCSACW, other Federal technical assistance centers (if applicable), and your own sponsors and stakeholders which will be instrumental in carrying out this effort.

Following the April cross-site meeting, this scope of work will be submitted for approvals to our Federal sponsors, the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment and the Administration on Children, Youth and Families' Children's Bureau, Office on Child Abuse and Neglect. The detailed work plan will specify the action steps, work assignments and timelines to achieve the goals and yield the products identified in the scope of work. Over the course of this process, we will actively seek opportunities to institutionalize this work in your continuing efforts to serve children and their families.

Consultant Liaison

As noted in the NCSACW's solicitation, your State is being assigned a Consultant Liaison who will work with you to reach these goals, and one of the final products during our technical assistance will be a longer-term plan for your site. All NCSACW Consultant Liaisons are senior-level consultants with extensive experience and knowledge in substance abuse services, child welfare and family courts. They have been selected and trained by NCSACW, and will be supervised by NCSACW staff. The Consultant Liaison assigned to your site is Pam Baston; I have enclosed a copy of her resume. You will see that she has extensive experience in substance abuse services, child welfare and the court. She has previously worked with the State of Connecticut in the IDTA program, as well as many other jurisdictions in the country in her work as a SAMHSA consultant.

Your Consultant Liaison will work with you to develop an initial three-month work plan for your site, which will outline the preliminary planning tasks specific to the TA needs and priorities you identified in your application and in our follow-up conversations with you. She will be contacting you in early January to review this with you and to establish dates for an initial site visit with your Core Team.

We look forward to working with New Jersey in its on-going efforts to improve the lives of children and families involved in the child welfare and family court systems who are also affected by substance use disorders. If you have any questions or would like to keep in touch with me over the course of the IDTA program, please feel free to contact me directly at (714) 505-3525, or nkyoung@cffutures.org.

Sincerely,

A handwritten signature in black ink that reads "Nancy Young". The signature is fluid and cursive, with the first name "Nancy" and last name "Young" clearly distinguishable.

Nancy K. Young, Ph.D.
Director

Enclosed: Pam Baston resume



State of New Jersey

JON S. CORZINE
Governor

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Youth and Family Services
PO Box 717
Trenton, NJ 08625

KIMBERLY S. RICKETTS
Commissioner

March 27, 2009

Greetings:

We are inviting you to participate in a kickoff meeting on May 20-21, 2009 to launch the collaborative project of the National Center for Substance Abuse and Child Welfare (NCSACW) with the New Jersey Department of Human Services, Division of Addiction Services; Department of Children and Families, Division of Youth and Family Services, and the Administrative Office of the Courts.

This is a unique opportunity, as New Jersey was chosen to participate in this project to receive 15 months of In-Depth Technical Assistance (IDTA) from the NCSACW in order to improve outcomes for clients involved with the three New Jersey agencies. Our work together will not only develop effective practices in New Jersey, but will also provide national leadership to states and tribes that may want to replicate this program. As a participant in the IDTA kickoff meeting you will become a member of the State Advisory Committee. The role of this committee is to review products in development and participate and report on assigned workgroups. The State Advisory Committee meetings will be held on a quarterly basis throughout the length of the project.

The kickoff event will be held at Harrison Williams Academy at Integrity House, 1091 – 1093 Broad Street, Newark, New Jersey. On Wednesday, May 20, the event hours are 9:00 a.m. to 4:00 p.m., and on Thursday, May 21, the hours are 9:00 a.m. until 1:00 p.m. Attendance is required both days.

Please find the following documents enclosed:

- Meeting Agenda for May 20 & May 21
- A Four Page Synopsis of the NCSACW Technical Assistance
- The IDTA Project Structure Chart
- A Project Summary
- Registration Form

We are convinced you will find this meeting beneficial and productive as you assist in the development of our scope of work for this technical assistance project. By the end of the two days, you will have a clearer understanding of the role and function of the three New Jersey cross systems and your role in investing in the project work ahead and in achieving the intended outcomes.

Page 2
March 27, 2009

Please reply to Ms. Jennifer Klecan, jennifer.klecan@dhs.state.nj.us, with your intent to attend no later than April 14, 2009. If you are unable to attend, please select a designee and provide Ms. Klecan with contact information for that person.

Directions to the Harrison Williams Academy at Integrity House are attached.

Sincerely,



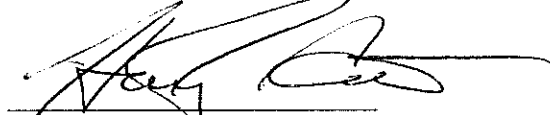
Christine M. Mozes

Director, Division of Youth and Family Services



Raquel Mazon Jeffers

Director, Division of Addiction Services



Harry T. Cassidy

Assistant Director, Family Practice Division

MEMORANDUM OF AGREEMENT

BETWEEN

**THE DEPARTMENT OF HUMAN SERVICES (DHS)
DIVISION OF ADDICTION SERVICES (DAS)
OFFICE OF TREATMENT**

AND

**THE NEW JERSEY STATE PAROLE BOARD (NJSPB)
DIVISION OF COMMUNITY PROGRAMS**

FOR

MUTUAL AGREEMENT PROGRAM

WHEREAS the New Jersey Department of Human Services (DHS), Division of Addiction Services (DAS), and the New Jersey State Parole Board (NJSPB) wish to purchase, on a fee-for-service basis, a full continuum of care of DAS licensed substance abuse treatment services, including long-term and short-term residential treatment, partial care, halfway house, intensive outpatient and outpatient counseling services, detoxification, TB tests, ASI assessments, and co-occurring services including psychotropic medications for the placement of parolees during State Fiscal Year 2011 to benefit the parolees demonstrably in need of such treatment; and

WHEREAS DAS has the statutory authority under N.J.S.A. 26:2B-7 et seq. and N.J.S.A. 26:2G-1 et seq. to ensure that treatment services for criminal offenders are provided and the Governor has allocated funding for such services in the State Fiscal Year 2011 budget; and

WHEREAS DAS and NJSPB find it in the public interest to reduce prison overcrowding, reduce recidivism and provide substance abuse treatment to alcohol and other drug addicted parolees within community-based residential and outpatient substance abuse treatment programs through the Mutual Agreement Program (MAP); and

WHEREAS NJSPB has the statutory authority to assign parolees to DAS licensed facilities for alcohol and drug treatment services as a specific condition of parole; and

WHEREAS NJSPB and DAS believe providing a full continuum of care of DAS licensed providers to parolees not only provides the offenders the opportunity to address his/her substance abuse as part of his/her rehabilitation, but also is a more cost effective measure than the daily costs of incarcerating offenders;

NOW, THEREFORE, THE PARTIES HERETO AGREE AS FOLLOWS:

- I. Attachment A, Section VI, Budget/Cost Proposal in this MOA shall make available a total of \$3,272,889 for the period of July 1, 2010 until June 30, 2011. The total funding of \$2,618,000 is to be provided by NJSPB; \$654,889 is to be provided by DAS.

II. **Obligations and Rights of the Funding Agencies**

(A.) **The New Jersey State Parole Board Obligations**

All of the requirements of this section apply to NJSPB:

1. NJSPB shall provide funding to DAS in the amount up to \$2,443,000 for the purchase of a full continuum of care for MAP community-based DAS licensed substance abuse treatment including long term and short term residential treatment, partial care, halfway house, intensive outpatient, outpatient, detoxification, TB tests, ASI assessments, co-occurring services including psychotropic medications and quality assurance, program coordination and management functions on a fee-for-service basis, and to offset administrative costs. Payment is contingent upon the satisfactory delivery of services as described herein in this MOA, Section II (C.) Department of Human Services obligations. Payment obligations, as well as reporting and monitoring requirements, and other special conditions to this agreement, are contained in Attachment A, which is incorporated herein by reference. Payments shall be made in accordance with the provisions in Attachment A, Section I. Payments shall be made for approved costs, contained in Attachment A, which is incorporated herein by reference.
2. NJSPB will provide \$175,000 to DAS for administrative support and fiscal agent fees. See Section II. 5. k.
3. Beginning SFY 2011 DAS will be utilizing Covanysys (CSC), the new fiscal agent. This service requires \$34,646 of NJSPB funds which is included in the funding provided in #2 above.
4. NJSPB shall monitor the progress of this project to ensure that services are being provided in accordance with Section II (C.), which establishes the work products that must be completed in order for funds to be provided, and the timelines for completion. All financial and performance reporting and MOA monitoring requirements are contained in Attachment A Sections II and III and IV.
5. This section establishes all other obligations of NJSPB:
 - a. NJSPB shall screen offenders prior to their release on parole from a

county or state correctional facility in order to determine the need for substance abuse assessments.

- b. NJSPB shall refer parolees under the supervision of the NJSPB granted a parole release date to appropriate DAS licensed community-based substance abuse treatment services including long-term and, short term residential treatment, partial care, halfway house, intensive outpatient, outpatient counseling, detoxification, TB tests and ASI assessments. Co-occurring services will be provided by DAS/SPB co-occurring providers and will include psychotropic medications.
- c. NJSPB shall identify the supervising parole officer as the contact person to work with each of the treatment providers on the following issues and concerns: parole release dates; any other problems which might arise in connection with the transfer of an NJSPB MAP referral from the institution to the substance treatment program; and problems relating to the MAP parolee's progress in or continued participation in the recipient substance abuse treatment program and advise DAS of any concerns accordingly.
- d. NJSPB will work with DAS to continue to improve their referral process to make it American Society of Addiction Medicine, (ASAM), driven and assure that referrals are to the appropriate level of care whenever possible.
- e. NJSPB contact person shall also work to connect the parolee and treatment program staff with the parolee's Parole Officer to ensure a smooth transition to aftercare (if applicable) and to community supervision at the conclusion of residential care.
- f. NJSPB shall notify each substance abuse treatment provider of the Parole Officer's name, address, telephone number, and/or other contact person at the District Parole Office responsible for the parolees in that treatment program utilizing the SPB/DAS referral form which includes the parolees SBI number.
- g. NJSPB shall work with the institutional medical provider to help ensure that a two-week supply of medication, if indicated, is available for each parolee at the time of the parolee's arrival at the treatment program. Following the two-week period, the MAP treatment provider shall be responsible for obtaining medications for parolees through other available means.
- h. NJSPB shall ensure that infectious medical clearance required by health facility licensure regulations is obtained prior to parolee's admission to

receiving substance abuse treatment programs. DAS SPB MAP providers will be eligible for reimbursement for TB tests for SPB referrals as one means to expedite the admission of clients to residential treatment.

- i. NJSPB District Parole Offices may refer and assign appropriate parolees to appropriate DAS licensed community-based substance abuse treatment including long-term and, short-term residential treatment, partial care, halfway house, intensive outpatient, outpatient counseling, detoxification, TB tests and co-occurring services. It is understood that placements into treatment are best determined by the ASAM Level of Care Placement Criteria; and, if a Parole Officer makes a placement that does not meet this criteria, a network treatment provider may reassess and request a transfer for a more appropriate level of care for that client.
- j. NJSPB shall notify DAS of any changes in NJSPB's policies or procedures that may affect parolee referrals or obligations of DAS contracted agencies that provide treatment services to MAP parolees in order that DAS may notify its contractees to take other appropriate measures to ensure the continued effectiveness of the MAP. NJSPB shall not communicate directly with DAS contractees regarding changes in policies or procedures without previous notification and agreement with DAS.
- k. NJSPB shall transfer a portion of its funding into such administrative accounts as DAS shall specify to support administrative and professional positions and costs associated with management of the MAP program.
- l. NJSPB shall review actual utilization of fee-for-service MAP substance abuse treatment services purchased through DAS on a monthly basis, using the monthly and cumulative utilization reports submitted to DAS by CSC for NJSPB utilization.
- m. NJSPB, in making placements to MAP, shall only utilize DAS licensed, MAP network providers. All referrals shall be clinically driven unless it is for a Parole Board mandated client and shall address client needs without disruption to treatment services.
- n. NJSPB will work with their Board to ensure that all referrals are made for lengths of stay that are clinically driven and allow for step down from residential to outpatient services as appropriate. SPB will update DAS on progress toward this goal.
- o. NJSPB shall share information on any utilization and/or programmatic deficiencies in MAP agencies with DAS in order to jointly develop and implement appropriate corrective actions.

- p. NJSPB shall participate in a two-way information exchange with DAS for tracking of census and status of MAP parolees, as well as incident reporting.
 - q. NJSPB shall advise DAS in detail, by February 28, 2011 of any and all planned changes in funding or service configurations for State Fiscal Year 2011 with respect to the MAP services purchased through DAS pursuant to Section II (A.) 1. of this MOA.
6. In addition to the above, NJSPB is required to abide by all general requirements contained in Sections III, (General Provisions) and IV, (Terms and Termination) of this MOA.

(B.) The New Jersey State Parole Board Rights

All of the rights outlined in this section are applicable to NJSPB.

1. Audit

For audit purposes, the recipients of these funds must be in compliance with State Circular Letter 04-04 OMB. In addition, NJSPB shall have the right to, at any time, audit any and all accounts and/or records maintained by DAS pertaining to these funds. To effectuate this provision, NJSPB shall be afforded, upon reasonable notice and during normal business hours, access to all records and/or data of DAS that pertain to this MOA. The provisions of this subparagraph shall continue for a period of seven years after the submission and acceptance of the financial and programmatic reports required under this MOA.

2. Work Product

All data, technical information, materials gathered, originated, developed, prepared, used or obtained in the performance of the requested services, including but not limited to, all papers, reports, surveys, plans, charts, records, analyses or publications produced for or as a result of this MOA by DAS shall bear an acknowledgment of the support of NJSPB. No work product produced utilizing funds or data obtained under this MOA shall be published or distributed to the public without the prior written consent of NJSPB and DAS. NJSPB and DAS shall have the right to edit said work product and shall further have the right to add disclaimers as they deem appropriate.

