New Jersey

UNIFORM APPLICATION
FY 2021 Mental Health Block Grant Report

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
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Center for Mental Health Services
Division of State and Community Systems Development

A. State Information

State Information

State DUNS Number

Number	806418257
Expiration Date	

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

Agency Name	New Jersey Division of Mental Health and Addiction Services
Organizational Unit	Office of Olmstead, Compliance, Planning and Evaluation
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II. Contact Person for the Grantee of the Block Grant

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

From	7/1/2019
To	6/30/2020

IV. Date Submitted

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

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Footnotes:

B. Implementation Report

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

Priority #: 1

Priority Area: Pregnant Women/Women with Dependent Children

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

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

Strategies to attain the goal:

• Annual provider meetings include licensed women's treatment providers who provide gender specific treatment and system partners. Attendees, the Division of Mental Health and Addiction Services (DMHAS) women's treatment coordinator, representatives from NJ Department of Children and Families (DCF), Division of Family Development (DFD), Work First New Jersey Substance Abuse Imitative (WFNJ-SAI) and other relevant stakeholders. Meeting address issues related to best practices such as retention, engagement, access and referrals, recovery supports, medication assisted treatment, systems collaboration, Substance Exposed Infants (SEI) and Neonatal Abstinence Syndrome (NAS) and training needs.

• Professional development – women's treatment provider contract requirements include service elements and language from the National Association of State Alcohol/Drug Abuse Directors (NASADAD) "Guidance to States: Treatment Standards for Women with Substance Use Disorders" document that emphasizes best practice. Contracted providers are required to address the full continuum of treatment services: family-centered treatment, evidence-based parenting programs, trauma-informed and trauma-responsive treatment using Seeking Safety, Strengthening Families, evidence-based parenting classes, recovery supports, etc. and assist women with housing supports by linking women to transitional, permanent and/or supportive or sober living homes such as an Oxford House. Contracted women's treatment providers new staff are required to complete National Center on Substance Abuse and Child Welfare (NCSACW) online tutorials "Understanding Child Welfare and the Dependency Court: A Guide for Substance Abuse Treatment Professionals" and document completion of tutorials in their employee personnel files.

• Plans of Safe Care - women's treatment provider contract language requires providers to develop Plans of Safe Care for pregnant and postpartum women. Plans of Safe Care will address the needs of the mother, infant and family to ensure coordination of, access to, and engagement in services. For a pregnant woman, the Plan shall be developed prior to the birth event whenever possible and in collaboration with treatment providers, health care providers, early childhood service providers, and other members of the multidisciplinary team as appropriate. Documentation of the Plan shall be included in the woman's file.

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

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

Three workgroups convened: (1) Data Workgroup looked at statewide data systems (Medicaid ICD codes and DOH) that capture prenatal screening, linkage to treatment services, follow-up for parenting women, prevalence of NAS and associated costs. During the initiative, the team analyzed 2013 and 2014 Medicaid data to establish prevalence and costs of treatment NAS. (2) Prenatal Screening, Early Identification of Infants & Referral to Service Workgroup focused on how to increase connections to appropriate treatment and supportive services such as Central Intake and Perinatal Cooperatives, by mapping out current screening and referral practices across the state using Pregnancy Risk Assessment (PRA) data; New Jersey implemented the 4Ps+ across the State and embedded the tool within the PRA. The workgroup found high utilization (over 80%) of 4Ps+ within doctors serving pregnant women on Medicaid. The mapping allowed the team to target low utilization areas to increase the prevalence of prenatal screening. (3) Labor, Delivery and Engagement (Infants) Workgroup developed a comprehensive survey with input from the medical community and

perinatal cooperatives. The Hospital Birth Survey was disseminated statewide March 2017 to the labor and delivery hospitals. The survey sought to understand how pregnant women with SUD and substance-exposed infants are identified, treated, and triaged with partners at discharge, and if treatment for NAS was explored. The Hospital Birth Survey results was intended to guide Departments in establishing statewide guidelines for best practice; aid in the development of cross system models to ensure families get access to services; establish education needs on issues of SEI/NAS and identify high risk areas. The IDTA commenced in 2017, however DMHAS as the IDTA lead state agency, requested modified technical assistance from the NCSACW to support New Jersey to interpret the key findings from the Birthing Hospital Survey, and apply these findings to the Project ECHO program design.

In late Fall of 2018, Robert Wood Johnson and the Nicholson Foundation, in partnership with the three Departments (Health, Human Services, and Children and Families) and other stakeholders began planning to launch Project ECHO (Extension for Community Outcomes) for SEIs. The New Jersey Project ECHO is aimed at Statewide adoption of best practice clinical care and community-based interventions to support SEIs and their parents to support recovery, family formation, and child development through a multidisciplinary case-based learning platform. Project ECHO for SEI and parents focuses on prevention, birth, and the infant's first year of life. DCF is the lead State agency on Plans of Safe Care for SEI, mothers and their families and has developed protocols for integrating Plans of Safe Care into child protection services and child welfare and child welfare assessments.

• Maternal Wrap Around Program (MWRAP) – MWRAP provides intensive case management and recovery support services for opioid dependent pregnant and postpartum women. Opioid dependent women are eligible for services during pregnancy and up to one year after the birth event. Intensive case management focuses on developing a single, coordinated care plan for pregnant/postpartum women, their infants and families. Intensive Case Managers work as liaisons to all relevant entities involved with each woman. The Recovery Support Specialists provide non-clinical assistance and recovery supports while maintaining follow-up with the women and their infants.

The MWRAP goal is to alleviate barriers to services for pregnant opioid dependent women through comprehensive care coordination that is implemented within the five major timeframes when intervention in the life of the substance exposed infants (SEI) can reduce potential harm of prenatal substance exposure: pre-pregnancy, prenatal, birth, neonatal and early childhood. MWRAP is intended to promote maternal health, improve birth outcomes, and reduce the risks and adverse consequences of prenatal substance exposure. MWRAP is a statewide program located in seven regions with each region serving approximately 30 unduplicated opioid dependent pregnant women, their infants and families.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increase the number of pregnant women or women with children entering substance abuse treatment.
Baseline Measurement:	SFY 2019: 32,276 admissions count
First-year target/outcome measurement:	Increase number of pregnant women or women with children entering substance abuse treatment in SFY 2020 by 1%.
Second-year target/outcome measurement:	Increase number of pregnant women or women with children entering substance abuse treatment by 2% by the end of SFY 2021. The change in SFY 2021 will be measured by calculating the percent difference from SFY 2019 to SFY 2021.