3. NJSPB shall also not be held liable for any termination of this MOA due to the absence of available funding appropriations from the New Jersey

legislature to NJSPB but shall pursue best efforts to seek replacement funding through transfers or supplemental appropriations.

(C.) The Division of Addiction Services Obligations

All of the requirements of this section apply to DAS:

1. DAS shall, on a fee-for-service basis, contract with appropriate DAS licensed and SPB approved provider network approved community-based substance abuse treatment providers including long-term and short-term residential treatment, partial care, halfway house, intensive outpatient, outpatient counseling, detoxification, TB tests, ASI assessments, and co-occurring services including psychotropic medications.
2. DAS shall provide services in accordance with Section II (C.) 5. which establishes the service deliverables which this agency must perform, in accordance with the established time frames established for each item in Section II (C.) 6.
3. DAS shall be required to submit expenditure and final reports. DAS shall request funds from NJSPB in accordance with the requirements of Attachment A.
4. DAS shall be required to maintain all records related to this MOA for a period of seven years following submission and acceptance of the financial and programmatic reports required under this MOA.
5. Service Deliverables to be provided. In exchange for funding provided by NJSPB as indicated in Section II (A.) 1., DAS agrees to perform the following:
 - a. DAS program monitors shall visit each MAP treatment program and assess the quality and frequency of treatment received by each referred client relative to that client's documented needs. DAS program monitors shall review that treatment lengths of stay in all levels of care will be clinically driven (currently Parole Board mandated clients may have a legally driven length of stay instead of a clinically driven length of stay) with ongoing assessments of clinical needs, and include discharge and transfers as clinically indicated. Additionally, DAS monitors shall review programs' administration, staffing and other aspects of the treatment programs' operations consistent with DAS review of all substance abuse treatment contractees.
 - b. DAS shall share information on any MAP utilization and/or programmatic deficiencies in MAP agencies with NJSPB in order to jointly develop and

implement appropriate corrective actions.

- c. DAS shall participate in a two-way information exchange with NJSPB for census tracking and status of MAP parolees as well as incident reporting.
 - d. DAS shall make available for MAP referrals an updated MAP Provider Network Directory.
 - e. DAS, in collaboration with NJSPB, agree to monitor the assessment and referral program to ensure optimum utilization of services.
6. Time Frame for Performance of Service Deliverables. This section contains the timetable for each of the services indicated in Section II (C.) 5. DAS agrees that the service deliverables indicated in Section II (C.) 5. shall be performed by the corresponding date or time period as follows:
- a. DAS shall perform annual site monitoring visits, as appropriate to program scope and size. Monitoring activities to maintain service accountability shall occur on a more frequent schedule, as determined in collaboration with NJSPB. (Section II (C.) 5. a.
 - b. DAS shall share programmatic deficiencies with NJSPB, as needed. (Section II (C.) 5. b.
 - c. DAS shall conduct MAP/SPB Provider Meetings as needed.
 - d. DAS shall participate in information exchange with NJSPB. (Section II (C.) 5. c.
 - e. DAS shall provide monthly and cumulative utilization reports which shall be provided by CSC to NJSPB within 14 days of the end of each month.
7. In addition to the above, DAS is required to abide by all general requirements contained in Sections III and IV of this MOA

(D.) The Division of Addiction Services Rights

All of the rights of this section apply to DAS:

- 1. DAS shall not be required to fulfill its obligations under this MOA should funding from NJSPB required pursuant to Section I not be made available in a timely manner.
- 2. DAS shall also not be held liable for any termination of this MOA due to the absence of available funding appropriations from the New Jersey Legislature to DAS.

3. DAS shall be permitted a minimum of 60 days lead time to implement any changes in accordance with the notice requirements applicable to its contracting process and Section I of this MOA.

III. General Provisions

(A.) Mandatory General Provisions

1. During the term of this MOA, DAS and NJSPB shall comply with all federal, state and municipal laws, rules and regulations generally applicable to the activities performed pursuant to this MOA.
2. DAS and NJSPB shall maintain accurate books and records of all disbursements, funds received, funds spent and funds available as a result of this MOA.
3. DAS and NJSPB are independent entities and no party shall hold itself out as an agent, partner or representative of the other.
4. Failure by any party to exercise any right or demand performance of any obligation under this MOA shall not be deemed a waiver of such right or obligation.
5. If any of the provisions of this MOA are, or become invalid, to any extent, the other provisions of this MOA shall not be effected thereby. In the event of the invalidity of a provision, the parties agree to accept a provision that reflects as closely as possible the intention of the invalid provision.
6. This MOA may not be assigned without the prior written consent of all parties.
7. The laws of the State of New Jersey govern this MOA.
8. This document represents the entire MOA among the parties and shall not be amended except by the express written consent of all parties, in accordance with the provisions of Attachment A, Section III.

(B.) Other Applicable Provisions

1. DAS and NJSPB reserve a royalty-free, nonexclusive, and irrevocable license to reproduce, publish or otherwise use, and to authorize others to use, the copyright in any work developed under the agreement.
2. The parties agree that all parolee data, records and information resulting from

this agreement are to be considered confidential and shall be solely used for the purposes as outlined above. All parties are required to use reasonable care to protect the confidentiality of this information and to comply with 42 CFR, part 2.

3. Any research resulting from this MOA shall comply with all applicable State and Federal requirements for protection of human subjects.
4. In the event services end by either MOA expiration or termination, DAS and NJSPB agree to collaboratively arrange for alternative placements of parolees until new services can become completely operational or to continue existing MAP services for a transitional period. If a transition period is requested by NJSPB, such period shall not exceed more than 180 days beyond the expiration date of the MOA, or any extension thereof. Subject to availability of appropriations to NJSPB, DAS shall be reimbursed for services and administration during the transitional period at the rate in effect when the transitional period clause is invoked by NJSPB.

IV. Terms and Termination

- (A.) Subject to any rights of termination hereinafter set forth, this MOA shall become effective as of July 1, 2010 and shall remain valid through June 30, 2011, unless extended pursuant to Section III or Section V. A portion of the project period is retroactive, and neither party shall incur penalties as a result of any non-compliance prior to the execution of this MOA.
- (B.) This MOA may be terminated by either party to this MOA with or without cause upon sixty (60) days advance written notice. Notice of termination shall be delivered via U.S. mail, return receipt requested, and shall be effective upon receipt. Notice shall be sent to the appropriate contact person identified in Section V.
- (C.) Upon the issuance of notice of termination by DAS, automatic termination under Section IV (A), or upon receipt by DAS of notice of termination issued by NJSPB, all funds contributed by NJSPB that are not due and owing to either DAS or a Service Provider Agency, in any DAS account whatsoever, shall be returned to NJSPB through the contact person identified in Section V without any further assessment or expenditure except as specifically approved by NJSPB in writing.

V. Principal Contacts

The principal contacts for all notifications required or otherwise necessary under this MOA shall be as follows:

For the Department of Human Services:

Program Management Officer

Christine Scalise
Division of Addiction Services
609-292-7293 (office)
609-292-3816 (fax)
120 S. Stockton St.
PO Box 362
Trenton, NJ 08625

Fiscal Officer

Jose Gonzalez
Acting Director, Administrative Services
Division of Addiction Services
609-984-0895 (office)
609-292-3816 (fax)
120 S. Stockton St.
PO Box 362
Trenton, NJ 08625

For the New Jersey State Parole Board:

Program Management Officer

Leonard Ward, Director
Division of Community Programs
609- 633-7703 (Office)
609-633-7930 (fax)
PO Box 862
Trenton, NJ 08625

Fiscal Officer

William Cranford
Chief, Fiscal and Administrative Services
609-292-3974 (phone)
609-777-0183 (fax)
PO Box 862
Trenton, NJ 08625

VI. We, the undersigned, consent to the contents of this MOA.

New Jersey Department of Human Services, Division of Addiction Services:

Signature:

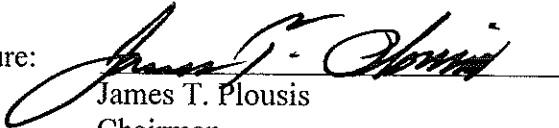


Raquel Mazon Jeffers
Director

10 | 22 | 10
Date

New Jersey State Parole Board:

Signature:



James T. Plousis
Chairman

12/10/10
Date

Attachment A

The provisions and conditions of this attachment are deemed to be incorporated in the Memorandum of Agreement between the New Jersey State Parole Board (NJSPB) and the New Jersey Department of Human Services, Division of Addiction Services (DAS), entitled “Mutual Agreement Program”.

I. Method of Payment

Cost reimbursement payments shall be made by NJSPB on the following basis:

- ☐ Monthly
- ☐ Quarterly
- ☐ Lump Sum
- ☐ Based on submission of the following reports:
- ☒ Other

- A. DAS shall submit monthly utilization of service reports indicating the providing agency, client name(s), and type of service, cost of service, SBI number, total of all services by providing agency and total of all services for all agencies. The reports shall be due within 14 calendar days of the end of each month for the previous two month’s utilization.
- B. On a monthly basis, on or about the 20th of each month, a fiscal/program utilization meeting or telephone conference call shall occur between NJSPB and DAS to review prior and future utilization, funding levels, and future funding allocations. Advance receipt of statistical, program utilization and funding reports provided by DAS shall be provided prior to the monthly meeting/conference call. If an analysis by DAS and NJSPB concludes that the advance funding provided by NJSPB is insufficient, additional funding shall be provided by NJSPB within 14 calendar days.
- C. Upon execution of this Agreement, NJSPB shall provide DAS with six months of advance payment for the estimated cost of fee for service substance abuse treatment services projected for \$2,443,000 at the SFY11 annualized level.
- D. In January 2011, NJSPB will advance the remaining balance in the amount of \$1,221,500 for the remaining six months of SFY11.
- E. A quarterly reconciliation shall be performed by DAS and submitted to NJSPB for review to ensure that billings and actual utilization are in agreement. Any adjustments will be reflected in subsequent requests for additional funding.

II. Financial and Performance Reporting and MOA Monitoring

- A. Monthly expenditure reports are required.
- B. NJSPB requires technical assistance meetings with DAS on the following basis:
☐ Initial ☒ Monthly ☐ Quarterly ☐ Final ☐ Other (Describe)

III. Modifications to the Agreement

- A. MOA extensions may be made to this MOA with the approval of the signatories identified in Section VI.
- B. Budget revisions may be made to this agreement with the approval of the Program Management Officers and Fiscal Officers identified in Section V.
- C. Modifications to Section II of the MOA, regarding service deliverables to be performed under Sections II (A.) and II (C.) may be made with the approval of the Program Management Officers identified in Section V.

IV. Special Conditions

This MOA does not include any other special conditions.

V. Multi-Year Agreements

This MOA is for a period of one year from July 1, 2010 until June 30, 2011 and authorization is approved for that period of time, except if Section III (a.) of Attachment A is invoked. This MOA may be renewed for an additional year in writing by agreement of both parties. Approval may be granted by the signatories identified in Section VI or their successors. Funding for the renewal period is subject to the Annual Appropriations Act.

VI. Budget/Cost Proposal

Under this Memorandum of Agreement (MOA), a total of \$3,272,889 shall be made available for the period of July 1, 2010 until June 30, 2011.

The total funding of \$2,443, 000 to be provided by NJSPB shall be transferred to DAS during SFY 11

NJSPB will also be required to provide \$175,000 to offset administrative costs. This amount shall be due on an annual basis and is inclusive of \$34,646 fiscal agent costs.

DAS will contribute up to \$654,889 for eligible network services as it deems appropriate.

NJSPB shall have the opportunity, at NJSPB discretion, to transfer at any time additional amounts to DAS for use in NJSPB fee-for-service network. Such a transfer shall not impact the allocation of DAS program or Cost of Living Adjustments funds available to the program, after the date of signature of this MOA. The addition of monies may be made as specified under Section II (A.) 3.

Attachment C**DAS MAP Fee-for-Service Reimbursement Rates**

SERVICE TYPE	REIMBURSEMENT RATE
Outpatient Individual/Family	\$26 per ½ / \$49 per hour
Outpatient Group	\$23 per hour
Intensive Outpatient	\$71 per diem
Partial Care	\$84 per diem
Long Term Residential	\$68 per diem
Short Term Residential	\$147 per diem
Halfway House	\$57 per diem
Subacute Detoxification	\$208 per diem
ASI Assessment	\$45 per session

Attachment D**MAP Co-Occurring Services for Reimbursement Rates**

SERVICE TYPE	REIMBURSEMENT RATES
Comprehensive Intake Evaluation	\$26.00 per 30 minutes
Crisis Intervention-Individual	\$13.00 per 15 minutes
Family Therapy (with patient)	\$24.50 per 30 minutes
Family Therapy (without client)	\$24.50 per 30 minutes
Individual Therapy – half session	\$24.50 per 30 minutes
Individual Therapy – full session	\$49.00 per 60 minutes
Clinical Consultation	\$25.00 per 15 minutes
Medication Monitoring	\$42.00 per 15 minutes
Psychiatric Evaluation (15 min)	\$32.00 per 15 minutes

Attachment E

MAP Fee-for-Service Reimbursement Rates

Clinical Reviews

<u>SERVICE TYPE</u>	<u>REIMBURSEMENT RATE</u>
Urine Drug Screen	\$8.00
Oral Swab	\$8.00
Continuing Care LOCI	\$25.00 per 20 minutes

NJPCA

New Jersey Primary Care Association, Inc.

Katherine Grant-Davis
President & CEO

May 3, 2011

Raquel Mazon Jeffers
Director
Division of Addiction Services
P.O. Box 362
Trenton, NJ 08625

Dear Ms. Mazon Jeffers:

The NJPCA is pleased to support the Division of Addiction Services' (DAS) application for federal funding under the Substance Abuse and Mental Health Services Administration (SAMHSA) grant announcement TI-11-005: Cooperative Agreements for Screening, Brief Intervention and Referral to Treatment. Additional funding to New Jersey will expand and enhance the State's continuum of care for substance misuse services; reduce alcohol and drug consumption and its negative health impact; increase abstinence and reduce costly health care utilization; and promote sustainability and behavioral health information technology.