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

Data Source:

The number of pregnant women and women with children from SFY 2019 – 2021 will be tracked by the SSA's New Jersey Substance Abuse Monitoring System (NJSAMS).

New Data Source*(if needed)*:

Description of Data:

All agencies licensed to provide substance abuse treatment in New Jersey must report on NJSAMS, the SSA's real-time web-based client administrative data system. The system collects basic client demographic, financial, level of care and clinical information for every client. All national outcome measures (NOMS) are incorporated into the system. Outcome measures are linked to the client at admission and discharge.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Outcome measures are collected at a client's admission and discharge per the approach used with TEDS and not at different periods of time during the course of treatment.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Priority #: 2

Priority Area: Persons Who Inject Drugs

Priority Type: SAT

Population(s): PWID

Goal of the priority area:

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

Strategies to attain the goal:

• Referral to substance use disorder (SUD) treatment from statewide Harm Reduction Centers (HRCs) that are operational throughout New Jersey.
• Providing services in convenient locations, specifically utilizing mobile medication units, in order to reduce barriers and engage individuals in care as easily as possible.
• Promoting the use of medication assisted treatment (MAT) (e.g., methadone, buprenorphine, injectable naltrexone) for individuals with an opioid use disorder (OUD).
• Educating providers, individuals with an OUD, family members and the public about the benefits of MAT through a planned statewide public awareness campaign as well as public presentations on this topic.
• Contracts to three regional providers to provide community education and trainings for individuals at risk for an OUD, their families, friends and loved ones to recognize an opioid overdose and to subsequently provide naloxone kits to individuals in attendance.
• Increase the number of naloxone trainings specifically for underserved populations, such as schools, jails, licensed SUD treatment providers, Offices of Emergency Management, Emergency Medical Services teams, fire departments, homeless shelters and community health clinics.
• Contracts awarded to implement an opioid overdose recovery program with recovery specialists and patient navigators in all 21 counties for individuals who present in emergency departments following an opioid overdose reversal with naloxone in order to link them to treatment or other recovery support services in their communities.
• Contracts awarded to 11 providers for the Support Team for Addiction Recovery (STAR) program to provide case management and wraparound services for individuals with an OUD. Goals include linking clients to needed services, housing, primary care and treatment including MAT.
• Maternal Wraparound Program (M-WRAP) provides intensive case management and recovery support services for opioid dependent pregnant and postpartum women. Opioid dependent pregnant women are eligible for M-WRAP services during pregnancy and up to one year after birth event. Intensive case management focuses on developing a single, coordinated care plan for pregnant/postpartum women, their infants and families. Intensive Case Managers provide care coordination and warm hand-offs to appropriate service providers when necessary. Recovery Support Specialists provide non-clinical assistance and recovery supports while maintaining follow-up with the women and their infants. The M-WRAP program covers all 21 counties of NJ and alleviates barriers through comprehensive care coordination using a multi-system approach with the goal to improve outcomes for pregnant/postpartum opioid dependent women and their children.
• In September 2016, DMHAS was awarded a five-year grant to "Prevent Prescription Drug/Opioid Overdose-Related Deaths (PDO)" from SAMHSA to implement the Opioid Overdose Prevention Network (OOPN) initiative which entails the development and implementation of a comprehensive prescription drug/ opioid overdose prevention program which includes Naloxone training and distribution. Plans are to train 3,000 individuals and distribute 2,500 naloxone kits annually.
• In September 2016, DMHAS was awarded a "Strategic Prevention Framework for Prescription Drugs (SFP Rx)" five-year grant from SAMHSA to implement the NJAssessRx initiative. NJAssessRx expands interagency sharing of the state's Prescription Drug Monitoring Program data and gives DMHAS the capability to use data analytics to identify prescribers, prescriber groups and patients at high risk for inappropriate prescribing and nonmedical use of opioid drugs. Informed by the data, DMHAS and its prevention partners will strategically target communities and populations needing services, education or other interventions. The target population is youth (ages 12-17) and adults (18 years of age and older) who are being prescribed opioid pain medications, controlled drugs, or human growth hormone (HGH), and are at risk for their nonmedical use.
• In May 2017, SAMHSA awarded $12,9995,621 through the State Targeted Response (STR) to New Jersey annually for two years. The program aims to address the opioid crisis by increasing access to treatment, reduce unmet treatment need and reduce opioid overdose related deaths through the provision of prevention, treatment and recovery activities for OUD. A major activity of the grant is to implement and expand access to clinically appropriate evidence-based practices (EBPs) for OUD treatment, particularly, the use of MAT. To address these objectives, a new State Targeted Opioid Response Initiative (STORI) fee-for-service (FFS) treatment initiative was developed within the existing addiction fee for service treatment network, which provides access to treatment for under-insured and uninsured clients. It includes a wide range of services, specifically including MAT. DMHAS was awarded a no-cost extension for the STR grant to continue funding the STORI FFS treatment for part of SFY 2020.

• In September 2018, SAMHSA awarded $21.5 million through the State Opioid Response (SOR) to New Jersey annually for two years to continue to address the opioid crisis. The key objectives of the SOR grant are to increase access to MAT, reduce unmet treatment need and reduce opioid related deaths.
• In March 2019, DMHAS received notification from SAMHSA that its plan for an additional $11.2 million was approved through the SOR Grant for the period through FFY 2020. DMHAS submitted a plan proposing to use the SOR supplemental award to fund additional treatment, recovery support, prevention and education/training efforts to address the opioid epidemic.
• As part of SOR funding, the Low Threshold Buprenorphine Induction program (Low Threshold) is designed to make Buprenorphine treatment easily accessible to individuals who access syringes at Harm Reduction Centers (HRCs) located at South Jersey AIDS Alliance (SJAA) in Atlantic City and the Visiting Nurse Association (VNA) of Central Jersey in Asbury Park. Through the Low Threshold program, individuals will be offered same day, immediate enrollment in Buprenorphine treatment and care management services. The program will offer services to individuals who seek this type of service in a safe and nonjudgmental environment, despite continued drug use or lapses in care.
• As part of SOR and state funding, DMHAS is collaborating with NJ's 21 counties to establish MAT programs or enhance existing MAT services for inmates with OUD at county correctional facilities. In addition, DMHAS is working with county correctional facilities to establish justice involved re-entry services for detainees where case managers at county jails will conduct intake assessments and establish pre-release plans for needed services in the community.
• An attempt to increase access to MAT, specifically buprenorphine, has been the development of statewide buprenorphine training courses utilized as an educational component for physicians, Advanced Practical Nurses (APNs) and Physician Assistants (PAs) to attain their Buprenorphine Waiver. The State plans to hold a total of 16 trainings through both Rutgers University (northern region) and Rowan University (southern region) in CY 2019 in an effort to train over 1,000 prescribers in CY 2019.
• Interim Services have been a requirement of provider contracts, but a new initiative allows DMHAS to pay for these services through a fee-for-service (FFS) mechanism. The Interim Services initiative provides funding to agencies to support individuals awaiting admission to treatment following a SUD assessment. Interim Services are an engagement level of service intended to link individuals to services they may not be able to access due to lack of provider capacity. This service is designed to be provided by agencies contracted for any licensed ASAM level of care. Interim services will be made available to any individual eligible for treatment within the public system who cannot be admitted for the assessed level of care within 72 hours. Prior to this initiative agencies enrolled in the Block Grant initiatives were required to provide this service. Once launched in October 2019, funding for Interim Services will be open to all contracted FFS providers.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increase the number of PWID entering treatment.
Baseline Measurement:	SFY 2019: 29,053 admissions count
First-year target/outcome measurement:	Increase the number of PWID entering treatment by 1%.
Second-year target/outcome measurement:	Increase the number of PWID entering treatment by 2% by the end of SFY 2021. The change in SFY 2021 will be measured by calculating the percent difference from SFY 2019 to SFY 2021.

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

Data Source:

The number of PWID in SFY 2019 through SFY 2021 will be tracked by the SSA's New Jersey Substance Abuse Monitoring System (NJSAMS).

New Data Source*(if needed)*:

Description of Data:

All agencies licensed to provide substance abuse treatment in New Jersey must report on NJSAMS, the SSA's real-time web-based client administrative data system. The system collects basic client demographic, financial, level of care and clinical information for every client. All national outcome measures (NOMS) are incorporated into the system. Outcome measures are linked to the client at admission and discharge.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Outcome measures are collected at a client's admission and discharge per the approach used with TEDS and not at different periods of time during the course of treatment.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Indicator #: 2

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

Baseline Measurement: SFY 2019: 47,007 admissions count

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

Second-year target/outcome measurement: Increase number of opiate dependent individuals entering treatment by 2% by the end of SFY 2021. The change in SFY 2021 will be measured by calculating the percent difference from SFY 2019 to SFY 2021.

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

Data Source:

The number of opiate dependent individuals in SFY 2019 and SFY 2021 will be tracked by the SSA's New Jersey Substance Abuse Monitoring System (NJSAMS).

New Data Source*(if needed)*:

Description of Data:

All agencies licensed to provide substance abuse treatment in New Jersey must report on NJSAMS, the SSA's real-time web-based client administrative data system. The system collects basic client demographic, financial, level of care and clinical information for every client. All national outcome measures (NOMS) are incorporated into the system. Outcome measures are linked to the client at admission and discharge.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Outcome measures are collected at a client's admission and discharge per the approach used with TEDS and not at different periods of time during the course of treatment.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Priority #: 3

Priority Area: Heroin/Opioid Users

Priority Type: SAT

Population(s): Other (Heroin/Opioid Users)

Goal of the priority area:

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

Strategies to attain the goal:

• Utilize a public awareness campaign focusing on reducing stigma/discrimination regarding MAT to assist in engaging individuals with an OUD, their families, friends, loved ones, providers and other community members so that they understand the use of MAT is a best practice in the treatment of an OUD.
• Buprenorphine Medical Support- This new initiative will focus on the challenges faced by licensed ambulatory SUD programs that require start-up funds to increase their capacity to offer MAT, specifically buprenorphine to their clients. Ambulatory SUD treatment programs will be expected to build capacity to offer MAT in compliance with all federal and New Jersey state regulations. Agencies will be required to receive referrals from other programs that offer MAT where clients stabilized on MAT.
• DMHAS will continue its Vivitrol Enhancement through its Fee-for-Service (FFS) Network. This enhancement allows providers to be reimbursed for the provision of Vivitrol as well as other ancillary services in FFS initiatives. Licensed SUD agencies can apply for the enhancement by submitting applications to DMHAS and are reviewed for approval on a quarterly basis.
• DMHAS is collaborating with NJ's 21 counties to establish MAT programs or enhance existing MAT services for inmates with OUD at county correctional facilities. In addition, DMHAS is working with county correctional facilities to establish justice involved re-entry services for detainees where case managers at county jails will conduct intake assessments and establish pre-release plans for needed services in the community, which include linking individuals to community MAT services.
• DMHAS will continue to distribute American Society of Addiction Medicine (ASAM) booklets entitled "Opioid Addiction Treatment: A Guide for Patients, Families and Friends" which provide facts about treatment, including MAT as a best practice, and provides NJ-specific resources to accessing treatment and recovery services.
• DMHAS has a Memorandum of Agreement (MOA) with Rutgers University, Robert Wood Johnson Medical School to develop a train-the-trainer program on MAT, the opioid epidemic (specific to New Jersey) and concepts of SUD (specific to OUD) for a minimum of 40 graduate students at Rutgers University. The goal of this project is to educate, support, and mentor graduate students to give free educational talks, through use of PowerPoint presentations, to the community.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increase the number of heroin/other opiate admissions for whom MAT was planned.
Baseline Measurement:	SFY 2019: 20,887 heroin/other opiate admissions for whom MAT was planned.
First-year target/outcome measurement:	Increase the number of heroin/other opiate admissions for whom MAT is planned by 1%
Second-year target/outcome measurement:	Increase the number of heroin/other opiate admissions for whom MAT is planned by 2%. The change in SFY 2021 will be measured by calculating the percent difference from SFY 2019 to SFY 2021.

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

Data Source:

The number of heroin/other opiate admissions for whom MAT was planned from SFY 2019 - 2021 will be tracked by the SSA's New Jersey Substance Abuse Monitoring System (NJSAMS).

New Data Source*(if needed)*:

Description of Data:

All agencies licensed to provide substance abuse treatment in New Jersey must report on NJSAMS, the SSA's real-time web-based client administrative data system. The system collects basic client demographic, financial, level of care and clinical information for every client. All national outcome measures (NOMS) are incorporated into the system. Outcome measures are linked to the client at admission and discharge.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Priority #: 4

Priority Area: Tobacco

Priority Type: SAP

Population(s): PP, Other (Persons aged 12 – 17)

Goal of the priority area:

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

Strategies to attain the goal:

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

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

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

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

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Past month tobacco product use (any) among persons aged 12 to 17.