The NJPCA represents the 20 Federally Qualified Health Centers (FQHCs) in the State of New Jersey. FQHCs have been in the forefront of managed primary care for the indigent, the underinsured, and Medicaid patients in this country and in New Jersey for the last 40 years. Today, a network of more than 1,000 health centers operating in 4,000 delivery locations around the United States provide a primary care safety net for more than 14 million patients, who otherwise would face major financial, social, and language barriers to obtaining health care.

We wish you success in your federal grant application, as it will help improve health outcomes across a range of primary settings in New Jersey, including primary care and community-based settings. We also pledge to work with you to ensure that Medicaid will indeed turn on the SBIRT codes.

Sincerely,



Katherine Grant-Davis
President and CEO

KGD:DVZ

3836 Quakerbridge Road, Suite 201, Hamilton, NJ 08619
(609) 689-9930 FAX (609) 689-9940/41



State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF ADDICTION SERVICES
PO BOX 362
TRENTON, N.J. 08625-0362

CHRIS CHRISTIE
Governor

JENNIFER VELEZ
Commissioner

KIM GUADAGNO
Lt. Governor

RAQUEL MAZON JEFFERS
Director

October 14, 2010

Jerry Fischer
Director
Department of Law and Public Safety
Division of Alcoholic Beverage Control
P.O. Box 087
Trenton, NJ 08625

Dear Mr. Fischer:

As you may know, the Division of Addiction Services (DAS) is within the New Jersey Department of Human Services. DAS' mission is to promote the prevention and treatment of substance abuse and support the recovery of individuals affected by the chronic disease of addiction. As the Single State Agency for substance abuse, DAS is responsible for regulating, licensing, monitoring, planning and funding substance abuse prevention, treatment and recovery support services in New Jersey.

DAS is currently in the preliminary stages of developing an Addiction-Prevention Strategic Plan. This Plan will become a roadmap for statewide prevention activities and funding decisions; and is intended to support population-level changes across the life span, prevent misuse of substances, and reduce the harmful consequences of alcohol and drug use.

Drug abuse and addiction are a major burden to society. Estimates of the total overall costs of substance abuse in the United States—including health- and crime-related costs as well as losses in productivity—exceed half a trillion dollars annually. This includes approximately \$181 billion for illicit drugs, \$168 billion for tobacco, and \$185 billion for alcohol. Staggering as these numbers are, however, they do not fully describe the breadth of deleterious public health and safety implications, which include family disintegration, loss of employment, failure in school, domestic violence, child abuse, and other crimes.

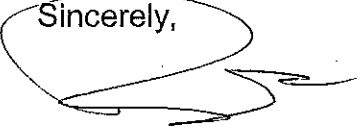
To develop a truly comprehensive Statewide Addiction-Prevention Strategic Plan, DAS seeks to identify opportunities to collaborate and coordinate with other New Jersey

State departments and agencies whose work includes efforts to eliminate or minimize the deleterious personal and societal consequences resulting from the misuse and abuse of alcohol, tobacco and other drugs.

To this end, DAS invites you or your representative to participate in the development of the Addiction-Prevention Strategic Plan. Meetings will last approximately 2-3 hours and will be held monthly from October through February at DAS' offices in Trenton. **The first meeting will be held on Wednesday, October 27th from 10:00 – 1:00.**

Please contact Helen Staton at DAS at 609-633-8781 or helen.staton@dhs.state.nj.us to indicate that you or your representative will participate in developing the Addiction-Prevention Strategic Plan. We look forward to developing a plan that will truly guide all our efforts to prevent the misuse of substances, and reduce the harmful consequences of alcohol and drug use throughout New Jersey.

Sincerely,



Raquel Mazon Jeffers
Director



State of New Jersey

DEPARTMENT OF HUMAN SERVICES

DIVISION OF ADDICTION SERVICES

PO BOX 362

TRENTON, N.J. 08625-0362

CHRIS CHRISTIE

Governor

JENNIFER VELEZ

Commissioner

KIM GUADAGNO

Lt. Governor

RAQUEL MAZON JEFFERS

Director

October 14, 2010

Gary Poedubicky
Acting Director
Department of Law and Public Safety
Division of Highway Traffic Safety
P.O. Box 048
Trenton, NJ 08625

Dear Mr. Poedubicky:

As you may know, the Division of Addiction Services (DAS) is within the New Jersey Department of Human Services. DAS' mission is to promote the prevention and treatment of substance abuse and support the recovery of individuals affected by the chronic disease of addiction. As the Single State Agency for substance abuse, DAS is responsible for regulating, licensing, monitoring, planning and funding substance abuse prevention, treatment and recovery support services in New Jersey.

DAS is currently in the preliminary stages of developing an Addiction-Prevention Strategic Plan. This Plan will become a roadmap for statewide prevention activities and funding decisions; and is intended to support population-level changes across the life span, prevent misuse of substances, and reduce the harmful consequences of alcohol and drug use.

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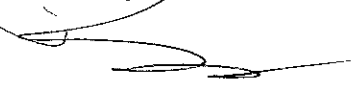
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Sincerely,



Raquel Mazon Jeffers
Director



State of New Jersey

DEPARTMENT OF HUMAN SERVICES

DIVISION OF ADDICTION SERVICES

PO BOX 362

TRENTON, N.J. 08625-0362

CHRIS CHRISTIE
Governor

JENNIFER VELEZ
Commissioner

KIM GUADAGNO
Lt. Governor

RAQUEL MAZON JEFFERS
Director

October 14, 2010

Patricia A. Walker
Director
Department of Law and Public Safety
Juvenile Justice Commission
Office of Local Programs and Services, Prevention and Early Intervention
P.O. Box 107
Trenton, NJ 08625

Dear Ms. Walker:

As you may know, the Division of Addiction Services (DAS) is within the New Jersey Department of Human Services. DAS' mission is to promote the prevention and treatment of substance abuse and support the recovery of individuals affected by the chronic disease of addiction. As the Single State Agency for substance abuse, DAS is responsible for regulating, licensing, monitoring, planning and funding substance abuse prevention, treatment and recovery support services in New Jersey.

DAS is currently in the preliminary stages of developing an Addiction-Prevention Strategic Plan. This Plan will become a roadmap for statewide prevention activities and funding decisions; and is intended to support population-level changes across the life span, prevent misuse of substances, and reduce the harmful consequences of alcohol and drug use.

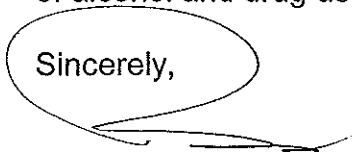
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To develop a truly comprehensive Statewide Addiction-Prevention Strategic Plan, DAS seeks to identify opportunities to collaborate and coordinate with other New Jersey State departments and agencies whose work includes efforts to eliminate or minimize the deleterious personal and societal consequences resulting from the misuse and abuse of alcohol, tobacco and other drugs.

To this end, DAS invites you or your representative to participate in the development of the Addiction-Prevention Strategic Plan. Meetings will last approximately 2-3 hours and will be held monthly from October through February at DAS' offices in Trenton. **The first meeting will be held on Wednesday, October 27th from 10:00 – 1:00.**

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Sincerely,



Raquel Mazon Jeffers
Director



State of New Jersey

DEPARTMENT OF HUMAN SERVICES

DIVISION OF ADDICTION SERVICES

PO BOX 362

TRENTON, N.J. 08625-0362

CHRIS CHRISTIE
Governor

JENNIFER VELEZ
Commissioner

KIM GUADAGNO
Lt. Governor

RAQUEL MAZON JEFFERS
Director

October 14, 2010

Lisa Von Pier
Director
Department of Children and Families
Division of Prevention and Community Partnerships
P.O. Box 717
Trenton, NJ 08625

Dear Ms. Von Pier:

As you may know, the Division of Addiction Services (DAS) is within the New Jersey Department of Human Services. DAS' mission is to promote the prevention and treatment of substance abuse and support the recovery of individuals affected by the chronic disease of addiction. As the Single State Agency for substance abuse, DAS is responsible for regulating, licensing, monitoring, planning and funding substance abuse prevention, treatment and recovery support services in New Jersey.

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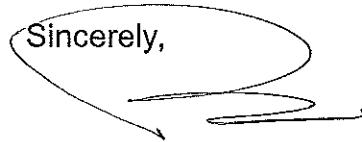
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To this end, DAS invites you or your representative to participate in the development of the Addiction-Prevention Strategic Plan. Meetings will last approximately 2-3 hours and will be held monthly from October through February at DAS' offices in Trenton. **The first meeting will be held on Wednesday, October 27th from 10:00 – 1:00.**

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Sincerely,

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Raquel Mazon Jeffers
Director



State of New Jersey

DEPARTMENT OF HUMAN SERVICES

DIVISION OF ADDICTION SERVICES

PO BOX 362

TRENTON, N.J. 08625-0362

CHRIS CHRISTIE

Governor

JENNIFER VELEZ

Commissioner

KIM GUADAGNO

Lt. Governor

RAQUEL MAZON JEFFERS

Director

October 14, 2010

Brian Hancock
Acting Director
Department of Children and Families
Division of Child Behavioral Health Services
P.O. Box 717
Trenton, NJ 08625

Dear Mr. Hancock:

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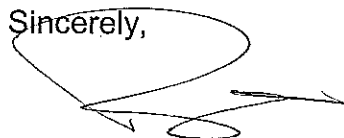
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CHRIS CHRISTIE
Governor

JENNIFER VELEZ
Commissioner

KIM GUADAGNO
Lt. Governor

RAQUEL MAZON JEFFERS
Director

October 14, 2010

Gary M. Lanigan
Commissioner
Department of Corrections
P.O. Box 863
Trenton, NJ 08625

Dear Mr. Lanigan:

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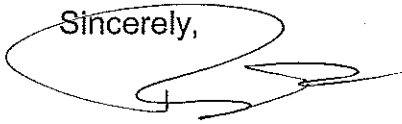
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Raquel Mazon Jeffers
Director



State of New Jersey

DEPARTMENT OF HUMAN SERVICES

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PO BOX 362

TRENTON, N.J. 08625-0362

CHRIS CHRISTIE
Governor

JENNIFER VELEZ
Commissioner

KIM GUADAGNO
Lt. Governor

RAQUEL MAZON JEFFERS
Director

October 14, 2010

Gary Vermeire
Program Coordinator, Safe and Drug-Free Schools
Department of Education
P.O. Box 500
Trenton, NJ 08625

Dear Mr. Vermeire:

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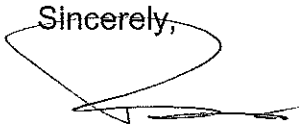
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Raquel Mazon Jeffers
Director



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CHRIS CHRISTIE
Governor

JENNIFER VELEZ
Commissioner

KIM GUADAGNO
Lt. Governor

RAQUEL MAZON JEFFERS
Director

October 14, 2010

Celeste Andriot-Wood
Assistant Commissioner
Department of Health and Senior Services
Division of Family Health Services
P.O. Box 364
Trenton, NJ 08625

Dear Ms. Andriot-Wood:

As you may know, the Division of Addiction Services (DAS) is within the New Jersey Department of Human Services. DAS' mission is to promote the prevention and treatment of substance abuse and support the recovery of individuals affected by the chronic disease of addiction. As the Single State Agency for substance abuse, DAS is responsible for regulating, licensing, monitoring, planning and funding substance abuse prevention, treatment and recovery support services in New Jersey.

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Raquel Mazon Jeffers
Director



State of New Jersey

DEPARTMENT OF HUMAN SERVICES

DIVISION OF ADDICTION SERVICES

PO BOX 362

TRENTON, N.J. 08625-0362

CHRIS CHRISTIE
Governor

JENNIFER VELEZ
Commissioner

KIM GUADAGNO
Lt. Governor

RAQUEL MAZON JEFFERS
Director

October 14, 2010

Patricia Polansky
Assistant Commissioner
Department of Health and Senior Services
Division of Aging and Community Services
P.O. Box 807
Trenton, NJ 08625

Dear Ms. Polansky:

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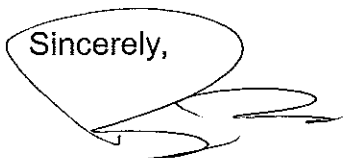
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Raquel Mazon Jeffers
Director



State of New Jersey

DEPARTMENT OF HUMAN SERVICES

DIVISION OF ADDICTION SERVICES

PO BOX 362

TRENTON, N.J. 08625-0362

CHRIS CHRISTIE
Governor

JENNIFER VELEZ
Commissioner

KIM GUADAGNO
Lt. Governor

RAQUEL MAZON JEFFERS
Director

October 14, 2010

Raymond L. Zawacki
Deputy Commissioner
Department of Military and Veterans Affairs
P.O. Box 340
Trenton, NJ 08625

Dear Mr. Zawacki:

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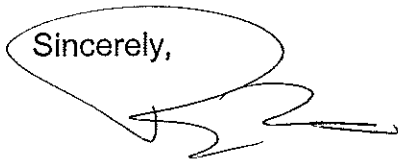
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Raquel Mazon Jeffers
Director



State of New Jersey

DEPARTMENT OF HUMAN SERVICES

DIVISION OF ADDICTION SERVICES

PO BOX 362

TRENTON, N.J. 08625-0362

CHRIS CHRISTIE
Governor

JENNIFER VELEZ
Commissioner

KIM GUADAGNO
Lt. Governor

RAQUEL MAZON JEFFERS
Director

October 14, 2010

Mary L. Powner
Executive Director
Department of the Treasury
Governor's Council on Alcoholism and Drug Abuse
P.O. Box 345
Trenton, NJ 08625

Dear Ms. Powner:

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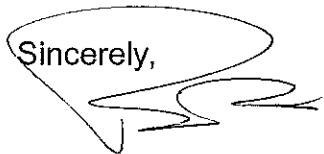
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Raquel Mazon Jeffers
Director



State of New Jersey

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CHRIS CHRISTIE
Governor

JENNIFER VELEZ
Commissioner

KIM GUADAGNO
Lt. Governor

RAQUEL MAZON JEFFERS
Director

October 14, 2010

Dr. Glenn Lang
Acting Executive Director
New Jersey Commission on Higher Education
P.O. Box 542
Trenton, NJ 08625

Dear Dr. Lang:

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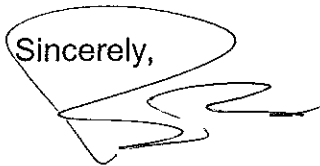
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Raquel Mazon Jeffers
Director



State of New Jersey

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DIVISION OF ADDICTION SERVICES

PO BOX 362

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CHRIS CHRISTIE
Governor

JENNIFER VELEZ
Commissioner

KIM GUADAGNO
Lt. Governor

RAQUEL MAZON JEFFERS
Director

October 14, 2010

Kenneth W. Ritchey
Assistant Commissioner
Department of Human Services
Division of Developmental Disabilities
P.O. Box 726
Trenton, NJ 08625

Dear Mr. Ritchey:

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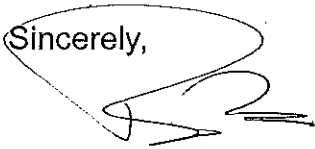
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Raquel Mazon Jeffers
Director



State of New Jersey

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CHRIS CHRISTIE
Governor

JENNIFER VELEZ
Commissioner

KIM GUADAGNO
Lt. Governor

RAQUEL MAZON JEFFERS
Director

October 14, 2010

Deborah E. Cohen
Director
Department of Human Services
Office for Prevention of Developmental Disabilities
P.O. Box 726
Trenton, NJ 08625

Dear Ms. Cohen:

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Raquel Mazon Jeffers
Director



State of New Jersey

DEPARTMENT OF HUMAN SERVICES

DIVISION OF ADDICTION SERVICES

PO BOX 362

TRENTON, N.J. 08625-0362

CHRIS CHRISTIE

Governor

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KIM GUADAGNO

Lt. Governor

RAQUEL MAZON JEFFERS

Director

October 14, 2010

John R. Guhl
Director
Department of Human Services
Division of Medical Assistance and Health Services
P.O. Box 712
Trenton, NJ 08625

Dear Mr. Guhl:

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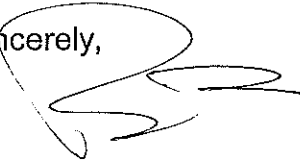
To develop a truly comprehensive Statewide Addiction-Prevention Strategic Plan, DAS seeks to identify opportunities to collaborate and coordinate with other New Jersey State departments and agencies whose work includes efforts to eliminate or minimize the deleterious personal and societal consequences resulting from the misuse and abuse of alcohol, tobacco and other drugs.

To this end, DAS invites you or your representative to participate in the development of the Addiction-Prevention Strategic Plan. Meetings will last approximately 2-3 hours and

will be held monthly from October through February at DAS' offices in Trenton. **The first meeting will be held on Wednesday, October 27th from 10:00 – 1:00.**

Please contact Helen Staton at DAS at 609-633-8781 or helen.staton@dhs.state.nj.us to indicate that you or your representative will participate in developing the Addiction-Prevention Strategic Plan. We look forward to developing a plan that will truly guide all our efforts to prevent the misuse of substances, and reduce the harmful consequences of alcohol and drug use throughout New Jersey.

Sincerely,

A handwritten signature in black ink, appearing to read 'Raquel Mazon Jeffers', written over a circular stamp or seal.

Raquel Mazon Jeffers
Director



State of New Jersey

DEPARTMENT OF HUMAN SERVICES

DIVISION OF ADDICTION SERVICES

PO BOX 362

TRENTON, N.J. 08625-0362

CHRIS CHRISTIE

Governor

JENNIFER VELEZ

Commissioner

KIM GUADAGNO

Lt. Governor

RAQUEL MAZON JEFFERS

Director

October 14, 2010

Valerie Larosiliere
Acting Assistant Commissioner
Department of Human Services
Division of Mental Health Services
P.O. Box 727
Trenton, NJ 08625

Dear Ms. Larosiliere:

The Division of Addiction Services (DAS) is currently in the preliminary stages of developing an Addiction-Prevention Strategic Plan. This Plan will become a roadmap for statewide prevention activities and funding decisions; and is intended to support population-level changes across the life span, prevent misuse of substances, and reduce the harmful consequences of alcohol and drug use.

Drug abuse and addiction are a major burden to society. Estimates of the total overall costs of substance abuse in the United States—including health- and crime-related costs as well as losses in productivity—exceed half a trillion dollars annually. This includes approximately \$181 billion for illicit drugs, \$168 billion for tobacco, and \$185 billion for alcohol. Staggering as these numbers are, however, they do not fully describe the breadth of deleterious public health and safety implications, which include family disintegration, loss of employment, failure in school, domestic violence, child abuse, and other crimes.

To develop a truly comprehensive Statewide Addiction-Prevention Strategic Plan, DAS seeks to identify opportunities to collaborate and coordinate with other New Jersey State departments and agencies whose work includes efforts to eliminate or minimize the deleterious personal and societal consequences resulting from the misuse and abuse of alcohol, tobacco and other drugs.

To this end, DAS invites you or your representative to participate in the development of the Addiction-Prevention Strategic Plan. Meetings will last approximately 2-3 hours and

will be held monthly from October through February at DAS' offices in Trenton. **The first meeting will be held on Wednesday, October 27th from 10:00 – 1:00.**

Please contact Helen Staton at DAS at 609-633-8781 or helen.staton@dhs.state.nj.us to indicate that you or your representative will participate in developing the Addiction-Prevention Strategic Plan. We look forward to developing a plan that will truly guide all our efforts to prevent the misuse of substances, and reduce the harmful consequences of alcohol and drug use throughout New Jersey.

Sincerely,

A handwritten signature in black ink, appearing to be 'Raquel Mazon Jeffers', written over a faint, stylized outline of the state of New Jersey.

Raquel Mazon Jeffers
Director



State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF ADDICTION SERVICES
PO Box 362
TRENTON NJ 08625-0362

JON S. CORZINE
Governor

JENNIFER VELEZ
Commissioner
RAQUEL MAZON JEFFERS
Director

MEMORANDUM OF AGREEMENT

BETWEEN

**THE DEPARTMENT OF HUMAN SERVICES
DIVISION OF ADDICTION SERVICES
(Hereafter DAS)**

AND

**UNIVERSITY OF MEDICINE AND DENTISTRY OF NEW JERSEY-
ROBERT WOOD JOHNSON MEDICAL SCHOOL
(Hereafter UMDNJ-RWJ)**

FOR

RAPID HIV TESTING SERVICES

WHEREAS, the New Jersey Department of Human Services (DHS), Division of Addiction Services (DAS) and the University of Medicine and Dentistry of New Jersey Robert Wood Johnson-Medical School (UMDNJ-RWJ) wish to provide HIV screening by ensuring rapid HIV testing for clients in State funded methadone treatment programs; and

WHEREAS, the DHS/DAS wishes to purchase administrative services to include lab directorship, consultation, lab oversight, authorization and technical support through UMDNJ-RWJ to ensure rapid HIV testing for clients in State licensed substance use disorder treatment programs; and

WHEREAS, the DHS/DAS and UMDNJ-RWJ recognize that individuals with substance use disorders, particularly intravenous drug users, are at a higher risk for contracting HIV/AIDS than the general population DAS and UMDNJ-RWJ find it in the public interest to provide rapid HIV testing at DAS licensed substance use disorder treatment programs;

NOW, THEREFORE, THE PARTIES HERETO AGREE AS FOLLOWS:

Under this Memorandum of Agreement (MOA), a total of \$667,414 will be made available for the period of October 1, 2009 until September 30, 2010 to provide rapid HIV testing for approximately 10,000 unduplicated clients at a maximum of 44 DAS-funded drug treatment programs statewide.

I. Obligations and Rights of the Funding Agency

(A.) New Jersey Department of Human Services, Division of Addiction Services Obligations

1. The DAS shall provide funding annually in an amount not to exceed \$667,414. Payment is contingent upon the satisfactory delivery of services as described herein, Section II, (A.) "UMDNJ-RWJ Obligations." Payment obligations are contained in Attachment A, and incorporated herein by reference. Payments shall be made in accordance with the provisions in Attachment A, Section I.
2. DAS shall maintain the right to monitor the progress of this project to ensure that services are being provided in accordance with Section II (A.), which establishes the work products and deliverables which must be completed. All financial, performance and MOA monitoring requirements are contained in Attachment A, Sections II, III and IV.
3. DAS shall notify UMDNJ-RWJ of any changes in policies or procedures that may affect the service agency's obligations. Changes in policies, procedures or agency contact information will include notification and discussion with UMDNJ-RWJ.
4. In addition to the above, DAS is required to abide by all general provisions and requirements contained in Sections III and IV of this Agreement.

(B.) The New Jersey Department of Human Services, Division of Addiction Services Rights

1. DAS reserves the right to terminate this MOA should the funding be depleted prior to the end of the Agreement.
2. DAS shall not be held liable for any termination of this MOA due to the absence of or a change in available funding from the Federal Block Grant to DAS.
3. Audit. For audit purposes, the recipients of these funds must be in compliance with State Circular Letter 04-04 OMB. In addition, DAS shall have the right to at any time audit any and all accounts and/or records maintained by UMDNJ-RWJ pertaining to these funds. To effectuate this provision, the DAS shall be afforded, during normal business hours, access to all records and/or data of UMDNJ-RWJ or its agent/consultants which pertain to this Agreement. The provisions of this subparagraph shall continue for a period of seven years after the submission and acceptance of the financial and programmatic reports required under this MOA.
4. Work Product. All data, technical information, materials gathered, originated, developed, prepared, used or obtained in the performance of the requested services, including but not limited to, all papers, reports, surveys, plans, charts, records, analyses or publications produced for or as a result of the Agreement shall bear an acknowledgment of the support of DAS. No work product produced utilizing funds or data obtained under this Agreement shall be released to the public without the prior written consent of both DAS and UMDNJ-RWJ. DAS shall have the

right to edit and shall further have the right to add disclaimers as they deem appropriate.

5. Publishing. Any research, which must be conducted on populations served under this Agreement, will be subject to review by an Institutional Review Board prior to initiation. All reports, data sheets, documents, etc. generated under this Agreement shall be accessible to DAS. UMDNJ-RWJ shall deliver to DAS, upon demand, all copies of materials relating or pertaining to this Agreement when it is completed or terminated. UMDNJ-RWJ shall inform DAS in advance of any publication or other public disclosure of any material and/or information related to this Agreement.
6. Subgrants. DAS must approve any contract entered into by UMDNJ-RWJ with third-party providers of services authorized under this MOA. Reimbursement for services provided by a sub-contractor will not be authorized by DHS unless DAS Program Management Officers (PMOs) and Grants Management Officers (GMOs) have approved the legal agreement and budget for such services. UMDNJ-RWJ must provide no less than 75% of the services directly.

II. Obligations and Rights of the Recipient Agency

(A.) University of Medicine and Dentistry of New Jersey- Robert Wood Johnson Medical School Obligations

1. UMDNJ-RWJ shall provide services in accordance with Section II (A.) 4. which establishes the service deliverables which this agency must perform. .
2. UMDNJ-RWJ shall be required to submit expenditure, progress and final reports and state invoices in accordance with the requirements of Attachment A.
3. UMDNJ-RWJ shall be required to maintain all records for a period of seven years.
4. Services to be provided in exchange for funding provided by DAS as indicated in Section I (A.) (1.):

UMDNJ-RWJ staff shall provide administrative services to include consultation, lab oversight and authorization to ensure rapid HIV testing for clients in State funded methadone treatment programs. Services will include, but not be limited to:

- a. Providing the clinical laboratory directorship as required to maintain New Jersey clinical laboratory licensure on behalf of the DHS/DAS at 44 sites designated by DAS.
- b. Providing technical assistance to DHS/DAS agencies to ensure clients are offered testing at admission and again thereafter every six months while in treatment.
- c. Providing technical assistance to DHS/DAS agencies to ensure testing targets are being met at each agency.
- d. Submitting necessary documentation to maintain laboratory licenses at DAS-funded agencies.
- e. Providing laboratory policies and procedures to ensure accurate and uniform procedures at each of the locations where rapid HIV testing is provided.

- f. Ensuring standard quality assurance policies are in place and reviewing the compliance within these policies.
 - g. Providing laboratory oversight of all personnel at designated DAS sites certified to perform laboratory testing.
 - h. Providing and reviewing the results of proficiency tests and assisting DAS site monitoring staff to develop corrective action plans, when necessary, as laboratory correction plans are developed, reviewed and updated.
 - i. Conducting monthly on-site reviews and inspections of locations where testing is provided to include, but not limited to the review of testing procedures, storage area compliance, controls, inventory of test kits, unusual events, staff certification, etc.
 - j. Conducting on-site reviews to assist the sites in developing work flows to better incorporate rapid HIV testing in daily operations.
 - k. Ensuring the personnel training programs are in place so that personnel conducting rapid HIV tests are trained in the appropriate testing procedures.
 - l. Being available by telephone to answer calls from agency staff performing tests in locations where rapid HIV testing is provided; and reviewing any problems identified above with the DAS, or other designated parties.
 - m. Following-up on all discordants (clients with confirmatory test results that are not consistent with the initial positive rapid test) including but not limited to telephone consultation with a physician, consultation with a patient, specimen pickup and database management.
 - n. Training and implementation of the rapid-rapid algorithm at all sites when comfortable with the primary rapid testing process.
 - o. Assuming the role of inventory manager purchasing all reagent test kits and controls and other bulk laboratory supplies on behalf of the DAS and distributing orders to the sites complete with appropriate monitoring systems.
 - p. Collecting data and maintaining reporting systems for all sites performing laboratory tests, to facilitate for monthly reporting of all activity to DAS.
 - q. Monthly performance reporting for all State funded substance use disorder treatment programs.
 - r. Quarterly reporting of all expenditures to DAS.
 - s. Participating on behalf of DAS in eligible protocols from other agencies such as SAMHSA, CDC, etc.
5. A copy of all reports, including but not limited to, status reports of desk audits and interim and final reports shall be available for review by DAS as requested or required.
6. In addition to the above, UMDNJ-RWJ is required to abide by all General Provisions and requirements contained in Sections II, III and IV of this agreement.