Baseline Measurement: According to 2016-2017 NSDUH data, 4.14 percent of the target population reported tobacco product use (any) during the month prior to participating in the survey.

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

Second-year target/outcome measurement: An additional reduction of .25% below the first year measure.

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

Data Source:

National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia), Tobacco Product Use in the Past Month, by Age Group and State: Percentages, Annual Averages Based on 2016 and 2017 NSDUH – data for New Jersey

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Priority #: 5

Priority Area: Alcohol

Priority Type: SAP

Population(s): PP, Other (Persons aged 12-17)

Goal of the priority area:

Reduce the percentage of persons aged 12 – 17 who report binge drinking in the past month

Strategies to attain the goal:

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

Environmental Strategies
• Enhance Access/Reduce Barriers – Enhance access to effective prevention strategies and information through the use of a social media campaign and the development of human capital and networks of support.
• Enhance Barriers/Reduce Access - Increase education among merchants, bars, and restaurants who sell alcoholic beverages. Also, provide education to parents and guardians.
• Change Consequences/Enhance Access/Reduce Barriers – Work with municipal and county government to assure that underage drinking laws are enforced at the local level.
• Change Physical Design – Through the compliance check report and GIS mapping, provide municipalities and state Alcoholic Beverage Commission with details regarding how outlet density and location impact tobacco availability to youth.
• Modify/Change Policies – Enhance or create policies related to underage drinking among 12-17 years olds on a countywide level.

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Binge Alcohol Use in the Past Month by persons aged 12-17.

Baseline Measurement: According to 2016-2017 NSDUH data, 5.48 percent of the target population reported binge drinking during the month prior to participating in the survey.

First-year target/outcome measurement: A reduction of .20% below the baseline measure.

Second-year target/outcome measurement: An additional reduction of .20% below the baseline measure.

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

Data Source:

Binge Alcohol Use in the Past Month, by Age Group and State: Percentages, Annual Averages Based on 2016 and 2017 NSDUH – data for New Jersey

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Priority #: 6

Priority Area: Marijuana

Priority Type: SAP

Population(s): PP, Other (Persons aged 12-17)

Goal of the priority area:

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

Strategies to attain the goal:

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

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

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

programs and other community-based initiatives.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Marijuana Use in the Past Year by persons aged 12-17.

Baseline Measurement: According to 2016-2017 NSDUH data, 10.28 percent of the target population reported marijuana use during the year prior to participating in the survey.

First-year target/outcome measurement: A reduction of .10% below the baseline measure.

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

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

Data Source:

Marijuana Use in the Past Year, by Age Group and State: Percentages, Annual Averages Based on 2016 and 2017 NSDUH – data for New Jersey

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Priority #: 7

Priority Area: Prescription Drugs

Priority Type: SAP

Population(s): PP, Other (All residents in New Jersey)

Goal of the priority area:

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

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Opioid Dispensations in New Jersey.

Baseline Measurement: According to data from NJ CARES – A Realtime Dashboard of Opioid-Related Data and

Information (maintained by the Office of the New Jersey Attorney General), in 2018, 4,266,645 prescriptions for opioids were provided in New Jersey.

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

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

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

Data Source:

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

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Priority #: 8

Priority Area: Heroin

Priority Type: SAP

Population(s): PP, Other (Persons aged 12-17)

Goal of the priority area:

Increase the percentage of persons aged 12 – 17 who report perceptions of Great Risk from Trying Heroin Once or Twice

Strategies to attain the goal:

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

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

Individual Strategies
• Provide information – Educate parents and youth on the dangers of illegal substances (including heroin) by youth through awareness efforts, workshops, and countywide events. These programs will be provided through county alcohol and drug funding, municipal alliances, and other

community organizations.
• Provide Information – Educate youth on the dangers of illegal substance and heroin use by means of evidence-based middle and elementary school prevention programs and other community-based initiatives.

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: According to 2016-2017 NSDUH data, 68.23 percent of the target population reported Perceptions of Great Risk from Trying Heroin Once or Twice.

First-year target/outcome measurement: An increase of .50% above the baseline measure.

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

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

Data Source:

Perceptions of Great Risk from Trying Heroin Once or Twice, by Age Group and State: Percentages, Annual Averages Based on 2016 and 2017 NSDUH – data for New Jersey

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Priority #: 9

Priority Area: TB

Priority Type: SAT

Population(s): TB

Goal of the priority area:

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

Strategies to attain the goal:

• Notifications. All block grant recipients will be notified of the contractual and regulatory requirements to screen all clients for TB symptoms. Methods used will be a formal letter to all block grant recipients and an overview presented at the next quarterly Professional Advisory Committee (PAC) and other upcoming Division/agency meetings.
• Ongoing monitoring. Monitors will review compliance during the annual site visit, and require an acceptable plan of correction for non-compliance. If repeat deficiencies are found, an alternate plan of correction and proof of implementation will be required.

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: According to SFY 2019 Annual Site Monitoring Reports of DMHAS' SAPT Block Grant contracted agencies, 75% of the agencies that were monitored (27 of 36 agencies) were in compliance with offering every client a tuberculosis evaluation.

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

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

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

Data Source:

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

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Priority #: 10

Priority Area: In coordination with New Jersey's Aligning Early Childhood with Medicaid (AECM) technical assistance project, DCF/ Children's System of Care (CSOC) will develop and implement screening, identification, and intervention among at risk children age 0-3

Priority Type: MHS

Population(s): SED

Goal of the priority area:

NJ Children's System of Care (CSOC) will collaborate with system partners to develop and implement screening, identification, and intervention among at risk children age 0-3.

Strategies to attain the goal:

New Jersey has joined Aligning Early Childhood and Medicaid, a multi-state initiative aimed at improving the health and social outcomes of low-income infants, young children, and families through cross-agency collaboration. This national program is led by the Center for Health Care Strategies (CHCS) in partnership with the National Association of Medicaid Directors and ZERO TO THREE. Through this 20-month initiative, participating states will:

1.Align state programs and investments between Medicaid and other early childhood systems to drive more strategic, evidence-based investments for

infants and toddlers in low-income families; and
2.Demonstrate the value of early childhood cross-sector alignment for improving near- and long-term health and social outcomes.

NJ DCF/CSOC has identified the following goals:

1. Identify and adopt best practice standards to identify social-emotional, behavioral, and social determinant health risk in the pediatric medical home, including creating a plan to implement a strategy to increase capacity for stratified care coordination in the pediatric medical home to effect linkage to behavioral health and other services by January 2020.

2. Develop a written strategy, including programmatic recommendations and funding options to provide infant mental health services on a statewide basis by July 2020.

3. Drafting a State Plan Amendment expanding the use of care coordination and community health workers to ensure new mothers and their infants stay connected to physical and behavioral health care, and other health influencing benefits, such as food, housing and child care across the health care delivery system.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Completed plan for screening, care coordination, and development of infant mental health srvice capacity for at risk children age 0-3
Baseline Measurement:	To be determined after the first year of implementation of screening services to children age 0-3
First-year target/outcome measurement:	An increase in the percentage of children age 0-3 receiving screening srvices in SFY 2021. The percentage will be determined when the baseline measure is set.
Second-year target/outcome measurement:	An increase in the percentage of children age 0-3 receiving screening srvices in SFY 2022. The percentage will be determined when the baseline measure is set.

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

Data Source:

DCF will implement their anticipated project-related goals(s) and activities, and track progress over time.
PerformCare NJ - the CSOC Administrative Services Organization

New Data Source*(if needed)*:

Description of Data:

DCF self- assessment and written organizational plans.
The number of children age 0-3 receiving screening services during a specified state fiscal year.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

The baseline measurement of will be determined after the first year of implementation of screening services to children age 0-3.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

CSOC has made great progress by collaborating with the Department of Human Services / Medicaid, with support from the Center for Health Care Strategies / Aligning Early Childhood and Medicaid (AECM), and by participating with a broad group of stakeholders to develop the report, "Unlocking Potential: A Roadmap to Making New Jersey the Safest, Healthiest, and Most Supportive Place to Give Birth and Raise a Family," which outlines steps to expand infant mental health services in New Jersey (the Executive Summary of this report can be found online. https://acnj.org/downloads/2020_06_24_Unlocking_Potential_Executive_Summary.pdf). While a component

of this report establishes clear steps to expand infant mental health (IMH) services to 7,247 more low-income infants and toddlers annually, beginning in 2023, the public health emergency caused conflicts that precluded further development of a plan for screening, care coordination, and increased service capacity. CSOC is continuing to engage in the AECM and Pritzker initiatives and is exploring additional opportunities to build IMH capacity within CSOC. Efforts include the In-Home recovery Program (priority area 12).

Priority #: 11

Priority Area: NJ Children's System of Care (CSOC) will continue to increase the integration of community-based physical and behavioral health services for children, youth and young adults with mental/behavioral health challenges and/or substance use challenges and chronic medical conditions

Priority Type: MHS

Population(s): SED

Goal of the priority area:

The New Jersey Children's System of Care (CSOC) will increase integration of community-based physical and behavioral health services for children, youth and young adults with mental/behavioral health challenges and/or substance us challenges and chronic medical conditions.

Strategies to attain the goal:

In order to further operationalize the DCF vision of ensuring New Jersey children and families are safe, healthy and connected, the Department of Children and Families has revised its Strategic Plan to best align the priorities of CSOC with the DCF vision and values. The Strategic Plan identifies promoting integrated health and behavioral health as a priority. Integrated care and wellness activities will be incorporated across the CSOC continuum by expanding existing integration models and exploring development of other primary health-behavioral health integration models.

Currently, NJ's Behavioral Health Homes (BHH) are operational in Bergen, Mercer, Cape/Atlantic, and Monmouth counties. Each BHH is a designated Care Management Organization (CMO) with enhanced care management teams that include medical expertise and health/wellness education for purposes of providing fully integrated and coordinated care for youth remaining in their home and who have chronic medical conditions. Each BHH employs Nurse Managers (1-40 ratio) and Health and Wellness coaches (1-65 ratio). Nurse Managers are required to hold a New Jersey Registered Nurse (RN) license or higher nursing credential. Health and Wellness Coaches are required to have a Bachelor's Degree and two years of experience in nutrition, health education or a related field.

BHH services are a "bridge" that connects prevention, primary care, and specialty care. Medical and wellness staff are integrated into the existing CMO Child Family Team (CFT) structure responsible for care coordination and comprehensive treatment planning for youth and their families which includes planning for the holistic needs of the youth. The CFT structure and approach (CMO, FSO, Family, Youth and other designated service providers and supports) enhanced with BHH RN, Health/Wellness Coach staffing plans for the holistic needs of a youth with both behavioral health and medical needs (inclusive of substance use and developmental and intellectual challenges). Nurse Manager and Health/Wellness staff communicate with youth's medical providers (primary care specialty providers, urgent or emergent medical care) and connect the medical domain and planning with the existing CFT process.

New Jersey is among the first states using Targeted Case Management (TCM) to deliver Behavioral Health Home services for youth only.

The structure of the CMO is a strategic fit for the health home program. The BHH Core Team builds on the current CMO array of staff with the intent to provide a holistic approach to care for children. This expanded team will constitute the services of the BHH and will broaden the current CMO care coordination and care management functions to include the ability to identify, screen and coordinate both primary care and specialty medical care.

During SFY 2018, 484 youth were enrolled in BHH services. To be eligible, youth must meet the criteria for CMO and have a qualifying medical condition which is inclusive of intellectual and developmental challenges as well as substance use.

Place background information on Certified Community Behavioral Health Clinics (CCBHCs) here. Include number of children served during SFY 2018

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increased number of children, youth or young adults provided with integrated physical and behavioral health services.

Baseline Measurement: In SFY 2019 CSOC proved Behavioral Health Home services to 503 youth.

First-year target/outcome measurement: CSOC will increase the number of youth served by Behavioral Health Homes/other Integrated Care models by 5%. Target outcome measurement is 528 youth.

Second-year target/outcome measurement: CSOC will increase the number of youth served by Behavioral Health Homes/other Integrated Care models by 5%. Target outcome measurement is 554 youth.

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

Data Source:

Performcare NJ - the NJ DCF/CSOC Administrative Services Organization

New Data Source*(if needed)*:

Description of Data:

Number of youth receiving Behavioral Health Home/integrated physical and behavioral health services in a specified state fiscal year.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Priority #: 12

Priority Area: NJ Children's System of Care (CSOC) will increase access to evidence-based services and supports across the CSOC service continuum

Priority Type: MHS

Population(s): SED

Goal of the priority area:

CSOC will increase access to evidence-based services and supports across the CSOC service continuum.

Strategies to attain the goal:

In order to further operationalize the DCF vision of ensuring New Jersey children and families are safe, healthy and connected, the Department of Children and Families has revised its Strategic Plan to best align the priorities of CSOC with the DCF vision and values. The Strategic Plan identifies building capacity to deliver evidence-based interventions and services as a priority. CSOC will support evidence-based practices in the continuum by increasing EBP capacity in both community-based and out of home services

The Nicholson Foundation, in partnership with New Jersey Department of Children and Families (NJDCF), issued a Request for Proposals (RFP) to solicit proposals for a family-based recovery program from New Jersey–based mental health and substance use disorder treatment providers serving adults, families, and/or young children.