(B.) University of Medicine and Dentistry of New Jersey- Robert Wood Johnson Medical School Rights

- 1. UMDNJ-RWJ shall not be required to fulfill its obligations should funding from DAS not be made available.
- 2. Work Product. All data, technical information, materials gathered, originated, developed, prepared, used or obtained in the performance of the requested services, including but not limited to, all papers, reports, surveys, plans, charts, records,

analyses or publications produced for or as a result of this Agreement shall bear an acknowledgment of the support of DAS. No work product produced utilizing funds or data obtained under this Agreement shall be released to the public without the prior written consent of both DAS and UMDNJ-RWJ. UMDNJ-RWJ shall have the right to edit and shall further have the right to add disclaimers as they deem appropriate.

III. General Provisions

(A.) Mandatory General Provisions

1. During the term of this Agreement, DAS and UMDNJ-RWJ shall comply with all Federal, State and municipal laws, rules and regulations generally applicable to the activities performed pursuant to this Agreement.
2. DAS and UMDNJ-RWJ shall maintain accurate books and records of all disbursements, funds received, funds spent and funds available as a result of this Agreement.
3. DAS and UMDNJ-RWJ are independent entities, and neither party shall hold itself out as an agent, partner or representative of the other.
4. Failure by either party to exercise any right or demand performance of any obligation under this Agreement shall not be deemed a waiver of such right or obligation.
5. If any of the provisions of this Agreement are, or become invalid, to any extent, the other provisions of this Agreement shall not be effected thereby. In the event of the invalidity of a provision, the parties agree to accept a provision which reflects as closely as possible the intention of the invalid provision.
6. This Agreement may not be assigned without the prior written consent of all parties.
7. The laws of the State of New Jersey govern this agreement.
8. This agreement may be modified in accordance with the provisions of Attachment A, Section III, which includes extensions, budget revisions and modifications to this agreement, with the approval of the Program Management Officers (PMOs) and Grant Management Officers (GMOs) identified in Section V.
9. Monthly programmatic reports must be submitted to the HIV Program Coordinator within 20 days after the end of month. Fiscal reports must be submitted quarterly and be submitted by the end of the month following the close of the quarter. The expenditure report for the month ending September 30, 2010 must show the disposition of all Agreement funds. All funds must be expended and a final expenditure report must be submitted to DAS within 60 days following the end of the Agreement year. Any funds not expended or obligated by September 30, 2010 shall be returned to DAS.
10. All expenditure reports and audit reports related to this allocation shall be submitted to Adam Bucon, HIV Program Coordinator, Office of Treatment

Services, DAS.

11. DAS and the UMDNJ-RWJ reserve a royalty-free, non-exclusive, and irrevocable license to reproduce, publish or otherwise use, and to authorize others to use, the copyright in any work developed under the agreement.
12. The parties agree all data resulting from this agreement are to be considered confidential and shall be solely used for purposes as outlined above. All parties are required to use reasonable care to protect the confidentiality of the data and comply with HIPAA and 42 CFR, Part 2.
13. Any research resulting from this Agreement which is subject to the Institutional Review Boards of either of the parties shall be confidential. Each party is responsible for adhering to the rules of the Institutional Review Board which are hereby incorporated by reference.

IV. Terms and Termination

- (A.) Subject to any rights of termination hereinafter set forth, this Agreement shall become effective on October 1, 2009 and shall remain valid through September 30, 2010. A portion of the project period is retroactive and neither party will incur penalties as a result of any non-compliance prior to the execution of this Agreement.
- (B.) This Agreement may be terminated by either of the parties to this agreement with or without cause upon sixty (60) days advance written notice.
- (C.) Notice of termination shall be delivered via U.S. mail, return receipt requested, and shall be effective upon receipt. Notice shall be sent to the appropriate contact person identified in Section V.
- (D.) Upon the issuance of notice of termination by DAS or UMDNJ-RWJ, or automatic termination under Section IV (A), all unexpended funds appropriated by DAS to UMDNJ-RWJ, in any account whatsoever, shall be returned to DAS through the contact person identified in Section V without any further assessment or expenditure except as specifically approved by DAS in writing.

V. Principal Contacts

The principal contacts for all notifications required or otherwise necessary under this Agreement shall be as follows:

New Jersey Department of Human Service, Division of Addiction Services:

Program Management Officer
Adam Bucon, HIV Program Coordinator
Office of Quality Assurance
Division of Addiction Services
120 South Stockton Street, 3rd floor
P.O. Box 362
Trenton, NJ 08625
609-984-3316 (office)
609-292-3816 (fax)

Fiscal Officer
Lewis Borsellino, Director
Administrative Services
Division of Addiction Services
120 South Stockton Street, 3rd floor
P.O. Box 362
Trenton, NJ 08625
609-984-0895 (office)
609-292-0145 (fax)

University of Medicine and Dentistry of NJ- Robert Wood Johnson Medical School:

University Representative
Denise Mulkern
Senior Vice President for Finance
University of Medicine and Dentistry of New Jersey, Suite 1419
65 Bergen Street, P.O. Box 1709
Newark, New Jersey 07107-1709
973 972-7981 (office)
973-972-7670 (fax)

Grants Manager
Anthony Mayo, Manager, Grants and Contracts
Liberty Plaza
335 George Street
New Brunswick, NJ 08903
732-235-9358 (office)
732-235-9231 (fax)

VII. We, the undersigned, consent to the contents of this Agreement.

New Jersey Department of Human Services:

Signature: _____

Raquel Mazon Jeffers
DAS Director

11/23/09
Date

UMDNJ/ Robert Wood Johnson Medical School:

Signature: _____

Denise Mulkern
Senior Vice President for Finance

11/5/09
Date

Attachment A

Attachment A is hereby incorporated to and provide for additional provisions and conditions between the New Jersey Department of Human Services, Division of Addiction Services and the University of Medicine and Dentistry of New Jersey-Robert Wood Johnson Medical School for a Memorandum of Agreement entitled, "Rapid HIV Testing Services."

I. Method of Payment

Cost reimbursement payments shall be made by the Funding Agency on the following basis:

- ☐ Monthly
- ☒ Quarterly
- ☐ Lump Sum
- ☒ Based on submission of the quarterly fiscal report.

II. Financial and Performance Reporting and MOA Monitoring

A. Expenditure reports are required. If applicable, these will be submitted, by the Service Provider agency no later than 30 days after the end of each:

☐ Initial ☐ Monthly ☒ Quarterly ☐ Final ☐ Other (Describe)

B. Performance reports are required. Performance reports shall be in the form specified by the Funding Agency and shall be submitted on a:

☐ Initial ☒ Monthly ☐ Quarterly ☐ Final ☐ Other (Describe)

C. The Funding Agency will provide technical assistance meetings with the Service Provider Agency on the following basis:

☐ Initial ☐ Monthly ☒ Quarterly ☐ Final ☐ Other (Describe)

D. The Service Provider Agency will provide technical assistance meetings with the Funding Agency on the following basis:

☐ Initial ☐ Monthly ☒ Quarterly ☐ Final ☐ Other (Describe)

E. Other Financial, Reporting or Monitoring Requirements

1. Particular forms are not required to be utilized. If applicable these are attached.

No special forms are required.



State of New Jersey

DEPARTMENT OF CHILDREN AND FAMILIES

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

ALLISON BLAKE, PH.D., L.S.W.
Commissioner

To the Residents of New Jersey,

We are pleased to present you with the *New Jersey Youth Suicide Prevention State Plan 2011-2014*. This plan was developed by the Department of Children and Families (DCF) - Division of Child Behavioral Health Services (DCBHS) with input provided by the New Jersey Youth Suicide Prevention Advisory Council (NJYSPAC).

DCF would like to take this opportunity to thank the NJYSPAC for their work and ideas on the development of our Youth Suicide Prevention Plan. While this plan was edited and published by DCF and not all of the recommendations made by the NJYSPAC were utilized, the NJSPAC deserves much credit for their dedicated work to present a quality draft plan to DCF. We thank you.

This plan has been developed to guide the State's efforts to prevent youth suicides. While New Jersey has a comparatively low rate of suicide, consistently ranking one of the fourth lowest in the United States, youth suicide remains the fourth leading cause of death for New Jersey's youth. We are dedicated to continuing to work to prevent youth suicides in New Jersey and this plan helps provide guidance for this important work.

Although New Jersey had not adopted a formal State plan for youth suicide prevention until now, for many years New Jersey has provided resources to suicide prevention in many ways including funding the Traumatic Loss Coalition for Youth (TLC). The TLC is a state-wide suicide prevention program funded by DCBHS and led by the University of Medicine and Dentistry of New Jersey (UMDNJ)-University Behavioral Health Care (UBHC). This program remains a strong initiative in our suicide prevention efforts. More information and the most recent TLC state report can be found at <http://ubhc.umdj.edu/brti/TLC.htm>.

Preventing youth suicide is a collaborative effort and we look forward to working in partnership with our communities to move this plan forward. We welcome your comments or questions at cbh_dcf@dcf.sate.nj.us.

Sincerely,

A stylized signature of Jeffrey J. Guenzel.

Jeffrey J. Guenzel, MA, LPC
DCBHS Director

A stylized signature of Allison Blake.

Allison Blake, Ph.D., L.S.W.
Commissioner

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New Jersey Youth Suicide Prevention Plan 2011 – 2014

**New Jersey
Department of Children and Families
Allison Blake, Ph.D., L.S.W
Commissioner**

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Introduction

In 2008, sixty-eight individuals aged 24 years and younger completed suicide (New Jersey Office of the State Medical Examiner). This number places youth suicide as the fourth leading cause of death for New Jersey's youth (National Center for Injury Control and Prevention, Centers for Disease Control).

The New Jersey Department of Health and Senior Services, reports:

- Every month seventy New Jersey youth make a suicide attempt serious enough for hospitalization.
- Over forty percent of the suicide attempts by minors are subsequent to previous suicidal behaviors.
- Suicide attempts result in significant medical and non-medical costs and include physical, emotional, and psychological damage to the victims as well as to their families and friends.
- Clusters of suicide attempts and deaths of youth have been reported in New Jersey.

NJ Suicide Statistics Relative to Other States

Relative to other states, New Jersey has low suicide rates at all ages. New Jersey has ranked as one of the four lowest states for suicide rates in the country (Thomson Healthcare). The reasons for New Jersey's relatively good standing can be attributed in part to the implementation of state regulations, policies, guidance, and resources identified in the professional literature to successfully prevent youth suicide (Cecil G. Sheps Center).

NJ's Suicide Prevention Activities

There are many factors and actions that have aided the suicide prevention efforts in New Jersey. New Jersey has had strict laws restricting minor's access to guns. The State has mandated staff training in schools for suicide prevention and the detection of warning signs. New Jersey has mandated the establishment of psychiatric screening centers in every county that include crisis hotlines staffed 24 hours a day, seven days a week. In addition, beginning in 2001, New Jersey has developed a state-wide Mobile Response and Stabilization System (MRSS) for youth available in every county in the State. This program provides 24/7 in community crisis intervention in situations where there may not yet be suicidal gestures, but there are often significant risk factors. The MRSS program is also able to provide up to eight weeks of immediate in-home/in-community therapeutic interventions.

These efforts regarding New Jersey's suicide prevention activities were noted as a "promising practice" in a 2004 report by the Cecil G. Sheps Center at the University of North Carolina at Chapel Hill. The report also indicated that New Jersey has a high degree of collaboration among state and local organizations as exemplified by the makeup of the New Jersey Youth Suicide Prevention Council (NJYSPAC) which includes representatives from the New Jersey Department of Health and Senior Services, the Department of Children & Families, the

Department of Education, the Department of Human Services, the Division of Mental Health Services, and the Juvenile Justice Commission.

New Jersey's lead State agency for youth suicide prevention is the Department of Children and Families (DCF). As of the writing of this plan, DCF's lead youth suicide prevention program is the Traumatic Loss Coalition for Youth at the University of Medicine and Dentistry – University Behavioral Health Care. This program is funded by the Department of Children and Families – Division of Child Behavioral Health Services.

The Traumatic Loss Coalition (TLC) has operated as a county-based collaborative since the year 2000. Each county employs a Coordinator who conducts meetings throughout the year bringing together school personnel, mental health clinicians, juvenile justice personnel, law enforcement officials, social service agencies, child welfare workers and many others who work closely with youth. The meetings are effective forums for reviewing traumatic loss events, identifying service needs, and providing professional development through the inclusion of an educational component. Speakers for the educational component are experts in topics related to the needs of youth. The Coordinators often collaborate with other agencies in their respective counties to co-sponsor workshops and conferences focused on issues pertinent to the mental health of the youth.

The Coordinators also work within their counties to direct a Lead Response Team (LRT) to assist schools when needed following a traumatic loss event, or as in the case of several counties, support the director of an existing team. Post Traumatic Stress Management (PTSM) training is provided for members of these teams.

The State report completed by TLC in 2010 indicated that in the 18 month period ending March, 2010:

- **3,991** individuals received on-site trauma response assistance to schools and communities including postvention after a death by suicide, homicide, accident or illness, and other critical incidents;
- **9,740** individuals attended training programs on mental health disorders and suicide prevention for youth-serving individuals and groups; and
- **2,448** individuals attended training programs for school and community personnel who must respond to the needs of youth in the aftermath of suicide, homicide, accidental death, and other critical incidents such as a natural disaster or terrorist strike (postvention).

The Traumatic Loss Coalitions for Youth Program has created an expanding statewide network that effectively works to prevent suicide and promote healing and resiliency in the aftermath of traumatic loss (UBHC, UMDNJ, Traumatic Loss Coalitions for Youth, 2010).

NJ Youth Suicide Prevention Advisory Council

In January of 2004 due to an overwhelming concern about youth suicide, The State of New Jersey created through legislation (N.J.S.A. 30:9A-22 et seq.) the New Jersey Youth Suicide Prevention Advisory Council (NJYSPAC). This purpose of the NJYSPAC is to examine existing needs and services and make recommendations to the Department of Children and Families for youth suicide reporting, prevention, and intervention; advise the Department of Children and Families on the content of informational materials to be offered to persons who are required to report attempted or completed suicides; and to advise the Department of Children and Families on the development of regulations pursuant to the act which created the NJYSPAC.

Everyone is affected by suicide. Council members are dedicated to youth suicide prevention and give freely of their time and commitment to developing strategies for suicide prevention and intervention.

***This plan is dedicated to the youth and families
whose life has been touched by suicide.***

Council Members and Contributors to the State Plan 2010

***Organizational affiliations are those at the time of the individual's involvement.**

Leadership

Charles Goldstein, LCSW, Chair
CEO, CGS Family Partnership, Inc.

Paula Bloom, MHA, Co-Chair
Commissioner Designee
NJ Department of Education

New Jersey State Government

Donna Amundson, LCSW
Coordinator
NJ Traumatic Loss Coalition

Paula Bloom, MHA
Commissioner Designee
NJ Department of Education

Teresa Buxton, BS
Commissioner Designee
NJ Juvenile Justice Commission

Alexander Glebocki, MA
Commissioner Designee
NJ Department of Human Services

Celina Gray, Ad Hoc Member
NJ Council of Mental Health Stigma

Kathleen Mackiewicz
Commissioner Designee
NJ Department of Health and Senior Services

Linda Wiles, LCSW
Commissioner Designee
NJ Department of Children and Families

Advisory Committee Members

Andrew Evangelista, LCSW, LCADC
Montclair School District

Peggy Farrell, BS, RN
American Foundation for Suicide Prevention
**Parent Affected by Suicide*

Karen Dunne-Maxim, RN, MS
**Sibling Affected by Suicide*

George Gordon, PhD
American Foundation for Suicide Prevention
**Parent Affected by Suicide*

Theodore Petti, MD, MPH, Psychiatrist
University of Medicine and Dentistry of NJ

Thomas Priory, Guidance Counselor
Retired

Nancy Scott, EdS, LPC, NCC
TCNJ Clinic, The College of New Jersey
**Friend Affected by Suicide*

Bernard D. Shapiro, EdD
Ad Hoc Member

Barbara K. Snyder, MD, Pediatrician
University of Medicine and Dentistry of NJ

Mario Tommasi, PhD, ABPP
Community Treatment Solutions

New Jersey's Youth Suicide Prevention Plan

In 2001, the U.S. Department of Health and Human Services released a report entitled, "National Strategy for Suicide Prevention: Goals and Objectives for Action." This report described suicide as a serious public health problem throughout the United States, and introduced a blueprint for addressing suicide prevention. The Surgeon General also recommended that each state adopt a youth suicide prevention plan that would incorporate the national recommendations.

This New Jersey Youth Suicide Prevention Plan seeks to build on the existing efforts in New Jersey by remaining focused on the risk and protective factors associated with the prevention of suicide in children, youth, and young adults. The plan outlines goals, rationale, and objectives for increasing the prevention effort throughout the state. Achieving these goals will require the continued partnership and collaboration among all stakeholders. Accountability for the goals will necessitate that all stakeholders work in concert with each other focused upon the needs of our children, youth, young adults, their families, and support networks.

The plan presents the overall goals for the prevention of suicide and is broken down into ten sections. Found within each section are specific objectives. The sections and format of the plan were not arbitrary. Rather the plan was modeled in content and in form after the 2001 National Strategy for Suicide Prevention and the joint Suicide Prevention Resource Center and SPAN USA 2010 Progress Review of the National Strategy.

New Jersey's Youth Suicide Prevention Plan Goals

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

¹ A strategy or approach that is implemented after a crisis or traumatic event has occurred

Goal # 1: Improve and expand surveillance systems.

Rationale

The quality of surveillance data on completed suicides is relatively high in New Jersey due to our state's participation in the CDC-funded National Violent Death Reporting System. The New Jersey Violent Death Reporting System (NJVDRS) is a detailed surveillance system of all violent fatalities, which integrates medical examiner, death certificate, and law enforcement data to provide accurate and timely data on all suicides. Additionally, the NJVDRS provides detailed information about suicide circumstances, and how they differ for adolescents as compared with those in other age groups. Despite this, death certificates sometimes fail to correctly identify suicides as the cause of the death. Information on completed suicides is obtained from the New Jersey Department of Health and Senior Services, Vital Records, as coded by medical examiners on death certificates. A problem arises in those ambiguous youth deaths where suicide is suspected, but no clear evidence is available to make a definitive statement of this specific cause. In those cases, the medical examiners will enter another code based on secondary circumstances surrounding the death (e.g., substance abuse, motor vehicle accident, undetermined, unintentional). This problem leads to potential under-reporting of youth suicide.

Data on suicide attempts or ideation are lacking and are similarly affected by some of the same surveillance challenges noted above. These data are expected to be collected by mental health providers, screening centers, and emergency room personnel. But there are gaps in how these data are collected and made available for further review by prevention initiatives.

A related issue is the extent to which information on youth suicide from schools is utilized regarding broad-based prevention efforts. The New Jersey Board of Education requires public middle and high school students to complete the New Jersey Student Health Survey, which is administered periodically to middle and high school students in the state. This survey asks about depression, suicide plans, ideation, and attempts. However there is an enormous discrepancy between the prevalence of self-reported attempts and the prevalence as captured by hospital discharge data, suggesting that the majority of these self-reported attempts are relatively low in terms of lethality. As adolescents age, their rate of reporting suicidal plans and attempts declines, while the rate of actual attempts increases. This is a serious problem as a 2009 nationwide survey of youth in grades 9-12 in public and private schools in the United States (U.S.) found that 13.8 % of students reported seriously considering suicide, 10.9 % reported creating a plan, and 6.3 % reported trying to take their own life in the 12 months preceding the survey (CDC Youth Risk Behavior Surveillance).

Objectives:

1.1 The Department of Children and Families will publish an annual report on suicide in New Jersey that integrates data from multiple state data management systems.

1.2 Improve coordination of data collection regarding suicide investigations with state, local agencies, and their partners.

1.3 Establish surveillance mechanisms across entities that track the use of mental health services as well as suicide attempts.

1.4 Establish a mechanism for systematic collection and analysis of suicide attempt data.

Goal # 2: Promote awareness that suicide is a preventable public health problem.

Rationale

Many individuals are not aware that suicide is the fourth leading cause of youth death in New Jersey. Therefore, enhanced awareness that suicide is a serious public health issue is expected to influence people to be more vigilant about identifying the risk of suicide in themselves, peers, and others.

Increased awareness should result in more caregivers of children, youth and young adults to seek assistance when there is a risk of suicide. Awareness among policy makers may result in efforts to modify policies and to allocate resources toward suicide prevention efforts.

Objectives

2.1 Develop and implement a public information campaign that explains that suicide in youth is preventable and is related to mental health, substance abuse and other at-risk behaviors.

2.2 Establish and enhance existing mechanisms and structures for suicide prevention designed to foster collaboration with stakeholders and the general public on prevention strategies across disciplines.

2.3 Increase the number and quality of both public and private institutions that are involved in collaborative and complementary dissemination of current suicide prevention information on the Internet.

2.4 Promote awareness of youth suicide as a public health issue in communities through community-based organizations.

2.5 Increase awareness of suicide risk and prevention strategies for all providers of DCF out-of-home services including resource homes, treatment homes, and various residential placements.

Goal # 3: Develop broad-based support for youth suicide prevention.

Rationale

Because youth suicide and attempts are the result of complex, multidimensional biological and psychosocial factors, the prevention of suicide requires an ecological, multidisciplinary approach. Similar collaborative efforts will be required at the state and local levels in New

Jersey. These collaborative efforts like NJYSPAC will need public and private partnerships at the local, state and national level to generate the greatest impact regarding suicide prevention.

The National Strategy for Suicide Prevention supports the development of collective leadership and of increasing the variety of groups working to prevent suicide. This effort applies to the state and local level. The development of broad-based support for suicide prevention will require ready access to information, research, literature resources, best practices, and program models. This effort will include the identification of multiple sites that can disseminate these resources.

Objective

3.1 Encourage agencies and organizations involved in suicide prevention to work within a collaborative framework at the state and local level.

3.2 Promote access to materials such as monographs, periodicals, videos, outreach posters, information pamphlets, electronic communication and related materials on suicide prevention in New Jersey.

3.3 Increase the number of state, local, professional, volunteer, and other groups that can integrate suicide prevention activities into their ongoing programs and activities.

3.4 Include suicide prevention information on the DCF website and encourage DCF contracted agencies to include suicide prevention information on their websites.

Goal # 4: Develop and implement strategies to reduce the stigma associated with needing and receiving mental health, substance abuse and suicide prevention services.

Rationale

Harris and Barraclough, 1997, found that sixty to ninety percent of all suicidal behaviors are associated with some form of mental illness and/or substance use disorder (National Strategy for Suicide Prevention). The negative stigma of mental illness and substance abuse prevents many children, youth and young adults from seeking assistance and has contributed to the silence and shame associated with mental health problems and suicide. Family members of those surviving a suicide attempt often hide the behavior from those that could help or provide support, believing that it reflects badly on their own relationship with the suicide attempter or that attempting suicide is shameful or sinful (National Strategy for Suicide Prevention).

Objective

4.1 Increase coordination among state agencies and entities such as the Governor's Anti-stigma Council and DCF to decrease stigma.

4.2 Increase public knowledge that mental health and physical health are intertwined components of overall health.

4.3 Increase public knowledge that mental illness and substance abuse, similar to physical illness, respond to specific treatments.

4.4 Increase public knowledge that consumers of mental health, substance abuse, and suicide prevention services are pursuing fundamental care and treatment for their overall health.

4.5 Encourage professional groups, associations, and individuals to address the issue of stigma associated with using mental health and substance abuse services.

Goal # 5: Strengthen and expand community-based suicide prevention and postvention programs.

Rationale

Effective suicide prevention requires a broad-based community commitment. Although there is not any one “suicide type,” there are youth who are at a higher risk based on particular risk factors. To help youth in need, community professionals and organizations must mobilize resources, identify risk and protective factors, and bring focused attention to the issue of suicide.

Successful suicide prevention, intervention and postvention strategies are based on the public health approach. Evidence-based methods are needed. Evaluations are also needed as programs are developed and implemented. The science of suicide prevention is still developing. Therefore, emerging strategies, promising practices, and other strategies with a foundation based in best practices may be used in addition to existing evidence-based strategies. These programs require an even more rigorous evaluation process to measure effectiveness.

Objectives

5.1 Expand and improve training efforts in suicide prevention to increase knowledge regarding best practices for suicide prevention, intervention and postvention for community-based organizations and schools.

5.2 Improve coordination with cultural and faith-based entities to share resources and information on issues of suicide.

5.3 Focus specific suicide prevention and postvention efforts towards higher risk populations such as adolescents, college students, gay/lesbian/bisexual/transgender youth, immigrants, non-English speaking youth, those addicted to and/or abusing substances, and youth in the correctional/juvenile justice system or other out-of-home settings.

Goal # 6: Implement professional training programs for those who are in regular contact with youth at-risk for self injury or suicide.

Rationale

There are many different settings where trained personnel can intervene with youth at-risk for self-injury or suicide. Pirkis & Burgess, 1998, found that approximately 45 percent of all individuals who die by suicide have had some contact with a mental health professional within the year of their death (National Strategy for Suicide Prevention). Trained personnel who come into contact with youth at risk for suicide are referred to as “key gatekeepers.” Key gatekeepers include, but are not limited to, teachers, clergy, police, resource parents, physicians, nurses, and therapists. Providing appropriate training for this broad array of key gatekeepers is an opportunity to enhance suicide prevention efforts.

Objectives

6.1 Maintain and expand key gatekeeper suicide prevention training programs in New Jersey to ensure adequate recognition and treatment of youth who are at-risk for suicide.

6.2 NJYSPAC will make concrete and specific recommendations to DCF about the adequacy of existing training for DCBHS and DMHS providers and about improvement, including specific curricula, which are preferable.

6.3 Maintain training programs in the recognition and treatment of risk factors associated with suicide across disciplines, including physical and mental health and substance abuse systems, legal systems, the education systems, and religious organizations. These trainings should include instruction on the identification of persons at risk, appropriate counseling, and referral to community-based services.

6.4 NJYSPAC will make specific recommendations to DCF:

6.4.1 That identifies who the “key gatekeepers” are; determine how they are organized across the state; recommend engagement strategies for each group; and suggests courses of action for engagement in youth suicide prevention efforts.

6.4.2 That identify preferred youth suicide prevention training strategies for key gatekeeper groups; training strategies will be cognizant of and sensitive to the particular mission, goals, needs, and organizational structures of each group.

Goal # 7: Develop and promote effective clinical practices to reduce suicide attempts and completions.

Rationale

For every youth who completes suicide there are many others who have made non-lethal attempts. Professionals in the health and mental health/substance abuse fields, clergy, education, and law enforcement are involved in the identification and referral of people at-risk for suicide. Service referrals should be made to programs evidencing high quality services, best practices and evidence based treatments when possible and appropriate. The quality of treatment for at-risk youth will be improved by the identification and implementation of these effective clinical practices. It is essential that all referral sources know how and where to locate providers whose practices are evidence based and reliant upon best practices. It is necessary that individuals at risk for suicide are engaged in prompt and effective treatment.

Objectives

7.1 DCF will facilitate interdepartmental collaboration to develop and promote best practice on the recognition of the antecedents of suicidal behavior.

7.2 Identify, disseminate and train the various provider groups on evidence-based and best practice guidelines in the diagnosis and treatment of suicide and self-injury. The primary audiences for this effort may include emergency care providers, primary care providers, mental health care providers, substance abuse providers, juvenile corrections personnel, school personnel, clergy, and other professionals who work with youth at-risk for suicide. Training should support providers efforts to treat youth at high-risk for suicide, youth that attempt suicide, and families, friends and those likely to be affected by a suicide or suicide attempts.

7.3 Promote, and support evidence-based and best practice guidelines for prevention and treatment of suicide or self-injury.

7.4 Facilitate the training of providers who treat children, youth, and young adults who are suicidal in best practices and evidenced based treatments.

Goal # 8: Promote access to mental health and substance abuse services.

Rationale

Youth with untreated mental health and substance abuse problems are at high risk for suicide; therefore, access to high quality mental health and substance abuse services is critical. Barriers to access should be reduced and linkages among various community agencies, mental health, and substance abuse treatment programs need to be enhanced. Where possible, services should be integrated and coordinated to avoid conflicting policies from potential funding sources.

Objectives

- 8.1 Identify and address barriers to mental health and substance abuse services.
- 8.2 Increase community awareness of risk behavior and increase awareness of culturally competent and linguistically relevant services.
- 8.3 Work with all appropriate state departments to increase access to an integrated network of effective, efficient, culturally competent and linguistically accessible mental health and substance abuse services that include suicide prevention and counseling services.
- 8.4 Promote DCF's youth helpline, "2nd Floor." Continue to enhance this helpline's ability to respond to youth at risk and explore potential for this helpline serving as a National Suicide Prevention Lifeline networked hotline.
- 8.5 Increase the number of calls answered in New Jersey from New Jersey residents that call the National Suicide Prevention Lifeline. Identify, coordinate, and prepare New Jersey based hotlines to serve as a recipient of National Suicide Prevention Lifeline calls.
- 8.6 Encourage all DCF contracted agencies to promote NJ Mental Health Cares helpline as a resource for families seeking mental health services.

Goal # 9: Improve reporting and the depiction of suicide, mental illness, and substance use in the electronic and print media.

Rationale

Media representations of suicide can potentially influence the suicidal thoughts and actions of youth. The collaborative efforts of the American Foundation for Suicide Prevention, American Association of Suicidology, and Annenberg Public Policy Center with support from the Centers for Disease Control, National Institute of Mental Health, Office of the Surgeon General, and Substance Abuse and Mental Health Services Administration have issued guidelines for reporting on suicide.

Objectives

- 9.1 Disseminate information on nationally recognized guidelines for reporting about suicide with an effort to reduce the stigma and prevent future suicides.
- 9.2 Utilize the nationally recognized guidelines outlined in the Reporting on Suicide: Recommendations for the Media (Annenberg Public Policy Center 2001) for reporting on suicide and local experts on suicide and suicide prevention for consultation and training with the media and academic programs in journalism.
- 9.3 Work with New Jersey academic journalism programs to include guidance on the appropriate depiction and reporting of mental illness, suicide and self-injury in their curricula.

Goal # 10: Promote and support research on youth suicide and suicide prevention and its dissemination and incorporation into clinical practice and public health efforts.

Rationale

Suicide prevention is a growing field, with an expanding knowledge base. More youth suicide prevention programs have been evaluated and resources are available to help community-based programs evaluate their suicide prevention efforts. Additional research on suicide prevention efforts and information from an increased number of evidence-based practices needs further systematic replication and evaluation.

Suicide prevention efforts at the state and local program level can be strengthened by promoting research-based strategies, using research in program planning and development, collection of data on process and outcome and an evaluation component for each program. There is a need for more training in evaluating suicide prevention efforts.

Objectives

10.1 Promote ongoing dissemination of evidence-based suicide prevention models and use of research-based strategies for suicide prevention.

10.2 Encourage all New Jersey suicide prevention programs to review best-practice and evidence-based research and to include an evaluation component that demonstrates outcome effectiveness.

10.3 Increase the number of suicide prevention programs that conduct program-specific research or participate in research and evaluation efforts of others.

10.4 Establish and maintain a directory of suicide prevention programs with demonstrated effectiveness as recognized by best-practice.

Next Steps

This plan is a three (3) year plan; however it is designed to be a base for longer range planning as well. Not all of the objectives listed in this plan will be able to be met within three years and will carry over to future plans. It is the hope of DCF that the NJYSPAC will provide ongoing recommendations for suicide prevention and planning and this State plan may be amended as often as annually. At a minimum, the plan will be fully reviewed and updated every three (3) years.

DCF will continue to accept and review all advice and recommendations provided by the NJYSPAC. The NJYSPAC will meet on a regular schedule and DCF will provide a liaison to the NJYSPAC.

References:

1. American Foundation for Suicide Prevention. American Association of Suicidology. Annenberg Public Policy Center. (2001). Reporting on Suicide: Recommendations for the Media.
2. CDC. Web-based Injury Statistics Query and Reporting System (WISQARS™). U.S. Department of Health and Human Services, CDC, National Center for Injury Prevention and Control, 2007. Available at <http://www.cdc.gov/ncipc/wisqars/default.htm>.
3. Guild, P. A., Freeman, V. A., & Shanahan, E. (2004). Promising Practices to Prevent Adolescent Suicide: What we can Learn from New Jersey. University of North Carolina at Chapel Hill, Cecil G. Sheps Center for Health Services Research.
4. New Jersey Department of Health & Senior Services, Center for Health Statistics.
5. New Jersey Office of the State Medical Examiner. (2009). Final Report: Independent Assessment of New Jersey's Children's Behavioral Health Care System. Trenton, NJ: Author.
6. Suicide Prevention Resource Center and SPAN USA. David Litts, editor. Charting the Future of Suicide Prevention: A 2010 Progress Review of the National Strategy and Recommendations for the Decade Ahead. (2010). Newton, MA: Education Development Center, Inc.
7. Thomson Healthcare. Mental Health America. (2007, December). Ranking America's Mental Health: An Analysis of Depression Across the States. Washington, DC: Author.
8. University Behavioral Healthcare, University of Medicine and Dentistry of New Jersey. (2010, March). Traumatic Loss Coalitions for Youth. Piscataway, NJ: Author.
9. U.S. Dept. of Health and Human Services, Public Health Service. (2001). National Strategy for Suicide Prevention: Goals and Objectives for Action. Rockville, MD: Author.
10. U.S. Dept. of Health and Human Services. Centers for Disease Control and Prevention. (2010, June). Youth Risk Behavior Surveillance-United States, 59 (SS-5).
11. U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. National Center for Injury Prevention and Control. (1994, April). Suicide Contagion and the Reporting of Suicide: Recommendations from a National Workshop, 4 (22).

SUBSTANCE ABUSE TREATMENT SERVICES

Counseling/Therapy Services

Individual Counseling Session:

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

Individual Therapy Session:

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

Group Counseling:

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

Family Counseling:

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

Family Therapy:

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

Psychoeducation

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

Didactic Session:

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

Family Education and Information:

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

OUTPATIENT SUBSTANCE ABUSE TREATMENT Level 1

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

Counseling/Therapy Services:

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

Psychoeducation:

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

INTENSIVE OUTPATIENT SUBSTANCE ABUSE TREATMENT Level II.I

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

Counseling/Therapy Services:

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

Psychoeducation:

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

PARTIAL CARE SUBSTANCE ABUSE TREATMENT Level II.5

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

Counseling/Therapy Services:

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

Psychoeducation:

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

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

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

Medical Services: Must be provided as per licensing requirements.

Counseling/Therapy Services:

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

Psychoeducation:

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

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

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

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

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

Medical Services: Must be provided as per licensing requirements.

Counseling/Therapy Services:

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

Psychoeducation:

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

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

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

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

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

Medical Services: Must be provided as per licensing requirements.

Counseling/Therapy Services:

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

Psychoeducation:

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

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

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

MEDICALLY MONITORED INPATIENT DETOXIFICATION Level III.7D

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

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

Counseling/Therapy Services:

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

Psychoeducation:

- Minimum of two hours per detox episode.

MEDICALLY MONITORED INPATIENT DETOXIFICATION ENHANCED 111.7D Enhanced

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

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

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

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

Required Medical Services:

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

Counseling Services:

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

Psychoeducation:

- Minimum of two hours per week.

Co-occurring Services included as part of this service:

- Case Management.
- Medication Monitoring.

SUBSTANCE ABUSE TREATMENT SERVICES CO-OCCURRING SERVICE ENHANCEMENTS

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

Psychiatric Evaluation

Description:

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

Who Can Provide the Service?

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

Comprehensive Intake Evaluation

Description:

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

Who Can Provide the Service?

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

Medication Monitoring

Description:

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

Who Can Provide the Service?

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

Clinical Consultation

Description:

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

Who Can Provide the Service?

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

Case Management

Description:

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

Who Can Provide the Service?

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

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

Family Therapy

Description:

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

Who Can Provide the Service?

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

Individual Therapy

Description:

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

Who Can Provide this Service?

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

Individual Therapy - Crisis Intervention

Description

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

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

Who Can Provide the Service?

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

SUBSTANCE ABUSE TREATMENT SERVICES MEDICATION ASSISTED TREATMENT SERVICE ENHANCEMENTS

Methadone Treatment

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

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

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

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

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

Required Medical Services for Methadone Maintenance:

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

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

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

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

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

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

Buprenorphine Treatment

Description:

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

Detoxification:

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

Induction:

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

Maintenance:

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

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

Required Staff:

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

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

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

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

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

Required Medical Services:

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

Naltrexone Treatment**Description:**

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

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

Induction:

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

Maintenance:

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

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

Required Staff:

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

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

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

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

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

Required Medical Services:

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

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

Medical Services

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

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

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

Comprehensive Assessment

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

Continuing Care Assessment

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

Case Management

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

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

Court Liaison

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

Recovery Mentor

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

Transportation

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

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

Women with Dependent Children Services

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

MEMORANDUM OF AGREEMENT

BETWEEN

**THE NEW JERSEY DEPARTMENT OF HUMAN SERVICES (DHS)
DIVISION OF ADDICTION SERVICES (DAS)
OFFICE OF TREATMENT**

AND

THE ADMINISTRATIVE OFFICE OF THE COURTS (AOC)

FOR

DRUG COURT TREATMENT SERVICES

WHEREAS a Memorandum of Agreement ("the Agreement") between the Administrative Office of the Courts (AOC) and the Department of Human Services, Division of Addiction Services (DAS) for the management of Drug Court Treatment Services is effective July 1, 2010, and

WHEREAS DAS' Office of Treatment and the AOC wish to purchase substance abuse treatment services as described herein the Agreement, Section III(A)(1a) for Drug Court participants, and

WHEREAS pursuant to N.J.S.A. 26:2B-7 et. seq. and N.J.S.A. 26:2G-31 et. seq. for the provision of substance abuse treatment services for criminal offenders, the goal of this Agreement is:

- To reduce prison overcrowding and recidivism, and provide substance abuse treatment to alcohol and other drug dependent individuals who are eligible for sentencing under N.J.S.A. 2C:35-14 or other provisions of the New Jersey Code of Criminal Justice.

WHEREAS the AOC and DAS shall effectuate an efficient data driven program and fiscal management process to coordinate the treatment delivery system described in Section III (A) (1a) of this Agreement,

NOW, THEREFORE, THE PARTIES HERETO AGREE AS FOLLOWS:

I. Under this Agreement, the AOC is hereafter referred to as "the Judicial Oversight Agency" and DAS is hereafter referred to as "the Treatment Oversight Agency."

II. Obligations and Rights of the Judicial Oversight Agency

(A.) Obligations of the Judicial Oversight Agency

1. The AOC shall provide funding to DAS in the amount of approximately \$29,163,000 for the purchase of licensed treatment services which spans the full continuum of care for Drug Court participants including, but not limited to, long-term residential, short-term residential, detoxification, halfway house, partial care, outpatient and intensive outpatient, clinical reviews, recovery enhancements, co-occurring and medication-assisted treatment services.
2. DAS will not be responsible for treatment expenditures in excess of AOC funding allocation of section II (A) (1). The AOC shall project annual volume and maximum service levels for SFY 2011 for Drug Court participants by vicinage. The AOC will keep DAS advised of any changes in levels of performance or need in the individual vicinages, which might affect these projected service levels.
3. If the AOC and DAS identify the need for increased funding for Drug Court it is the AOC who is responsible for formal budget requests from OMB and the legislature.
4. AOC shall support and staff a Drug Court Treatment Sub-Committee, chaired by a Vicinage Drug Court Coordinator, to enhance the coordination of case management activities between the drug court teams and the treatment providers who service Drug Court participants. The AOC agrees to collaborate with DAS on the selection of treatment provider representatives for this committee, through an open and fair application process.
5. AOC will maintain data on new admissions to drug court and initial treatment referrals and provide that information to DAS on a monthly basis, especially on pre-sentence treatment referrals. AOC and DAS will coordinate data collection efforts in order to manage and, when necessary, contain the costs incurred by participants re-admitted to treatment. AOC will refer no more clients for treatment than can be serviced by existing resources. DAS will not be held responsible for treatment expenditures beyond the current fiscal year allocation.
6. AOC agrees that every new Drug Court participant being referred for treatment will have as their unique identifiers, the SBI number and social security number, alerting the Drug Court network providers of the approved payor source.

7. The AOC will ensure that all Drug Court participants initially referred to treatment have a current (within 3 months) Addiction Severity Index (ASI) completed, DAS licensure required medical documentation, and a completed American Society of Addiction Medicine (ASAM PPC-2R)-informed narrative assessment with initial placement recommendations, which is forwarded to the admitting DAS Drug Court Network Provider prior to admission.
8. AOC will work with each vicinage to identify a contact person responsible to work with each DAS Drug Court Network treatment provider to address any treatment issues or concerns that may arise throughout the Drug Court participant's course of treatment and who will also notify DAS, as appropriate. The contact person will be the Vicinage Drug Court Coordinator unless otherwise indicated by the AOC.
9. The AOC will authorize DAS's utilization of up to \$325,000 of the funds allocated for drug treatment for operating expenses for the fiscal agent in 2011. This represents the maximum funding available for the projected Drug Court percentage of total volume of claims submitted to the fiscal agent. The AOC's understanding is that DAS's administrative costs will be set at \$615,000 for FY2011. The \$29,163,000 in funding provided to DAS includes contracts, fee-for-service provider network, DAS administrative, fiscal agent, recovery supports and co-occurring treatment costs.
10. The AOC agrees to work collaboratively with DAS on any changes in program eligibility criteria and increases in types of services or rates paid for services to or on behalf of clients for all programs under the purview of the Department of Human Services, not mandated by federal law. Approval by the Director of the Division of Budget and Accounting must be obtained prior to implementation of any desired changes in program eligibility, types of services or rates paid.
11. In addition to the above, the AOC is required to abide by all general provisions, terms, and terminations contained in Sections IV and V of this Agreement.

(B.) Rights of the Judicial Oversight Agency

1. The AOC shall not be held liable for any termination of this Agreement due to the absence of available funding appropriations from the New Jersey Legislature to the AOC. Notice shall be provided to DAS in the manner outlined in Section V of this Agreement

WEB
SITE

2. Work Product: Information used or obtained in the performance of Drug Court treatment services, produced for or because of this Agreement shall bear an acknowledgment of the participation of both the AOC and DAS. AOC shall be given the opportunity for advance review of work products and publications of DAS, which relate to utilization of drug treatment services by the AOC or vicinage Drug Courts.

III. Obligations and Rights of the Treatment Oversight Agency

(A.) Obligations of the Treatment Oversight Agency

1. DAS agrees to perform the following services:
 - a. DAS shall execute all contracts and network agreements and provide oversight and management of the statewide Drug Court licensed treatment provider network's full continuum of care including, but not limited to, long-term residential treatment, short-term residential treatment, detoxification, halfway house, partial care, intensive outpatient and outpatient, clinical reviews, recovery enhancements, co-occurring and medication assisted treatment services.
 - b. DAS will utilize a combination of slotted and fee-for-service mechanisms to maintain flexibility, funding accountability and access to care. Fee-for-service beds shall be purchased based on existing rate schedules with slotted beds to be purchased on existing DAS rates with Cost of Living Adjustment percentage (COLA %) increases as available.
 - c. DAS will require Drug Court network providers to gather financial data through the administration of the DASIE. Data gathered will be reviewed by AOC and DAS to inform future income eligibility decisions.
 - d. DAS monitors shall review program administration, staffing and all other aspects of the treatment program operation consistent with DAS' review of all substance abuse treatment programs.
 - e. DAS complaints unit agrees to conduct an investigation to address any formal Vicinage Drug Court complaints that are received through DAS' formal complaint process. In addition, upon reasonable suspicion, DAS monitors and/or DAS drug court designated staff will review and investigate incidents of treatment and/or billing concerns as reported by the AOC.

2. DAS, through a responsive bidding process, has contracted with a Fiscal Agent who will maintain a database of services provided and reimbursed for Drug Court participants, train providers to use their billing system, and provide the AOC and DAS with previously agreed upon monthly reports that will inform the ongoing utilization management.
3. DAS staff will provide technical assistance (TA) and training to providers relevant to clinical and administrative issues, as needed.
4. In addition to the above, the DAS is required to abide by all general provisions, terms, and terminations contained in Sections IV and V of this Agreement.

(B.) Rights of the Treatment Oversight Agency

1. DAS shall not be required to fulfill its obligations should funding for Drug Court activities not be made available by the New Jersey Legislature. Notice shall be provided to the AOC in the manner outlined in Section V of this Agreement.
2. Work Product: Information used or obtained in the performance of Drug Court treatment services, produced for or because of this Agreement shall bear an acknowledgment of the participation of both DAS and AOC. DAS shall be given the opportunity for advance review of work products and publications of AOC, which relate to utilization of drug treatment services by the AOC or vicinage Drug Courts.

IV. DAS and AOC Collaborative Section

- (A.) AOC, in partnership with DAS, shall work to establish and support the activities of Committees and Workgroups convened to address a variety of program elements including but not limited to: best practices, utilization of services, performance improvement practices, collaboration and coordination among program partners, and recovery support services.
- (B.) DAS shall work in collaboration with the AOC to add or delete services.
- (C.) DAS and AOC shall exchange data on a regular basis to ensure client matching. DAS and AOC shall remain flexible in the data exchange process to avoid needless duplication of effort in the development of management reports based on collective data. DAS and AOC shall work in collaboration to analyze collective data to more effectively monitor and manage treatment funds.
- (D.) DAS and AOC shall work in collaboration to develop budgetary parameters and best practices for the courts and treatment providers to deal with participant

relapses and treatment re-admissions. The goal is to both contain costs and assist the teams in responding in an effective and clinically appropriate manner to participant relapse and treatment needs.

- (E.) AOC and DAS shall collaborate on the development of parameters for pre-sentence treatment services to more effectively service the Drug Court population.
- (F.) AOC and DAS shall collaborate on resource development for Drug Court including recovery support services, client cost sharing and federal funding opportunities.

V. General Provisions

(A.) Mandatory General Provisions

1. During the term of this Agreement, DAS and AOC shall comply with all federal, state and municipal laws, rules and regulations generally applicable to the activities performed pursuant to this Agreement.
2. DAS and AOC are independent entities and neither party shall hold itself out as an agent, partner or representative to the other.
3. Failure by either party to exercise any right or demand performance of any obligation under this Agreement shall not be deemed a waiver of such right or obligation.
4. If any of the provisions of this Agreement are, or become invalid, to any extent, the other provisions of this Agreement shall not be effected thereby. In the event of the invalidity of a provision, the parties agree to accept a provision, which reflects as closely as possible the intention of the invalid provision.
5. This Agreement may not be assigned without the prior written consent of both parties.
6. The laws of the State of New Jersey govern this agreement.
7. Extensions may be made to this agreement with the approval of the Program Management Officers and Fiscal Officers identified in Section VII.

VI. Terms and Termination

- (A.) If funds are not received in a timely manner and in advance of the need to pay for services authorized by the AOC, or their agents including DAS, then DAS is not liable for non-payment to provider agencies. Upon notice to the AOC, DAS is

empowered to initiate immediate contract decreases to avoid any overspending of funds.

- (B.) The presence of funding alone in subsequent years without a signed Agreement is insufficient to renew the agreement; however, due to the responsibilities placed on the AOC and DAS to appropriately manage this program, each agency will make a good faith effort to renew this agreement on a timely basis.
- (C.) Funds received by DAS but not projected to be spent for the service period will be returned by July 31, 2011.
- (D.) All other provisions of the Agreement shall remain valid through the remaining term of the Agreement unless modified.
- (E.) Subject to any rights of termination set forth, this Agreement shall become effective on October 1, 2010 and shall remain valid through June 30, 2011.
- (F.) This Agreement may be terminated by either party with or without cause upon thirty (30) days advance written notice.
- (G.) Notice of termination shall be delivered via United States mail, return receipt requested, and shall be effective upon receipt. Notice shall be sent to the appropriate contact person identified in Section VI.

VII. Principal Contacts

The principal contacts for all notifications required or otherwise necessary under this Agreement shall be as follows:

For the Department of Human Services, Division of Addiction Services:

Program Management Officer

Vicki Fresolone
Director, Treatment Services
609-633-8693 [office]
609-292-3816 [fax]
120 S. Stockton St.
P.O. Box 362
Trenton, NJ 08625

Fiscal Officer

Jose Gonzalez
Acting Director, Administrative Services
609-984-6961 [office]
609-292-3816 [fax]
120 S. Stockton St.
P.O. Box 362
Trenton, NJ 08625

For the New Jersey Administrative Office of the Courts:

Program Management Officer

Joseph J. Barraco, Esq.
Assistant Director, Criminal Practice
Administrative Office of the Courts

Fiscal Officer

James Agro
Assistant Director, Management Services
Administrative Office of the Courts

609-292-4638 [office]
609-292-9659 [fax]
Hughes Justice Complex Building
P.O. Box 982
Trenton, NJ 08625

609- 292-0499 [office]
P.O. Box 985
Trenton, NJ 08625

VIII. We, the undersigned, consent to the contents of this Agreement.

New Jersey Department of Human Services, Division of Addiction Services:

Signature: _____

Raquel Mazon Jeffers
Director

9/30/10
Date

New Jersey Administrative Office of the Courts:

Signature: _____

Hon. Glenn A. Grant, JAD
Acting Administrative Director of the Courts

10/4/10
Date

Attachment A

The provisions and conditions of this attachment are deemed to be incorporated in the Memorandum of Agreement between the Administrative Office of the Courts (AOC) and the New Jersey Department of Human Services, Division of Addiction Services (DAS), entitled Drug Court.

I. Method of Payment

Cost reimbursement payments shall be made by AOC on the following basis:

☐ Monthly

☐ Quarterly

☐ Lump Sum

☐ Based on submission of the following reports:

☒ Other: Per DAS' letter requesting additional funds from AOC.

II. Budget Proposal

Under this Memorandum of Agreement, a total of approximately \$29,163,000 shall be made available for the period of July 1, 2010 until June 30, 2011.

The total funding amount supports DAS' slot based and fee-for-service contracts, incentive, medication-assisted, co-occurring and recovery enhancement services, fiscal agent, DAS administration costs, and expansion development costs.

DAS' Drug Court treatment budget projections include, but are not limited to, the following licensed treatment services: long-term and short-term residential, long-term women with children, detoxification, halfway house, partial care, intensive outpatient, outpatient, medication-assisted, co-occurring services, clinical reviews and recovery enhancements for post conviction clients.

ADMINISTRATIVE OFFICE OF THE COURTS
STATE OF NEW JERSEY

GLENN A. GRANT, J.A.D.
ACTING ADMINISTRATIVE DIRECTOR OF THE COURTS



RICHARD J. HUGHES JUSTICE COMPLEX
PO Box 037
TRENTON, NEW JERSEY 08625-0037
(609) 984-0275
FAX: (609) 292-3320

October 5, 2010

Raquel Mazon Jeffers, Director
Division of Addiction Services
Department of Human Services
P.O. Box 362
Trenton, NJ 08625-0362

Re: *Memorandum of Agreement – SFY 2011, The Administrative Office of
the Courts and the Department of Human Services/Division of Addiction
Services*

Dear Director Jeffers:

Enclosed herewith please an original signed copy of the Memorandum of Agreement for SFY 2011 between the Department of Human Services, Division of Addiction Services and the Administrative Office of the Courts, which has been signed by the Honorable Glenn A. Grant, Acting Administrative Director.

Thank you.

Sincerely,

A handwritten signature in dark ink, appearing to read "Glenn A. Grant".

GLENN A. GRANT, J.A.D

GAG:jaa
Enclosure

Cc: Joseph J. Barraco, Asst. Director, Criminal Practice Division
James S. Agro, Asst. Director, Management Services



State of New Jersey

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES
CAPITAL CENTER, 50 EAST STATE STREET
PO Box 727
TRENTON, NJ 08625-0727

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

JENNIFER VELEZ
Commissioner

LYNN A. KOVICH
Assistant Commissioner

August 29, 2011

Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Room 7-1091
Rockville, MD 20857

RE: New Jerseys Joint Mental Health and Substance Abuse Prevention and Treatment Block Grant for 2012-2013

Dear SAMHSA Grants Management:

On behalf of the New Jersey Mental Health Planning Council (herein referred to as The Planning Council), I am pleased to submit this letter of endorsement for the combined Mental Health and Substance Abuse Prevention and Treatment Block Grant for 2012-2013 submitted by the New Jersey Division of Mental Health and Addiction Services (DMHAS). The Council has met on a monthly basis throughout the past year with a focus on being informed and advised of the integration of the former Division of Mental Health Services and Division of Addiction Services into the newly merged DMHAS. Therefore, a Joint Block Grant submission is the most suitable choice for New Jersey for this Block Grant Application.

The Planning Council has had the opportunity to review the new guidelines and provide input regarding the Joint Block Grant Application. With the use of Survey Monkey and WebBGAS Citizen's log in, Planning Council members have had the opportunity to review and comment on the Joint Block Grant Application prior to submission.

The Planning Council will continue to evaluate and monitor the implementation of the planning and needs assessment of this application and make recommendations as needed. In addition, the Planning Council will continue to work over the next year to add to its membership consumers, family members and providers of addiction and co-occurring services.

New Jersey Is An Equal Opportunity Employer

The New Jersey Mental Health Planning Council believes that this Joint Block Grant Application will foster greater collaboration of mental health and addiction services for both adults and children. The Planning Council is most grateful for this occasion to participate in the discussion and provide recommendations for New Jersey's mental health and addiction service system.

Sincerely,

A handwritten signature in dark ink, appearing to read "Phillip Lubitz", with a stylized flourish at the end.

Phillip Lubitz, Chair
New Jersey Mental Health Planning Council

cc: Lynn Kovich, Assistant Commissioner, DMHAS
Jacob Bucher, Vice Chair, New Jersey Mental Health Planning Council
Raquel Jeffers, Deputy Director, DMHAS
Jeff Guenzel, Division of Child Behavioral Health Services
Geri Dietrich, Division of Child Behavioral Health Services
Donna Migliorino, DMHAS
Valerie Larosiliere, DMHAS
Dona Sinton, DMHAS
Roxanne Kennedy, DMHAS