The goals of the In-Home Recovery Program (the Program) are to improve outcomes for parents who have a substance use disorder and are actively parenting a child under 36 months old and to expand the service array for these families through implementation of a specific evidence-informed, in-home treatment program. Post-intervention changes on parental substance use and involvement with child protective services will be evaluated. The RFP process will result in one award for the implementation of two (2) Project sites within Ocean County, NJ managed by one agency. Each Project team will treat a caseload of twelve (12) families concurrently and serve a minimum of eighteen (18) families over the 18-month grant period, beginning on September 1, 2019, for a budget not to exceed $1,064,855.

An important objective of the Program is to demonstrate the effectiveness of a trauma informed in-home treatment for families involved with the NJDCF

Division of Child Protection and Permanency (DCP&P) who have an index parent (client) with a substance use disorder and an index child (child) under the age of 36 months. Outcome measures will include parental substance use, child placement at discharge, and a client's repeat involvement with child protective services.

Key model components include toxicology testing (for clinical purposes only); positive reinforcement in the form of gift cards/vouchers for positive behavioral change (negative toxicology screen); collaboration with DCF regarding the clients progress, success, or any concerns about functioning; collaboration with MAT providers; outreach to support client's participation; utilization of standardized measures to inform and guide treatment, and identify and track symptoms over the course of the intervention; and tools for obtaining family history and the fit between the client and the clients family system.

Measures are divided into three domains: client, child, and parent-child relationship. Areas of focus in the three domains are as follows:
a. client: depression, anxiety, post-traumatic stress, and childhood trauma history;
b. child: development, resilience, behaviors, and trauma exposure; and
c. parent-child relationship: parenting stress, parental reflective capacity, attachment styles, and parenting attitudes.

The full text of the RFP is available here:
https://thenicholsonfoundation.org/news-and-resources/request-proposals-trauma-informed-recovery-program-ocean-county

Additionally,the following evidence based programs are currently provided by CSOC

Functional Family Therapy for Foster Care (FFT-FC)

CSOC in partnership with the Division of Child Protection and Permanency (DCP&P) and a local provider offer access to and service delivery of Functional Family Therapy – Foster Care (FFT-FC) through the CSOC Mobile Response and Stabilization Service and Intensive In-Community service lines. FFT is a relationally focused, trauma informed, evidence-based treatment model for youth in resource care that increases the likelihood of successful adjustment for youth in their resource placements as well as positive permanency outcomes. This treatment model is targeted toward youth aged 12-18 who are demonstrating behaviors that place them at risk of disruption in their resource care placement and are in the legal custody of the DCP&P and have the intellectual capacity to benefit from the treatment intervention. The model uses the relationally focused techniques of Functional Family Therapy (FFT) in a comprehensive and systemic approach adapted to helping youth and families involved with DCP&P to overcome individual and relational trauma to promote placement stability, increase youths' lifelong connections and improve youths' permanency outcomes.

Function Family Therapy (FFT) and Multi-Systemic Therapy (MST)

Beginning in 2008, through an RFP process DCF established providers of Multi-systemic Therapy (MST) and Functional Family Therapy (FFT) in New Jersey. MST and FFT have proven efficacy with youth involved in the juvenile justice system through dozens of empirically validated and peer-reviewed studies. Too often, the child welfare system endeavors to serve these youth and families with inadequate resources and misdirected efforts. Consistent with the needs of many families served by the child welfare system, the challenges at hand are best served by intensive, "whatever it takes" treatment by well-trained and qualified professionals. As evidence-based practices, the licensing and program requirements for providers of MST and FFT, from start-up through on-going delivery of service, are stringent. The goal was to have national organizations ensure that local implementation maintains fidelity to the treatment model to ensure outcomes are consistent with other states. Awards were granted around June 2008. There are currently 5 CSOC-contracted agencies providing FFT/MST. During SFY XXXchildren, youth and young adult received FFT/MST services.

ARC-GROW Model
CSOC, through the Intensive In-Community (IIC) service line, in partnership with the Children's Center for Resilience and Trauma Recovery (CCRTR), and MRSS and CMO partners, offers access to and delivery of the ARC-GROW model. The ARC-GROW Model is an adaptation of the Attachment, Regulation, and Competency framework for intervention with youth and families who have experienced multiple and/or prolonged traumatic stress. The Attachment, Self-Regulation, and Competency (ARC) framework is a core-components treatment model, developed to provide a guiding framework for thoughtful clinical intervention with complexly traumatized youth from early childhood to adolescence and their caregiving systems. GROW is a caregiver skill building intervention designed to enhance resilient outcomes for families who are impacted by chronic adversity or stress (Kinniburgh et al. 2011). This parenting support program is delivered as a 12-session home visiting service by parent support workers or clinical staff providing safety and stabilization support. The home visiting hours include psychoeducation and skill practice in areas including, but not limited to, caregiver self-care, attunement to the developmental impact of trauma, supporting child/youth regulation, effective parenting practices and strategies for building daily routines.

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Under New Jersey's child welfare modified settlement agreement (MSA), the State was required to seek approval from the federal government for a Medicaid rate structure "to support the use of new services for children and families, including community-based and evidence-based informed, or support practices, such as Functional Family Therapy and Multi-Systemic Therapy" (Section II.C.2 of the MSA).

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There are currently 5 CSOC-contracted agencies providing evidence-based practices.

• Functional Family Therapy (FFT):
• Atlantic and Ocean Counties
Cape Counseling and Jewish Family Services
• Burlington and Ocean Counties
Community Treatment Solutions
• Cumberland, Gloucester and Salem Counties
Robins' Nest

• Multisystemic Therapy (MST):
• Camden County
Center for Family Services
• Hudson and Essex Counties
Community Solutions, Inc.

CSOC plans to undertake a comprehensive review of its evidence-based practices, in terms of utilization and outcomes, to ensure these services are having the expected, positive impact on the lives of children and families.

ARC-GROW Model
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Community Treatment Solutions
• Cumberland, Gloucester and Salem Counties
Robins' Nest

• Multisystemic Therapy (MST):
• Camden County
Center for Family Services
• Hudson and Essex Counties
Community Solutions, Inc.

CSOC plans to undertake a comprehensive review of its evidence-based practices, in terms of utilization and outcomes, to ensure these services are having the expected, positive impact on the lives of children and families.

ARC-GROW Model
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Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	In coordination with the NJ Department of Children and Families, the Nicholson Foundation will fund one award for the implementation of the In-Home Recovery Program (IHRP) which provides two (2) Project sites managed by one agency. Each Project team will treat a caseload of twelve (12) families concurrently and serve a minimum of eighteen (18) families over the 18-month grant period, beginning on September 1, 2019
Baseline Measurement:	This in-home service does not exist within NJ DCF at this time
First-year target/outcome measurement:	Total number of families served between January 1, 2020 and June 30, 2020
Second-year target/outcome measurement:	Each Project team will treat a caseload of twelve (12) families concurrentlyand serve a minimum of eighteen (18) families over the 18-month grant period, beginning on September 1, 2019

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

Data Source:

Grant awardee

New Data Source*(if needed)*:

Description of Data:

Total number of families served over the 18-month grant period. Target measurement is 36 families served.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

The program was implemented four months later than anticipated and the period of observation (18 months) now does not end until June 30, 2021 (original end date of observation period: February 28, 2021). We believe we are on target to reach our goal of 36 families served by June 30, 2021, although continued concerns around the public health emergency may impact this outcome.

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

Priority #: 13

Priority Area: Housing Services in Community Support Services

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

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

Strategies to attain the goal:

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

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

SMHA staff will monitor the continued development of new Supportive Housing opportunities. The BEDS data system will foster more timely and

accurate tracking of residential resources, as well as facilitate their more efficient utilization (e.g., to reduce vacancy rates and increase community placements), and enable monitoring of compliance with Administrative Bulletin 5:11 (Residential Placement from Psychiatric Hospital).

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Consumers who remain in Community Support Services (CSS) during the fiscal year as a proportion of total consumers served in Community Support Services.

Baseline Measurement: The total number of clients served in CSS in SFY 2018 were 4,762. 80.72% of the total consumers served in CSS remained in CSS during SFY 2018. The total number of clients served in CSS in SFY 2019 will be available by September 2019. At that time, the percentage for SFY 2019 will be calculated.

First-year target/outcome measurement: The percentage of consumers who remain in Community Support Services during SFY 2020 will be no less than 85% of total consumers served in Community Support Services.

Second-year target/outcome measurement: The percentage of consumers who remain in Community Support Services during SFY 2021 will be no less than 87% of total consumers served in Community Support Services.

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

Data Source:

The number of consumers served by Community Support Services is tracked by the SMHA's QCMR database starting SFY 2018.

New Data Source*(if needed)*:

Description of Data:

The QCMR Database collects quarterly, cumulative, program-specific data from each of the service providers contracted by DMHAS. The current QCMR for Community Support Services contains 50 data elements. The key data fields relevant for this performance indicator are "Ending Active Caseload (Last Day of Quarter)" and Number of terminations in the Quarter. Currently 39 agencies contracted by the SMHA to provide QCMR data for Community Support Services.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

The QCMR emphasizes aggregate program processes and units of service/persons served, rather than individual consumer outcomes. Proposals awarded under current and forthcoming RFPs for Community Support Services will be monitored through contract negotiations. Data will be maintained through the QCMR database.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

The total number of clients served in CSS in SFY 2020 was 5,535 with 651 individuals terminated. The percentage of consumers who remained in CSS for SYF 2020 was 88.24%. In SFY 2020, 37 agencies were contracted by the SMHA to provide QCMR data for Community Support Services.

Priority #: 14

Priority Area: Olmstead Access to Service/Occupancy Rate

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

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

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: In SFY2019, the occupancy rate (of CSS housing units that are occupied and/or have a consumer assigned to them) was 95.9%. Conversely, the vacancy rate (state-funded CSS housing units that are vacant and/or have no consumers assigned to them) was 4.1%.

First-year target/outcome measurement: In SFY 2020, the occupancy rate (i.e., occupied CSS housing units and those units with an assignment) is expected to be 97%.

Second-year target/outcome measurement: In SFY 2021, the occupancy rate (i.e., occupied CSS housing units and those units with an assignment) is expected to be 97%.

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

Data Source:

The 2019 baseline value was generated from newer and slightly improved Provider Weekly Reports. The denominator was the sum of capacity reported from 33 different CSS programs. The numerator was the number of needed assignments requested by those same organizations.

New Data Source*(if needed)*:

Description of Data:

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

The 2019 values were calculated by dividing the sum of the reported number of requested assignments, by the sum of the reported capacities at each program. The SMHA collected this data from 33 CSS providers at the end of SFY19.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

The reporting of occupancy strictly among CSS provider agencies necessitated the use of the Provider Weekly Reports (PWRs). The rollout of the standardized PWRs came late in SFY19, so there is a small number of providers who have yet to submit their data in the proscribed fashion. This performance indicator is expressed as a proportion, and the SMHA does not feel that the SFY19 occupancy rate

of 95.9% would be materially different if/when all of the data was reported.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

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

Priority #: 15

Priority Area: First Episode Psychosis (FEP)

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

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

Strategies to attain the goal:

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

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

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

In SFY 2019, the three CSC programs had over 277 referrals and served 215 clients in their programs. New Jersey plans to continue utilizing the 10% set-aside funding in the FY 2020-21 to support these three CSC teams in providing evidence-based services for individual with FEP. With increased demand for FEP services, the CSC programs have expanded from serving 35 clients to 70 clients per agency and increased clinical staff from 5.2 FTE to 6.8 FTE levels in FY 2019.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Medication adherence among clients who need psychotropic medication prescribed for FEP treatment.
Baseline Measurement:	In SFY 2018, among clients who were taking or in need of antipsychotic medication for the treatment of their psychosis at intake, 78.4% adhere to their medication regimen. In SFY 2019, out of 215 clients being served, 190 were taking or in need of antipsychotic medication. Among them, 86.8% (165) adhered to their psychotropic medication regimens.
First-year target/outcome measurement:	In SFY 2020, it is anticipated that at least 88% of the client who are taking or in need of antipsychotic medication adhere to the medication regimen.
Second-year target/outcome measurement:	In SFY 2021, it is anticipated that at least 90% of the client who are taking or in need of antipsychotic medication adhere to the medication regimen.

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

Data Source:

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

New Data Source*(if needed)*:

Description of Data:

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

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

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

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

The original first-year (SFY 2020) target was set at 88%. The results showed that 87% of the clients who were taking or in need of antipsychotic medication adhered to the medication regimens in SFY 2020, which is consistent with the rate in SFY 2019 (86.8%). It seems the targets for SFY 2020 (88%) and SFY 2021 (90%) were set too high. We, therefore, propose the new second-year (SFY 2021) target to be 88%.

Due to COVID-19 and working from home arrangement, some agencies have difficulty submitting the complete clean data to SMHA. The SMHA are aware of the data quality issues and are working with the agencies to fix the data issues.

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

Priority #: 16

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

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

System wide assessment for delivering services to diverse populations.

Strategies to attain the goal:

Since 1985, the Division of Mental Health and Addiction Services (DMHAS) has had the commitment to improve services to individuals from diverse backgrounds, including LGBTQ. The mechanism for addressing these system needs began with the 2015 reformation of DMHAS' multicultural activities into a Multicultural Services Advisory Committee (MSAC). The MSAC has developed a process for systems assessment that will begin by surveying all contracted agencies about their existing planning and service delivery to diverse populations. As the SMHA reviewed the results of these surveys, gaps in service and needs for technical assistance (TA) were identified. Beginning in early 2016, TA groups were held in the north and south to assist agencies in formulating multicultural plans. Those plans became a part of the SMHA's contracting process in FY 2017 and have been followed by the

DMHAS Multicultural Training and Technical Assistance Center each year to ensure that the plans continue to grow. In addition, in FY 2018, DMHAS contracted with a diversity consultant to provide administrative and research-based assistance with this initiative. The diversity consultant was charged with securing scholarly presenters for trainings and workshops to further educate and engage providers with completing their Cultural Competence Plan. The diversity consultant's role expanded in FY 2019 to include qualitative and quantitative analysis of data in order to present a more robust picture of DMHAS' agency gaps and trends leading to greater concentration of creating and sustaining a culture of inclusion.

The MSAC, with assistance from DMHAS and the diversity consultant, is developing a "Center for Cultural Competency Excellence" designation for agencies that meet exemplary criteria in addition to completing their Cultural Competency Plans.

Each mental health community provider is required to develop a Cultural Competence Plan describing the integration of cultural and linguistic competence throughout the organization, including direct attention to issues of gender, age, and culture. An organizational self-assessment helps prioritize the steps needed to develop those congruent behaviors and improve culturally responsive services. The plan that results from that assessment, which has 47 items, should address all diverse groups that are served within the agency: for example, cultural, ethnic and linguistically diverse people, individuals who are deaf and hard of hearing, Lesbian, Gay, Bisexual, Transgender people, older people; and outline strategies for recruiting, hiring, retaining, and promoting culturally competent, diverse staff members; the use of interpreters or bilingual staff members; staff training, professional development, and education; fostering community involvement; facilities design and operation; development of cultural and diversity appropriate program materials; how to incorporate diverse treatment approaches; and development and implementation of supporting policies and procedures, including reassessment processes.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Proportion of agencies that have three areas identified from their self-assessment included in their Cultural Competence Plans.
Baseline Measurement:	The baseline variable is the number of provider agencies that complete their self-assessments and have a written Cultural Competence Plan containing at least three of the areas needed to enhance cultural competency. The establishment of a baseline is still in process and is expected to be completed in SFY 2020. The MSAC will complete the "Center for Cultural Competency Excellence" designation for agencies.
First-year target/outcome measurement:	Thirty (30) percent of all providers will have written Cultural Competence Plans which include at least three areas identified in their self-assessment. Agencies will apply for "Center for Cultural Competency Excellence" designation.
Second-year target/outcome measurement:	Fifty percent (50%) of all providers will have written Cultural Competence Plans which include at least three areas identified in their self-assessment. Agency "Center for Cultural Competency Excellence" designations will be reviewed and awarded.

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

Data Source:

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

New Data Source*(if needed)*:

Description of Data:

The establishment of written organizational plans for addressing culture and diversity based upon agency self-assessment. The areas covered: Governance, Leadership, and Workforce; Communication and Language Assistance and Engagement, Continuous Improvement, and Accountability. Plans identify a minimum of at least three activities from these areas.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Some agencies have been reluctant to initiate a multicultural plan due to staffing demands, cultural competency misinformation, and fiscal issues. The addition of the diversity consultant and "Center for Cultural Competency Excellence" agency designation may help in this regard.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

Less than 10% of the Division of Mental Health and Addiction Services (DMHAS) behavioral health providers have written Cultural Competence Plans despite the division providing on-going technical assistance, workshops, and training surrounding multicultural issues and the importance of providing cultural competence services. Although the need for cultural competence for DMHAS providers is well established, the integration of cultural competence approaches in most organizations is not yet a reality due to several challenges. The primary barrier surrounding provider development of a cultural competence plans is that it is not an action item for leadership. For example, some organizations have not dedicated time and resources to develop a cultural competence plan. Other providers have assigned team members to work with technical assistance centers who have little interest in developing a cultural competence plan or who are not agency decision-makers. Finally, the advent of Covid-19 has had many providers shifting priorities to combat crisis situations and emergency protocols.

To increase and prioritize the percentage of providers who develop cultural competence plans, DMHAS will provide specific workshops addressing leadership responsibility in creating an agency culture where diversity is valued and not dismissed. In addition, DMHAS proposes contract requirements and corrective action steps for those providers who have yet to complete cultural competence plans.

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

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

C. State Agency Expenditure Reports

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

Reporting Period Start Date: 7/1/2019 Reporting Period End Date: 6/30/2020

Statewide Expenditures for Children's Mental Health Services			
Actual SFY 1994	**Actual SFY 2019**	**Estimated/Actual SFY 2020**	**Expense Type**
$20,612,000	$162,877,405	$162,877,405	○ Actual ◉ Estimated

If estimated expenditures are provided, please indicate when actual expenditure data will be submitted to SAMHSA: **1/31/2021**

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

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

SMHA fiscal office is waiting for data from various departments to submit SFY20 data. Once we have SFY20 data, we will be able to submit most current and up to date data.

C. State Agency Expenditure Reports

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

Reporting Period Start Date: 07/01/2019 Reporting Period End Date: 06/30/2020

Period (A)	Expenditures (B)	B1(2018) + B2(2019) 2 (C)
SFY 2018 (1)	$476,496,393	
SFY 2019 (2)	$467,306,902	$471,901,648
SFY 2020 (3)	$472,253,305	

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

SFY 2018	Yes	X	No	
SFY 2019	Yes	X	No	
SFY 2020	Yes		No	X

If estimated expenditures are provided, please indicate when actual expenditure data will be submitted to SAMHSA: **1/31/2021**

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Footnotes: