New Jersey

UNIFORM APPLICATION
FY 2016/2017 - STATE BEHAVORIAL HEALTH ASSESSMENT AND PLAN

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 06/30/2018
(generated on 11/10/2015 12.28.06 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

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

State Information

State Information

Plan Year

Start Year 2016

End Year 2017

State SAPT DUNS Number

Number 806418257

Expiration Date

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

Agency Name Division of Mental Health and Addiction Services

Organizational Unit

Mailing Address 222 South Warren Street, PO Box 700

City Trenton

Zip Code 08625-0700

II. Contact Person for the SAPT Grantee of the Block Grant

First Name Suzanne

Last Name Borys

Agency Name Division of Mental Health and Addiction Services

Mailing Address 222 South Warren Street, PO Box 700

City Trenton

Zip Code 08625-0700

Telephone 609-984-4050

Fax 609-341-2317

Email Address Suzanne.Borys@dhs.state.nj.us

State CMHS DUNS Number

Number 80-641-825

Expiration Date

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

Agency Name New Jersey Division of Mental Health and Addiction Services

Organizational Unit Office of Olmstead, Compliance, Planning and Evaluation

Mailing Address 222 South Warren Street, PO Box 700

City Trenton

Zip Code 08625-0700

II. Contact Person for the CMHS Grantee of the Block Grant

First Name Donna

Last Name Migliorino

Agency Name New Jersey Division of Mental Health and Addiction Services

Mailing Address 222 South Warren Street, PO Box 700

City	Trenton
Zip Code	08625-0700
Telephone	609-777-0669
Fax	609-341-2319
Email Address	Donna.Migliorino@dhs.state.nj.us

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

From	
To	

IV. Date Submitted

Submission Date	8/31/2015 2:34:42 PM
Revision Date	11/10/2015 12:27:00 PM

V. Contact Person Responsible for Application Submission

First Name	Helen
Last Name	Staton
Telephone	609-633-8781
Fax	609-341-2317
Email Address	helen.staton@dhs.state.nj.us

Footnotes:

Children's Mental Health Planner – Geri Dietrich, Phone 609-888-7191, Fax 609-292-3743, Email Geri.Dietrich@dcf.state.nj.us
National Treatment Network Representative – Vicki Fresolone, Phone 609-777-0750, Fax 609-341-2312, Email Vicki.Fresolone@dhs.state.nj.us
National Prevention Network Representative – Donald Hallcom, Phone 609-984-4049, Fax 609-341-2315, Email Donald.Hallcom@dhs.state.nj.us

State Information

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

Fiscal Year 2016

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
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Section 1953	Continuation of Certain Programs	42 USC § 300x-63
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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

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

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

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

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

Signature of CEO or Designee[1]: _____

Title: Assistant Commissioner

Date Signed: _____

mm/dd/yyyy

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

Footnotes:

State Information

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Fiscal Year 2016

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

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

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

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

Signature of CEO or Designee[1]: Valerie L. Mielke

Title: Assistant Commissioner

Date Signed: August 28, 2015
mm/dd/yyyy

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

Footnotes:

State of New Jersey
OFFICE OF THE GOVERNOR
PO BOX 001
TRENTON, NJ 08625-0001

CHRIS CHRISTIE
Governor

August 17, 2015

Pamela S. Hyde, Administrator
Substance Abuse and Mental
Health Services Administration
1 Choke Cherry Road
Rockville, MD 20857

Dear Ms. Hyde:

As the Governor of the State of New Jersey, for the duration of my tenure, I delegate signatory authority to the Assistant Commissioner for the Division of Mental Health and Addiction Services within the New Jersey Department of Human Services, for all transactions required to administer the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment (SAPT) Block Grant, Mental Health Block Grant (MHBG) and Projects for Assistance in Transition from Homelessness (PATH) grant.

Sincerely,

Chris Christie
Governor

c: Virginia Simmons, SAMHSA
Elizabeth Connolly, Acting Commissioner, DHS
Valerie Mielke, Assistant Commissioner, DMHAS

State Information

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

Fiscal Year 2016

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Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
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2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
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7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

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

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

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

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

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

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

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

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

Signature of CEO or Designee[1]: _____

Title: Assistant Commissioner

Date Signed: _____

mm/dd/yyyy

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

Footnotes:

State Information

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

Fiscal Year 2016

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
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New Jersey

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

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

Signature of CEO or Designee[1]: Valerie L. Mielke

Title: Assistant Commissioner

Date Signed: August 28, 2015
mm/dd/yyyy

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

Footnotes:

New Jersey Page 9 of 9

State of New Jersey
OFFICE OF THE GOVERNOR
PO BOX 001
TRENTON, NJ 08625-0001

CHRIS CHRISTIE
Governor

August 17, 2015

Pamela S. Hyde, Administrator
Substance Abuse and Mental
Health Services Administration
1 Choke Cherry Road
Rockville, MD 20857

Dear Ms. Hyde:

As the Governor of the State of New Jersey, for the duration of my tenure, I delegate signatory authority to the Assistant Commissioner for the Division of Mental Health and Addiction Services within the New Jersey Department of Human Services, for all transactions required to administer the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment (SAPT) Block Grant, Mental Health Block Grant (MHBG) and Projects for Assistance in Transition from Homelessness (PATH) grant.

Sincerely,

Chris Christie
Governor

c: Virginia Simmons, SAMHSA
Elizabeth Connolly, Acting Commissioner, DHS
Valerie Mielke, Assistant Commissioner, DMHAS

State Information

Disclosure of Lobbying Activities

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

Standard Form LLL (click here)

Name	
Title	
Organization	

Signature: _____ Date: _____

Footnotes:

This form is not applicable to the Division of Mental Health and Addiction Services.

Planning Steps

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

Narrative Question:

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

Footnotes:

Planning Step 1: Assess the Strengths and Needs of the Service System to Address the Specific Populations

I. Organization of the Public Behavioral Health System at the State and Local Levels

New Jersey manages the public behavioral health system separately for adult and children services. The adult and children's mental health systems were separated in 2006 for those programs that served children only. The Children's Crisis Intervention Services (CCIS) and blended mental health programs (serving both children and adults) are still under the purview of DMHAS. The substance abuse programs that serve children under 18 years were transferred in July 2013 and children in the South Jersey Initiative were transferred in December 2013. Specifically, the adult behavioral health system falls within the Department of Human Services (DHS) Division of Mental Health and Addiction Services (DMHAS) while the children's system is within the Department of Children and Families (DCF) Children's System of Care (CSOC).

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

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

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

On July 11, 2006, legislation was signed creating the New Jersey Department of Children and Families (DCF), the state's first Cabinet-level department focused solely on child and family well-being. All services provided by the DHS Office of Children Services were transferred to the DCF. The new Department included DYFS, DCBHS, DPCP, the Office of Education and the New Jersey Child Welfare Training Academy.

On June 29, 2012, Governor Chris Christie signed a bill that further reorganized DCF into a single point of entry for all families with children, youth and young adults with developmental disabilities and/or substance abuse disorders. This realignment of services is intended to remove barriers to accessibility, provide more complete care through all service offerings, and improve

efficiency for those families served by DCF throughout the state. The transition of these services to DCF's CSOC from DHS began January 1, 2013. The bill also established and renamed four divisions within DCF. The former DYFS is now known as the Division of Child Protection and Permanency (DCP&P). This Division is the state's child welfare agency and is responsible for child protection services for New Jersey youth. The former DCBHS is now the CSOC and continues to coordinate the state mental health plan for children, youth and young adults; provide support and assistance to child welfare youth who need to access intensive or multiple mental health services; allocate state and federal resources for mental health programs; promulgate standards for services; and is now responsible for the provision of services for children, youth and young adults with developmental disabilities as well as substance abuse disorders. The former DPCP is now the Division of Family and Community Partnerships. The Division on Women has been transferred to DCF from the Department of Community Affairs. Additionally, the Office of Education and the New Jersey Child Welfare Training Academy remain under the auspices of DCF.

II. Overview of the Public Behavioral Health System

Substance Abuse Services

DMHAS is the Single State Authority (SSA) for substance abuse in New Jersey. Between the Substance Abuse Prevention and Treatment (SAPT) Block Grant and other federal and state resources, in FFY 2014 and 2015, the SSA funds: a) 17 community-based prevention coalitions for the provision of prevention programs with a focus on environmental strategies, b) over 60 community-based prevention providers that offer a variety of evidence-based curricula for children, adolescents, older adults, and families, c) two state institutions of higher education that provide early intervention services: Rutgers University and The College of New Jersey, d) a Federally Qualified Health Center (FQHC) for delivery of Screening, Brief Intervention, and Referral to Treatment (SBIRT) in two emergency departments, e) three intensive supported housing programs, f) a 24-hour Addictions Hotline, g) two non-profit corporations for the operation of recovery support centers, Recovery Center at Eva's Village and Living Proof Recovery Center, h) tobacco cessation services, h) an addictions workforce training and development initiative, and i) 21 county governments for the provision of services throughout the continuum of care. As of April 2015, there were 315 licensed outpatient providers and 67 licensed residential delivering substance abuse treatment services.

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

motivational interviewing and American Society for Addiction Medicine Patient Placement Criteria, 2nd Revised Edition (ASAM PPC-2R).

The SSA provides services across the continuum of care, which includes prevention, early intervention, treatment and recovery support. Within its treatment continuum levels of care range from detoxification, outpatient, intensive outpatient, residential (short-term, long-term, halfway house), partial hospitalization and opioid maintenance.

In Calendar Year 2014, there were 65,553 substance abuse treatment admissions and 62,525 discharges reported to the SSA through its New Jersey Substance Abuse Monitoring System (NJSAMS). Of these admissions, 46,441 were unduplicated. For primary drug at admission, 49% reported heroin and other opiates and 27% reported alcohol. Methadone was planned to be used in treatment for 13% and Suboxone for 5% of the clients. Most admissions were to outpatient care (22%), followed by intensive outpatient care (23%). Regarding age, 3% were under 18 years old, 8% were 18-21 years old, 31% were 22-29 years old, 53% were 30 to 54 years old and 6% were over 55 years old. For race/ethnicity, 61% were white, 22% were black and 15% were of Hispanic origin. Most clients did not have insurance at admission (66%).

The SSA's primary population served are the indigent in need of substance use disorder treatment. Priority is given to special target groups: IVDU, pregnant women and women with dependent children, and individuals with/or at risk of HIV or TB. Other special target groups include individuals with: co-occurring mental illness; homeless; deaf, hard of hearing or disabled; criminal justice; older adults; GLBTQ; military, and intoxicated drivers.

Mental Health Services

DMHAS is the state mental health authority (SMHA) that oversees the state's public system of adult mental health services. The SMHA operates three non-forensic, regionally-based, adult psychiatric hospitals, one adult forensic hospital, and contracts with approximately 120 not-for-profit community provider agencies. In addition to its network of state psychiatric hospitals and contracted community providers, four county-operated psychiatric facilities (Bergen Regional Medical Center, Essex County Hospital Center, Meadowview Hospital, and Runnells Specialized Hospital) all function as part of the continuum of services and receive most of their funding from the SMHA.

New Jersey's 21 counties are organized into three mental health service regions; North, Central, and South. Each county has a Mental Health Board that is staffed by a Mental Health Administrator. The Boards advise the SMHA and the Behavioral Health Planning Council of issues and programs that are of significance to their locale and residents. In each county, System's Review Committee (SRC) is convened monthly in accordance with state regulation (NJAC10:31-5.3(a)). The SRC is comprised of representatives from the acute care community and include staff from: state and county hospitals, short-term care facilities (inpatient units serving individuals on commitment status), voluntary psychiatric inpatient units, the county Mental Health Board, family and consumer organizations and the SMHA. The SRC is charged with the collection and review of service data as well as monitoring the provision of acute care services statewide. In addition, each county has at least one Designated Screening Center with

mobile outreach and 24-hour access. The county-based Designated Screening Centers generally determine who meets the commitment standard and requires inpatient treatment.

The community mental health system of services provides for three levels of care in each county: (1) acute care programs and crisis stabilization; (2) intermediate care and rehabilitation; and (3) extended/ongoing support programs. The SMHA contracts for statewide, regional and county/local behavioral health services. Statewide contracted services include services for specialty populations such as: Statewide Clinical Consultation and Training (SCCAT*)* program which provides consultation and training to our hospital and community provider community regarding individuals dually diagnosed with a mental illness and developmental disability; Statewide Clinical Outreach Program for the Elderly (S-COPE) which provides consultation and training to nursing facilities and DMHAS residential providers who serve older adults (55 years of age and older) who are at risk of psychiatric hospitalization; *ACCESS* which provides consultation, residential, outpatient and case management services to individuals who are deaf or hard of hearing and diagnosed with a mental illness. Additional statewide contract services include contracts to provide training and technical assistance to specialized segments of the provider workforce and statewide depositories of behavioral health resource information and self-help information. The SMHA contracts for regional services including: Mental Health Cultural Competence Training Centers to provide training and information to providers regarding cultural competence, co-occurring inpatient services for individuals with substance use disorders and a mental illness, and housing for specialty populations.

According to its 2014 URS Data Table 3, & 14a, the SMHA served 323,501 unduplicated adult (age 18≤) consumers. Of these, 303,165 (93.71)% were served in community settings—including county hospitals and STCFs; 3,903 (1.21%) were served in State Psychiatric Hospitals, and 16,433 (5.08%) were served in other psychiatric inpatient settings. Of the total number of unduplicated adults (323,501) served in all settings by the SMHA in SFY 2014, 125,773 (38.88%) were reported to have SMI. Although complete FY 2015 QCMR data is unavailable at the time of writing, the projected number of unduplicated consumers estimated[1] to be served in community settings in SFY 2015 (spanning the time period from July 1, 2014 to June 30, 2015) is 327,604.

Persons who are SMI are the primary target population for SMHA funded services. However, the SMHA also prioritizes services to persons with special access needs, including older adults, ethnic and linguistic minorities, and individuals with co-occurring mental health and substance abuse disorders, hearing impairment, developmental disabilities, and criminal justice involvement. Many of the activities of the SMHA focus on inter-organizational coordination and collaboration to improve access by special needs populations. This is achieved through interface with the various Divisions within the DHS including the Division of Developmental Disabilities, Division of Aging Services, Division of Deaf and Hard of Hearing, Division of Family Development (Welfare), and Division of Medical Assistance and Health Services (Medicaid). In addition, there is coordination with the DCF DCP&P, Department of Health, Department of

[1] To approximate the 4th Quarter of QCMR data not yet submitted at the time of writing, this estimate is based on: the beginning annual caseload at the start of SFY 2015, plus new admissions & transfers during quarters 1 – 3, plus the average number of new admissions & transfers in quarters 1 – 3. The resulting sum is the estimated number of unduplicated consumers served in SFY 2015.

Community Affairs (housing/homeless) and the New Jersey Housing and Mortgage Financing Agency (NJMHFA). There is also coordination with the Division of Vocational Rehabilitation Services (DVRS) within the Department of Labor, and with the Department of Corrections.

Children's Behavioral Health Services

The New Jersey Department of Children and Families – Children's System of Care (CSOC) is responsible for overseeing the public system of providers who serve children with emotional and behavioral health care challenges, children under the age of 21 with developmental disabilities and youth up to age 18 with substance use challenges.

III. Description of the Organization of the Public Behavioral Health System at the State and Local Levels

State Government

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

The SMHA supports adult services in the following capacities: (1) direct service provider; (2) purchaser of services; (3) regulator of standards and services; (4) coordinator for immediate mental health disaster response; and (5) systems planner. In executing these functions, the SMHA must ensure continuity of care and coordination of services within the state and between the public and private sectors. In order to do so, the SMHA must provide leadership in the: (1) interface between the state and county psychiatric hospitals and community providers; (2) establishment and participation in key advisory boards and committees whose missions impact upon the delivery of mental health care and treatment; (3) promotion of effective communication internally as well as in the broader mental health and human services communities; (4) advocacy of the needs of the mental health community at the state and federal levels; and (5) initiation of planning activities with input from key constituents and interested parties, that address the changing needs of New Jersey's residents.

County Government

In New Jersey, county governments also play an important part in the overall functioning of the public behavioral health system. Since 1983, a portion of the proceeds of the state's alcoholic beverages tax has been dedicated to the production and implementation of county comprehensive plans in all 21 counties. The plans correlate county resources to the needs of individuals with

alcohol and drug use disorders. Originally, the scope of these plans was limited to the needs of individuals with an alcohol use disorder. In 1989, both the scope of the county plans and corresponding financial resources for which the counties were made responsible expanded to include the needs of individuals with drug use disorder. Additionally, in the same year, a governor's advisory council was established to coordinate the actions of all departments and divisions of state government with regard to substance abuse and to oversee locally-driven prevention efforts by municipal alliances.

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

The SSA also launched an education, training, and technical assistance (ETTA) initiative for county planners in conjunction with the continuing education department of Rutgers, The State University of New Jersey. Planners who successfully completed the program earned a Certificate in Community-Based Planning issued by the Rutgers School of Social Work. The program was initially offered to County Alcohol and Drug Directors, then to County Mental Health Administrators and eventually to DMHAS staff responsible for monitoring substance abuse agencies. An evaluation of the ETTA program is planned during FY2016 to determine if the needs of the participants were met and if the County Plans that will be received have in fact improved as a result of this program.

The SSA's current county planning activities focus on the four-year period from 2016 to 2019. As federal and state governments implement the Affordable Care Act and New Jersey implements its Medicaid Waiver (1115) establishing a managed behavioral health care organization, counties will provide the state with a critically-important monitoring and feedback function "on the ground," as well as develop investment proposals for early intervention and recovery support services that remain the least well developed segments of the continuum of care. Additionally, the county plans will direct greater attention than ever before to the problems of citizens dually afflicted with both substance use and mental health disorders. Thus, the county Mental Health Administrators were invited to participate in the community-based planning certificate program and the comprehensive planning process with the hope that, over time, both the substance abuse and mental health planning processes and products will integrate under a single county comprehensive, behavioral health plan.

New Jersey's 21 counties are organized into three mental health service regions; north, central, and south. Each county has a mental health board that is staffed by a mental health administrator. The boards advise the SMHA and the Behavioral Health Planning Council of issues and programs that are of significance to their locale and residents. A Mental Health Administrator representative is a member of the Behavioral Health Planning Council.

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

Department of Human Services, Division of Medical Assistance and Health Services (DMAHS). The SMHA and DMAHS collaborated to implement a prior authorization process for community partial care that began on July 1, 2009. As a result, both the SMHA and DMAHS have realized both cost savings from this initiative as well as the first step in transforming the long-term day program into one that is more recovery oriented, shorter term, focusing on rehabilitation and attaining community integration and inclusion goals.

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

The DMHAS and DMAHS are collaborating on several initiatives that are part of the New Jersey approved Medicaid Comprehensive Waiver. These include: transitioning of services for consumers with the dual diagnosis of Intellectual/Developmental Disorders and Managed Long Term Services and Supports (MLTSS) and the development of Behavioral Health Home (BHH) Services.

The Behavioral Health Home initiative is being developed jointly by DMHAS, DMAHS (Medicaid), and the NJ Department of Children and Families with all partners having responsibilities for implementation of the service(s) upon approval by CMS of any and all submitted State Plan Amendments (SPAs). Two counties, Bergen and Mercer, are preparing to offer behavioral health home services to individuals with a serious mental illness, with SPAs having been approved for both counties and a 3rd SPA being submitted. The agencies certified to provide services in Mercer County include Greater Trenton Behavioral Health Care, Catholic Charities, and All Access for Mental Health. In Bergen County, CarePlus NJ is certified to provide services with Comprehensive Behavioral Health Care and Vantage Health System anticipating achieving certification very soon. Plans to expand the initiative continue, with three additional counties being targeted to offer BHH services in the very near future. Exploration into a health home for individuals with a substance use disorder is underway as DMHAS considers avenues to link services to those individuals in need.

Behavioral health services for MLTSS participants will be carved in to the Managed Care Organizations (MCOs). The DMHAS is working with DMAHS and the Division on Aging Services (DoAS) to continue to develop and coordinate the behavioral health requirements for MLTSS.

In collaboration with Medicaid, the SMHA initiated work on a disease management program with the goal of educating physicians in the Best Practices of prescribing medications to mental health consumers. The SMHA launched this as a pilot program with Medicaid and the Department of Health (DOH) to coordinate and provide primary medical care services between a

community mental health program and a federally qualified health center (FQHC), thus meeting a consumer's mental health care needs in a primary health care facility (the FQHC). The pilot phase has ended, and due to its success, this program continues on its own without DMHAS funding. This program (Greater Trenton) is still operating as described, and is now one of four mental health agencies that are being funded by a SAMHSA Primary and Behavioral Health Care Integration Grant to coordinate with FQHCs for primary care services. The grant has consumers being medically screened and referred to the local FQHC by a nurse care manager situated at the mental health agency. This is combined with wellness activities in the mental health program. DMHAS is working with DOH to support co-location of behavioral health services (SUD and mental health) at FQHCs to further promote integration efforts.

On 11/20/14, NJ's office within Medicaid responsible for eligibility determinations provided training to the state hospitals' Supervisors of Patient Accounts (SPAs) and Social Service staff responsible for assisting with Community Care Waiver Medicaid applications. In addition, a Medicaid Tracking grid was established to monitor the status of pending Medicaid applications. Both the training and weekly monitoring of the Medicaid Tracking grid have resulted in improved communication and ability to resolve systems in a timely manner and a decrease in the number of pending referrals. Prior to the training and weekly communication, Medicaid applications were taking 90 days or more to be approved for eligibility. The current time frame for approval is consistently less than 90 days, except for cases that have complicating factors. The Division is also collaborating with a representative from Medicaid to develop a contact list identifying a person in each County that will handle Medicaid applications from the State Hospitals. DFD will commence training BH providers in the fall and certifying them to be able to determine individuals as presumptively eligible for Medicaid.

Department of Human Services, Division of Developmental Disabilities (DDD). SMHA staff collaborates with DDD staff regarding discharge planning of dually diagnosed consumers with both intellectual developmental disabilities and mental illness (DD/MI) in the state psychiatric hospitals. Staff from DDD are also members of the Behavioral Health Planning Council. As a result of this collaboration, SMHA and DDD staff has developed an RFP process to promote the development of community-based supportive housing opportunities and other support services for DDD service eligible patients residing in our state hospitals. The Division plans to utilize this RFP process to develop the resources to facilitate the discharge of 20 DD/MI consumers from the state hospital system during this calendar year. The DD/MI consumers for this initiative will be jointly chosen by SMHA and DDD staff. DDD has also hired 3 full time Transitional Case Managers (TCMs) that are stationed at each respective state hospital. The DDD TCMs will have their sole or primary responsibilities at the state hospitals focusing on the state hospital DDD population, the DDD referrals and working with hospital staff to address any discharge barriers that may be present. Joint DDD and State Hospital meetings occur at each hospital on a monthly basis to discuss discharge planning and address any systems issues.

Department of Children and Families. Interdivisional and interdepartmental collaboration between DMHAS and the DCF CSOC is frequent. Executive Staff from each Division have collaborated to make system recommendations for youth with mental illness and/or substance use challenges and families currently served in the CSOC whose youth are emerging adults. Recommendations were made in the form of policies, procedures and protocols that will ensure a

seamless transition of youth and their families to all adult mental health services. In addition, several staff from CSOC attend monthly Behavioral Health Planning Council meetings to better coordinate services.

Treatment for parents with substance use disorders is currently addressed via a Memorandum of Understanding between the SSA and DCF Division of Child Protection & Permanency (DCP&P). The SSA coordinates its efforts with those of DCF to provide more effective and far-reaching services while minimizing unnecessary service duplication. As part of the Child Welfare Reform, the DCF will continue to provide funding to the SSA to support an initiative for gender specific treatment with specialized services in all modalities of care to women with dependent children and parents who are at risk of losing custody of their young children due to the abuse or neglect of these children resulting from, or aggravated by their substance abuse.

DMHAS Medical Director's Integration Office. The SMHA Medical Director's Office has an Integration Office that is promoting integration between behavioral health agencies and primary health care providers. This office is working closely with the state Medicaid Office (Division of Medical Assistance and Health Services, or DMHAS) and DCF. The main goal of the initiative is to increase access to primary care and improve collaboration between behavioral health agencies and primary health care providers. Health homes are considered the first step of a plan to integrate behavioral health and physical health services within the three systems. DMHAS, DMAHS, and DCF worked with CMS and their technical advisor, CHCS, on developing a state plan amendment (SPA) to incorporate health home services in the targeted counties. As of August 17, 2015, NJ has an approved health home SPA for both Bergen County and Mercer County for children and adults. Expansion has been planned for health home services in three additional counties beginning with the enrollment of interested providers in a second learning community cohort in Atlantic, Cape May, and Monmouth Counties. DMHAS, DMAHS, and DCF continue to work together to build volume within the established target areas, develop a more robust provider network, and further expand the capacity of the program as a whole throughout the state.

New Jersey was fortunate to have four agencies in four different counties who were awarded PBHCI grants through SAMHSA. The goal of the PBHCI grant is to introduce physical health care in to behavioral health settings. Each of the NJ grantees is in different phases of implementation, with two having already completed the four year cycle. The counties where the two grantees who have completed the SAMHSA grant cycle provide services are the initial counties in the health home project.

In addition to the health home project, DMHAS and DMAHS have partnered to expand integrated care throughout the adult system. In January of 2015, both agencies were awarded a joint grant from the National Academy of State Health Policy (NASHP) to further expand integration projects. Currently that team is working on the development of a model that will integrate behavioral health care into a primary care setting.

DMHAS has also partnered with DMAHS and Rutgers-University Behavioral Health Care (UBHC) to implement an Interim Managing Entity (IME) to allow a single point of entry into substance abuse treatment throughout the state. The IME launched the first phase of the project

on 7/1/15. The IME will coordinate the necessary care of an individual and insure it is delivered at the appropriate level for the applicable time required. This allows NJ to manage its resources across the continuum of care.

Lastly, DMHAS has launched a multiagency Suicide Advisory Council to aid in the prevention of suicide within all demographics. This initiative has partnered with a number of state agencies, including the Department of Health.

New Jersey Judiciary, Administrative Office of the Courts. A Memorandum of Agreement (MOA) with the Administrative Office of the Courts (AOC) will be maintained to fund a full continuum of treatment services for Drug Court applicants who are deemed legally and clinically eligible for Drug Court. State funding appropriated to the AOC for this purpose will be transferred to the SSA to implement and manage the statewide network of treatment services in coordination with the AOC and participating Superior Court vicinages. Enhanced services will be maintained as funding permits, including: medication, psychiatric/psychological evaluations, medication monitoring, physical exams, transportation, counselor appearances, partial care, co-occurring integrated services, methadone, and methadone intensive outpatient services.

New Jersey State Parole Board and the Department of Corrections. A Memorandum of Agreement (MOA) will be maintained between the New Jersey State Parole Board (NJSPB) and the SSA to purchase, within a fee-for-service (FFS) network, community-based substance use disorder treatment for NJSPB parolees under the Mutual Agreement Program (MAP). A similar Memorandum of Agreement (MOA) will be maintained between the New Jersey Department of Corrections (NJDOC) and the SSA to purchase, within a FFS network, community-based long term residential substance use disorder treatment for NJDOC inmates.

Department of Education. The SSA will continue to coordinate with the Department of Education (DOE) to develop school health goals and priorities. The primary focus of this interdepartmental group will be to reduce risky behaviors and promote adoption of health enhancing behaviors. Additionally, the SSA will continue to collaborate with the DOE in identifying and creating survey instruments that can be jointly used to collect data required by both entities, and to coordinate schedules for administering student surveys so as to minimize duplication of data collection efforts.

DMHAS is also participating in a new initiative from DOE involving the development of a Social and Emotional Learning (SEL) curriculum. The mission of the group is to support the NJ DOE in ensuring that all children, regardless of life circumstances, graduate from high school ready for college and career by improving school climate and increasing overall academic achievement. The group will determine practices reflect current research to produce desired social and emotional learning outcomes including, knowledge, responsibility, care and social awareness, and propose sustainable social emotional learning standards that can be implemented with fidelity.

State Police. In 2014, the Regional Operations Intelligence Center operated by the New Jersey State Police created the Drug Monitoring Initiative (DMI), to address the epidemic of the pervasive use of heroin, opiates, and the violent crimes and burglaries that are directly correlated

to this nationwide crisis. The DMI is a cutting-edge program with a robust multi-state drug intelligence capability that collects and analyzes law enforcement and healthcare data in order to help law enforcement and public healthcare experts develop strategies to combat drug activity in their jurisdictions. Some highlights of the initiative are:

- The incorporation of public health into the drug monitoring intelligence cycle
- The ability to coordinate the collection, analysis, and mapping of drug incidents statewide
- The expedited analysis of seized drugs to better direct investigators and health resources
- Training law enforcement, fire service, and emergency medical service personnel statewide

DMHAS and the DMI are active and committed partners in substance abuse prevention throughout New Jersey. Representatives from the DMI participate in activities of the State Epidemiological Outcomes Workgroup (SEOW) and DMHAS and the DMI frequently share data and other resources.

Core Opioid Work Group. DMHAS convenes and facilitates a monthly Core Opioid Workgroup meeting with the Department of Health, Department of Children and Families, Attorney General's Office, New Jersey State Police, Juvenile Justice Commission, Division of Medical Assistance and Health Services and the Governor's Council on Alcohol and Drug Abuse whose mission is to work on a comprehensive strategic approach to the opioid epidemic.

Opioid Study Team. DMHAS participates on an Opioid Data Study Team with the Department of Health. The purpose of the team is to identify, use and build upon existing data related to opioid use and misuse. The New Jersey Opioid Study Team is in the process of developing Prevention Pathways, which mirrors the New Jersey State Police – Regional Operations Intelligence Center's Journey to Crime surveillance system. Journey to Crime drug arrest data and points of origination are plotted on state maps to geographically demonstrate heavily traveled routes (often, from suburban areas to the inner city) for the purpose of buying and using illicit drugs. The Opioid Study Team will use these mappings to help prioritize where state resources should be allocated to implement educational and interventional Prevention Pathways.

V. Description of Regional, County and Local Entities that Provide Behavioral Health Services

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

Likewise, the SSA is centralized and awards funding to 228 substance use disorder treatment agencies that provide a continuum of treatment. It provides funding to 30 substance use disorder

prevention agencies. It also provides awards to the 21 County Governments. The counties in turn, sub-contract to providers for additional services needed in their respective counties.

County Resources. Chapter 51 of the Laws of 1989, C.26:2BB-12 et seq, amended an act of 1983 that established the "Alcohol, Education, Rehabilitation and Enforcement Fund" (AEREF). The AEREF is a non-lapsing, revolving trust fund into which $11 million are deposited annually from a tax on the sale of alcoholic beverages. Approximately $9 million from the AEREF plus an additional $6.9 million in supplemental funds from the state treasury are distributed per statutory formula to the counties each year, for a total of $15.9 million for CY 2015. In order to participate in this county program, each county must develop a plan to deliver comprehensive addiction services across the full continuum of care, including prevention, early intervention, treatment and recovery support, based on a county-sponsored, community-based needs assessment and planning process. Under this program, counties must match 25% of their respective annual AEREF allocation with a contribution of county revenues. The funds support county-wide needs assessment, planning, coordination and provision of the full range of addiction services for indigent adult and adolescent county residents. The Office of Planning, Research, Evaluation and Prevention is responsible for overseeing the county planning.

The SSA collaborates with the 21 counties of New Jersey in a joint state and county comprehensive behavioral health planning process intended to: 1) coordinate system development and service delivery at state and local levels, and 2) unify community-based planning for prevention and treatment. As established by statute, a key component of the county comprehensive planning system is the County Local Advisory Committee on Alcoholism and Drug Abuse (LACADA), an independent citizen's advisory group. The LACADAs are required to develop and present to their county boards of freeholders a County Comprehensive Plan (CCP) for adoption. The LACADAs are also required to establish a County Alliance Steering Subcommittee (CASS), which is the county-level planning body for each county's Municipal Alliance (MA) that stems from the Governor's Council on Alcoholism and Drug Abuse (GCADA). The MAs are coalitions of municipal level residents and other stakeholders who volunteer to conduct data analysis and prevention service inventories as the basis for adopting a set of local prevention priorities and recommending these to the LACADAs. Through the CASS, the MA plans are coordinated with the LACADA's CCP through a process known as "Unification Planning." Beginning in FFY 2012 and continuing with the 2016-2019 cycle of Unification Planning, the SSA, in collaboration with the GCADA, intends to: 1) help counties identify and implement a greater number of evidence-based prevention programs, 2) support counties to establish environmental approaches to prevention planning at the county and municipal levels, and 3) encourage counties to develop and operationalize community-based and culturally appropriate recovery support systems of care. The plan will also provide direction in the development of future prevention funding opportunities made available by the SSA over the next four years.

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

Substance Abuse Services

Prevention

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

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

Employing the five-step Strategic Prevention Framework (SPF) developed by SAMHSA's Center for Substance Abuse Prevention (CSAP) as well as DMHAS' Addiction Prevention Strategic Planning, the SSA plans prevention and early intervention services in the state, awards funding to providers through RFPs and funds 17 regional prevention coalitions as well as more than 60 community-based programs that offer a variety of evidence-based curricula for children, adolescents, older adults, and families to reduce substance abuse related problems in the communities they serve. The SSA monitors contracts, provides on-going technical assistance to contracted provider agencies, and oversees outcome evaluations for each program. All DMHAS-funded coalitions and programs focus their efforts on addressing the prevention priorities identified in the Prevention Strategic Plan:

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

Additionally, as a result of Partnerships for Success (PFS) funding from CSAP that was awarded effective in 2013, regional coalitions utilize resources to address tobacco prevention. Coalitions also use PFS funds for services to older adults and returning veterans, when warranted.

Strategic Prevention Framework State Incentive Grant (SPF-SIG). Using Strategic Prevention Framework – State Incentive Grant funding, which was awarded in 2006, the SSA identified eleven communities that adopted and implemented the SPF to deliver and sustain effective substance abuse prevention and mental health promotion programs in their communities by institutionalizing a data-driven planning process to decrease both underage drinking and the harmful consequences of alcohol and drug use among 18 to 25 year olds at the community level. The New Jersey SPF is a public health, outcomes-based prevention approach that uses data to drive prevention decision-making. The goals and objectives of the New Jersey SPF continue to be achieved through strong collaborations among state, community, and academic partners, who work together to implement the New Jersey SPF, and develop and maintain prevention expertise and infrastructure throughout New Jersey.

Services to Families of Military Veterans. Working with the New Jersey National Guard Family Program and its eight Family Assistance Centers based at armories around the state, the SSA funds the New Jersey Prevention Network to provide programs to serve returning military

personnel and their families through two evidence-based programs, Coping with Work and Family Stress and the Strengthening Families Program. Both programs are designed to enhance protective factors to support military members and their families in making responsible parenting and individual choices in regards to drug and alcohol use.

Services to Gay, Lesbian, Bisexual, Transgendered and Questioning Youth. According to a study by University of Pittsburgh researchers published in the April 2008 issue of *Addiction*[2].the likelihood of substance use by gay, lesbian bisexual, transgendered and questioning (GLBTQ) youth are on average 190 percent higher than for heterosexual youth, The SSA funds the North Jersey Community Research Initiative to continue and expand their existing programs for high-risk GLBTQ youth of color by adapting a prevention model developed by the Centers for Disease Control and Prevention, early intervention services, social marketing, and structured recreational activities. A CSAP-sponsored evaluation of the program determined that the program was effective in reducing rates of substance use among participants and that participants were highly satisfied with the services that were provided.

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

In addition to serving these high-need communities, New Jersey utilized SPE funding to make numerous enhancements to its prevention infrastructure by: addressing gaps in data regarding older adults and binge drinking rates among young adult women of child bearing age (21-29 years), expanding the capacity of the Prevention Outcomes Monitoring System (POMS - DMHAS' prevention management information system), and to collect data on environmental strategies and programs. Additionally, DMHAS was able to update its *Chartbooks of Social and Health Indicators*, the information in which can be used to identify health problems directly or indirectly related to substance use and to aid in the assessment of needs for prevention and treatment services. Funding was also used to create a database of all prevention services and programs delivered throughout the State.

The training and services that DMHAS provided to high-need communities as well as the enhancements to its prevention infrastructure better enables New Jersey to support more strategic, comprehensive systems of community-oriented care and allows us to deliver services

[2] Marshal, Michael P., Friedman, Mark S., Stall, Ron, King, Kevin M., et. al. (2008). Sexual orientation and adolescent substance use: a meta-analysis and methodological review. *Addiction, 103*(4), 546-556.

and programs that are simultaneously consistent in their application throughout the State yet able to identify and address problems and needs on a local level.

Partnership for Success (PFS). In October 2013, DMHAS received a five-year Strategic Prevention Framework - Partnerships for Success (SPF-PFS) cooperative agreement from CSAP. The goals of New Jersey's SPF-PFS initiative are threefold: 1) to strengthen and enhance the work of 17 DMHAS-funded regional prevention coalitions; 2) to further develop the prevention data infrastructure and information systems capacity at the state level; and 3) in collaboration with state partners and community stakeholders, to continue work in developing a unified statewide prevention planning and service delivery system. Specifically, New Jersey's SPF-PFS seeks to 1) reduce underage drinking among persons aged 12 to 20; and 2) reduce prescription drug misuse and abuse among persons aged 12 to 25. As additional components of its PFS programming, New Jersey also focuses on unhealthy drinking patterns and prescription drug abuse among adults age sixty and older; and serves military families with prevention education, addressing military community risk levels, striving to mitigate the risk factors, and enhancing the protective factors to support military members and their families in making responsible parenting and individual choices in regards to drug and alcohol use.

The New Jersey SPF-PFS initiative addresses state-identified priorities at the regional level through the work of 17 DMHAS-funded coalitions that use the Strategic Prevention Framework to identify and address priorities in their region. Coalitions utilize evidence-based environmental programs and strategies to achieve their goals and objectives.

DMHAS also utilizes SPF-PFS funds for numerous prevention infrastructure developments and enhancements, some of which are:

- The NJSAMS is the state's client information system that captures early intervention and treatment information on all individuals who enter substance abuse treatment in New Jersey. In order to capture treatment data related to the mandated priority addressing prescription drug abuse among 18 to 25 year olds and the state added priority to address this among the elderly, modifications will be made to NJSAMS and fields will be added to provide this information.
- New Jersey is taking advantage of emerging technologies to better promote prevention messaging, and has developed a prevention-focused mobile app for iPhone and Android smartphones called "Be the One".
- The first New Jersey Epidemiological Profile of Substance Abuse was published in May 2008. It included a comprehensive array of substance abuse-related components and indicators and is organized around indicators for mortality, morbidity, crime, consumption and other factors. Since then, there has been a new DMHAS Middle School Risk and Protective Factor Survey, New Jersey Household Survey, and Department of Education Student Health Survey of High School Students, and more current administrative data from other governmental agencies. There was a need to update the profile since it is used as a guide for establishing prevention priorities for the state and used by county and municipal staff to guide prevention planning efforts. New data indicators will be added related to depression, suicide, violence, school dropouts and delinquency. The updated Profile will include more indicators related to mental health in order to also support mental health

prevention efforts. This updated Epi Profile also will address one of the most prominent data gaps – substance use and mental health data for older adults.

- New Jersey is focused on returning Veterans as a priority population for its PFS initiative. This is another population for which there is limited information. The SEOW has reached out to New Jersey Department of Military and Veteran's Affairs as well as the New Jersey National Guard to solicit their active participation on the SEOW and Advisory Council in light of this priority. DMHAS is collaborating with our partner at Rutgers University to conduct a survey of returning Veterans and is in the process of finalizing the instrument and fielding the survey.
- An Older Adult Survey was conducted during 2012 utilizing funding from the SPE grant. However, there were insufficient funds for a large enough sample to obtain reliable county level estimates. The goal of the survey for this PFS opportunity is to obtain enough data to create small area estimates of the prevalence of substance abuse and mental illness among older adults in New Jersey. A telephone interview survey will be developed and random digit dialing with a multistage cluster design will be used to generate probability-based samples of the adult population of each New Jersey County or relevant geographic area. Synthetic estimation techniques will then be applied using the results of the survey and other archival data to create small area estimates of the prevalence of substance abuse for the target population in specific geographic areas (e.g., municipality).
- A critical challenge for the 17 regional coalitions, as well as County Drug and Alcohol Directors, and Municipal Alliance Coordinators in New Jersey, has been the lack of available data at very specific and detailed geographic units of analysis (e.g., municipal, census tract, neighborhood, etc.). A social indicator database project was completed under the SPE grant which used a variety of methods to acquire new data and merge information from existing systems to provide a foundation for an integrated data infrastructure. Purposes of this database are: a tool to help identify high need communities; promote data-driven planning; support funding allocation methods based on need; enhance capacity in local communities and strengthen their ability to identify meaningful local indicators; and to help produce community-level epidemiological profiles. PFS funding is being utilized to continue to maintain this database and update it.

Suicide Prevention. New Jersey is committed to join the 43 states in the U.S. who have developed and implemented Adult Suicide Prevention Plans/Initiatives/Strategies. In order to adequately and effectively respond to this national health problem, the Adult Suicide Prevention Plan for New Jersey was developed in 2013 in accordance with and guided by the National Strategy for Suicide Prevention: Goals and Objectives for Action, published by the U.S. Department Of Health And Human Services (2008). In addition, the committee used as guidance and reference, the New Jersey Youth Suicide Prevention Plan and other States' suicide prevention plans.

The plan contains strategies and actions in addition to crisis responses for the specific concerns of adult New Jersey citizens; addressing current N.J. needs and activities and linking up-to-date science for prevention with practical application in the field. The plan and the action steps go beyond organizations and agencies and stress the importance of everyone's contribution to keeping all individuals in the State safe. Although N.J.'s rate of suicide is second lowest in the nation, DMHAS believes that every suicide is unacceptable and can potentially be prevented.

Overwhelming evidence suggests that alcohol and drug abuse are second only to depression and other mood disorders when it comes to risk factors for suicide. In one study, for example, alcohol and drug abuse disorders were associated with a six-fold increase in the risk of suicide attempts. And substance abuse and mental disorders often go hand-in-hand. As such, the plan acknowledges substance abuse as a risk factor for suicide and includes programs, policies, and approaches to address the problem.

In July 2014, DMHAS applied for federal funding for the *Prevent Suicide in New Jersey* project under the Substance Abuse and Mental Health Services Administration's Cooperative Agreements to Implement the National Strategy for Suicide Prevention. The goals of the project were to better identify individuals with suicide risk being served in the targeted settings health care settings, including emergency departments (EDs) and Federally Qualified Health Centers (FQHCs) and to increase accountability and facilitate treatment and follow up by use of a single statewide screening and referral process. The project also sought to increase the use of evidence-based tools for assessment and treatment of at-risk individuals with mental health and co-occurring disorders. Expected outcomes were increased numbers of screenings and referrals in the targeted settings, as well as greater use of empirically based assessment and treatment interventions for suicide risk; and reduced suicide attempts and suicide. The Division was not awarded funding for the project but seeks to apply for future funding opportunities.

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

One mission of the Governor's Council on Alcoholism and Drug Abuse (GCADA) is to reduce addiction stigma as a top priority. Through outreach and education, the Council will send a message that addiction stigma must no longer be tolerated. In 2014, GCADA unveiled the Addiction Doesn't Discriminate campaign, which is dedicated to increasing public awareness of substance abuse issues. The awareness campaign represents a partnership between GCADA and the New Jersey Office of the Attorney General, including its Division of Consumer Affairs, Division of Criminal Justice, Office of the Insurance Fraud Prosecutor, and Division of State Police; the New Jersey DHS and its DMHAS; the U.S. Attorney's Office, District of New Jersey; the New Jersey Department of Education; and the Partnership for a Drug-Free New Jersey.

Drug Free Communities Support Program (DFCSP). New Jersey is home to 22 DFCSP grantees. Additionally, extensive prevention programming and education is provided by other state agencies such as: the Department of Education's Office of Safe and Drug-Free Schools, DCF, the Juvenile Justice Commission, DOH, the Division of Highway Safety, and law enforcement agencies.

Governor's Council on Alcoholism and Drug Abuse (GCADA). The SSA works collaboratively with the GCADA on various addiction prevention related projects, including participation on the

Prevention Unification Planning Process. The Unification Planning process is designed to provide guidance in the identification of prevention priorities and goals. The process was instrumental in the development of the RFP to fund individual and family prevention programming that was issued in early 2014.

Through the Municipal Alliance Program, the GCADA unites New Jersey's communities in a coordinated and comprehensive grass roots prevention effort. Municipal Alliances are local planning and coordinating bodies established in all 21 counties to assess needs, set priorities, develop plans and implement programs that form the foundation of New Jersey's substance abuse prevention activities. New Jersey's Municipal Alliances provide over 3,800 prevention programs statewide. GCADA's Municipal Alliance Program provides 395 grants to 529 municipalities throughout New Jersey, with the majority of grants averaging between $10,000 - $20,000. The primary CSAP strategy utilized by the alliances is education, followed by alternatives, which provide social, athletic and recreational activities as an alternative to situations in which alcohol and drug use might occur. The majority of programming is delivered in communities and schools served by the alliances.

Policy Academy. In 2014, New Jersey was 1 of 10 states (out of 24 applicants) selected by SAMHSA to participate in the Prescription Drug Abuse Policy Academy. The goal of the Academy was to develop and strengthen state strategic plans to address prescription drug abuse. Representatives from DMHAS, along with partners from: the NJ Attorney General's Office, Department of Health, Department of Children and Families, the prevention/treatment provider community, as well as a family member who lost her son to an overdose participated in the academy.

New Jersey's approach to the problem of Prescription Drug Abuse emphasizes that drug overdose deaths are preventable. We chose to focus our efforts on three components that have proven to be essential aspects of an effective approach to combating the issue: A. Public Awareness, B. Collaboration and Coalition Action, and C. Surveillance and Ongoing Evaluation of Our Efforts.

A. Public Awareness will involve: 1. Utilizing existing or developing new social marketing and public information campaigns that target the General Public and provides information to address existing obstacles such as stigma and beliefs such as prescription drug abuse only happens in "bad" families, or that, if a physician prescribes a medication, there are no risks involved and misperceptions. 2. Utilizing existing or developing new social marketing and public information campaigns that target Youth and Young Adults (12-25 year olds) and provides information to address obstacles and misperceptions.
B. Collaboration and Coalition Action: according to Community Anti-Drug Coalitions of America (CADCA), coalitions are by their very nature in the business of strategic social interaction. The central mission of any coalition is to develop a collective understanding across the region of the social issue at hand as well as to envision new ways of living that will yield better outcomes. The work being done by the DMHAS-funded regional coalitions, Municipal Alliances, and Drug-Free Community coalitions around this issue is invaluable and should be coordinated and further enhanced.
C. Surveillance and Ongoing Evaluation of Our Efforts: will involve 1. Monitoring events and trends related to prescription drug abuse to identify geographic "hot-spots" and/or

particular populations at risk and, 2. Evaluating policies and programs that have been implemented to address prescription drug abuse.

The policy academy provided an opportunity to refine and enhance the strategies listed above.

In September 2014, Governor Christie and Pastor Joe A. Carter of Newark's New Hope Baptist Church hosted a summit on drug addiction. The event acted as a call to action and conversation – bringing together public leaders, treatment professionals and advocates, and survivors of drug addiction – focused on ending the stigma around drug addiction and treatment. The following month, Governor Christie created the Facing Addiction Task Force, a 12-member team of leaders and experts from inside and outside of government chaired by Pastor Joe Carter and co-chaired by former Governor Jim McGreevey to fight addiction through treatment and prevention.

Core Opioid Working Group. In August 2014, DMHAS was one of ten states selected to participate in SAMHSA's Prescription Drug Abuse Policy Academy. Representatives from DMHAS, the NJ Departments of Health, Law and Public Safety, Children and Families, the NJ Assembly, and a family member, derived great benefit from participating in the Academy, the goal of which was to further implement a public health approach to the prevention of prescription drug misuse and abuse. Upon its return to NJ, the Policy Academy group further expanded its membership to include representatives from: the NJ State Police, The Governor's Council on Alcoholism and Drug Abuse, Medicaid, NJ's Juvenile Justice Program, and Rutgers University. Representatives from the group have engaged the support and commitment of Department-level commissioners in directing the resources and expertise of their particular department in addressing the issue of opioids and the attendant issues.

Overdose Prevention. As a result of the Opioid Antidote and Overdose Prevention Act passed in May, 2013, DMHAS issued contracts to licensed, contracted opioid treatment programs to provide community education and training, to include the distribution of naloxone kits to individuals who attend and complete training. Contracts were awarded to four opioid treatment programs located in, or adjacent to, five counties which had the highest rates of opiate overdose death reported for the period of January 1, 2013- June 30, 2014. Efforts to educate and dispense naloxone are focused on individuals who are high risk for opioid overdose and include individuals admitted to opioid treatment programs and other substance abuse treatment programs, as well as those individuals engaged with local syringe access programs. Another priority is educating, training and distributing naloxone to family members, friends and loved ones who are in contact with individuals at risk for an opiate overdose. Since that contract will be expiring, an RFP was issued in July 2015 to continue this initiative on a statewide basis, known as the Opioid Overdose Prevention Program (OOPP). Efforts during this Federal planning cycle will focus on implementing and monitoring this project.

Early Identification/Intervention

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

Early Intervention Services (ASAM level .5). Level .5 services are offered in the SSA's continuum of care. In CY 2014 there were 933 individuals admitted for Early Intervention

services. This service is most commonly delivered to clients referred from DMHAS' Driving Under the Influence (DUI) program.

NJ Connect for Recovery Call Line. The NJ Connect for Recovery Call Line was recently established by the Mental Health Association of New Jersey to support two distinct groups across the state: those concerned with their own opiate use; and, those who are experiencing distress related to the opiate use of a friend or family member. This service is a safe, confidential, nonjudgmental forum that New Jerseyans may call to connect, grow and transform through a unique combination of supportive counseling from Certified Alcohol and Drug Counselors and Peer Specialists.

SBIRT. In July 2012, SAMHSA awarded DMHAS a five-year $7.5 million cooperative agreement for Screening, Brief Intervention and Referral to Treatment (SBIRT) services. Entitled *NJ SBIRT*, the project is a partnership between the DMHAS, the Henry J. Austin Federally Qualified Health Center (HJA), and Rutgers University, School of Social Work and the Center for Alcohol Studies. The NJ SBIRT project seeks to expand and enhance the existing continuum of care by integrating evidence-based services, proven effective in reducing substance use and associated negative health consequences, in primary care and community health settings. The project goals are to: 1) reduce alcohol and drug consumption and its negative health impact; 2) increase abstinence; 3) reduce costly health care utilization among Trenton residents accessing primary care services through an FQHC and hospital emergency departments; and 4) promote policy and systems change that identify and overcome barriers to consumers accessing and engaging in treatment.

The HJA implemented SBIRT services in its four (4) primary care sites and in two (2) affiliated hospital emergency departments throughout the city of Trenton. Services provided include universal screening of adult patients for the identification of substance use risk and clinically appropriate brief intervention, brief treatment, referral to specialty treatment and care coordination services as indicated. DMHAS recently terminated its contract with HJA, since the service in Mercer county is now sustainable, in order to expand the service into four additional NJ counties through agreement with the Rowan School of Osteopathic Medicine, which will become effective October 2015. DMHAS will expand SBIRT services into Middlesex County through agreement with the Rutgers University, Robert Wood Johnson Medical School, Department of Family Medicine and Community Health starting in 2015.

The Rutgers University, School of Social Work serves as the NJ SBIRT project evaluator, conducting process and outcome evaluations, in addition to overall project data management. The Center of Alcohol Studies serves as the NJ SBIRT training contractor.

College Campuses. This initiative awarded funds in November 2014 for 5 years to Rutgers University and The College of New Jersey to provide recovery support and/or environmental prevention strategies to systematically identify and help students who have a substance use disorder (SUD) diagnosis as well as those who intermittently abuse AODs. Each college or university is required to provide: individual and group substance abuse recovery-oriented programs and services, assessment, academic and personal counseling services, and/or offer recovery-based housing for students. Environmental Management strategies seek to reduce the

supply of and demand for AODs by making them less available and their use less acceptable within the campus environment.

Gambling. In 2014, the New Jersey Legislature enacted legislation directing that $110,000 be collected from each casino located in Atlantic City or their internet gaming affiliate(s) that were issued a permit to conduct internet gaming. The purpose of the legislation is to increase/enhance the scope of disordered gambling treatment services in New Jersey. In that DMHAS is the state agency responsible for the coordination of all statewide mental health and addiction services, it developed a memorandum of agreement for the delivery of professional services from University Behavioral Health Care (UBHC) at Rutgers University. UBHC was directed to develop, enlarge, and manage a network of licensed clinicians to provide treatment services for individuals suffering from disordered gambling who meet financial and programmatic eligibility criteria. As such, UBHC will develop, expand, and administer a Gambling Disorder Network of specialized and licensed clinical staff in a timely and cost effective manner to meet the need for problem gambling treatment in the State of New Jersey. The Network will begin providing services in the fall of 2015.

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

Conduct Disorder. DMHAS is currently collaborating with University Behavioral Health Care at Rutgers University to develop a substance abuse prevention study/intervention for children age 8- 11 who display behaviors consistent with or meet diagnostic criteria for one of the diagnoses included in the definition of Conduct Disorders. Conduct Disorder is a childhood psychological disorder in which a child demonstrates a persistent pattern of behavior, which violates the basic rights of others or disregards major societal norms or rules. Conduct disorders in youth are a significant predictor of the development of substance use disorders in adolescence and adulthood. DMHAS recognizes the need to identify, create and deliver innovative, quality outpatient services to those children at increased risk for the development of substance use disorders with the hope that these interventions will forestall or prevent their development. The project will include an intensive clinical component in combination with the 14-week Strengthening Families Program.

Treatment

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

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

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

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

SAPT Women's Set-Aside. The SSA provides funding through the women's set aside federal block grant to a statewide network of licensed substance abuse treatment providers in all modalities of care: outpatient, methadone outpatient, short-term and long-term residential for substance abuse treatment to pregnant women and parenting women. The women's programs are designed to meet the specific needs of women such as gender specific substance abuse treatment and other therapeutic interventions for their children. Gender responsive treatment is trauma informed and trauma specific, strengths-based and relational. Gender specific treatment includes gender specific therapies with family focused services, such as individual and group sessions, child care, transportation, services for children, parenting, linkages and recovery supports.

Child Welfare/Parents with Dependent Children Programs. July 1, 2015, the treatment contracts for parents with substance use disorders that is currently addressed via a Memorandum of Understanding between the SSA and DCF Division of Child Protection & Permanency (DCP&P) transitioned over to DCF.

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

medication assisted treatment, and to individuals referred through the Sterile Syringe Access Programs.

In May 2015, DMHAS submitted an application for federal funding for its three-year Medication Assisted Treatment Outreach Program (MATOP) under the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) Targeted Capacity Expansion: Medication Assisted Treatment-Prescription Drug and Opioid Addiction grant opportunity. DMHAS was awarded this grant with a start date of August 2015. MATOP will provide accessible, comprehensive and integrated care, using evidence-based programs such as medication assisted treatment (MAT), mindfulness based recovery maintenance, smoking cessation and other recovery support services for individuals with an opioid use disorder. Three New Jersey licensed Opioid Treatment Programs (OTPs) will participate in this initiative and provide outreach and other engagement strategies to diverse populations at risk such as incarcerated individuals, pregnant and parenting women, veterans, parents and caregivers involved with the child welfare system, opioid overdose reversals and syringe access program participants. In addition, DMHAS will partner with Rutgers University, Robert Wood Johnson Medical School to provide trainings and webinar series for OTP providers, patients and their families. Trainings and webinar series will focus on increasing understanding of the effectiveness of MAT among patients and providers throughout New Jersey, as well as to address misconceptions regarding the use of MAT, smoking cessation and mindfulness based recovery maintenance. New Jersey's project will serve 130 unduplicated individuals annually and 390 unduplicated individuals over the entire project period.

Drug Court. Drug Court is a cooperative initiative between the Administrative Office of the Courts (AOC) and the SSA which commenced in 2002. This agreement allows the AOC to transfer treatment funding to the SSA who then secures and makes available, based upon clinical need, a complete continuum of care for Drug Court offenders sentenced in New Jersey Superior Court. Drug Court participation has been voluntary. Fifteen vicinage serving all 21 counties Drug Courts function within the existing Superior Court structure to provide treatment along the full continuum of care and diversion opportunities for non-violent offenders who otherwise may be incarcerated in state prisons for drug related offenses. New Drug Court Legislation S881was signed into law in July 2012. The bill stipulated a two phase Drug Court expansion: 1) part one broadened the legal eligibility to include second degree burglary and robbery, 2) part two required a phase-in mandatory sentencing to Drug Court. Mandatory sentencing is being implemented in three new vicinages each year until it is accessible in all fifteen. The first three years of mandatory vicinage phase-in have taken place (Phases 1-3) and added 9 vicinages. During that time DMHAS has issued RFPs and funded 364 new treatment beds, 57% of which are operational with the rest in process. This is in line with the number of new drug court participants expected.

Mutual Agreement Program. The SSA oversees the Mutual Agreement Program (MAP), an Inmate/Parolee Substance Use Treatment Project implemented through Memoranda of Agreements between the SSA, the New Jersey State Parole Board (NJSPB) and the New Jersey Department of Corrections (NJDOC). This funding is a combination of direct appropriations from DMHAS and funds transferred from the NJDOC and NJSPB. Funding for long term residential is available for DOC inmates pending parole through a network of FFS providers. For

the NJSPB, these funds support a similar FFS network which offers the full continuum of care including long term and short term residential care, halfway house, partial care, detoxification, outpatient and intensive outpatient treatment, co-occurring services, psychotropic medication reimbursement, and medication assisted treatment by way of Naltrexone injections for NJSPB parolees.

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

Recovery and Rebuilding Initiative (RRI). The Recovery and Rebuilding Initiative (RRI) is funded through the federal Supplemental Social Service Block Grant. These resources have been made available to the New Jersey Department of Human Services to support its disaster recovery and response efforts in the aftermath of Superstorm Sandy. RRI is designed to increase access and capacity to substance use disorder treatment services for consumers who were living in one of the ten significantly storm-impacted counties between the dates of October 28 and October 30, 2012. The amount of funding dedicated to RRI is $10 million. This will be available until September 30, 2017.

There were 784 unduplicated* consumers served through the Recovery and Rebuilding Initiative in SFY14 (November 11, 2013 to June 30, 2014). This generated 1,839 total level of care authorizations including: assessment (363), detoxification (674) and short-term residential (802) authorizations. There were 1,588 unduplicated* consumers served through the Recovery and Rebuilding Initiative in SFY15 (July 1, 2014, 2014 to June 30, 2015). This generated 3,614 total level of care authorizations including: assessment (1,033), detoxification (969) and short-term residential (1,612) authorizations. From July 1, 2015 to today, an additional 220 unduplicated* consumers were served through the Recovery and Rebuilding Initiative. This has generated a total of 325 level of care authorizations, including: Assessment (61), Detoxification (114) and Short Term Residential (150) authorizations.

*Unduplicated within SFY15. Duplicates may occur when combining SFY14 and SFY15 treatment data.

Services for the Deaf and Hard of Hearing. Annualized funding of $350,000 is provided for prevention, education, treatment, intervention, communication accessibility, and advocacy services for the population of individuals who are Deaf, hard of hearing, and/or disabled. Communication accessibility is coordinated to provide sign language interpreters or Computer Assisted Real-Time Translation (CART) for individuals who were identified as Deaf or hard of hearing seeking substance abuse treatment at any level of care.

Driving Under the Influence Initiative. New Jersey set aside $7.5 million in state funds beginning in November 2005 to support the treatment of financially indigent residents of New Jersey who have been convicted of Driving Under the Influence (DUI). Convicted DUI Offenders who are financially indigent can receive the appropriate level and duration of treatment warranted, thus reducing the incidence of recidivism and ultimately creating safer

highways. There are over 150 licensed sites in the DUII network providing all levels of treatment services. In addition, there was a Vivitrol Sub-Network that had been created within the DUII, for those clients who are either alcohol or opiate dependent, which has now been expanded to most addictions fee-for-service initiatives.

HIV Services. The Division funded Early Intervention Services (EIS) and HIV Specialist positions at 14 substance abuse treatment providers statewide at 15 site locations, one of which is in a rural locale. Services were available in areas of the state that had the highest rate of HIV infection, as well as the greatest need for these services. Since DMHAS recognizes that individuals with substance use disorders, specifically injectable drug users, are at a higher risk for contracting HIV/AIDS than the general population, DMHAS obligated a portion of its HIV Block Grant funds to implement a Memorandum of Agreement (MOA) with Rutgers, Robert Wood Johnson (RWJ) Medical School, Department of Pathology and Laboratory Medicine, that provides administrative services including lab directorship, consultation, lab oversight, authorization, HIV test kits and technical support to ensure rapid HIV testing for clients in several licensed substance abuse treatment facilities statewide.

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

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

Recovery Support

Recovery support is defined as the coordination of personal, family, and community resources to achieve the best possible quality of life for every client entering the substance abuse early intervention and treatment system. The chronic nature of addiction requires sustained recovery support to promote sustained periods of wellness and to continuously reduce the need for additional acute care. Correspondingly, a modern addiction treatment system must support sustained recovery. In New Jersey, substance abuse treatment does not end upon discharge; a continuum of care plan, including personal, family and community resources, must be

established. It can range from low level contact such as quarterly telephone conversations to high level contact such as coaching, depending on support needed.

In an effort to increase recovery supports, the existing Mental Health Planning Council was renamed the Behavioral Health Planning Council in 2014 and is moving to expand membership to include individuals, families and providers involved in substance abuse services. In essence, this increase in membership will evolve the current Planning Council into a more behavioral health focused Planning Council.

The intention of the SSA is to expand addiction recovery support services throughout the state to mirror the extensive mental health support system, which includes both self-help support centers and supportive housing. The SSA currently funds two Addiction Recovery Centers, and 63 units of supportive housing. It recently awarded a contract to provide supportive housing for an additional 10 women with children.

Citizen's Advisory Council (CAC). The Citizen's Advisory Council is composed of consumer and citizen members representing the voices of New Jersey residents at risk for, struggling with, or otherwise affected by the chronic disease of addiction. The CAC supports education, prevention, intervention, treatment, and recovery from alcohol, drug, and other addictive disorders and the elimination of associated stigma. The Council provides input and guidance to DMHAS in furthering its mission, linking the Division with consumers and advocating for the needs and interests of individuals, families, and communities. The CAC believes:

- In the rights of all citizens to access and receive quality prevention, treatment, recovery and support services without stigma;
- In quality, holistic, comprehensive, affordable, client centered treatment services within a continuum of care that recognizes the need for life-long management;
- In encouraging informed consumer choice, and that our collective voices are integral to DMHAS in fulfilling its mission.

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

Peer Recovery Support Specialists. Peer-based recovery support is defined as a process of giving and receiving non-professional, non-clinical assistance to achieve long-term recovery from alcohol and/or drug related problems. In New Jersey, these supports are provided by people who are experientially credentialed and/or state certified and are delivered through a variety of settings and a variety service roles (including paid and volunteer recovery support specialists – coaches, mentors, etc.). Peer-based recovery support services are one form of peer-based recovery support and can span all stages of recovery – from initiation/stabilization through recovery maintenance & the enhancement of quality of life in long-term recovery. Peer support can exist within the context of individual level and/or family levels. Our recovery support services are designed to mobilize "Recovery Capital": Internal and External resources that can be drawn upon to initiate and sustain recovery (White, 2009). External Recovery Capital includes, but is not limited to, financial assets, health insurance, safe and recovery-conducive shelter, clothing, food, and access to transportation. Internal Recovery Capital includes, but is not limited

to, values, knowledge, educational/vocational skills and credentials, self-awareness, self-esteem, self-efficacy, hopefulness/optimism, perception of one's past/present/future, sense of wholeness and healing. Family and/or Social Recovery Capital includes, but is not limited to, intimate relationships, family and kinship relationships (defined here non-traditionally, i.e., family of choice), and social relationships that are supportive of recovery efforts. Recovery specialists encourage families (biological, nuclear or self-chosen) to become willing to participate in their loved one's treatment and recovery. The presence of others in recovery within the family and social network can help access sober outlets for sobriety-based fellowship/leisure, and relational connections to conventional institutions (school, workplace, church, and other mainstream community organizations).

In New Jersey, our Recovery Mentors/Peer Specialists provide a bridge to treatment during the client's care through outreach and motivational support. Peer-Recovery Specialists are included in some Women's programs, the SSA's Medication Assisted Treatment Initiative (MATI) and the New Jersey Recovery Center at Eva's Village and Living Proof Recovery Center. There are multiple pathways toward Peer-Specialist certification in New Jersey. The Addiction Professionals Certification Board of New Jersey has created a new credential, called the Chemical Dependency Associate (CDA) in Peer Support that broadens the already existing Certified Recovery Support Practitioner (CRSP). The CRSP was designed primarily for peers working in the mental health field but has expanded to include helping those with co-occurring disorders. However, the new CDA is specific to recovery support in addiction services and supports. Finally, independent agencies and individuals across New Jersey are also using a Recovery Coach credential from the Connecticut Community for Addiction Recovery (CCAR).

Opioid Overdose Recovery Program. A Request for Proposals (RFP) was issued in June 2015 to develop an Opioid Overdose Recovery Program to respond to individuals reversed from opioid overdoses and treated at hospital emergency departments as a result of the reversal. This new two-year initiative funded by DMHAS, the Governor's Council on Alcoholism and Drug Abuse (GCADA) and the Department of Children and Families (DCF) will fund programs in Atlantic, Camden, Essex, Monmouth and Ocean Counties. The Opioid Overdose Recovery Program will utilize recovery specialists and patient navigators to engage individuals reversed from an opioid overdose to provide non-clinical assistance, recovery supports and appropriate referrals for assessment and substance use disorder treatment. The recovery specialists and patient navigators will also maintain follow-up with these individuals. It is planned that, at minimum, recovery specialists will be accessible and on-call from Thursday evenings through Monday mornings in the specific locations where funding is made available. This new initiative is planned to commence in fall 2015.

Recovery Centers. The SSA opened New Jersey's first Recovery Center at Eva's Village in Paterson in September 2009 and its programs have grown exponentially in the last six years. This peer-driven and peer-operated center, which is open 365 days per year, provides the following services in the large metropolitan area and surrounding communities: referral to treatment, peer support services, housing assistance, employment assistance, and language assistance, and self-help advocacy, childcare assistance, and recreational activities, wellness classes of interest to the community and advocacy activities in support of recovery. Client choice to participate in program activities is paramount. Additionally, the Recovery Center's participants and staff

continue to take leadership roles in community oriented recovery activities such as hosting a Recovery Month walk and picnic celebration in the large catchment area of Passaic County as well as organizing transportation for many (four bus loads) of their program participants to attend the largest Recovery celebration in the tri-state area in Philadelphia.

The SSA issued a RFP and subsequently awarded a contract to the Center for Family Services in Camden County in April 2012 to provide New Jersey's second Recovery Center. It opened in December 2012 at a suburban location in Camden County. Staff working seven days a week provide outreach to individuals in recovery as well as to provider treatment programs throughout the state. Like Eva's village before them, Living Proof Recovery Center has a peer advisory board and a full monthly calendar with weekly self-help meetings, anger management, resume-building and financial workshops. There are also sober social activities such as line dancing, wrap sessions and recovery movies on the weekends. Both recovery centers also provide Telephone Recovery Support (TRS) which has been is an evidence-based and data driven method of successful recovery support (White, 209). Both centers have a strong core of volunteers who are helping with day to day operations and recruitment. At present, staff and volunteers at both centers have used CRSP and updated CDA certification for staff and volunteers.

Grassroots Recovery Centers. The Recovery Movement that began in the late 1990's with Faces and Voices of Recovery and most recently celebrated in the 2012 movie *The Anonymous People* has begun to take root in New Jersey. On the social media front, there are numerous NJ Recovery Support pages on Facebook, Instagram and Twitter – ranging from parent to parent support groups sprung from the loss of their own children, to groups advocating for more treatment and recovery options for those not involved in the criminal justice system. On the ground, at the grassroots level, New Jersey has seen tremendous efforts in advocacy and recovery support. The New Jersey chapter of the National Association on Alcoholism and Drug Dependence (NCADD – NJ) has developed a program of "Recovery Advocates" that are divided into regional teams across the state. These Advocacy Leaders are trained on how to give testimony before the NJ Statehouse as well as create regional events meant to educate the community on the success of recovery as well as reduce stigma. Additionally, four (4) peer-developed, peer designed and peer run Recovery Centers have opened across the state without NJDMHAS dollars. They are 1. City of Angels in Mercer County http://www.cityofangelsnj.org/ 2. The Hope All Day Recovery Center in Atlantic County http://hopeallday.org/ 3. The Center for Addiction Recovery, Education and Success in Morris and Warren Counties http://www.caresnj.org/ 4. CFC Loud and Clear in Monmouth County http://www.cfcloudnclear.com/. 5. Recovery Advocates of America in Mercer County http://recoveryadvocates.org/ and, 6. A Change for Nick in Passaic County http://achangefornick.org/. All of these agencies use and adapt the CCAR model. They are primarily volunteer run and often receive donations from families who lost loved ones to addiction and want to help others. Two other non-profit organizations are also in the process of developing Recovery Centers: The Hope Sheds Light Foundation in Ocean County is currently in development of a recovery center http://www.hopeshedslight.org/ as well as The Center for Prevention and Counseling in Sussex County http://centerforprevention.org/.

These organizations are NJ homegrown efforts to help individuals get referred to treatment, coach them throughout their treatment experience and remain there for individuals post-discharge for aftercare/relapse prevention supports and services. These are peer-designed, non-12 step affiliated groups, although 12 step meetings are often held on site.

Recovery High School. In the fall of 2014, New Jersey opened its first Recovery High School - the Raymond Lesniak ESH Recovery High School, which is located on the campus of Kean University in Union County. It is open to students throughout NJ. A Recovery High School is exclusively for young people that struggle with substance use disorders. Every member of the staff, faculty and administration in each school is required to attend numerous trainings regarding addiction and recovery. The school provides social, academic and counseling. The initial class enrolled approximately 20 students. The number of students enrolled is expected to increase annually.

Sober Housing. Funding is provided to Oxford Houses to provide administrative and programmatic oversight of the statewide network of peer-led group recovery homes in New Jersey. There are a total of 121 houses; 91 men's and 30 women's houses. The administration of the loans is through the $100,000 Revolving Loan fund and provides for the maintenance of the existing homes and the addition of new homes in New Jersey. A substance use treatment contract in the amount of $215,849 and the Revolving Loan Fund (administered by Oxford House) exists to establish four new homes (two men, one women and one women with children) yearly and continue to administer the existing homes. Funding in the annual amount of $76,515 is provided from the AOC for a full-time outreach worker exclusive for the Drug Court population.

Supportive Housing. The SSA has two existing supportive housing programs modeled on Housing First and incorporated into its MATI. These two contracts combined provide for a total of 63 housing units, 31 units in Camden and 32 units in Atlantic City. Services are provided to individuals with substance abuse disorders who are homeless or at risk of becoming homeless, and are intravenous drug users. Women with children are given top priority. It includes rental subsidies and support services.

The SSA has developed a Women's Intensive Supportive Housing (WISH) Program. This program develops permanent supportive housing for pregnant and/or parenting women with a co-existing substance abuse disorder and mental illness who are homeless or at risk of homelessness and being discharged from a licensed long-term residential substance abuse treatment and/or halfway house facility. An RFP was developed and released in January 2015. This RFP calls for the development of a WISH team to provide case management and supportive housing services for 10 women and their children. The SSA is seeking to partner with a provider that will serve identified WISH Program clients in supportive housing and has demonstrated success in managing permanent supportive housing programs. An award was made in May 2015. DMHAS outpatient treatment system will be able to accommodate the substance abuse treatment needs of the project participants. In addition to WISH, DMHAS has provided additional subsidies to DCP&P to develop housing for parents with children in the child welfare system.

Mental Health Services

The SMHA contracts for county/local services including: Consumer Run and Operated Community Wellness Centers, Programs for Assertive Community Treatment (PACT), Integrated Case Management Services (ICMS), Involuntary Outpatient Commitment (IOC), Residential Services, Supportive Housing (SH), Outpatient Services (OP), Supported Employment (SE) and Supported Education (SEd), Partial Care, Intensive Family Support Services (IFSS), Systems Advocacy including legal services, Intensive Outpatient Treatment and Support Services (IOTSS), Designated Screening Centers (DSC), Affiliated Emergency Services (AES), Early Intervention Support Services (EISS), Justice Involved Services (JIS) and Projects for Assistance in Transition from Homelessness (outreach to persons who are homeless) and Short Term Care Facility (STCF) beds. These services are funded with Community Mental Health Block Grant, other federal or state funds.

The programs that the SMHA funds fall within four levels of service along the continuum of care.

1. *Acute Care Services (DSC; AES; STCFs; EISS; Involuntary Outpatient Commitment (IOC); IOTSS and Projects for Assistance in Transition from Homelessness (PATH))*

Acute Care Services. The SMHA funds and regulates acute mental health care programs for individuals with intensive outpatient mental health needs and for those experiencing psychiatric crisis. In order to meet the needs of individuals who require involuntary in-patient services, the SMHA currently designates 417 STCF beds. The SMHA has allocated roughly $22.6 million in subsidies[3] for STCF beds. There are currently 377 STCF beds which are currently online in New Jersey in 24 general community hospitals, These beds are operated by 24 different agencies and serve all 21 New Jersey counties. In addition there are 40 beds at Bergen Regional Medical Center. In October 2015 three new STCF beds are expected to come online at Trinitas Hospital, in Union County. Most of these agencies are community hospitals and the STCF beds permit the state's residents to access a hospital based level of psychiatric care at the local community level. Since the end of 2007, community hospital based involuntary psychiatric inpatient service capacity has been increased by approximately 21% (71 beds). According to the most available SRC data for STCFs in SFY 2015, the occupancy rate for all of these the STCF units was 91.41%. The data available at the time of writing included approximately 77% of SFY 2015 SRC STCF data. Through past and recent Certificate of Need (CN) application approvals, an additional 20 STCF beds can be brought on line pending implementation by the relevant hospitals.

The SMHA also funds 176 Diversion (intermediate) inpatient beds at approximately $29.7M annualized at private psychiatric facilities (e.g. Carrier, Hampton, Northbrook, Summit) that offer an alternative to state psychiatric hospitalization.

Designated Screening Centers (DSC). In FY15, the SMHA funded 23 Designated Screening Service (Screening and Screening Outreach) programs across the 21 Counties at a total cost to DMHAS of approximately $44 million. The Screening and Screening Outreach Program is designed to provide psychiatric emergency services including screening, assessment, crisis

[3] Half of this 22.6 million is assumed to be covered by Medicaid.

intervention, referral, linkage, and crisis stabilization services, 24 hours per day, 365 days per year, in every geographic area in the state. According to the SMHA's Quarterly Contract Monitoring Report (QCMR) database of information self-reported by the screening programs, there were 89,451 admissions to these screening centers during SFY 2015. The SMHA also provides annualized funding of approximately $6.4 million to 12 Affiliated Emergency Service (AES) programs, which provide for behavioral health staffing at high volume emergency departments. During SFY 2015, the state's 12 Affiliated Emergency Service Programs delivered 27,131 episodes of crisis care.

Please note that beginning in SFY16, the State has received approval for a Medicaid State Plan Amendment for Psychiatric Emergency Services. Accordingly, hospital providers will be able to bill the Medicaid program at established rates and generate Medicaid revenue to partially offset their operating costs. Consequently, DMHAS' costs, which previously contributed to a much larger share of provider costs, are expected to be reduced.

Early Intervention Support Service (EISS). In 2008, the SMHA began investing $3.0 million annually in Early Intervention Support Service (EISS) programs in Morris and Atlantic Counties. These urgent care mental health clinics are intended to provide rapid access to short-term, non - hospital based crisis intervention and stabilization services for persons with a mental illness. These early intervention programs are community-based programs aimed at offering individuals mental health service options that can divert undue use of emergency room and in-patient programs. Access to this intensive diversionary program is intended to provide a direct and specific alternative to hospital emergency department based crisis services. The SMHA now funds eleven community based EISS programs at a total annual cost to the state of $11.5 M in SFY 2015. These programs provide rapid access to short term, recovery-oriented crisis intervention and stabilization services for persons with a serious mental illness. A comprehensive range of pharmacologic, therapeutic, recovery and supportive services are offered in order to divert undue use of emergency room and in-patient programs. Currently, EISS programs are funded for approximately $11.5M (annualized) and serve Atlantic, Camden, Essex, Middlesex, Monmouth, Morris, Bergen, Cumberland, Hudson, Mercer Counties and Ocean Counties and are funded for approximately $1M each. These programs delivered 10,737 episodes of care during 2014, with episodes ranging from one contact with immediate referral to four-six weeks of short term crisis stabilization.

Intensive Outpatient Treatment Support Service (IOTSS). Since 2008, the SMHA has funded Intensive Outpatient Treatment Support Service (IOTSS) programs in 19 counties, in order to create quick access to intensive outpatient services for individuals seeking access to treatment through the acute mental health system. These new programs are designed to create dedicated access for consumers referred from emergency rooms and other acute settings.

Homeless Adults/PATH. The SMHA is the recipient of the federally funded PATH program, which is matched with state funding. The PATH program is authorized by the Public Health Service Act Title 42 of the U.S. Code "The Public Health and Welfare", Chapter 6a "Public Health Service," Subchapter III-A, Part C - Projects for Assistance in Transition from Homelessness. The target population is homeless adults or those at risk of homelessness who have a serious mental illness, including those with co-occurring substance use disorders who are

not currently engaged in and are resistant to mental health and other community support services. The primary objective of PATH is to provide outreach to, identification and engagement of the target population into an array of community services through active case management and referral.

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

The SMHA contracts with 25 non-profit agencies to operate PATH programs within the state's 21 counties. A small number of PATH programs use PATH funding to directly provide psychiatric assessment and outpatient mental health services. Many PATH providers are Community Mental Health Centers and link their consumers to mental health in their agency outpatient or partial care programs. All PATH programs link individuals to behavioral health and co-occurring services within their communities.

All PATH providers are required to complete Intended Use Plans in which they identify the services to be provided, evidenced-based practices to be deployed, strategies for making housing available, the gender, race and ethnicity of the individuals they are serving in their community; the gender, racial and ethnicity of their staff; and to specify how their staff will provide culturally sensitive services and what cultural competency training and support their staff is provided.

2. *Intermediate and Rehabilitative (SH; Residential Services; Supported Employment; Supported Education (SEd); PACT; IFSS; Illness Management and Recovery (IMR); JIS; Integrated Case Management Services (ICMS); Outpatient Services; Partial Care; Statewide Clinical Outreach Program for the Elderly (S-COPE); and Legal Services*

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

As a long-term program, in which the course of treatment has no pre-determined end point, most New Jersey PACT teams are staffed with eight to ten full-time equivalent direct care staff and can serve between 60-75 consumers at any point in time. There are 31 PACT teams in New Jersey, serving all of the 21 counties. The SMHA contracts with 12 different non-profit agencies that operate these teams. Since state fiscal year 2010, the SMHA has expanded sixteen of the 31 teams with additional staffing. This has increased the maximum service capacity for the program from 1,997 to 2,128.

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

New Jersey PACT team admission criteria are explicitly defined, as recommended in the ACT literature. ACT is targeted to persons, who have a severe mental illness and have been acute mental health system users, as evidenced by involuntary hospitalization within the sixteen months preceding admission to PACT. ACT services are highly individualized and are tailored to service recipients' needs. PACT teams in New Jersey serve a diversity of individuals of racial, ethnic and sexual/gender minorities backgrounds.

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

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

DMHAS anticipates continued targeting of dedicated funding to expand the state's PACT. As an Evidence-Based Practice (EBP), ACT is endorsed by SAMHSA. PACT will continue to be integral to enhancing the network of community mental health services. In the current fiscal year (SFY 2015) to date, two more PACT teams (Mercer Team II , Passaic Team II) were expanded by a total of 10 slots. These community slots have been created to facilitate discharge of individuals who are in state psychiatric hospitals and have been placed on CEPP status. SFY 2015 is the sixth consecutive year in which the statewide PACT capacity has been expanded. According to the 2014 URS Data Table 16, there were 2,150 consumers served by PACT.

Supportive Housing. The SMHA contracts with approximately 49 Supportive Housing providers (including Medically Enhanced and Enhanced Supportive Housing models) and Supervised Residential providers in all 21 counties. These services range from being completely consumer-driven in the consumer's leased-based housing to supervised settings with 24/7 staffing. In addition, the State funds Residential Intensive Support Teams (RIST). RIST is a team-based Supportive Housing model with a high staff-consumer ratio and SMHA funded rental subsidies serving consumers discharged directly from the state hospital system, as well as those at risk of hospitalization.

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

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

Supportive housing services promotes community inclusion, housing stability, wellness, recovery, and resiliency. Illness management, socialization, work readiness and employment, peer support, and other skills that foster increased self-direction and personal responsibility for one's life are also addressed. Consumers are expected to be full partners in identifying and directing the types of support activities that would be most helpful to maximize successful community living. This includes use of community mental health treatment, medical care, self-help, employment and rehabilitation services, and other community resources, as needed and appropriate. Staff support should be provided through a flexible schedule that is adjusted as consumer needs or interests change, up to and including 24/7 support.

Homeless Adults/Housing First. The SMHA, the United Way of NJ, and Mercer County are members of the Mercer County Housing First Collaborative and contributing funders of supportive services for the Mercer Housing First Program. The program includes the identification of homeless individuals with disabilities, including SMI and substance use disorders, the provision of permanent supportive housing through vouchers and an array of wrap around services, including behavioral health, primary health monitoring and linkage, referral to financial assistance and vocational services.

Supported Employment (SE). The SMHA has been providing the EBP of supported employment since 1988. SE is provided statewide and jointly funded by the Division of Vocational Rehabilitation and the SMHA. Adults (18 years of age and older) with severe mental illness and/or co-occurring mental illness and substance use disorders are assisted to choose, obtain and keep integrated employment in jobs of their choosing within their skill and credential set. The SMHA provides SE through 21 contracted community mental health provider organizations.

Supported Education (SEd). Although the SMHA has been promoting the concept of SEd since 1993, contracts for SEd services have only been offered by the SMHA since 2006. SEd programs target individuals with SMI and or co-occurring disorders who either want to or are currently matriculating in post-secondary education. The SMHA provides, through four existing contracted supported employment community provider organizations, mobile outreach services aimed to assist people with psychiatric disabilities to reach their postsecondary academic goals. Services are individualized and flexible based on student choice and career goals.

Integrated Case Management Services. ICMS works collaboratively with the consumer, their family/significant others (as appropriate) and other collateral contacts to assesses the individual's strengths and needs, develop a service plan based on this assessment, refer and link individuals to needed services and monitor their engagement in services. In SFY 2014, the SMHA served 10,855 with ICMS services[4].

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

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

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

[4] DMHAS Evaluation Table 1, July 2015

In SFY 2014, the SMHA served 12,543 with Partial Care services.[5]

TRINITAS ~ Statewide Clinical Outreach Program for the Elderly (S-COPE). The Division of Mental Health and Addiction Services (DMHAS) continues to strive to provide services to older adults and individuals diagnosed with a mental illness by improving access to the most integrated settings and treatment appropriate to meet their needs. As a result of this continued effort, DMHAS has funded the development of a statewide program to provide specialized clinical consultation, assessment, treatment and intervention to older adults (around 55 years of age and older) who are at risk of psychiatric hospitalization.

The Statewide Clinical Outreach Program for the Elderly (S-COPE) provides clinical consultation and intervention that includes individual client assessments, crisis intervention / stabilization, collaboration with treating primary care physician and psychiatrist, development of an individualized formal treatment plan, development of an individualized behavior modification program, follow up evaluations for effectiveness of recommended interventions and education on mental illness and medications to client and family. This program is available 24 hour / 7 day a week to offer face-to-face clinical consultative services. These specialized services are designed to ensure the appropriate assessment and treatment of this at risk population in order to facilitate and support their continued residence in the community.

S-COPE will also provide training and technical assistance to administrators, clinical staff, direct care staff and support staff. The purpose of these ongoing training is to improve staff's ability to assess, provide treatment, manage behavioral disturbances and stabilize crises for the targeted population.

The goals of S-COPE include:

(A) Provide onsite and offsite individual client assessments, consultation, crisis intervention and stabilization and follow up care to the target population who are present at designated screening centers, affiliated emergency service providers, nursing facilities or other long term care settings, contracted DMHAS residential providers and/or who are referred to the DMHAS PASRR Unit and Centralized Admissions Unit.

(B) Provide training to increase the knowledge and positively affect the attitudes and behaviors of staff from designated screening centers, affiliated emergency service providers, contracted DMHAS residential providers, nursing facilities and other long term care settings who are responsible for the care of the target population resulting in improved management of behavioral disturbances and crisis and enhanced lifestyle for older adults.

(C) Decrease unnecessary emergency department designated screening visits, short term care facility, inpatient psychiatric hospitalizations and special care nursing facility admissions of the targeted population.

Staffing:

[5] *ibid*.

S-COPE provides a multidisciplinary treatment team approach to address the statewide crisis needs of older adults with SMI. The multidisciplinary team includes two Advanced Practice Nurse (APN), a Masters Level Clinicians, a PhD Psychologist as Clinical Administrator and Psychiatrist(s). Additional staff includes a Quality Review Evaluator to monitor and report ongoing performance outcomes.

S-COPE has been rolled out in counties with large geriatric populations, originally with a pilot in Monmouth, Union, Somerset, Morris, Camden, and Ocean counties. S-COPE is now statewide and offers its services to all New Jersey counties.

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

Family psychoeducation is offered as part of an overall clinical treatment plan for individuals with mental illness to achieve the best possible outcome through the active involvement of family members in treatment and management and to alleviate the suffering of family members by supporting them in their efforts to aid the recovery of their loved ones. Family psychoeducation programs may be either multi-family or single-family focused. Core characteristics of family psychoeducation programs include provision of emotional support, education, resources during periods of crisis and problem solving skills. More specifically,, family psychoeducation enhances family functioning by providing the family with a greater knowledge of mental illness, treatment options, the mental health system and skills useful in managing and reducing symptomatic behaviors of the member with a serious mental illness. Family psychoeducation is offered in each of New Jersey's twenty-one counties via the county Intensive Family Support Services Program. According to the SMHA's 2014 URS data table 17a, 3,495 individuals were served with family psychoeducation services via the Division's IFSS program.

Services offered include psycho-education presentations, family support groups, single family consultation, respite activities and referral/linkage. Services are delivered in the family home, at the agency or at other sites in the community convenient to individual family members. Engaging minority families has always provided a significant challenge for the IFSS programs. IFSS programs invest significant effort and energy in attempting to attract minority families. Visits occur on a regular basis to a wide variety of mental health programs.

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

separate ethnic groups through the following programs: Family to Family en Espanol, South Asian Mental Health Awareness in New Jersey (SAMHAJ), Chinese American Mental Health Outreach Program (CAMHOP), and the African American Community Takes New Outreach Worldwide (AACT-NOW!).

3. Extended and Ongoing Support Programs (Consumer Operated Services)

Consumer Operated Services. New Jersey continues to expand its commitment to partner with consumers and family members to ensure that programming and services are inclusive, cutting-edge, recovery-based, and respectful of consumer rights. The state seeks to include the voice of consumers and family members in the development of policies and programs, planning and the evaluation and monitoring of systems of care at both the state and local levels.

Specifically DMHAS currently funds and supports 33 Community Wellness Centers in the 21 counties across the state, all being consumer-operated and providing dedicated space for mental health consumers to grow in their recovery through self-help, socialization, peer support, opportunities for employment, and specialized wellness programs. During the last several years, all of the Community Wellness Centers in New Jersey have successfully incorporated significant changes as the Wellness and Recovery Model has become an integral part of the overall mission and is being used more actively to inform the service delivery model.

Community Wellness Centers (formerly known as Self-Help Centers) provide a comfortable, relaxed and supportive setting to mental health consumers where they can feel respected and accepted; develop friendships; and gain support from other people who have similar life experiences. They are places of learning and personal growth where people learn to access resources to help them realize a lifestyle centered on wellness and recovery. Persons who attend the centers have the opportunity to take advantage of empowerment and leadership and prevent a life based on loneliness and isolation due to the availability of peer support.

New Jersey Community Wellness Centers now provide a variety of activities both at the Center itself and off-site. The Centers offer support and services such as: peer support, mutual aid support groups, self-esteem building, cultural competency and diversity activities such as learning a foreign language at some centers. Consumers are offered support to develop their wellness resources like PADs (Psychiatric Advance Directives) development of their Wellness and Recovery Action Plan (WRAP) (M.E. Copeland's model); a variety of resources for consumers who are dually-diagnosed, mobile community outreach, learning to budget, individual savings or financial planning, exercise, walking clubs, dance, yoga, healthy eating and cooking, Hearing Voices Groups, camping trips, shopping activities, sharing meals, meal planning, budgeting, selecting healthy snack alternatives, some faith-based satellite services, certified individual peer wellness coaching, WRAP scrap-booking, smoking cessation groups, movie night, crafts and game night. Other activities include topics like conflict resolution, men's and women's group, meditation and relaxation groups, preparing for education and employment opportunities, SE groups, and many more. Planned Parenthood comes to the Community Wellness Centers and provides educational programs for consumers. These educational opportunities are provided at a few of the Community Wellness Centers during the year.

The 33 Community Wellness Centers collectively received funding of approximately $6 million dollars in FY 2015. There are full time Center Managers at every Community Wellness Center, which has proven to be a stabilizing force for change and growth at the centers. These Center Managers are required to accept a great deal of responsibility for the well-being of the membership, yet the retention rate for the position is impressively high. This is primarily due to the DMHAS funded Self-Help Leadership Training Academy and to the support and skills of the full-time Life Coach who was hired to assist the Center Managers in performing their duties by providing them with supportive counseling, mentoring and training necessary to handle the stresses associated with the demands of a management position. The centers have vans and transport individuals to and from the center, as well as to sporting and theater performances, community meetings and shopping excursions. Consumers are assisted in daily living skills, if needed, as well as independent living skills. If an individual desires, there are volunteer positions at the centers, through which the members learn sanitary food handling, how to prepare and plan their meals, what to do for general kitchen clean-up, how to properly sanitize the kitchen, including how to properly store and dispose of trash and kitchen cleaning products, storage of food items, and kitchen ware.

DMHAS appropriated funding has allowed the three state psychiatric hospitals to develop their own on-site Community Wellness Centers. A particularly exciting development for New Jersey's Community Wellness Centers Model has been the development of an accountability system called Self-Help Outcomes Tracking (SHOUT). This data tracking system was developed specifically to monitor utilization and to support outcomes evaluation for participants of Community Wellness Centers. In addition to these services, there are other service innovations in select Centers across the state that not only serve the population of that particular area well, but also hold great promise for replication should additional funding become available.

DMHAS provides opportunities like peer support recovery programs, family involvement and IFSS programs, the significant number of consumers and family members who hold membership on the Behavioral Health Planning Council (BHPC), inclusive of BHPC members on state steering committees, service and policy development surveys and forums, consumer participation in on-site monitoring reviews of hospitals and community providers, involvement in the RFP process by both mental health consumers and their family members, and the support of and partnership with advocacy groups throughout the state.

The state has strong working relationships with NAMI of New Jersey which facilitates consumer involvement and assists the state to keep up with the challenges facing consumers and their families. The state's support and funding of peer support and consumer-operated programs is probably the greatest evidence of the state's commitment to fostering a system of care that values the importance of consumer involvement in the recovery process. In Fiscal Year 2012, the state allocated $8,777,991 to support consumer-operated services that promote self-directed care.

The Division has moved forward with their community support services state plan and has received approval for reimbursable Peer Provided Services such as wellness coaching, Peer Outreach Support Teams (POST) and other such roles for which consumers are uniquely qualified. Implementation is pending the adoption of the regulations.

The state actively includes consumers and family members in Patient Services Compliance Unit. In 2012, the Patient Services Compliance Unit conducted five separate on-site reviews in all of the state psychiatric hospitals. The reviews were each conducted for a three-day period and each individual review team included one consumer and one family member. Consumers and family members are in all aspects of the review with the exception of medical records reviews. The process includes a review of therapeutic program, unit observations, patient care and staff development.

In accordance with New Jersey Administrative Code (NJAC) 10;190, consumer and family member participation is also required during on-site reviews of community mental health agencies conducted by DHS Office of Licensure.

In addition to state operated programs, NJ has a strong, active network of public consumer and family member organizations and programs, including but not limited to: Consumer-Operated Transportation Services, Leadership Training Academy, The Learning and Recovery Center of Wildwood, Consumer Advocacy Partnership, The Coalition of Mental Health Consumer Organization (COMHCO), The Institute for Wellness and Recovery Initiatives, Consumer Connections CORE Training, Certified WRAP Training, Certified Wellness Coach Training, CHOICES-a smoking cessation Program active in state hospitals and Community Wellness Centers across the state, Hearing Voices, CPA (Consumer Providers Association), NAMI of NJ, NAMI Connection, NAMI NJ en Espanol, Chinese Mental Health Self-Help Group (CAMHOP-NJ), NJ Self-Help Group Clearing House, and Mental Health Association of NJ (MHANJ).

Psychiatric Advance Directives (PADs). The SMHA has a PAD policy that promotes the empowerment of consumers to direct their own care with regard to the care and treatment they receive. This document is a permanent record in the consumer's chart which can be revoked or amended by legal authority. PADs are submitted to SMHA and available on a 24-hour basis.

Wellness Recovery Action Plans (WRAP). - Certified WRAP trainers from the MHANJ conduct trainings across NJ on the topic of wellness and recovery and WRAP plan development. In 2012, 651 people participated in these trainings, which ranged from an overview of WRAP to workshops designed to help people develop their own individual WRAP.

Peer Wellness Coaches. The Wellness Coaching role was developed as a workforce innovation to help support people with mental health and substance use disorders with risk factors and medical conditions that impact their recovery. The wellness coaching training curriculum was developed through collaboration between staff at Collaborative Support Programs of New Jersey and faculty in Department of Psychiatric Rehabilitation and Counseling Professions, and Rutgers-School of Health Related Professions.

Wellness for Life. Wellness for Life is a multi-disciplinary pilot project to address the prevention or management of metabolic syndrome for persons diagnosed with mental illness. The eight-week intervention meets weekly for three hour sessions and includes health supports from physical therapy, peer wellness coaching, dietetics, dental hygiene and psychiatric rehabilitation using education, peer wellness coaching and supported exercise. Each participant is provided an

individual wellness assessment and is helped to create and attain a personalized health goal. Preliminary outcomes appear positive and evaluation is ongoing.

Institute for Wellness and Recovery. The Institute for Wellness and Recovery Initiatives of CSPNJ was designed to promote and provide innovative, state-of-the-art services aimed at creating wellness and recovery for individuals with and organizations serving persons with special needs. The Institute offers training, workshops, and educational opportunities. Through our many activities, we assist organizations in developing a workforce and service system grounded in a recovery and wellness orientation, and help individuals pursue their own paths towards wellness. The Institute provides innovative, state of the art services aimed at creating and enhancing wellness and recovery. Its monthly newsletter, Words of Wellness, and its website features valuable information and resources, including details about educational events to help people with psychiatric disabilities to achieve and maintain wellness.

Health Screenings. The Health Screenings have been occurring at Learning Recovery Center Community Wellness Center in Wildwood, Cape May County. The Wellness Institute has also performed screenings and distributed materials at the CSPNJ Annual Wellness Conference.

Consumers Helping Others Improve their Condition by Ending Smoking (CHOICES). This is consumer-driven program for smokers with mental illness in New Jersey. The goal is to increase awareness of the importance of addressing tobacco use and to create a strong peer support network that encourages mental health consumers to make a positive healthy lifestyle change by addressing smoking and tobacco use. CHOICES is innovative because it employs mental health consumers, called Consumer Tobacco Advocates, to deliver the vital message to smokers with mental illness that addressing tobacco is important and to motivate them to seek treatment.

Financial Management Bill Pay (FMBP) formerly known as Client Trust Account (CTA). It serves more than 300 people statewide. FMBP is an individualized, flexible community-based service product provided by Collaborative Support Programs of New Jersey (CSPNJ) for adult clients with mental health issues and other special needs. The FMBP is a money management service, providing collection and payment of funds on behalf of its clients, financial literacy training and education designed to promote financial stability and security consistent with the concepts of empowerment, personal responsibility and recovery.

Individual Development Account (IDA). This is a matched savings program designed to help people save for and acquire a productive asset, such as a home or business, or to pursue education (including post-secondary education) over the period of five years.

The Emergency Loan Program. This is offered to CSP-NJ/CEC residents assists with short-term financial emergencies and/or unanticipated expenses. The loan terms are usually no more than nine months.

Consumer Operated Transportation Services. Riverbank Transportation provides transportation to and from work for consumers in Burlington County who otherwise would be unable to get to work. The service also has enabled the consumers employed to become the providers of the service. Operating five days a week from 7:00 am to 10:00 pm, it serves approximately 24

consumers each week. The service employs two drivers and one dispatcher, all of whom are consumer providers.

Roads to Recovery provide transportation to consumers with co-occurring issues enabling them to attend meetings or groups in the community. Over 18 community groups and 16 geographic areas are accessed each week, with over 55 consumers using the service each month. This service employs one driver and one dispatcher who are consumer providers, operating three evenings per week.

Peer-Operated Warm Line. The peer operated warm line is a statewide initiative through the MHMNJ where consumers receive interventions and/or assistance during times of concern, need or crisis using the Intentional Peer Support Model. The Warm Line received national recognition in 2012 as a recipient of the Innovative Program of the Year from Mental Health America.

Dual Recovery Groups: MICA Link. People with the lived experience of mental illness and with a co-occurrence of substance use comprise a large percentage of the mental health population that CSPNJ serves. The MICA Link project is a way to address the needs of this group of consumers by providing technical assistance, training, support and information. As an addition to a 12-step approach, alternative coping methods, stress reduction techniques, and information on mental illness and substance abuse and their relationship to the whole person are presented.

Community Wellness Centers managers and facilitators attend trainings and activities that increase awareness of MICA issues and the need for MICA services while cultivating a growing leadership for MICA and other wellness groups.

Re-entry Groups. These services are provided on the Mental Health Unit of a jail in Bergen County. The meetings take place every Monday, including holidays and provide the men with an opportunity to have support from outside world. The groups engage with six to eight men in a typical week. The Community Wellness Centers staff provides a confidential environment where the inmates can talk about their mental health concerns, as well as other topics and know that someone is listening and cares. They are offered the support of their Community Wellness Centers should they get released. They are also provided housing information and given information on other items pertaining to release. These men are awaiting trial and can stay in the jail for a few days or a few years. They report that they are isolated in the jail system and seldom get a chance to talk to anyone. Through the Re-entry Groups they are connected to someone from the community. They also know that they can talk with other group members, provided opportunity, should they need a listening ear. The facilitator tells them to look around the room at one another and if they need someone to talk to they know they can count on other group members.

Parent Advocacy Project. The Consumer Parent Support Network provides bilingual support services to 34 parents in Passaic County. Parents with a mental illness can receive case management services, one-to-one peer support from another consumer parent, parenting education workshops, advocacy, and on-going parent support.

Community Wellness Centers. The Community Wellness Centers provide outreach to homeless shelters. During the visits to shelters, the goal is to engage the homeless consumers into peer-operated Community Wellness Centers using peer support, dual recovery groups, etc. Community Wellness Centers have operated a number of Substance Abuse Support Groups over the past year. These groups included: Substance Abuse MICA Link; Alcohol Anonymous; Double Trouble/DRA /MICA; Narcotics Anonymous, Smoking Cessation; and Nicotine Anonymous. There were 12,438 duplicated attendees.

Community Wellness Centers Enhanced Model. The DMHAS has awarded funding for three Enhanced Community Wellness Centers: The Hudson County Community Wellness Center in Jersey City, The Learning Recovery Center of Wildwood (Cape May County) and A Way to Freedom (Sussex County). The Enhanced Community Wellness Center Model was developed to meet specific consumer and/or community needs. With this model, the DMHAS has supported the opportunity to offer a broader range of options to consumers in a unique peer-run environment. Each center has utilized its resources to provide wellness and recovery based services that also meet distinct consumer and community needs.

The Learning Recovery Center of Wildwood (LRC of Wildwood). The newest enhanced Community Wellness Center was developed with the merger of the center and the Wildwood Wellness and Recovery Center (W2R2). The W2R2 functions as an overnight retreat and training site for Community Wellness Center members and other consumers statewide. As happened to The Hudson County Community Wellness Center, over the past year, the LRC of Wildwood has experienced a sizeable increase in membership of persons in recovery who cope with mental health issues as well as challenges of addiction, homelessness, shelter/motel residency and other special needs. The LRC of Wildwood has worked to develop more extensive and culturally sensitive services that meet the needs of their consumer community. The services include traditional Community Wellness Center activities and groups, but the LRC of Wildwood has introduced or expanded a host of other services including: a community food pantry, a winter warmth closet, clothing bank and a nutritious meal. In addition, the LRC of Wildwood has made connections with many agencies in order to better serve community needs as varied as the membership itself.

Hearing Voices Network. Voice Hearers groups have been operating for more than a year in New Jersey. This is a philosophical trend in how people who hear voices are viewed. The groups are made up of people who are voice hearers or experience any unusual perceptions. The groups are seeking more holistic health solutions to problematic voices that cause distress to people. Most voice hearers have experienced trauma and the group assists people by creating a safe environment where people make the connection between their voices and their trauma. The groups also offer strategies to deal with voices when they become overwhelming which include: listening to music, reading, journaling, meditation, positive self-talk and affirmations, eating healthy, sleep, TV, radio, praying, imagery etc.

Shared Decision Making Tool. In an effort to further promote recovery-oriented services and consumer driven care, Rutgers, Behavioral Research and Training Institute and the DMHAS have jointly developed a brochure on Sharing Decisions about Medication. This brochure is

designed as a helpful tool for consumers and their family members in working together with their service providers, such as doctors, nurses, pharmacists, or mental health/addiction professionals.

Statewide Consumer Advisory Committee (SCAC). SCAC meets once a month in each of the three regions of the state (northern, central and southern). These meetings are a platform for SCAC members to give input on specific DMHAS-sponsored initiatives. SCAC makes recommendations to DMHAS on all issues affecting consumers like: housing, transportation, medication, co-pays, employment opportunities, etc. During monthly meetings SCAC members share in their ideas on wellness and recovery-focused activities and groups that different Community Wellness Centers offer. This permits an open forum for members to exchange their vast assortment of wellness and recovery approaches that are innovative and fresh, and are taking place in the various community centers throughout the state.

Coalition of Mental Health Consumer Organizations (COMHCO). COMHCO is New Jersey's statewide consumer membership organization. Their main purpose is to provide consumers with necessary education about personal and system wide options to enhance the lives of their members and the multitude of others across the state. Through empowerment and advocacy training at the monthly meetings and annual conference, COMHCO members are able to bring voice to the concerns and problems that those suffering mental illness face daily. They also work to raise awareness of the issues that affect mental health consumers by sitting on local, state, and national advisory boards, committees, and councils.

Consumer Oriented Recovery Education (CORE) Training. The Mental Health Association of New Jersey (MHANJ) offers CORE training. CORE training has grown to 144 hours, and the WRAP is 18 hours (over three days). Completion of the CORE and WRAP satisfies the education and training component for the Certified Recovery Support Practitioner (CRSP) credential. Additionally, CRSP applicants must document 500 hours of either paid or volunteer related work experience, of which 100 hours must include a supervised practicum.

4. State and County Psychiatric Hospitals

State Hospitals

The SMHA operates three non-forensic, regionally-based, adult psychiatric hospitals and one adult forensic hospital that serve people with persistent and severe mental illnesses who are in need of intensive, inpatient care and treatment. Each has person-centered treatment planning, Community Wellness Centers (at Ancora, Greystone and Trenton), and shared decision-making. IMR services are also offered. The hospitals are dedicated to patient-focused treatment planning, emphasizing a continuum of care that is: holistic and highly individualized, promotes positive outcomes based on patient strengths and available supports, values the full participation of each patient, relies on shared decision making and client-defined outcomes, and promotes patient choice, empowerment, resilience, and self-reliance.

Ancora Psychiatric Hospital is an adult inpatient facility located in Camden County, primarily serving the residents of southern New Jersey, that offers a multidisciplinary team approach to the development and implementation of mental health care. It offers acute and chronic psychiatric

treatment, gero-psychiatry, sub-acute medical care, forensic care, and dual diagnosis (mentally ill and developmentally disabled) services.

Greystone Park Psychiatric Hospital (GPPH) is located in the northern area of the state in Morris Plains and predominantly serves residents from this geographic area. In July 2008, a state-of-the-art hospital was opened on its grounds, replacing five aging treatment buildings and the 131-year-old administration building. In addition to new housing and care facilities, the new Greystone Hospital facility contains a treatment mall with over 21 rooms for various activities.

Hagedorn Psychiatric Hospital, a 288 bed facility, located in rural Hunterdon County primarily served older adult consumers with mental illness. As a result of the state's Olmstead initiatives, the state closed Hagedorn Psychiatric Hospital in June 2012. This facility is now used for transitional housing for veterans.

Trenton Psychiatric Hospital (TPH), located in West Trenton in Mercer County, primarily serves the residents of central New Jersey. TPH provides a holistic approach to patient care--from initial assessment and the treatment of the human response to current and potential mental health problems. TPH ensures its patients (and their families) competent, compassionate care as patients individualized care goals are reached.

Ann Klein Forensic Center (AKFC) is co-located in the same campus as TPH and serves New Jersey's statewide forensic population whom require a more secure environment. AKFC provides care and treatment to individuals suffering from mental illness whom are also under the custodianship of the legal system (e.g., Megan's law registrants, those found Not Guilty by Reason of Insanity, etc.)

County Hospitals

In addition to its network of state psychiatric hospitals, DMHAS also supports four county operated psychiatric facilities that operate as part of the continuum of services. These county hospitals receive most of their funding (85%) from the SMHA. At the time of writing there are four county operated psychiatric hospitals located in Bergen, Essex, Hudson, and Union Counties.

SMHA's Prevention Efforts

In addition to the four levels of service provided within the continuum of care described above, the SMHA has increased its efforts with regards to prevention. The following are the SMHA's specific prevention initiatives:

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

The mission of the Governor's Council on Mental Health Stigma is to combat mental health stigma as a top priority in New Jersey's effort to create a better mental health system. Through outreach and education, the Council will send a message that mental health stigma must no

longer be tolerated. The DMHAS is represented on the Council via a liaison who is the DMHAS Family Coordinator.

Each year the Council gives Ambassador Awards to those who champion the mission to raise mental health awareness and combat stigma, educate the public about mental illness, and engage communities in the process of embracing mental health. The 2014 awards occurred in April, and honored organizations that are exemplary in their hiring practices and maintaining a work environment that supports and accommodates employee mental health and wellness. The award categories are for New Jersey based Corporations, government agencies, small and large businesses, and educational programs that have shown exemplary, creative and/or innovative approaches in creating an environment that is supportive of the mental health and wellness of their staff. Nomination forms are distributed to consumers, families, NAMI organizations and the DMHAS contract agencies.

To provide education to the public, the Governor's Council on Mental Health Stigma partnered with state psychiatric hospital staff to celebrate hope, recovery and wellness in recognition of Mental Illness Awareness Week: October 5-11, 2014. Open houses were held at each of the state psychiatric hospitals. Participants heard speeches on wellness and recovery which offered words of hope and inspiration from hospital staff and consumers, were able to tour the treatment malls and see programs, and viewed displays of artwork. One hospital program featured a chorus and two hospitals entertained with a band. For 2015, Open Houses will once again be held in October. Creative arts festivals will be held, and planning is already underway with the hospital staff. Original works of art, poetry, short stories, music, and dance will be featured. Additionally, one hospital will feature a tour of the chapel and Community Wellness Center. Community agencies will be invited to attend along with families and consumers.

In cooperation with the New Jersey Office of Information Services (OIS), videos relating to stigma, messages of hope and recovery are being produced for posting on the Council's website. These videos will be used in training sessions and presentations statewide. The Council recognizes the importance of cultural competency in all of its efforts and inclusion of all groups in prevention efforts. All community partnerships focus on collaboration with all groups to ensure that all input, information and guidance in regard to messaging, content and approach are accurate and culturally competent.

Suicide Prevention

Suicide remains a significant cause of mortality for far too many of New Jersey's residents. According to the New Jersey's Department of Health's (DOH's) Office of Injury Surveillance and Prevention (OISP), an average of 580 people in New Jersey took their own lives each year between 1994 and 2003[6]. In CY 2011 this number sadly rose to 676 completed suicides in New Jersey[7].

The SMHA- continues to fund the NJ Suicide Prevention Hopeline, operated by Rutgers UBHC, which is set up to accept calls 24/7 from individuals who are seeking information or assistance

[6] http://www.nj.gov/health/chs/oisp/documents/njvdrs_suicide_06.pdf
[7] NJ Violent Death Reporting System v.03/06/2013, data obtained from New Jersey Department of Health.

for themselves or friends or relatives that may be at risk of suicide. Calls are received from anyone of any age and will be answered by peers, trained volunteers, and clinical staff. If a caller is assessed as being at serious risk of suicide, the caller can be "warm-transferred" to the appropriate local Screening Service or other entity (i.e. DCF children's program) that can provide emergency or other necessary services for that individual. For the month of July 2013, the Hopeline answered a total of 1,299 calls. Between 5/1/2014 and 4/30/2015, the Hopeline answered a total of 24,687 calls. This is an average of 2,058 per month. The NJ Hopeline is an approved National Suicide Prevention Lifeline Crisis Center and provides back up to the Lifeline Crisis Center call system in NJ.

In May 2014 DMHAS introduced the newly developed NJ Adult Suicide Prevention Plan to a large group of stakeholders. Steps towards practical implementation, including prioritization of suicide prevention goals and time lines were discussed. It was recommended to organize a State Interagency Committee (consistent with goal #2; objective # 2.1 in the original plan) that will expand the DMHAS Suicide Prevention Committee to function as an Adult Suicide Prevention Advisory Council.

In December 2014 the first meeting of the Adult Suicide Prevention Advisory Council took place and was well attended. The main topic of this first meeting was a review of the four goals that had been revised to be consistent with the 2012 National Strategy. At the second meeting of the Advisory Council in January 2015 four Advisory Council Workgroups were formed to develop action steps and outcome measures for each of the four prioritized goals (# 5, 7, 8, & 9). These Workgroups will be meeting independently for the next few months to review their respective objectives and develop deliverables, action steps, and outcome measures. In March 2015 the workgroups shared their first progress reports and received input from other members for incorporation.

With the formation of a broad-based Adult Suicide Prevention Advisory Council DMHAS has promoted that effective suicide prevention efforts have to be comprehensive and coordinated across organizations and systems at the national and local level. Working consistently and cooperatively together guided by a written strategic plan that is consistent with the 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action has the best chance of preventing suicides in New Jersey.

VII. DMHAS Services to Special/Target Populations

Co-Occurring Services. Beginning in SFY 2010, the SSA established a Co-Occurring Services Network (COSN), comprised of 53 substance abuse licensed treatment providers was established to provide treatment to clients with co-occurring disorders on a FFS basis. Agencies eligible to join the FFS Initiatives Co-Occurring Network must first meet Office of Licensure (OOL) requirements as a co-occurring provider before applying to the FFS Co-Occurring Network. Currently, there are 104 Provider agencies in the COSN. These agencies represent 203 individually licensed sites with COSN approval.

Approval to provide co-occurring services and medication assisted treatment services, is predicated on agency's submission of, and DMHAS approval of, agency's co-occurring and

medication assisted treatment policies and procedures as part of the agency's Co-Occurring and Medication Assisted Treatment Initiative Network Applications. Approval to provide Vivitrol enhancement services is predicated on agency submission and DMHAS approval of an application to the Vivitrol Network.

The contractee contracted for the SJI, DUII, RRI, SBIRT and MATI Initiatives shall meet agency criteria to participate in the co-occurring network and have demonstrated readiness to provide integrated care for dually diagnosed clients. The contractee shall be co-occurring capable and provide at a minimum: Assessments and treatment or Must be able to screen, refer and provide linkages to a co-occurring capable agency.

The contractee shall ensure that clients screened as "at risk" for co-occurring disorders (COD) shall receive a complete mental health assessment. If the screening contractee is not qualified to provide COD services, it is the contractee's responsibility to facilitate a referral for this service and coordinate ongoing care.

The SMHA fully supports and promotes creation of a co-occurring competent and seamless system of services for persons living with, and recovering from, co-occurring disorders (COD). Integrated Dual Diagnosis Treatment (IDDT) was implemented in April 2004. The SMHA currently has ten contracted community mental health providers that have fully implemented IDDT into their existing program (ICMS, Partial Care, and Supported Housing) in five different counties. However, IDDT is not fully implemented across the state. IDDT is provided a diverse mixed of consumers: male and female as well as individuals of Caucasian, African American, Hispanic, Asian and Asian Indian backgrounds and from many different countries.

Services to Families of Military Veterans. Working with the New Jersey National Guard Family Program and its eight Family Assistance Centers based at armories around the state, the SSA funds the New Jersey Prevention Network to provide programs to serve returning military personnel and their families through two evidence-based programs, Coping with Work and Family Stress and the Strengthening Families Program. Both programs are designed to enhance protective factors to support military members and their families in making responsible parenting and individual choices in regards to drug and alcohol use.

The SSA's most recent household survey, the 2009 New Jersey Household Survey on Drug Use and Health, also included a set of questions on substance use among New Jersey Veterans. This information, in combination with that found in NJSAMS on veteran status, will help to better inform the SSA on the treatment needs for this population.

New Jersey is focused on returning Veterans as a priority population for its PFS initiative and other programming. This is another population for which there is limited information. DMHAS has reached out to New Jersey Department of Military and Veteran's Affairs as well as the New Jersey National Guard to solicit their active participation on the SEOW and Advisory Council in light of this priority. DMHAS is collaborating with its partners at Rutgers University to conduct a survey of returning Veterans in order to gather information about behavioral health issues and concerns within this population in New Jersey. We are in the process of finalizing the instrument and will field the survey in the summer of 2015.

The SMHA has consistently provided mental health and related support services to members of the armed forces and veterans as part of its regular behavioral health service delivery system. When possible, the service member is connected to the VA healthcare system if eligible. In SFY 2012 approximately 7,000 individuals were provided with a range of services, the most frequent being emergency services, outpatient, partial care, case management, Justice Involved Services (JIS), Supported Employment (SE), and Supported Education (SEd). However, the SMHA believes that the actual number served is closer to 14,000 based upon discussion with the NJ Healthcare System (VA). The SMHA and SSA participate in the state's Veterans Services Enhancement Team, the result of participating in SAMHSA's Policy Academy on Service Members, Veterans and their families to better coordinate and provide services to this group in New Jersey. The SMHA also participated in Operation Immersion with the hopes that a similar training effort could be started in New Jersey. The SMHA has established quarterly meetings with the NJ Healthcare System (VA) to enhance collaboration, particularly around acute case services.

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

HIV. The SSA expends 5% of its SAPT Block Grant award to support the HIV Early Intervention Services (EIS) Initiative including 14 funded providers at 15 site locations. Of these, South Jersey Drug Treatment Center provided access to HIV EIS services to substance abuse clients residing in a rural area, defined as a census area of less than 2,500 residents, consistent with SAPT Block Grant requirements. Funding for these early intervention services allowed clients to receive some or all of these services, either provided on-site at the substance abuse treatment facilities, facilitated by the substance abuse treatment provider at a nearby medical facility in the community or provided at a combination of both of these settings.

In order to better understand the degree of HIV infection among clients presenting for substance abuse treatment in New Jersey, and to better inform calculation of the SAPTBG MOE for HIV, DMHAS provided the DOH with a file of cases served from 2009 to 2014 to be matched against the DOH eHARS registry of individuals with HIV/AIDS who were still living. Of the 236,517 unduplicated substance abuse records, 4,880 (2.1%) were matched to HIV/AIDS records, and accounted for 13,591 admissions over this 6-year time period. During 2014 there were 2,068 admissions with HIV/AIDS. DMHAS is working with HIV Governor's Council to share data and begin to plan for strategies that will encourage those with HIV/AIDS to enter substance abuse treatment.

Pregnant Women and Women with Dependent Children. New Jersey began their participation in the SAMHSA supported National Center on Substance Abuse and Child Welfare (NCSACW), program of In-Depth Technical Assistance (IDTA) January 2009 through 2013 with the goal to

improve outcomes for children and families involved with child welfare, substance abuse and the courts. The IDTA was led by the SSA, DCP&P and the Administrative Office of the Courts (AOC). Through the IDTA, the New Jersey team: (1) accomplished the first cross system drop off analysis; held a first ever statewide Values Conference from which a significant statewide cross-system training initiative emerged; developed policy changes reflecting improved practice for child welfare parents needing Medication Assisted Treatment (MAT); and completed initial planning for a Recovery Support Specialist model to work with highest risk priority parents.

In early 2014 the SSA reached out to the NCSACW to request continuation of IDTA to address emergent issues of concern where New Jersey like many other states, has been experiencing an increase in illicit opioid use among women. New Jersey's 2012 treatment data reflected the most commonly used substances among New Jersey's pregnant women include heroin and other opiates. The NCSACW granted an IDTA continuation for a limited scope of work with DMHAS as the lead agency to address NJ's increase in substance using pregnant women, and the associated Substance Exposed Infants (SEI), including those with Neonatal Abstinence Syndrome (NAS).

The IDTA continuation involved a Monmouth county walkthrough that included an MAT provider, local hospital, Maternal Health Consortia, the local DCP&P office, and other stakeholders who provide services to substance using pregnant women who reside in Monmouth County revealed both effective practices and unexpected yet significant SEI gaps. As this limited TA came to a close, NJ as a recent SAMHSA Prescription Drug Abuse Policy Academy State was eligible to apply for a unique IDTA offered through SAMHSA's NCSACW to address the multi-faceted problems of NAS and SEI. Since NJ identified significant SEI gaps with the Monmouth county walkthrough, NJ as the lead State agency partnered with DCF and DOH and submitted a successful application for IDTA on SEI and NAS. Multiple State Departments and their Divisions, as well as the provider community, will participate on the IDTA with the goal to strengthen collaboration and linkages across addiction treatment, medical communities, child welfare, providers and other organizations to improve services for pregnant women with opioid and other substance use disorders and outcomes for their babies.

Justice Involved Services (JIS). The SMHA has been providing JIS since 2000. The services work to divert from incarceration individuals whose legal involvement may have resulted from untreated mental illness or co-occurring mental health and substance abuse disorders. It is a short-term case management program designed to help consumers to successfully link to mental health or co-occurring and other services in order to stabilize and enter valued community roles reducing their incidence and length of incarceration. The program provides access to community-based mental health and substance abuse treatment services. Clients receive treatment services, case management, housing and medications. The SMHA provides JIS services through 15 contracted community mental health provider organizations in 15 of the state's 21 counties. JIS is provided to a diverse mix of consumers, male and female as well as individuals of Caucasian, African American, Hispanic, Asian and Asian Indian backgrounds and from many different countries.

Drug Court. Drug Court is a cooperative initiative between the Administrative Office of the Courts (AOC) and the SSA which commenced in 2002. This agreement allows the AOC to

transfer treatment funding to the SSA who then secures and makes available, based upon clinical need, a complete continuum of care for Drug Court offenders sentenced in New Jersey Superior Court. Drug Court participation has been voluntary. Fifteen vicinage serving all 21 counties Drug Courts function within the existing Superior Court structure to provide treatment along the full continuum of care and diversion opportunities for non-violent offenders who otherwise may be incarcerated in state prisons for drug related offenses. New Drug Court Legislation S881was signed into law in July 2012. The bill stipulated a two phase Drug Court expansion: 1) part one broadened the legal eligibility to include second degree burglary and robbery, 2) part two required a phase-in mandatory sentencing to Drug Court. Mandatory sentencing is being implemented in three new vicinages each year until it is accessible in all fifteen. The first three years of mandatory vicinage phase-in have taken place (Phases 1-3) and added 9 vicinages. During that time DMHAS has issued RFPs and funded 364 new treatment beds, 57% of which are open with the rest in process. This is in line with the number of new drug court participants expected.

Mutual Agreement Program. The SSA oversees the Mutual Agreement Program (MAP), an Inmate/Parolee Substance Use Treatment Project implemented through Memoranda of Agreements between the SSA, the New Jersey State Parole Board (NJSPB) and the New Jersey Department of Corrections (NJDOC). This funding is a combination of direct appropriations from DMHAS and funds transferred from the NJDOC and NJSPB. Funding for long term residential is available for DOC inmates pending parole through a network of FFS providers. For the NJSPB, these funds support a similar FFS network which offers the full continuum of care including long term and short term residential care, halfway house, partial care, detoxification, outpatient and intensive outpatient treatment, co-occurring services, psychotropic medication reimbursement, and medication assisted treatment by way of Naltrexone injections for NJSPB parolees.

DUI Offenders. New Jersey set aside $7.5 million in state funds beginning in November 2005 to support the treatment of financially indigent residents of New Jersey who have been convicted of Driving Under the Influence (DUI). Convicted DUI Offenders who are financially indigent can receive the appropriate level and duration of treatment warranted, thus reducing the incidence of recidivism and ultimately creating safer highways. There are over 150 licensed sites in the DUII network providing all levels of treatment services. In addition, there is a pilot Vivitrol Sub-Network that has been created within the DUII, for those clients who are either alcohol or opiate dependent.

Super Storm Sandy Victims. Superstorm Sandy hit New Jersey on Monday, October 29, 2012, causing extensive damage in the state. Supplemental Social Service Block Grant (SSBG) funding was made available to the New Jersey Department of Human Services to support disaster and response efforts such as the provision of housing assistance and behavioral health services. Supplemental SSBG funds provided detoxification and short-term residential treatment services and outpatient counseling and supportive housing services to individuals with substance use disorders meeting this eligibility criteria:

a. have been living in one of the 10 storm-impacted counties between October 28-30, 2012; (Atlantic, Bergen, Cape May, Cumberland, Essex, Hudson, Middlesex, Monmouth, Ocean and Union counties)

b. be a United States citizen or legal resident
c. be 18 years of age or older
d. no insurance benefit which pays for service
e. no current housing subsidy

Currently, 140 individuals are receiving supportive housing services. Need number receiving detox and STR.

Older Adults. In 2011 DMHAS saw a need to develop specialized services to assist nursing homes to respond to an increasing number of older adults with behavioral problems. In 2012 SMHA awarded a contract for the development of a program to provide specialized clinical consultation, assessment, treatment and intervention to older adults diagnosed with a mental illness. Trinitas Regional Medical Center in Elizabeth, New Jersey was the recipient and has been administering this Statewide Clinical Outreach Program for the Elderly (S-COPE). It is fully funded by NJ-DMHAS and has been in operation since April 2012 with significant reductions of transfers to psychiatric emergency screening centers and psychiatric hospital admissions.

S-COPE provides crisis intervention and stabilization, consultation, and training for the management of mental health and behavioral issues in older adults (55+) residing in nursing homes and State-funded residential care facilities. S-COPE functions as a multidisciplinary team consisting of a geriatric psychiatrist (consultant), a gero-psychologist, geriatric advanced practice nurse, and master level clinicians. Outcomes are carefully monitored and reported to DMHAS on a monthly basis.

Prior to S-COPE's interventions these individuals were being referred to mental health crisis screening centers and emergency rooms, and many were subsequently being admitted to inpatient psychiatric facilities, including state psychiatric hospitals.

The S-COPE program is available 24 hours / 7 day a week to offer face-to-face clinical consultative services. S-COPE staffs also provide training and technical assistance to administrators, clinical staff, direct care staff and support staff, primarily in nursing facilities to improve staff's ability to assess, provide treatment, manage behavioral disturbances and stabilize crises for this population.

In 2014, S-COPE conducted over 1500 face-to-face evaluations in various settings and well over 2000 telephone consultations. In addition to regional trainings this program also holds an annual conference to discuss best practices and systems issues that has been very well attended.
All trainings, assessments, and treatments offered are consistent with promising practices and/or evidence-based practices. Furthermore, S-COPE ensures that the program is culturally and linguistically competent, accessible, and responsive to agencies, consumers and families. The older adult mental health service system in New Jersey does not discriminate with regard to diverse racial, ethnic and sexual /gender minorities.

In 2015 S-COPE was selected as a Bright Idea from the Innovations in American Government Award Program at the Harvard Kennedy School. This is a great honor for the Department and

more specifically for the Division of Mental Health and Addiction Services, honoring S-COPE as an exemplary model of government innovation and advance efforts to effectively address one of the State's most pressing public concerns of diverting unnecessary psychiatric hospital admissions and keeping older people with mental illnesses and behavioral problems in the least restrictive environment.

S-COPE has also been accepting pre-doctoral psychology interns in State psychiatric hospitals for their one-day outpatient placements and a social work intern will be assigned to look into the effectiveness of S-COPE recommendations in Nursing homes in September. S-COPE is also planning on extending CEUs to professionals like nurses and psychologists who attend their regional trainings in addition to social workers.

The SSA has recognized that information concerning older adults and substance use is lacking, and this was also identified as a data gap by the SEOW. In order to help close that gap, the statewide results have yielded some interesting findings that will help drive planning efforts for this population over two years. Based upon results from the New Jersey Older Adult Survey on Drug Use and Health, DMHAS was led to focus on unhealthy drinking patterns and prescription drug abuse among adults age sixty and older. Data from the Older Adult Survey showed, that in terms of illicit drug use, respondents were more likely to use tranquilizers, sedatives, and opiates than older adults who responded to the New Jersey Household Survey. Data also showed a definite pattern of misuse of prescription drugs and alcohol, particularly among male respondents. New Jersey's 17 DMHAS-funded regional coalitions are addressing issues regarding the misuse of alcohol or prescription drugs among older adults through the use of appropriate environmental programs and strategies.

Nearly one in every four people residing in New Jersey (23.7% of New Jersey's population) is aged 55 or older. Also, compared to national statistics, New Jersey is expected to witness more significant decreases in two population groups: those under the age of 25 and those between the ages of 35-44 years. In addition, the New Jersey population will age more rapidly than the country as a whole. That is, since 2006, New Jersey has experienced a higher percentage point change in the 75 and older age group. Based upon analyses of New Jersey's Older Adult Survey, findings are consistent with those from national surveys as described below:

- The number of substance dependent and abusing adults over age 50 is predicted to rise: from 1.7 million 2002 to 4.4 million by 2020 (Office of National Drug Control Policy)
- A government survey of nearly 11,000 Americans aged 50 and up revealed:
- 23% of men and 9% of women ages 50 -64 admitted to binge drinking in the past month
- 14% of men and 3% of women ages 65 and older reported binge drinking

According to the National Survey on Drug Use and Health, 2013, rates of lifetime drug use will increase in the next two decades among the baby boom generation, probably because of less stigma among the cohort regarding "illicit" drug use; and because the current cohort of older adults tend to misuse alcohol and prescription medications if they misuse substances at all. As the baby boom generation ages, the cohort's size alone is predicted to double the number of persons needing treatment for substance use disorders. Therefore DMHAS has identified older adults as a priority population for substance abuse prevention services and provides funding for

both the environmental programs and approaches mentioned above as well as evidence-based curricular programs.

An Older Adult Survey was conducted during 2012 utilizing funding from the SPE grant. However, there were insufficient funds for a large enough sample to obtain reliable county level estimates. The goal of the survey for this PFS opportunity is to obtain enough data to create small area estimates of the prevalence of substance abuse and mental illness among older adults in New Jersey. A telephone interview survey will be developed and random digit dialing with a multistage cluster design will be used to generate probability-based samples of the adult population of each New Jersey County or relevant geographic area. Synthetic estimation techniques will then be applied using the results of the survey and other archival data to create small area estimates of the prevalence of substance abuse for the target population in specific geographic areas (e.g., municipality).

Deaf and Hard of Hearing. New Jersey has an array of services throughout the state for individuals who have mental health issues who are also deaf or hard of hearing. ACCESS at St. Joseph's Medical Center in Paterson is contracted to provide on-site outpatient services at several outpatient locations throughout the state with Master's level clinicians trained in American Sign Language (ASL). They also provide 24/7 statewide consultation for psychiatric emergency services (available onsite during business hours and by phone/TTY in the evening). Consultation is also available to inpatient settings, and outpatient programs. TTY capacity to ACCESS staff is also available. ACCESS staff participates in the New Jersey training for Certified Psychiatric Screeners so that they are able to understand and explain the state's screening process. ACCESS also provides onsite clinical consultation and liaison services to New Jersey's STCF assisting with treatment and discharge planning for each deaf patient.

ACCESS operates residential services in Passaic County. These include an eight bed 24-hour supervised community residence for deaf individuals with mental illness who have been discharged from a New Jersey state hospital or its equivalent, a four bed supervised residence, three semi-supervised apartments, and supportive housing services at apartments with consumers who are deaf and hard of hearing with a mental health diagnosis living in the community.

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

Two additional community programs located in the Northern Region of the state provide services to the deaf and hard of hearing population with mental health issues. The Integrated Case Management Services program in Paterson provides a staff member to work with this specialty population and the Partial Care program in Paterson has a specialty track for consumers who are deaf and hard of hearing.

The Alcohol and Drug Abuse Program for the Deaf, Hard of Hearing and Disabled and a Program Advisory Committee were established pursuant to PL 1995, c.318 (NJSA 26:2B-36 to

39), and continue to meet on a quarterly basis to ensure quality substance abuse treatment services are provided to individuals who identify as being Deaf, hard of hearing or disabled in the community.

GLBTQ. The SSA provides prevention services to Gay, Lesbian, Bisexual, Transgendered, and Questioning (GLBTQ) youth. The SSA awarded funding to the North Jersey Community Research Initiative to expand their existing programs for high-risk GLBTQ youth of color by using a "Street Smart" prevention model developed by the Centers for Disease Control and Prevention, as well as early intervention services, social marketing, and structured recreational activities.

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

Cultural Competency. Recently, the SSA was notified that its request to SAMHSA to enhance the cultural and linguistic competency of services will be provided. SAMHSA through its consultants JBS will provide on- and offsite technical assistance to develop a statewide cultural competency plan to include the development and/or retrofitting of the following:

- A tool/process to conduct external reviews of available cultural competency programming available to and being used by state-funded providers
- An assessment of the extent to which existing cultural competency training meets or exceeds state specifications
- Tools that will enable state monitors to assess cultural competence of contracted providers.

Multi-cultural Services Group (MSG). DMHAS defines cultural competence as: "…the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. Cultural competence is a dynamic, ongoing developmental process that requires a long-term commitment and is achieved over time" (HHS 2003a, p. 12).

The Division has had a long standing commitment to issues of cultural and diversity, originally forming a Multi-Cultural Advisory Committee in 1981. Since that time, the role and membership of this group has changed to meet the changing needs of the system. In June of 2015, the Multi-cultural Services Group (MSG) was formed to devise strategies that are appropriate to the lifestyles, special needs, and strengths of New Jersey's diverse minority and cultural groups who receive services in the behavioral health system of care. The MSG will address the needs for ongoing plans within all agencies in the system as we improve quality of care for: minority, cultural, linguistic, LGBTQ, deaf and hard of hearing, and aging.

MSG membership includes broad representation from providers in the behavioral health treatment community, consumer representatives, LGBTQ, administrators, academics. This group is soon to begin agency self-assessment process, development of a mechanism to incorporate agency cultural competence plans into contracting, development of a strategic plan, training curriculum development.

Consumers < 350% Federal Poverty Level (FPL). The SSA has established a guideline of 350% FPL for the receipt of state funded substance abuse treatment. Clients are means tested with a web-based tool, known as the DAS Income Eligibility (DASIE) prior to admission into substance abuse treatment to determine whether they qualify for public funding.

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

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

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

All DMHAS-funded prevention service providers (coalitions as well as organizations that provide individual and family curricula) are contractually-required to adhere to the standards listed below. Adherence to these standards is monitored as a component of the annual contract site visit conducted by DMHAS.

1. Promote and support the attitudes, behaviors, knowledge, and skills that are necessary to work respectfully and effectively with clients and each other in a culturally competent work environment.
2. Have a comprehensive management strategy to address culturally and linguistically appropriate prevention services, including strategic goals, policies, procedures, and designated staff responsible for implementation.
3. Develop and implement a strategy to recruit, retain, and promote qualified, diverse and culturally competent prevention staff that are qualified to address the needs of the communities being served.
4. Require and arrange for ongoing training for prevention staff in culturally and

linguistically competent service delivery.

5. Provide all clients with limited English proficiency (LEP) access to bilingual prevention staff or interpretation services.
6. Provide a Registries of Interpreters for the Deaf (RID) Certified Interpreter for Deaf or hard of hearing participants when requested as required by the ADA. (American with Disabilities Act).
7. Provide oral and written notices, including translated signage at key points of contact, to clients in their primary language informing them of their right to receive no-cost interpreter services.
8. Translate and make available signage and commonly-used written client educational material and other materials for members of the predominant language groups in service areas.
9. Use a variety of methods to collect and utilize accurate demographic, cultural, epidemiological and clinical outcome data for racial and ethnic groups in the service area, and become informed about the ethnic/cultural needs, resources, and assets of the surrounding community.

Based upon its National Evaluation Data Systems (NEDS) sponsored research on the proportion of treatment recipients with co-occurring disorders (2001), as well as its Center for Substance Abuse Treatment (CSAT) sponsored special population surveys of drug using behaviors of persons in outpatient mental health treatment, driving-under-the-influence programs, homeless shelters, the state's Temporary Assistance for Needy Families (TANF) program, pre-natal care, middle and high school, as well as the needs of veterans returned from foreign wars, the SSA has the planning data to design policies and programs that address the needs of diverse racial, ethnic, sexual, and transgendered minorities. The SSA attends to the needs of the gay, lesbian, bisexual, trans-gendered and questioning youth in the design of its prevention programs. Also, in the course of its planning efforts, the SSA has examined the demographic characteristics of substance abusing persons accessing and not accessing treatment to identify treatment outcomes over a three-year period by age, gender and race as measured by mortality rates, treatment goal achievement scores, and future hospital costs. Finally, the SSA has provided SAMHSA with valid and reliable data necessary to file the treatment needs assessment tables by age, sex, and race on each of its previous SAPT Block Grant applications.

The SMHA provides services to a diverse population of consumers. Several programs and the populations that they serve are described below. In addition, cultural competence mandates and training are also discussed.

By virtue of setting (e.g. hospital emergency departments), coverage (e.g. urban, suburban, rural entities) admissions practices, and regulatory protections, acute mental health care programs serve individuals of racial, ethnic and sexual/gender minorities.

All PATH providers are required to complete Intended Use Plans in which they identify the gender, race and ethnicity of the individuals they are serving in their community; the gender, racial and ethnicity of their staff; and to specify how their staff will provide culturally sensitive services and what cultural competency training and support their staff is provided. At minimum, all agencies provide cultural competency training at initial hiring and at least annually thereafter.

A number of agencies take advantage of the trainings offered by the regional Cultural Competency Training Centers and other regional training opportunities. All PATH programs are informed by SMHA staff of any and all cultural awareness trainings being offered through SAMHSA or the Homeless Resource Center.

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

SEd and SE are provided to a rich mix of diverse consumers: male and female as well as individuals of Caucasian, African American, Hispanic, Asian and Asian Indian backgrounds and from many different countries.

IX. Olmstead

Over the last few years, the SMHA has been successful in its delivery of services to its consumers. Much of this success is due to the implementation of various initiatives resulting from the Olmstead Lawsuit. In April 2005, New Jersey Protection and Advocacy, Inc., now known as Disability Rights of New Jersey (DRNJ) filed suit against the New Jersey DHS on behalf of psychiatric patients who have been found to no longer meet commitment standards, but for whom no appropriate placement is available. The official term for the status assigned is Conditional Extension Pending Placement (CEPP). The SMHA issued its Olmstead Plan known as the Home to Recovery CEPP Plan in January 2008, which can be viewed at http://www.state.nj.us/humanservices/dmhas/initiatives/olmstead/Home_to_recovery_slideshow.pdf.

Although the Olmstead Settlement agreement was a result of a lawsuit initiated in 2005, this Settlement has resulted in an investment in the mental health system in needed community residential and other services. The Olmstead Settlement agreement can be viewed at http://www.state.nj.us/humanservices/dmhas/initiatives/olmstead/olmstead_settlement_agreement.pdf.

From June 2006 to June 2015 the state hospital census (excluding Anne Klein Forensic Center (AKFC)) has decreased from 2,109 to 1,401, a reduction of 708 or 33.57%. From June 2009 to June 2015, the state hospital census (excluding AKFC) has decreased from 1,724 to 1,401, a reduction of 323, or 18.74%. On July 29, 2009, DHS and DRNJ came to a settlement in the Olmstead litigation that began in New Jersey in 2005. The settlement agreement set targets for the SMHA to meet by the end of each state fiscal year, from 2010 through 2014. Since July 2009, the SMHA has worked toward fulfilling the requirements of the settlement agreement, and in July of 2015, DRNJ granted an extension and modification on the few remaining elements not yet achieved by the SMHA over the five-year period. Below are some of the accomplishments achieved by the SMHA since the signing of the Olmstead settlement agreement.

From 2010 through 2014, DMHAS was charged with the creation of 695 beds expressly for the community placement of consumers on CEPP status in the hospitals and 370 beds to be created for consumers who are already in the community and at high-risk for hospitalization and/or

homelessness. This equates to a total of 1,065 placements to be created over the five-year period covered by the settlement. The SMHA has met and exceeded this goal, creating 1,437 new placements. Of these, 942 were set aside for the discharge of CEPP consumers from state hospitals (exceeding the settlement target of 695 by 247 or 35.53%), and 495 were reserved for consumers at risk of hospitalization (exceeding the target of 370 by 125 or 33.78%). In total, the SMHA exceeded its targets for placement creation by 34.93%, which amounts to 372 placements above its required deliverable.

In July 2015, DRNJ granted the SMHA's request to extend the state's Olmstead lawsuit through December 2015 rather than find the Division to be out of compliance with any of the targets listed in its the settlement agreement. While the SMHA did not meet the goals of discharging certain percentages of consumers within the settlement's required timeframes, DRNJ determined that the Division was in substantial compliance of the Olmstead lawsuit, based on:

1. The decrease in the total state hospital census, including CEPP consumers;
2. The decrease in the proportion of the state hospital census comprised of CEPP consumers;
3. The increase in the creation of Supportive Housing placements within the community, which was done in excess of the SMHA's settlement targets over the initial five-year period covered by the Olmstead lawsuit;
4. The reversal in proportions of consumers served in state hospitals versus those served in community settings. Supportive Housing now far exceeds state hospital utilization in serving the Division's mental health consumers, and is now the highest ranking placement among discharges of CEPP consumers;
5. The updated and streamlined treatment planning process, which calls for community provider involvement seven days from admission into the state hospitals.
6. The creation of the Office of Olmstead, Compliance, Planning, and Evaluation, which allows for the centralized collaboration of many key disciplines involved in implementing an overall paradigm of community integration.

In addition to the accomplishments listed above, a decision was made in July 2011 to close a state psychiatric hospital. The SMHA had been closing several units at its state hospitals prior to the announcement of the closure. Planning efforts began around the closure of a state hospital including statewide hearings that were held and a Stakeholder Task Force that was convened. Hagedorn Psychiatric Hospital, a 288 bed state hospital located in the northern region was closed on June 14, 2012. Admissions to the hospital stopped on October 3, 2011. As of June 30, 2011, the census was 1,554, excluding AKFC and on June 30, 2012, the census, excluding AKFC was 1,459. The SMHA was able to close one of its state hospitals primarily due to its Olmstead Initiative. Some of the activities leading to the decrease in census and closure of the state hospital are listed below:

1. Enhancement of community infrastructure via the development of community placements including SH, enhanced SH for consumers with behavioral or co-occurring service needs, medically enhanced SH, and enhancement of PACT services;
2. Continued use of the Individualized Needs for Discharge Assessment (INDA). Introduced shortly after admission to the hospital, the INDA serves as 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 Division's updated treatment planning process requires that assigned

community providers participate in the review of the consumer's needs via the INDA during every treatment team meeting as long as the consumer is in the hospital. Through regular review and updating of this assessment, the goal is to facilitate transition into the community and anticipate and address any barriers that may hinder or preclude placement within the community. This will decrease the likelihood of readmission to the hospital. The INDA also contains information from the Housing Preference Interview (HPI) regarding consumer preferences for housing placement type and county.

3. Continued utilization of the Intensive Case Review Committee (ICRC). Consumers are referred to this committee if they a.) have been on CEPP status for two months; b.) are determined, prior to two months on CEPP, to have significant barriers to discharge; or c.) are refusing placement. The cases that are referred are reviewed to ensure that referrals for discharge are being made in a timely manner, barriers to discharge are being addressed, systemic issues are addressed, and compliance with length of stay targets are maintained.

Efforts to enhance community residential placements and the continued reduction in census at New Jersey state hospital, enabled the SMHA to close one of its state hospitals. As the Olmstead efforts continue and the SMHA develops more opportunities for individuals living in the community, the SMHA will continue to evaluate and manage the hospital resources in an efficient and clinically appropriate manner.

In addition to its network of state psychiatric hospitals DMHAS also supports county operated psychiatric facilities which operate as part of the continuum of services. These county hospitals receive most of their funding from the SMHA. In August of 2012, the sale of Buttonwood County Hospital in Burlington County was finalized and the license was conferred to the new owners, a private vendor. At the end of April 2014, Camden County Health Services Center was privatized. As of May 1, 2014, there are four county hospitals remaining in the state.

X. Legislation:

Intensive Outpatient Commitment (IOC)

This law is an amendment to the civil commitment law creating the option to commit to outpatient treatment persons in need of involuntary commitment to treatment. The outpatient commitment law is intended to provide a treatment option in the community for a class of consumers who are not willing to receive treatment voluntarily and will become, in the foreseeable future, dangerous enough because of a mental illness to require supervision, but who are not so imminently dangerous that they need to be physically confined in an inpatient program.

The legislation became effective on August 11, 2010, and required phase in to seven counties each year, over a three year period, and included no appropriation. Due to the lack of sufficient funding in SFY 2011, implementation of the law was delayed by invoking "General Provision" #72 on page E-7 of the FY 11 Appropriations Handbook. A Request for Information (RFI) was issued January 26, 2011 to stakeholders to inform the development of a future, competitive RFP and to help estimate the amount of additional resources necessary to implement the law.

An IOC Advisory Committee on Implementation was established to provide input as to how NJ can best implement IOC in a manner which comports with the law and is also responsive to the needs of families, consumers and citizens. The first meeting was held in April 2011. This committee was comprised of representatives from consumer and family organizations, providers, the court system and DMHAS staff. Members of the IOC Advisory Committee on Implementation also participated in two subcommittees that were convened: the Screening Subcommittee and the Court Procedures Subcommittee. Meetings were held in April, May, June and July and the IOC Advisory Committee and the two subcommittees concluded deliberations in July 2011.On January 13, 2012, DMHAS issued a RFP for the implementation of IOC in up to seven counties using the $2 million that was appropriated in the FY 2012 budget. DMHAS funded five programs in response to this RFP at approximately $1.7 million annually. These programs were operational August 1, 2012. The second RFP was issued on August 1, 2012 and the sixth IOC program was awarded in November 2012 and became operational in the Spring of 2013. These six programs serve Burlington, Essex, Hudson, Ocean, Union and Warren Counties. DMHAS posted an RFP on March 17, 2014 aimed at expanding IOC so that it would be available in the fifteen New Jersey counties that did not have an operational IOC program. Nine awards were made in June of 2014, permitting IOC development in eleven additional counties (Atlantic, Bergen, Camden, Cape May, Cumberland, Gloucester, Hunterdon, Mercer, Passaic, Salem, Somerset). All of these programs are now operational. DMHAS issued a fourth RFP on February 18, 2015 for program development for the four remaining counties (Middlesex, Monmouth, Morris and Sussex Counties). In addition, IOC was rebid in Warren County because the current provider indicated that they needed additional resources to bring the amount up to what is paid to the other IOC providers. Provider interest in program development for these four counties (excluding Warren) had been minimal to non-responsive to date. Total annualized DMHAS funding for the fifteen operational programs (serving seventeen counties) is approximately $5.3M. The proposed budget increase for SFY 2016 is $3.35M.

During SFY 2014, the six operational IOC programs served 351 persons. As of January 31, 2015, 314 persons were served in IOC during SFY 2015. Challenges to program development and operations have included a lack of provider response to RFPs, provider recruitment of psychiatrists and operationalization of some aspects of the law, such as managing "unwilling to receive treatment voluntarily" in an outpatient setting and "material non-compliance" with the outpatient treatment plan. DMHAS has convened a stakeholder workgroup, consisting of provider agency staff from different acute care settings, Administrative Office of the Court personnel and local county counsel to develop recommendations for improvements to the statute. The outpatient commitment law requires that an evaluation on the implementation of involuntary commitment to outpatient treatment be conducted. It is required by the Law that the evaluation covers the following eight evaluation domains:

(1) how screening services, courts and mental health professionals apply the standard for determining whether a person is dangerous within the reasonably foreseeable future to self, others or property;
(2) the effect of involuntary commitment to outpatient treatment on persons with severe mental illness;
(3) the rate and geographic distribution of court orders for involuntary commitment to outpatient treatment;
(4) the responses of patients who have been committed to involuntary commitment to

outpatient treatment to such treatment;
(5) the extent to which the use of involuntary commitment to outpatient treatment affects the rates of institutionalization and incarceration;
(6) whether persons who have been involuntarily committed to outpatient treatment are receiving the mental health treatment services necessary for recovery;
(7) whether sufficient treatment services are available to persons who have been involuntarily committed to outpatient treatment;
(8) the effect of involuntary commitment to outpatient treatment on the availability of services to voluntary consumers with severe mental illness.

In August of 2014, at a cost of $490,474 the Division entered into a Memorandum of Agreement with the Rutgers University School of Social Work for the evaluation of these statutory requirements. The evaluation commenced in the fall of 2014 and is expected to continue until January 31, 2017. Only the original six IOC programs are the subject of this study.

XI. Promoting Health and Behavioral Health

The SMHA contracts with community service agencies to work collaboratively to treat the physical and emotional needs of consumers. Initiatives to promote a better understanding of the role of mental health to overall health include: Smoking Cessation; Illness Management and Recovery (IMR), and the Advanced Practice Nurse (APN) Program.

Smoking Cessation. On April 7, 2008, the state legislature passed a law banning smoking on state hospital grounds with the provision that a smoking cessation program shall be offered to patients one full year in advance of the ban. On July 8, 2009, Ancora Psychiatric Hospital and Greystone Park Psychiatric Hospital became tobacco free as a result of this legislation. Both Trenton and Hagedorn Psychiatric Hospitals became smoke free in the fall of 2009. The smoking cessation program is a SMHA funded university-based program targeted towards educating staff and patients in state hospitals and provider agencies about cardiac risk factors associated with smoking. The goal is to have a smoke-free environment for consumers and staff.

The Learning About Health Living (LAHL) manual is a widely recognized tool to help consumers with serious mental illness to address their smoking was developed by DMHAS's consultant Dr. Jill Williams, from Rutgers University, Robert Wood Johnson Medical School with support from DMHAS. DMHAS has funded training on the use of the LAHL manual in order to increase awareness of tobacco treatment. Three LAHL half day trainings were conducted last year:

- Jersey City Medical Center hosted on 10/16/14 - 31 mental health staff attended
- Trenton Rescue Mission hosted on 4/30/15 - 14 mental health staff attended
- Training for individuals from the 35 Community Wellness (self-help) Centers on 2/20/15 through funding for the CHOICES Program - 60 attended

Overall, 45 mental health staff and 60 consumer/ peer specialists were trained in the LAHL manual last year. DMHAS also helped to fund the CHOICES program, which consists of peers helping other consumers to quit smoking.

Illness Management and Recovery (IMR) in the State Psychiatric Hospitals. IMR is an evidence-based treatment and recovery program that helps consumers learn about mental illness and strategies for treatment; decrease symptoms; reduce relapses and hospitalizations; and make progress towards personal goals through recovery. The SMHA, in partnership with the Rutgers School for Health Related Professions (SHRP), has a goal to provide all consumers in the three regional state psychiatric hospitals with an opportunity to attend an IMR group (access to IMR is limited in the state's lone forensic hospital). The IMR groups have been provided on the hospital units and in the hospitals' centralized treatment malls. The SHRP provides ongoing training and technical assistance to the state hospital staff who lead the IMR groups. The SHRP also conducts regular evaluations of fidelity with the program model.

Advanced Practice Nurse (APN) Program. Through the APN Program, comprehensive health and mental health assessments of acute and chronic conditions are completed; medication is prescribed under joint protocols; and APNs participate in the development, implementation, and evaluation of treatment plans. Consumers are referred to APNs from a variety of sources, including state and county hospitals, emergency rooms, short-term care facilities, family members, self-referrals and community providers. APNs are accessible on site at the hospitals, some community programs, and in homeless shelters. The SMHA funds approximately 68 APN positions. The state hospitals are responsible to ensure that consumers receive all necessary medical treatment (including mammography, dental care, etc.). Some of the state and county hospitals have dental offices within their facilities.

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

Community Wellness Centers. New Jersey's Community Wellness Centers help individuals develop skills in all areas of the Eight Dimensions of Wellness. Particular emphasis is placed on improving a consumer's physical health around that particular wellness dimension. The goal is to help reduce the disparity of mental health consumers dying 25 years younger than the general population. DMHAS is proud of the goals of all the centers who work hard to maintain and improve upon the physical health of the membership. Through the work of New Jersey's various mental health initiatives they provide positive opportunities for people living with a mental illness, and allow them to not just live, but thrive in the community of their choice.

Multiple centers have YMCA/gym memberships and members regularly attend the gym and improve their overall physical fitness through increased physical activity. The memberships are open, so that it is not specific to a select few, and many individuals can take advantage of the services. Most centers have exercise equipment and members are welcome to use the equipment when the centers are open. Some centers have walking clubs. Several centers visit farm markets or flea markets regularly.

The centers address cardiovascular function, weight loss and can improve a person's self-esteem and self-efficacy. All centers have scales to help monitor consumers' weight. The centers also offer nutrition groups and help them to prepare healthy meals, where members can learn to read product labels, use less salt in foods, and monitor calories. Some Community Wellness Centers have sponsored health screenings, where they check things like blood pressure, BMI, screen for diabetes and even do HIV testing. Many centers had facilitators and managers who attended a DMHAS sponsored Learning about Healthy Living Training and now do regular groups on smoking cessation. Some of the members have cut back on the amount of cigarettes they smoke a day, some have stopped, and others continue to try to quit.

Wellness coaching is offered at some sites where there are regular sessions with a peer coach to work on specific areas of the Wellness Dimensions, especially focusing on physical health. Some centers provide weekly/daily meals for members and prepare them from healthy recipes and offer salad on the side or fresh fruit for dessert.

Centers work with individuals in developing personal WRAP plans or WRAP plans for Weight Loss using the Copeland model. Some have chosen to do WRAP Scrap, where scrapbooks are used instead of a form. The WRAP plans are visually crafted, as well as having some narrative. Some centers have brought in nutritionists to assist individuals who have chosen to work on goals related to eating a healthier diet or incorporating healthier food choices in to their lives. Other centers offer Nutrition Education, and some help teach members how to pick healthy options when eating out in a restaurant.

There are several DMHAS funded initiatives that also focus on the physical dimension of wellness. C.H.O.I.C.E.S.(Consumers Helping Others Improve their Condition by Ending Smoking) is made up of a group of peers that are invited into the centers to do presentations on Smoking Cessation. They use a carbon monoxide meter and the members are faced with the hard truth of how much residue from cigarettes is in their lungs. It forces them to think about what they are doing to their overall health by smoking. The goal is to increase awareness of the importance of addressing tobacco use and to create a strong peer network that encourages mental health consumers to make a positive healthy lifestyle change by addressing smoking and tobacco use. The C.H.O.I.C.E.S. team has also received numerous awards in the past ten years, including recognitions by the American Psychiatric Association, American Medical Association, Healthy People 2020, and SAMHSA. They have made more than 1000 site visits to behavioral health programs and residences in all 21 counties of NJ. This has allowed them to talk to more than 33,000 consumers who smoke to give them important education and feedback about the dangers of smoking and need to seek treatment to try and quit. They have run support groups in NJ Community Wellness Centers to provide consumers with tools and education that can help them to quit smoking.

Hearts and Minds is another initiative that DMHAS funds and sponsors. Through this training program, consumers are presented with research which has demonstrated that people living with severe psychiatric conditions may have an increased risk of heart disease and related health conditions. NAMI New Jersey's Hearts & Minds program is an hour-long live presentation focusing on inner and outer wellness for people living with a mental illness. Hearts & Minds seeks to raise awareness and provide information on: medical self-advocacy, smoking cessation, addictions, healthy eating, exercise, and diabetes. The program is free to any facility or group throughout the state and includes goal setting and exercise and food journals.

New Jersey is fortunate to be the home of the CSP-NJ Wellness and Recovery Institute's Annual Wellness Conference that literally draws in several hundred interested consumers, providers, scholars and family members both within and outside the state to share state-of-the art knowledge about practices and research about wellness and behavioral health.. Because it is so highly educational and interactive, DMHAS allows earmarked' "Wellness Dollar funding" to be used for consumers from the centers to attend the event. Collaborative Support Programs of NJ is a DMHAS funded agency that prints the *Words of Wellness* newsletter, which offers support and information on a number of informative topics covering all of the eight Wellness Dimensions. Many consumers who have incorporated wellness practices in to their own lives successfully, contribute inspiring stories of hope and healing to the newsletter to help reach others in their journey towards wellness and recovery.

New Jersey's Community Wellness Centers sponsor a number of Hearing Voices groups. These groups are all based on the literature from the Hearing Voices Network. Hearing Voices groups do not treat hearing voices, seeing visions or other unusual experiences as a pathology. Instead, group members explore these phenomena in an environment of mutual support and curiosity. The groups offer people time to share their experiences, learn some coping options, understand their experiences, and gain support from others. There are currently 9 Hearing Voices groups operating in NJ, with 4 more facilities recently trained. The goal is to have 13 groups functioning by August 1, 2015.

Informed Choices is a DMHAS funded initiative provided by CSPNJ. It includes: Making Informed Decisions about your Medications, Your Treatment, and Your Wellness Options.
The mission is to help people in their recovery journey make choices for themselves that will improve their quality of life. It provides support for free choice and teaches alternative approaches to wellness. Informed Choices recommends ongoing support from a health care professional. The purpose is to provide education, support, and information so people have a good balance of treatment and support that works best for them. Its goals are to develop skills in making informed treatment decisions, build knowledge about a variety of ways to get and stay well, learn how to ask questions about treatment, write a personal wellness plan, learn about systems change and advocacy to make that change happen.

Bi-Directional Integration of Behavioral Health and Primary Care Services. The state remains well positioned to take advantage of the Patient Protection and Affordable Care Act (PPACA) and move forward with a number of related initiatives that will promote medical homes, reform its Medicaid program, and further promote illness self-management for individuals with SMI and

other behavioral health issues.. New Jersey has approval from Centers for Medicare and Medicaid Services (CMS) for one State Plan Amendment (SPA) to provide health home services to the SMI population in Bergen County, one SPA pending approval in Mercer County for health home services, and anticipates submitting a SPA for health homes for three additional counties in FY'16.

New Jersey's Medicaid Comprehensive Waiver includes under Section 2703 of the ACA, Health Homes as part of its Medicaid state plan, thereby becoming eligible to receive additional federal funds (90/10 match) for health home services in the first two years after implementation. This component of the waiver includes provisions for Behavioral Health Homes (BHHs) for people with SMI. The SPA approved for health homes services in Bergen County has an effective date of 7/1/14 and the SPA for health home services in Mercer County has an expected effective date of 10/1/14.

As each SPA is approved by Centers for Medicare and Medicaid Services (CMS), care coordination services in the health home model, consistent with federal CMS guidelines under Section 2703 of the ACA, will be reimbursed as a new service at an enhanced rate for up to two years. The provider will be permitted to retain the funds for service expansion and/or investment into health information technology, such as a certified electronic health record, if certain outcomes are achieved. DMHAS received technical assistance from SAMHSA on financing models and developed a three phase service delivery model that is reimbursed at a per member-per month rate (PMPM) relative to the consumer's current phase of service. Additionally, DMHAS has supported system readiness activities and capacity building through state only funds for BHH certified providers.

In addition to the waiver regarding BHHs, DMAHS and DMHAS are partnering bidirectional behavioral health and primary care screening, identification, referral to, and linkage for consumers. The partnership between the two divisions is critical to the full integration of services and both divisions are committed to work together toward that goal.

DMHAS and DMAHS have explored several models of integration, and continues to evaluate the needs of all populations. While the health home is designed as a high intensity service targeting those with the most need, there also is a call for integrated care for others. DMHAS is currently working with several technical advisors, exploring how best to test and then implement integrated care in less intensive settings. This includes a CMS State Innovation Model grant that includes integration as one of its priorities, and technical assistance from National Academy for State Health Policy (NASHP) to assist with developing a more integrated systems.

The county Mental Health Administrators have been involved in the efforts to promote integration and wellness activities of agencies in their counties, as are stakeholders at every level. The behavioral health community has expressed considerable interest in these issues and is motivated to learn about opportunities to coordinate, collaborate or integrate behavioral health and primary care services. The New Jersey Association of Mental Health and Addiction Agencies (NJAMHAA), which is the provider organization for New Jersey behavioral health agencies, has issued a white paper entitled "Integrating Physical Health and Behavioral Health Care" in which it presented several recommendations for integration, and they have formed a task force and have held meetings on these issues, most of which have involved members of the

DMHAS Work Group on Integration. Several new community behavioral health agencies have received SAMHSA grants for pilot projects; these include CarePlus-NJ, which received a Primary and Behavioral Health Care Integration grant to provide primary care clinic services for consumers onsite, and also a consortium of four mental health agencies led by Catholic Charities-Trenton, which received a SAMHSA grant for coordination of primary care services with local FQHCs.

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

In July 2012, SAMHSA awarded the DMHAS a five-year $7.5 million cooperative agreement for Screening, Brief Intervention and Referral to Treatment (SBIRT) services. Entitled NJ SBIRT, the project is a partnership between the DMHAS, the Henry J. Austin Federally Qualified Health Center (HJA), and Rutgers University, School of Social Work, Center of Alcohol Studies, and the Robert Wood Johnson Medical School. The NJ SBIRT project seeks to expand and enhance the existing continuum of care by integrating evidence-based preventive intervention services, proven effective in reducing substance use and associated negative health consequences, in primary care and community health settings. The project goals are to: 1) reduce alcohol and drug consumption and its negative health impact; 2) increase abstinence; 3) reduce costly health care utilization among adults accessing healthcare services at the NJ SBIRT project sites; and 4) promote policy and systems change that identify and overcome barriers to consumers accessing and engaging in treatment.

The HJA has implemented SBIRT services in its four (4) primary care sites and in two (2) affiliated hospital emergency departments throughout the city of Trenton. The Rutgers, Robert Wood Johnson Medical School will soon implement SBIRT services in one of its Family Medicine practices in Middlesex County. Direct services include universal screening of adult medical patients for the identification of substance use risk, and the provision of clinically appropriate brief interventions or referral to specialty treatment services as indicated. In FY 2016, services will end at HJA and funding will be provided to the Rowan School of Osteopathic Medicine, where SBIRT will be implemented in four family practice sites in four counties: Atlantic, Burlington, Camden and Gloucester.

The Rutgers, School of Social Work serves as the NJ SBIRT Project Evaluator, conducting both process and outcome evaluations. The Rutgers, Center of Alcohol Studies is the NJ SBIRT Training contractor, focused on workforce development efforts and broad dissemination of SBIRT practice as an evidence-based public health strategy for addressing substance misuse.

The Delivery System Reform Incentive Payment (DSRIP) Program is one component of New Jersey's Comprehensive Medicaid Waiver as approved by CMS in October 2012. DSRIP seeks to result in better care for individuals (including access to care, quality of care, health outcomes), better health for the population, and lower cost through improvement by transitioning funding from the current Hospital Relief Subsidy Fund (HRSF) to a model where payment is contingent on achieving health improvement goals by hospitals. Hospitals designated as DSRIP participating hospitals will receive 2013 HRSF Transition Payments in demonstration year one. The DSRIP Pool is available in demonstration years two through five for the development of a project which includes activities that support the hospitals' efforts to enhance access to health care, the quality of care, and the health of the patients and families they serve. An update of projects that are currently being implemented that are particularly relevant to DMHAS includes:

Electronic Self-Assessment Decision Support Tool: The project is to create or implement an electronic tool that allows for shared decision-making and more engagement with the client in treatment planning and pharmacological and non-pharmacological therapies to improve patient wellness. The tool allows patients to report symptoms and functioning, medical compliance and side-effects, eating, sleeping and social support network, and graphs and trends key indicators to allow the clinician to determine areas to address during the visit (Bergen Regional Medical Center, St. Clare's Riverside Medical Center).

- *Integrated Health Home for the SMI:* This project is to develop an integrated medical and psychiatric home in one facility, with one EHR and one treatment plan, and where treatment outcomes are monitored and evaluated and is being undertaken by two hospitals (Monmouth Medical Center and Kimball Medical Center).

- *Hospital-wide screening for Substance Use Disorder:* The project is to develop and implement screening tools, interventions and algorithms to be included in order sets to achieve hospital-wide screening for substance abuse. The nurse administers a risk assessment and a withdrawal assessment if needed. If the withdrawal assessment is positive, the physician is notified and initiates a precaution algorithm to assess for withdrawal symptoms or treatment algorithm to administer medication, monitor vital signs and perform other assessments as ordered in the algorithm.

Managed Behavioral Health Care. DHS convened a formal Stakeholder Steering Committee in January 2012 to inform the DHS' values and vision regarding the design and implementation of the ASO/MBHO; elicit broad stakeholder input regarding the design and development of the various components of the ASO/MBHO; initiate a small group process to inform at a more detailed level the components of the ASO/MBHO; and identify and leverage opportunities under Health Care Reform to support a transformed system. Four Work Groups were formed to address key aspects of the design and development of the MBHO: access, clinical, fiscal, and outcomes. Each Work Group was asked to prepare a report that identified key issues for consideration, challenges and opportunities, and recommendations for the Steering Committee within their respective areas of focus. A full copy of the report, including an executive summary and the Work Group specific recommendations, can be accessed at http://www.state.nj.us/humanservices/dmhs/home/mbho/Stakeholder_final_report_june15_2012.pdf.

Since that time a decision was recently reached in 2015 that DMHAS would not pursue an ASO. However, it will continue to explore options to manage its behavioral healthcare.

Interim Managing Entity. In January 2015, the Governor announced that the Division of Mental Health and Addiction Services will develop an interim managing entity (IME) for addiction services as the first phase in the overall reform of behavioral health services for adults in New Jersey. University Behavioral Health Care (UBHC) will be the IME with an implementation date of 7/1/15. The IME will provide as a coordinated point of entry / no wrong door for those seeking treatment for substance use disorders. Clients can either call the IME directly to be screened and receive a warm handoff to a provider, or they can go to/call a provider directly to be screened and continue services. The IME will assist clients to find the right provider for their needs and help them navigate the substance abuse treatment network. This will allow the state to manage its resources across payors and across the continuum of care. The IME will be implemented in Phases and will eventually manage substance abuse services for Medicaid, block grant and the most state funded initiatives. Not all addiction services will be managed in the first phase of implementation of the IME.

Overview of the New Jersey Department of Children and Families' Children's System of Care

Children's advocates had long identified a need for fundamental structural reform of New Jersey's System of Care for children with emotional and behavioral disturbances and their families. Initially, like virtually every other state, a number of child-serving systems, each with its own mandates, perspective, and priorities, had responsibility to serve these children. Children and families entered services through many different doors (child welfare, mental health, juvenile justice, education and the courts), often with similar needs for behavioral health and other community support services. The access route generally defined the problem and the services available. This, in turn, tended to define treatment goals and objectives based on the mandates and priorities of the specific child-serving system. The available services within these systems were then organized as programs, requiring children to fit the program's structure rather than structured to meet the individual needs of the child and family.

In 1990 with the creation of the Youth Incentive Program (YIP) and the elimination of state operated inpatient beds for youth under the age of 11, YIP stressed community-based, family-centered services and a decreasing reliance on inpatient care and out of home placement. Progress towards a better system continued and was supported by a dramatic reworking of the Child Welfare System; the result of a lawsuit initiated in 1999 a settlement agreement filed in 2003 and a modified settlement agreement in 2006. In November 1999 New Jersey's child mental health System of Care received a System of Care grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) for Burlington County (Burlington Partnership).

In 2000, New Jersey (NJ) began a major statewide reform initiative to restructure the system for delivering services to children, youth and young adults up to age 21 with behavioral health needs and their families into a single System of Care, coordinated and integrated at the local level,

focused on improved outcomes for children and their families. By 2006 the System of Care had been fully implemented in every NJ County.

Recognizing the continued need for improvement within a 'system of care' is essential as the need for mental health services by those 'youth' within the child welfare system continually grows; New Jersey's CSOC has continuously sought to improve services and supports. New Jersey is one of the only states whose child welfare reform plan included a statewide restructuring which resulted in creation of a specific department to house all child/ family based structures. The Department of Children and Families (DCF) in July 2006 became the first cabinet agency whose mission was devoted exclusively to serve and safeguard the most vulnerable children and families in the state.

Included in the DCF were the Division of Youth and Family Services (DYFS), Division of Child Behavioral Health Services (DCBHS) as well as other divisions and entities. The mandate of the DCBHS was to serve children and adolescents with emotional and behavioral health care needs and their families. DYFS primary mandate was investigating/ protecting children from abuse and neglect while also working towards securing permanency for those children without primary caregivers. This restructuring of the DCF resulted in a new DYFS "case practice model" that would ensure better planning and coordination between DYFS and DCBHS. Throughout 2006 and 2007 the DCBHS continued to seek input through focus groups, public hearings and an independent assessment from the University of South Florida to address improvements to the system. During 2007 and 2008 and based upon the major recommendations received, the DCBHS began the process of planfully rolling out these system improvements.

Further reorganization and realignment of service delivery in DCF began in July 2012 when services provided to children with developmental disabilities were transferred from the New Jersey Department of Human Services-Division of Developmental Disabilities (DHS-DDD) into the DCF-newly constituted Children's System of Care (CSOC), formerly DCBHS; as well as the transfer of addiction services for adolescents up to age 18 and those ages 18-21 already under the protective supervision of DCF's-newly constituted Division of Child Protection and Permanency (DCP&P), formerly DYFS, or receiving behavioral health services through the DCF's COSC were transferred from the DHS's-Division of Mental Health and Addiction Services (DMHAS) to the DCF.

Effective July 1, 2013, DCF's Contracted Systems Administrator (CSA) began authorizing youth who meet specific criteria to receive substance use treatment (SAT) services from a limited number of providers who are contracted with the DCF, NJ CSOC. In January 2014, CSOC substance abuse treatment resources were expanded to include both South Jersey Initiative (SJI) adolescent treatment services as well as detoxification services for adolescents from the ten identified counties impacted by Superstorm Sandy.

This reform initiative required an organized CSOC with a foundation of core values and guiding principles.

Core Values

- Family driven

- Youth guided
- Individualized and community based
- Culturally and linguistically competent
- Evidence based

Principles

- All children who need services should receive the same accessibility to services.
- Availability and access to a broad, flexible array of community-based services and support for children, and their families and caregivers, to address their emotional, social, educational and physical needs, should be ensured.
- Services should be individualized in accordance with the unique needs of each child and family.
- Services should be guided by a strength-based, wraparound service planning process and a service plan that is developed in true partnership with the child and family.
- Services should be delivered in the least restrictive settings that are clinically appropriate.
- Treatment outcomes for children and families should be quantifiable

System Requirements

The CSOC continues to include components that support this structural reform of service organization, management, and delivery, requiring the following system components:

A Contracted System Administrator (CSA) facilitates and supports utilization management, care coordination, quality management, and information management for the statewide system of care. In this administrative support role, it provides DCF, the CMO and other system partners with the information needed to manage the Individualized Service Plans (ISPs) process toward quality outcomes and cost effectiveness. The CSA is the single point of access to services for New Jersey children with behavioral, emotional, intellectual, developmental, and/or substance use needs. (http://www.performcarenj.org/about/index.aspx - current DCF-funded CSA)

Mobile Response and Stabilization Services (MRSS) are available 24 hours a day, seven days a week, to help children and youth who are experiencing emotional or behavioral crises. The initial 72 hour services are designed to defuse an immediate crisis, keep children and their families safe, and maintain the children in their own homes or current living situation (such as a foster home, treatment home or group home) in the community. MRSS up to 8 weeks provide parents/caregivers/guardians with short-term, flexible services that assist in stabilizing children/youth in their home/community setting.

Care Management Organizations (CMOs) organize and coordinate community-based services and informal resources through face-to-face care management at the local level for individual children and families with multi-service needs and multi-system involvement.

Family Support Organizations (FSOs) provide direct peer support and assistance to children and families from family members of children with current or past system involvement.

Access and Eligibility

Access
The CSA partners with the CSOC as the single point of entry for all children, adolescents and young adults *(up to age 21)* who are in need of behavioral health, or developmental and intellectual disability, or certain substance abuse treatment services. All services are voluntary. The System of Care includes a broad range of services to support the needs of children with complex challenges. Generally speaking, these services fall into one or more of the following categories:

Urgent and emergency crisis response and stabilization.
Care Management.
In-home services (intensive in home/intensive in community).
Substance use treatment services.
Out-of-home treatment.
Support for families and caregivers.
Youth involvement and peer support

CSA staff is available 24 hours a day, 7 days a week to provide individualized care to eligible children. Access to services in the CSOC is *only* through the CSA and may consist of referral to CMO, FSO, MRSS or other in-home and in-community programs.

Access to services provided under the Children's System of Care (CSOC), such as Care Management Organization (CMO) or Mobile Response and Stabilization Services (MRSS), requires a completed Medicaid application. In doing so, the family may be found eligible for Medicaid as secondary insurance, or the child may be approved for state funds that cover the cost of certain behavioral health services to supplement the private insurance benefits.

Eligibility
In general, youth who are eligible for services through the CSA are primarily between the ages of 5 and 21 (up to his or her 21st birthday), reside in the State of New Jersey and have an emotional or serious mental health or behavioral need. Special consideration for services is given to children under the age five. Eligibility for CMO services for child/youth/young adult include but are not limited to:

- those receiving services from the CSOC and are not eligible for Medicaid or NJ FamilyCare;
- those individuals determined by the DCF, or its designated CSA, to require CMO services due to any one or any combination of the following:
- Serious emotional or behavioral health needs resulting in significant functional impairment which adversely affects his or her capacity to function in the community
- His or her CSOC assessment indicates a need for the intensive level of case management services provided by a CMO
- He or she is involved with one or more agencies or systems, including, but not limited to: DCP&P; Crisis/emergency service providers; Department of Human Services or Department of Children and Families provider agencies; JJC; or The court system;
- A risk of disruption of a current therapeutic placement exists;
- A risk of a psychiatric readmission exists; or

- A risk of placement outside the home or community exists, except for:
- Foster care placement, unless one or more of the conditions in (a)2i through v above are also present.

A Youth and Family Guide is available in English online at http://www.performcarenj.org/pdf/provider/youth-family-guide-eng.pdf.
A Youth and Family Guide is available in Spanish online at http://www.performcarenj.org/pdf/provider/youth-family-guide-span.pdf.

Clinical Criteria
The Clinical Criteria for the various services available are located on the CSA's website at http://www.performcarenj.org/provider/clinical-criteria.aspx.

Populations Served

Serious Emotional/Behavioral Disorders
"Seriously emotionally/behaviorally challenged' means a youth exhibiting one or more of the following characteristics: behavioral, emotional or social impairments that disrupt the youth's academic or developmental progress and may also impact upon family or interpersonal relationships. This disturbance shall have also impaired functioning for at least one year or the impairment shall be of short duration and high severity. (NJAC Title 10:191-1.2)

Youth with emotional/behavioral disorders must be in need of services that are not typically provided through primary health insurance (typical services include outpatient individual therapy or partial hospitalization) and must meet the specific eligibility rules for each service type.

Substance Use
"Substance use/dependence" means a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances including alcohol, tobacco and other drugs. There may be repeated failure to fulfill major role obligations, repeated use in situations in which it is physically hazardous, multiple legal problems and recurrent social and interpersonal problems. For the purpose of this chapter, substance abuse and substance dependence also means other substance-use related disorders as defined in the DSM-V. (NJAC Title10:161A-1.3)

Youth age 13 up until their 18th birthday may qualify for substance use treatment services through PerformCare. Youth who are 18 years-old may also qualify for CSOC substance use treatment services **IF** they are actively in high school or actively pursuing their education **AND** would be best served in an adolescent program.

The Substance Use Treatment Provider List identifies which providers serve 18 year-olds. If a youth turns 18 (or 19 if admitted at age 18) while receiving services in a contracted SUT program, PerformCare will continue the authorization until the youth is ready for transition to another level of service. At the time of completing their current course of treatment, youth will be transitioned to DMHAS for substance use treatment services. Further information is available online at: http://www.performcarenj.org/provider/substance/index.aspx.

Developmental-Intellectual Disability
Youth with intellectual/developmental disabilities must first be determined "Developmental Disability (DD) eligible" in order to receive services. The application is available on the CSA website at http://www.performcarenj.org/families/disability/determination-eligibility.aspx.

for youth up to their 18th birthday. Individuals/families who don't have access to the Internet, can call the CSA at 1-877-652-7624 and an application will be mailed. Youth who were determined DD eligible by the NJ Division of Developmental Disabilities do not have to reapply in order to receive services in the Children' System of Care.

Strengths and Needs Assessment (SNA)
The SNA is the Child Family Team (CFT) planning tool to support decision making about the individual treatment planning for children and families within the CSOC. It supports the rapid and consistent communication of the strengths as well as the needs of children and their families being served through the CSOC. It is intended to be completed by the individuals who are directly involved with the child/family as part of CFT. The SNA tool serves to document the identified strength and needs of the child/family throughout the time they are in the CSOC. The SNA tool serves as the documentation of the progress as well as to ensure the child and family receive the appropriate services for the appropriate length of time.

Individual Service Plan (ISP)
The ISP is the treatment plan developed by the Child Family Team. The ISP incorporates formal and informal services and supports into an integrated plan that, using the identified strengths of the youth and family, addresses the needs of the youth and family across life domains in order to support the youth and family in remaining in, or returning to, the community where they live, work and/or attend school.

Child Family Team (CFT) Process
A CFT consists of family members, professionals, and community residents organized by a CMO to design and oversee implementation of the ISP. To complete ISP, the CMO develops a CFT in coordination with the family member or caregiver. At a minimum, the following members comprise the CFT: a CMO care manager; the youth and the parent or other caregiver; any interested person the family wishes to include as a member of the team, including, but not limited to, clergy members, family friends, and any other informal support resource; a representative from the FSO, if desired by the family; a clinical staff member who is directly involved in the treatment of the youth that the comprehensive 30 day plan is being developed for, if desired by the family; representation from outside agencies the youth is involved with, including, but not limited to, current providers of services, parole/probation officers, and/or educators that the youth and his or her family/caregiver agree to include on the team; and, the DCP&P caseworker assigned to the child, if the child is receiving child protection or permanency services from DCP&P.

The CMO Care Manager assigned to the youth and their family/caregiver is responsible to: refer the youth or the family/caregiver for multi-system or any additional specialized assessments as indicated; serve as the facilitator of the CFT; actively engage the child and family as full partners

in the CFT, assuring their participation in the assessment, planning and service delivery process; ensure that all services and care management processes respect the youth and family/caregiver's rights to define specific goals and choice of providers and resources; ensure that all services and resources are family friendly and culturally competent; ensure that all CFT meetings are conveniently scheduled and located for the family/caregiver; ensure that the ISP is developed as a collaborative effort of all team members; ensure that the ISP is approved by each team member, including the family/caregiver and the child, at the team meeting.

Wrap Around

Wraparound is an evidence-based structured approach to service planning and care coordination for individuals with complex needs (most often children, youth and their families). Wrap Around is built on key system of care values: family and youth driven, team based, collaborative, individualized, and outcomes-based. Wraparound adheres to specified procedures: engagement, individualized care planning, identifying strengths, leveraging natural supports, and monitoring progress.

The Wraparound Process User's Guide A Handbook for Families is available at the following link: http://www.nwi.pdx.edu/pdf/Wraparound_Family_Guide09-2010.pdf.
The Youth Guide to Wrap Around Services is available at the following link: http://www.nj.gov/dcf/families/csc/documents/YouthGuideWraparound.pdf.

Family Support Organizations (FSO)

Family Support Organizations (FSO's) are family-run, county-based organizations that provide direct family-to-family peer support, education, advocacy and other services to family members of children with emotional and behavioral problems. To access services, families may call these organizations directly or call 1-877- 652-7624.

A list of the FSO's with their contact information is available at: http://www.nj.gov/dcf/families/support/support/.

Mobile Response Stabilization Services (MRSS)

MRSS-Initial 72 hours

Mobile Response and Stabilization Services are available 24 hours a day, seven days a week, to help children and youth who are experiencing emotional or behavioral crises. The services are designed to defuse an immediate crisis, keep children and their families safe, and maintain the children in their own homes or current living situation (such as a foster home, treatment home or group home) in the community.

The goals of Mobile Response Initial Services are to rapidly respond to any non-immediate life threatening mental health crisis reaction and/or youth with escalating emotional and/or behavioral health needs; provide immediate intervention to assist children/youth and their parents/caregivers/guardians in de-escalating behaviors, emotions and/or dynamics impacting youth life functioning ability' prevent/reduce the need for care in more restrictive settings e.g. inpatient psychiatric hospitalization, detention, etc. by providing timely community based intervention and wrap around service delivery/resource development; effectively engage, assess

and plan for appropriate interventions to minimize risk, aid in behavior stabilization, and improve life functioning, allowing the child/youth to remain in, or return to, his/her present living arrangement, functioning in school and community settings, and maintain least restrictive treatment setting; facilitate the child/youth's and the parent/caregiver/guardian's transition into identified supports, resources and services post Mobile Response Initial Services including but not limited to Mobile Response Stabilization Management Services, Care Management Services, outpatient services, evidence based services, community based supports and natural resources.

More detailed information is available at the following link:
http://www.performcarenj.org/pdf/provider/clinicalcriteria/mobile-response-serv-72-hrs.pdf.

MRSS-Up to 8 Weeks
Mobile Response Stabilization interventions provide parents/caregivers/guardians with short-term, flexible services that assist in stabilizing children/youth in their home/community setting. Interventions are designed to maintain the child/youth in his/her current living arrangement, to prevent repeated hospitalizations, to stabilize behavioral health needs and to improve functioning in life domains, as identified. Interventions at this level of care include the delivery of a flexible variety of services through the development of a comprehensive and coordinated Individual Crisis Plan (ICP). Children/youth, based upon need, enter Mobile Response Stabilization Services following the completion of the Mobile Response Assessment and the development of the ICP by the Mobile Response Team during the first 72 hours.

Interventions may include, but are not limited to, crisis intervention, counseling, stabilization bed services, behavioral assistance, in-home therapy, intensive in-community services, skill building, mentoring, medication management and/or parent/caregiver/guardian stabilization interventions. Mobile Response Stabilization Services are managed and monitored by the Children's Mobile Response Stabilization Services Agency and pre-authorized and reviewed by the CSA. Mobile Response Stabilization interventions can be delivered for up to eight weeks. Use of these interventions will vary by setting, intensity, duration and identified needs. The objective of Mobile Response Stabilization Services would be to ultimately defuse the current crisis and help link the youth and family with longer-standing therapeutic resources which are consistent with their treatment needs. This may involve linking the family with services outside of the CSOC system, such as Division of Developmental Disabilities, Autism specialized services, or community based therapeutic nursery programs, where available.

More detailed information is available at the following link:
http://www.performcarenj.org/pdf/provider/clinicalcriteria/mobile-response-serv-8-wks.pdf.

CMO Treatment Planning
The Individual Service Plan (ISP) is comprehensive in nature, strength based, and developed in partnership with the child, youth, young adult and the family or other caregivers. The ISP is based on the comprehensive assessments completed as indicated by the presenting challenges, needs and strengths of the child, youth or young adult and his or her family/caregiver; identifies the services to be provided and shall ensure that the services are provided to the child, youth, or young adult in the least restrictive manner possible; and, consists of outcome based, short term, interim, and long term goals to address each area of unmet need with measurable goals and time

frames, specific individual roles and responsibilities, a crisis/emergency response plan and a schedule for ongoing review and assessment. The ISP is developed within 30 days of the referral to the CSA and is submitted to the CSA for registration within 30 calendar days of the referral.

At a minimum, the ISP addresses areas of unmet need in all areas of the following life domains, as indicated by the multi-system assessment process, including, but not limited to: child safety; child risk; clinical needs; non-clinical needs, if deemed therapeutic and approved by the Child/Family Team; permanency planning; and community safety issues. Additionally the ISP includes child safety, child risk, permanency planning and community safety issues coordinated with the DCP&P worker, who has the primary responsibility for child safety under the Federal child protection mandates contained in Title IV-E of the Social Security Act.

The ISP must contain the following information: documentation of the participation of providers and local community partners and the integration of available and appropriate services and resources; documentation of the responsibilities, objectives, and requirements of child welfare, mental health, juvenile justice, the courts, and other service systems, as applicable; documentation of the coordination of system partner mandates and responsibilities with the assessment plan; documentation of the involvement of FSOs, if desired by the family; a plan for permanency, clinical care, and child and community safety (DCP&P maintains the primary responsibility for permanency and child safety for the DCP&P child.); a community based crisis management plan, which includes emergency response capability to respond in person to deliver in-home or off-site crisis support as warranted, and coordination of crisis response services, if intervention is needed beyond care manager response; a plan to develop and purchase those items and/or services necessary to support the individual's needs as determined by the team; documentation of the coordination of applicable services with the physical health insurer; measurable goals and the criteria to be met to obtain those goals; a plan for transitioning the youth and the family/caregiver from CMO services to a community based, natural support network of services; a plan to maintain enrollment for the youth receiving the CMO services on a "no eject/no reject" basis until the defined outcomes and discharge criteria specified in the ISP are met; and, the signatures of the CMO care manager, the parent/caregiver and the child, youth or young adult receiving the services.

Behavioral Health Homes (BHH)

CSOC, in coordination with the DHS Division of Mental Health and Addiction Services developed and implemented Behavior Health Homes (BHH) in Bergen and Mercer counties. BHH serve as a "bridge" that connects prevention, primary care, and specialty care, and is designed to avoid fragmented care that leads to unnecessary use of high end services (i.e. emergency rooms and inpatient hospital stays.) The current child family teams are to include medical expertise and health/wellness education for purpose of providing fully integrated and coordinated care for children who have chronic medical conditions. Behavioral Health Home provides services to children with serious emotional disturbance with the goal of improving health outcomes; promoting better functional outcomes (such as increased school attendance); decreasing overall cost, and the cost associated with the use of acute medical and psychiatric services; improving child/family’s satisfaction with care; and, improving the family’s ability to manage chronic illness.

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 constitutes 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.

Intensive In-Home Services (IIH)

IIH are an array of rehabilitation and/or habilitation services delivered face-to-face as a defined set of interventions by clinically licensed or certified practitioners. IIH are geared to augment those services already being provided in the school and other settings; they do not supplant existing services. All other benefits for which the youth may be eligible (such as SSI and private insurance) must be accessed before accessing IIH resources. Services are not a guarantee and are based on the youth's and family's need and availability of resources.

IIH are provided in the youth's home and/or in community-based settings, and not in provider offices or office settings. Providers must be able to safely address complex needs and challenging behaviors including but not limited to: noncompliance to verbal/written directions, tantrums, elopement, property destruction, physical/verbal aggression, self-injurious behaviors, and inappropriate sexual behavior.

These services are provided as part of an approved intensive individualized in-home service plan and encompass a variety of clinical and behavioral intervention supports and services including, but not limited to, Clinical (Rehabilitation) and Behavioral (Habilitation) services.

Clinical (Rehabilitation) supports and services are provided as part of an integrated plan of care which includes but is not limited to: CSOC Information Management Decision Support (IMDS) Strengths and Needs Assessment or other CSOC approved/required IMDS tools and other assessment tools as indicated. Clinicians must be familiar with the array of considerations that would indicate preferred assessment methods. IIH services may include individual, family and group counseling; Positive Behavioral Supports; instruction in learning adaptive frustration tolerance and expression, which may include anger management; instruction in stress reduction techniques; problem solving skill development; psycho-educational services to improve decision making skills to manage behavior and reduce risk behaviors; social skills development; trauma informed counseling; and the implementation of an individualized Behavior Support Plan, if present. The Clinician shall provide coordinated support with agency staff and participate as part of the clinical team; collaborate effectively with professionals from other disciplines that are also supporting the youth, including but not limited to: education staff, clinicians, physicians, etc.; and recommendation referrals for medical, dental, neurological or other identified evaluations.

Behavioral (Habilitation) supports and services are provided as part of an integrated plan of care which includes but is not limited to: Applied Behavior Analysis (ABA) Functional Behavior Assessment (FBA) and related assessments, e.g., preference assessments, reinforcer assessments; Level of Functioning in the six major life areas, also known as Activities of Daily Living (ADL) as measured by the Vineland or other similar accepted tool; augmentative and alternative communication supports and functional communication training, e.g. visual schedules, contingency maps, Picture Exchange Communication System (PECS), wait signal training; instruction in Activities of Daily Living; implementation of an individualized Behavior Support

Plan; individual behavioral supports such as Positive Behavioral Supports; training/coaching to address the youth/young adult's behavioral needs; support and training of parent/legal guardian to successfully implement Behavior Support Plan, use of Assistive Technology, and other support services as needed, gradually diminishing the need for outside intervention; modifying behavior support plans based on frequent, systematic evaluation of direct observational data; providing training and supervision to support staff providing in home ABA services; recommendations for referrals for medical, dental, neurological or other identified evaluations; providing coordinated support with agency staff and participating as part of the clinical team; collaborating effectively with professionals from other disciplines that are also supporting the youth, including but not limited to: education, clinicians, physicians, etc. The Functional Behavior Assessment and development of a Behavior Support Plan shall be an integral part of the treatment planning process for those identified youth.

Intensive In-Community Services (IIC)

IIC services are flexible, multi-purpose, in-home/community clinical support for parents/caregivers/guardians and children/youth with behavioral and emotional disturbances who are receiving care management or MRSS services. The purpose of these interventions is to strengthen the family, to provide family stability and to preserve the family constellation in the community setting. These services are flexible both as to where and when they are provided based on the family's needs. They may be provided as a component of the MRSS. This family-driven treatment is based on targeted needs as identified in the plan of care and includes specific intervention(s) with target dates for accomplishment of goals that focus on the restorative functioning of the child/youth.

The services provided will also facilitate a youth's transition from an intensive treatment setting back to his/her community. They are designed to be time limited in nature with the objective of helping the youth and family transition to longer term community based mental health services which are congruent with their treatment needs when needed. Interventions will be delivered with the goal of diminishing the intensity of treatment over time.

Each youth receiving intensive in-community services shall have an approved, documented comprehensive plan of care addressing the services. The plan shall be individually tailored to address identified behavior(s) that impact on the youth's ability to function at home, school or in the community, and shall incorporate generally accepted professional interventions. The plan of care shall be authorized by the DCF, the CSA or other authorized DCF designated agent(s). For those youth receiving CMO services, this plan shall be included as part of the youth's CMO ISP prepared by the CFT. For all other CSOC enrolled youth receiving intensive in-community services, this plan of care shall be included in the plan of care as coordinated and/or authorized by the CSA or other designated agent, prior to implementation.

New DCF Initiatives under the NJ Comprehensive Waiver

The three new DCF initiatives under the NJ Comprehensive Waiver are now operational. The services provide additional community support and coordination of services for an expanded population of youth that meet the clinical criteria for services. This includes services for certain NJ FamilyCare eligible individuals that have been diagnosed with a Serious Emotional Disturbance (SED), Autism Spectrum Disorder (ASD) and Individuals with Intellectual/

Developmental Disabilities and a co-occurring Mental Illness (ID/DD-MI). These waivered services are not yet included as part of NJ State Plan: The ASD pilot provides NJ FamilyCare children with needed therapies that they are unable to access through the NJ FamilyCare State Plan and are not yet available to other children with private health insurance. By providing intensive home and community based services, the ID-DD/MI pilot is built to provide a safe, stable and therapeutically supportive environment for children with developmental disabilities and co-occurring mental health diagnoses, age five up to 21, with significantly challenging behaviors. The SED demonstration provides health services for enrollees who have been diagnosed as seriously emotionally disturbed—an at-risk population for hospitalization and out-of-home placement. Over the past two and ½ years, the Children's System of Care has worked with the Division of Medical and Health Services (DMHAS) and its fiscal agency, Molina to build and implement the new service codes so that the Molina system would support the new program, and allow for CSOC Medicaid providers to successfully bill for services provided. These codes were operationalized on March 1. 2015.

Out-of-Home Treatment

Out-of-home (OOH) treatment is a time-limited intervention aimed at stabilizing a child/youth/young adult's identified behaviors/needs and addressing the underlying etiology of these behaviors/needs so that he/she may safety return home or to a non-clinical setting with as little disruption to his/her life as possible. The long-term goal of OOH treatment is to facilitate the youth's reintegration with his/her family/caregiver and community or in an alternative permanency plan preparing for independent living. OOH treatment is the CSOC's highest level of intervention and thus should only be accessed when all other therapeutic interventions have been exhausted. Prior to submission of an OOH Referral Request, CMO must facilitate a Child Family Team (CFT) meeting to discuss the current needs of the child, obtain consent from the youth/family for OOH care, and obtain supervisor approval. The CSA determination for an OOH Intensity of Service (IOS) is based on the clinical information provided in the OOH Referral Request as well as in required supporting documentation.

Out-of-Home Intensities of Service (IOS)

CSOC serves children, youth, and young adults with a wide range of challenges associated with emotional and behavioral health, intellectual/developmental disabilities, and substance use. CSOC is committed to providing these services based on the individualized need of each child and family within a family-centered, strength-based, culturally competent, and community-based environment. CSOC offers a full continuum of out-of-home services which are based on intensity, frequency, and duration of treatment.

The full continuum of out-of-home services (from highest to lowest intensity) includes the following:

Behavioral Health

(IRTS) Intensive Residential Treatment Services
(PCH) Psychiatric Community Home
(SPEC) Specialty
(RTC) Residential Treatment Services
(GH) Group Home

(TH) Treatment Home

Intellectual/Developmental Disabilities (IDD)
(IPCH-IDD) Intensive Psychiatric Community Home-IDD
(PCH-IDD) Psychiatric Community Home-IDD
SPEC-IDD (Specialty-IDD)
GH 2-IDD (Group Home Level 2-IDD)
GH-1 IDD (Group Home Level 1-IDD)
SSH IDD (Special Skills Home-IDD)

Substance Use
Short Term Detox
Short Term Residential
Long Term Residential

Children's Interagency Coordinating Council (CIACC)
Located within each county, CIACCs were created by statute to serve as the mechanism in each county to develop and maintain a responsive, accessible, and integrated system of care for children with emotional and behavioral challenges and their families, through the involvement of parents, consumers, youth and child serving agencies as partners. The CIACCs provide a forum where the system of services for children with emotional and behavioral challenges is developed, reviewed, revised and/or redirected, through collaborative decision-making process with DCF to promote optimal services provided in the least-restrictive, but most appropriate setting possible.

Each CIACC completes an annual county needs assessment to determine how CSOC community development funds should be allocated within that county.

CIACC Education Partnership
The mission of the *CIACC Education Partnership* is to promote, develop, and enhance collaborative efforts between school, behavioral health and child protective service systems and other interested parties to improve the well-being of children in Ocean County.

The Partnership was conceived in 2006 by members of the CIACC who recognized a need for ongoing, standardized exchange of procedural information between local schools, the child protective service agency and children's behavioral health programs. The services and supports available for children are continually growing and evolving. Through this Partnership, professionals from each of the three systems are provided up-to-date, ongoing training and education on the services that are available and how to access and effectively coordinate with those services, which will help ensure that children receive the help that they need. Through enhancing the knowledge of and communication between professionals, Ocean County children may see the full benefit of these systems working together to meet their multifaceted needs.

Educational Services
The McKinney-Vento Act defines homeless children as "individuals who lack a fixed, regular, and adequate nighttime residence." This includes youth in OOH/state facilities. The Department of Corrections, the DCF, the DHS, and the JJC are required to provide educational programs to

students in State facilities ages five through 20 and for students with disabilities ages three through 21 who do not hold a high school diploma. Students must be able to receive high school credit.

In general State agencies are required to:
provide a program comparable to the special education student's current individualized education program (IEP), and implement the current IEP or develop a new IEP; develop an individualized program plan (IPP), within 30 calendar days, for each general education student, in consultation with the student's parent, school district of residence, and a team of professionals with knowledge of the student's educational, behavioral, emotional, social, and health needs to identify appropriate instructional and support services; discuss the IPP with the student and make a reasonable effort to obtain parental consent for an initial IPP, including written notice; and, review and revise the IPP at any time during the student's enrollment, as needed, or on an annual basis if the student remains enrolled in the State facility educational program, in consultation with the school district of residence.

Attendance in educational programs is compulsory for all students, except for a student age 16 or above who may explicitly waive this right. For a student between the ages 16 and 18, a waiver is not effective unless accompanied by consent from a student's parent or guardian. A waiver may be revoked at any time by the former student.

The actual number of days a student with a disability must attend the educational program shall be determined by the student's IEP.

Students with a Disability
Each State agency shall ensure all students with a disability in the agency's State facilities are provided a free and appropriate public education as set forth under the Individuals with Disabilities Education Act, 20 U.S.C. §§1400 et seq., and shall provide special education and related services as stipulated in the individualized education program (IEP) in accordance with the rules governing special education.

The State of New Jersey Department of Education Homeless Education link at http://www.state.nj.us/education/students/homeless/ provides additional links for information/resources.

Educational Stability for Youth in Out-of-Home Placement
In October 7, 2008, the federal government signed into law the Fostering Connections to Success and Increasing Adoptions Act (P.L. 110-351). This act required all states to arrange for children and youth in foster care to remain in their "school of origin" to ensure educational stability unless it is determined to be in a child's best interest to go to the new district where the Resource Family Home is located. New Jersey responded to this charge by passing the Education Stability Law on September 9, 2010, which established a system that supports the act. The DCF, Department of Education (DOE) and Office of the Child Advocate (OCA) worked together to implement this law. For children, changing schools can affect their ability to thrive academically, socially, behaviorally and psychologically. This is especially true for children in resource family homes. For these children – who often suffer the lingering effects of abuse or neglect and the

trauma of being removed from their homes and families – school can often be the most stable part of their lives.

Work continues to fully implement the requirements of coordination between the DCF and the local school districts. To support the continued progress "*Improving the Educational Outcomes of Children in Out-of-Home Placements: An Interagency Guidance Manual*" is available on the DCF website at http://www.nj.gov/dcf/families/educational/stability/GuidanceManual.pdf and on the NJDOE website at http://www.state.nj.us/education/students/safety/edservices/stability. The guidance manual includes a model memorandum of agreement (MOA) and provides specific actions to reach the indicators and goals in the MOA. A one page flyer with information for School Registration of Youth in Out-of-Home Care is available at http://www.nj.gov/dcf/documents/divisions/dyfs/OOHflyer.pdf. A two page directory of local DCF Education Stability Liaison Staff is available at http://www.nj.gov/dcf/families/educational/stability/Directory.pdf.

Training and Technical Assistance

The mission of Training and Technical Assistance Services for the Children's System of Care is to support learning the requisite knowledge and skills to provide services and support the unique needs and strengths of families and children with complex needs. The training and technical assistance effort draws on a commitment to competency based curriculum design, training based on adult principles of learning and skill development, and development of local expertise and Training capacity.

Rutgers University Behavioral HealthCare (RUBHC), Behavioral Research and Training Institute, is responsible for all CSOC curriculum development, training and technical assistance activities statewide. This includes all IMDS training and certification, as well as the provision of training contact hours for social workers and counselors.

Additional information regarding the Training and Technical Assistance programs can be accessed at: http://nj.gov/dcf/providers/csc/training/.

Assess the Strengths and Needs of the Service System.

The summary of the CSOC strengths as well as unmet service needs and gaps within the current system of care is based on the following sources of information:

- DCF 2014 Inventory and Needs Assessment for New Jersey Behavioral Health – A Report by Children's System of Care, 2015
- CSOC Child and Youth Behavioral Electronic Record (CYBER) Data Collection and Reports SFY 2014-2015
- CSOC Internal Data Collection and Reports SFY 2014-2015
- CSOC Youth Services Survey for Families SFY 2014-2015
- Monthly "Meet the CSOC Director" statewide stakeholder input meetings
- Traumatic Loss Coalitions for Youth Program Reports
- Department of Children and Families Strategic Plan 2014-2016
- Monthly county-based Children's Inter-Agency Coordinating Council (CIACC) meetings

Strengths of the New Jersey Children's System of Care include:

- The consolidation of youth services under one department, the Department of Children and Families.

- Expanded system of care now provides services to youth with: mental/behavioral health challenges, developmental disabilities, and/or substance use

- CSOC maintained full implementation of and expanded the children's system of care, which includes CMO, FSO, and MRSS in every county/vicinage in New Jersey.

- For State Fiscal Year 2015, funding directly appropriated to CSOC from State and Federal sources, and the funds contributed by Juvenile Justice Commission for the provision of behavioral services across all service lines totaled $441,475,000. See Table 1 below.

Table 1

Sources of Funding for Children's Behavioral Health Services

Grants in Aid	$254,455,000
Title XIX (Federal)	$145,131,000
Title XXI (State and Federal)	$ 33,504,000
Juvenile Justice Commission	$ 573,000
Substance Abuse Block Grant (Federal)	$ 7,812,000
TOTAL	**$441,475,000**

- The Care Management Organization (CMO) model, which provides evidence based Wraparound services, is implemented statewide. These organizations combine advocacy, service planning and delivery, and care coordination into a single, integrated, cross-system process, in order to assess, design, implement and manage child-centered and family-focused individualized service plans for children, youth and young adults whose needs require either intensive or moderate care management techniques that cross multiple service systems.

- Peer support for families is provided to families of youth with moderate and intensive levels of need; and, Fidelity to the Wraparound model of care has been maintained.

- The inclusion of families in planning and implementing system change and the focus on the importance of family participation in treatment decision. CSOC recognizes of the importance of the role of parents and caregivers in determining the most appropriate services for their children is central to New Jersey's new service system. Parent input in policy and service development has become the accepted standard throughout the children's system of care.

- CSOC, with input from the NJ Youth Suicide Prevention Council developed the New Jersey Youth Suicide Prevention Plan, which serves as the guiding document for suicide prevention and intervention throughout the state.

- CSOC continues to support the implementation of evidence-based programs including Wraparound, MST, FFT, Therapeutic Nurseries and Treatment Homes (Therapeutic Foster Care).

- The number of youth receiving behavioral healthcare services in out-of-state treatment settings was reduced from over 300 in October 2006. In March 2013 a grant was awarded to Saint Joseph's Hospital and Medical Center to develop a RTC for Deaf and Hard of Hearing youth on the grounds of Marie Katzenbach School for the Deaf in Ewing, New Jersey. This site opened during SFY 2015 and no children remain out of state.

- The implementation of New Jersey's Child Welfare Reform Plan coincides with and is integrated with the children's system of care. Clinical Consultants report to DCP&P Area Offices four days per week and serve as liaisons, joined from the wraparound perspective, that translate system of care principles and values into case practice and planning and assist in the coordination of behavioral health services for youth involved in the child welfare system.

- County based Children's Inter-Agency Coordinating Councils (CIACCs) exist in each county in New Jersey and provide a forum where the system of services for children with emotional and behavioral challenges is developed, reviewed, revised and/or redirected, through collaborative decision-making process with DCF to promote optimal services provided in the least-restrictive, but most appropriate setting possible.

- CSOC development and implementation of uniform assessment tools and processes for all individuals referred for services.

- The inclusion of youth involved with juvenile justice in the children's system of care.

- Increased functionality, enhancement, and refinement of the Administrative Service Organization (ASO). CSOC utilizes an ASO to support care coordination, utilization management, quality management, and information management for the statewide children's System of Care. The ASO creates a virtual single point of processing that registers tracks and coordinates care for all New Jersey children who are screened into the system at any level. Through the creation of a single electronic record the ASO provides CSOC, the care management entities and other system partners with the information needed to manage the Individual Service Planning process toward child and family satisfaction, quality outcomes, and cost effectiveness. The ASO provides data to CSOC and providers through production and AdHoc reporting services. Utilization Management and Outlier Management are provided to ensure children and their families receive appropriate treatment for an appropriate length of time. These administrative services are supported through a highly innovative and customized Management Information System (MIS) solution. Embedded in the MIS is Outcomes Management. Outcomes Management is a comprehensive child focused set of tools and reports that track and disseminates data gathered through the comprehensive assessment tools,

allowing CSOC to track outcomes, use of Evidence Based Practices (EBP) and to more fully manage performance and effectiveness of service delivery.

- The continued rollout of increased capacity and functionality of the Administrative Services Organization (ASO) to include the provision of services to 16,000 youth with developmental disabilities and their families, which began transitioning to CSOC beginning January 1, 2013. Additionally, services to youth under age 18 with substance abuse challenges and their families began transitioning to CSOC beginning July 1, 2013.

- Development, Evaluation, and Award of Requests for Proposals for the following out of home treatment services: Residential Treatment (RTC) Center Intensity of Services (IOS) for varying populations-25 beds; RTC IOS for Youth with Co-Occurring Mental Health and Substance Abuse Diagnosis-10 beds; Intensive Residential Treatment Services (IRTS)-50 beds; Regional Crisis Stabilization and Assessment Services-15 beds.

- Development, Evaluation and Award of Requests for Qualifications for the following in-home treatment services: The Provision of Intensive In-Home individualized Clinical and Therapeutic Supports and Services for Children with Intellectual and/or Developmental Disabilities; The Provision of Intensive In-Home individualized Behavioral Intervention Supports and Services for Children with Intellectual and/or Developmental Disabilities; The Provision of Individual Support Services for Youth with Intellectual and Developmental Disabilities; One to One Support Services for Summer Camp for Youth with Developmental Disabilities; and Summer Camp Providers for Children, Youth, Adolescents, and Young Adults with Intellectual and Developmental Disabilities.

- The three new DCF initiatives under the NJ Comprehensive Waiver are now operational. The services provide additional community support and coordination of services for an expanded population of youth that meet the clinical criteria for services. This includes services for certain NJ FamilyCare eligible individuals that have been diagnosed with a Serious Emotional Disturbance (SED), Autism Spectrum Disorder (ASD) and Individuals with Intellectual/ Developmental Disabilities and a co-occurring Mental Illness (ID/DD-MI). These waivered services are not yet included as part of NJ State Plan: The ASD pilot provides NJ FamilyCare children with needed therapies that they are unable to access through the NJ FamilyCare State Plan and are not yet available to other children with private health insurance. By providing intensive home and community based services, the ID-DD/MI pilot is built to provide a safe, stable and therapeutically supportive environment for children with developmental disabilities and co-occurring mental health diagnoses, age five up to 21, with significantly challenging behaviors. The SED demonstration provides health services for enrollees who have been diagnosed as seriously emotionally disturbed—an at-risk population for hospitalization and out-of-home placement. Over the past two and ½ years, the Children's System of Care has worked with the Division of Medical and Health Services (DMHAS) and its fiscal agency, Molina to build and implement the new service codes so that the Molina system would support the new program, and allow for CCOS Medicaid providers to successfully bill for services provided. These codes were operationalized on March 1. 2015.

- Development and implementation of Behavior Health Homes (BHH) in Bergen and Mercer counties. BHH serve as a "bridge" that connects prevention, primary care, and specialty care, and is designed to avoid fragmented care that leads to unnecessary use of high end services (i.e. emergency rooms and inpatient hospital stays.) The current child family teams are to include medical expertise and health/wellness education for purpose of providing fully integrated and coordinated care for children who have chronic medical conditions. Behavioral Health Home provides services to children with serious emotional disturbance with the goal of improving health outcomes; promoting better functional outcomes (such as increased school attendance); decreasing overall cost, and the cost associated with the use of acute medical and psychiatric services; improving child/family's satisfaction with care; and, improving the family's ability to manage chronic illness. 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 constitutes 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 2016 three additional BHH will open in one each in Cape May, Atlantic and Monmouth counties.

- Development and implementation of a Division-wide Systems Review Committee and Systems Review process. The following Quality Improvement Plan serves as the foundation of the commitment of the Children's System of Care to develop a robust and fully functional CQI system:
    - To implement assessment processes which collect and integrate feedback from system partners to inform planning and decision making based on the needs of the child and family, in a family-centered, community based environment.
    - To ensure that contracted services meet the needs of those we serve through an ongoing monitoring process.
    - To develop a system review tool to ensure all services being provided to the children and families are evidence based best practices.
    - Develop a framework/mechanism to receive and respond to performance feedback.

- Continued enhancement of the CSOC training curriculum to include intellectual/developmental disabilities and substance use disorders.

SUBSTANCE ABUSE TREATMENT SERVICES

Counseling/Therapy Services

Individual Counseling Session:

Counseling provided on an individual basis to clients with a substance abuse or dependence diagnosis which includes therapeutic and supportive interventions designed to: motivate the client for recovery from addictive disease, facilitate skills for the development and maintenance of that recovery, improve problems solving and coping skills, and develop relapse prevention skills. Session content and structure are designed in accordance with client's treatment. Individual counseling can be delivered by a CADC, an alcohol and drug counselor intern or credentialed intern under the supervision of a qualified clinical supervisor per N.J.A.C. 13:34C-6.2, or by a New Jersey licensed behavioral health professional who is also credentialed to provide therapy in accordance with the DAS Service Descriptions. 1 hour = 1 unit

Individual Therapy Session:

The treatment of an emotional disorder, including a substance abuse disorder, as identified in the DSM through the use of established psychological techniques and within the framework of accepted model of therapeutic interventions such as psychodynamic therapy, behavioral therapy, gestalt therapy and other accepted therapeutic models. These techniques are designed to increase insight and awareness into problems and behavior with the goal being relief of symptoms, and changes in behavior that lead to improved social and vocational functioning, and personality growth. Individual Therapy must be provided by: Licensed Clinical Psychologist, Certified Nurse Practitioner-Psychiatric and Mental Health (CNP-PMH), Advanced Practical Nurse-Psychiatric and Mental Health (APN-PMH), Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), or Licensed Marriage and Family Therapist (LMFT). 1 hour = 1 unit.

Group Counseling:

Counseling provided on a group basis to clients which uses group processes and supports to: motivate the client for recovery from addictive disease, facilitate skills for the development and maintenance of that recovery, improve problems solving and coping skills, improve intra and inter personal development and functioning, and develop relapse prevention skills. Session content and structure are designed in accordance with client's treatment plan. Group counseling can be delivered by a CADC, an alcohol and drug counselor intern or credentialed intern under the supervision of a qualified clinical supervisor per N.J.A.C. 13:34C-6.2, or by a New Jersey licensed behavioral health professional who is also credentialed to provide therapy in accordance with the DAS Service Descriptions. 1 hour= 1 unit

Family Counseling:
Counseling provided to the family unit, with or without the client present, to impart education about the disease of addiction, elicit family support for the client's treatment, encourage family members to seek their own treatment and self-help, assess the clients environment during or after treatment and to assess the client's functioning outside of the treatment environment. Family counseling can be delivered by a CADC, an alcohol and drug counselor intern or credentialed intern under the supervision of a qualified clinical supervisor per N.J.A.C. 13:34C-6.2, or by a New Jersey licensed behavioral health professional who is also credentialed to provide therapy in accordance with the DAS Service Descriptions. 1 hour =1 unit

Family Therapy:
Treatment provided to a family utilizing appropriate therapeutic methods to enable families to resolve problems or situational stress related to or caused by a family member's addictive illness. In this service, the family system is the identified client and interventions are targeted to system change. Family and Individual Therapy must be provided by: Licensed Clinical Psychologist, Certified Nurse Practitioner-Psychiatric and Mental Health (CNP-PMH), Advanced Practical Nurse-Psychiatric and Mental Health (APN-PMH), Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), or Licensed Marriage and Family Therapist (LMFT). 1 hour = 1 unit.

Psychoeducation
Psychoeducation is the education of a client in way that supports and serves the goals of treatment.

Didactic Session:
Group session that involves teaching people about the disease of addiction, how to treat it, and how to recognize signs of relapse so that they can get necessary treatment and support services. 1 hour = 1 unit

Family Education and Information:
Family Education and Information is the education of the family in a way that services the goals of the identified client. Family Education and Information involves teaching family members of identified clients about the disease of addiction, how the disease affects the family, how to support the client's recovery and how to find services and treatment for the family members. 1 hour = 1 unit

OUTPATIENT SUBSTANCE ABUSE TREATMENT
Level 1

Definition: Outpatient Substance Abuse Treatment is provided in a DAS licensed outpatient facility which provides regularly scheduled individual, group and family counseling services for less than nine (9) hours per week. Services may be provided to patients discharged from a more intensive level of care, but are not necessarily limited to this population. Twelve (12) Step Meetings or other Self-Help Meetings cannot be counted as billable Counseling Services. This care approximates ASAM PPC-2R Level 1 care.

Counseling/Therapy Services:

- Individual: in a full session, this includes face-to-face for one (1) hour.
- Individual: in a half-session, this includes face-to-face for thirty (30) minutes.
- Group: minimum sixty (60) minutes of face to face contact.
- Family: in a full session for one (1) hour or a half-session for thirty (30) minutes. To be included during course of treatment as clinically indicated.

Psychoeducation:

- Didactic sessions.
- Family education and information sessions as clinically indicated.

INTENSIVE OUTPATIENT SUBSTANCE ABUSE TREATMENT
Level II.I

Definition: Intensive Outpatient (IOP) Substance Abuse Treatment is provided in a licensed IOP facility which provides a broad range of highly intensive clinical interventions. Services are provided in a structured environment for no less than nine (9) hours per week. Request for more than twelve (12) hours per week of services must be pre-approved by initiative case manager or DAS staff. **A minimum of three (3) hours of treatment services must be provided on each billable day to include one individual counseling session per week.** IOP treatment will generally includes intensive, moderate and step-down components. Twelve (12) Step Meetings or other Self-Help Meetings cannot be counted as billable services. This care approximates ASAM PPC-2 Level II.I care.

Counseling/Therapy Services:

- Individual: One hour per week minimum.
- Group: Six (6) hours per week minimum.
- Family: To be included during course of treatment as clinically indicated.

Psychoeducation:

- Didactic sessions: 2 hours/week minimum.
- Family education and information sessions as clinically indicated.

PARTIAL CARE SUBSTANCE ABUSE TREATMENT
Level II.5

Definition: Partial Care Substance Abuse Treatment is provided in a licensed Partial Care facility which provides a broad range of highly clinically intensive interventions. Services are provided in a structured environment for no less than 20 hours per week. **A minimum of four (4) hours of treatment services must be provided on each billable day to include one individual counseling session per week.** Lunch is not a billable hour. Twelve (12) Step Meetings or other Self-Help Meetings cannot be counted as billable services. Programs have ready access to psychiatric, medical and laboratory services. This care approximates ASAM PPC-2 Level II.5 care.

Counseling/Therapy Services:

- Individual: 1 hour/week minimum.
- Group: 8 hours/week minimum.
- Family: To be included during course of treatment as clinically indicated.

Psychoeducation:

- Didactic sessions: 3 hours/week minimum.
- Family education and information sessions as clinically indicated.

CLINICALLY MANAGED LOW-INTENSITY RESIDENTIAL TREATMENT
HALFWAY HOUSE SUBSTANCE ABUSE TREATMENT
Level III.1

Definition: Halfway House Substance Abuse Treatment is provided in a licensed residential facility which provides room, board, and services designed to apply recovery skills, prevent relapse, improve emotional functioning, promote personal responsibility and reintegrate the individual into work, education and family life. Halfway house services must be physically separated from short term and long term program. In addition, clinical services must be separate from short term and long term residential services. **This modality includes no less than 5 hours per week of counseling services.** A minimum of 7 hours per day of structured activities must be provided on each billable day. (Note: Self-help meetings may be included as part of structured activities. This care approximates ASAM PPC-2 Level III.1 care.

Medical Services: Must be provided as per licensing requirements.

Counseling/Therapy Services:

- Individual: 1 hour/week minimum.
- Group: 3 hours/week minimum.
- Family: To be included during course of treatment as clinically indicated.

Psychoeducation:

- Didactic sessions: 1 hours/week minimum.
- Family education and information sessions as clinically indicated.

Structured Activities: 7 hours a day required. Example of activities:

a. Counseling Services
b. Psycho Education
c. Employment
d. Vocational Training
e. Recovery Support Services
f. Recreation

CLINICALLY MANAGED HIGH-INTENSITY RESIDENTIAL TREATMENT
LONG TERM RESIDENTIAL SUBSTANCE ABUSE TREATMENT
Level III.5

Definition: Long Term Residential Substance Abuse Treatment or Therapeutic Community is provided in a licensed long term residential facility which provides a structured recovery environment, combined with professional clinical services, designed to address addiction and living skills problems for persons with substance abuse diagnosis who require longer treatment stays to support and promote recovery. (Note: Self-help meetings may be included as part of structured activities.) Long Term Residential includes **no less than 8 hours per week of counseling services on at least five (5) separate occasions.** A minimum of 7 hours per day of structured activities must be provided on each billable day. Intervention focuses on reintegration into the greater community with particular emphasis on education and vocational development. This care approximates ASAM PPC-2 Level III.5 care.

Medical Services: Must be provided as per licensing requirements.

Counseling/Therapy Services:

- Individual: 1 hour/week minimum.
- Group: 5 hour week minimum.
- Family: To be included during course of treatment as clinically indicated.

Psychoeducation:

- Didactic sessions: 3 hours/week minimum.
- Family Education and Information sessions as clinically indicated.

Structured Activities: 7 hours a day required. Example of activities:

a. Counseling Services
b. Psychoeducation
c. Vocational Training
d. Recovery Support Services
e. Recreation

MEDICALLY MONITORED INTENSIVE INPATIENT TREATMENT
SHORT TERM RESIDENTIAL SUBSTANCE ABUSE TREATMENT
Level III.7

Definition: Short Term Residential Substance Abuse Treatment is provided in a licensed short term residential facility which provides a highly structured recovery environment, combined with a commensurate level of professional clinical services, designed to address specific addiction and living skills problems for persons who are deemed amenable to intervention through short-term residential treatment. **Short Term Residential treatment must include no less than 12 hours per week of counseling services on at least 6 separate occasions.** A minimum of 7 hours of structured programming must be provided on a billable day. (Note: Self-help meetings may be included as part of structured activities.) This care approximates ASAM PPC-2 Level III.7 care.

Medical Services: Must be provided as per licensing requirements.

Counseling/Therapy Services:

- Individual: 2 hour/week minimum.
- Group: 10 hours/week minimum (4 sessions).
- Family: To be included during course of treatment as clinically indicated.

Psychoeducation:

- Didactic sessions: 8 hours/week minimum.
- Family Education and Information sessions as clinically indicated.

Structured Activities: 7 hours a day required. Example of activities:

a. Counseling Services
b. Psychoeducation
c. Vocational Training
d. Recovery Support Services
e. Recreation

MEDICALLY MONITORED INPATIENT DETOXIFICATION
Level III.7D

Definition: Medically Monitored Inpatient Detoxification is an organized service delivered by medical and nursing professionals, which provides 24-hour medically supervised evaluation and withdrawal management in a permanent facility with inpatient beds. Services are delivered under a defined set of physician-approved policies and physician monitored procedures for clinical protocols. This level provides care to patients whose withdrawal signs and symptoms are sufficiently severe to require 24-hour medical monitoring care**. Detoxification includes 2 hours per week of counseling services.** (Note: Self-help meetings may be included as part of daily activities) This care approximates ASAM PPC-2 Level III.7D care.

Medical Services: Must be provided in the facility under the supervision of a Medical Director. All other licensing requirements for medical services must be followed.

Counseling/Therapy Services:

- Individual: 1 hour/week minimum.
- Group: 1 hour/week.

Psychoeducation:

- Minimum of two hours per detox episode.

MEDICALLY MONITORED INPATIENT DETOXIFICATION ENHANCED
111.7D Enhanced

Description: Medically Monitored Inpatient Detoxification Enhanced is an organized service delivered by medical and nursing professionals, which provides 24-hour medically supervised evaluation and withdrawal management in a permanent facility with inpatient beds. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures for clinical protocols. This level provides care to patients whose withdrawal signs and symptoms are sufficiently severe enough to require 24-hour medically monitored care. **Detoxification includes substance abuse assessment, medication monitoring and two (2) hours per week of counseling services**. (Note: Self-help meetings may be included as a part of daily activities)

This care approximates ASAM PPC-2 Level III.7D care but enhances that level to include the ability to treat the following: 1) individuals with co-occurring disorders; 2) pregnant women; 3) poly-addicted persons, including those addicted to benzodiazepines; 4) individuals who may or may not be on opiate replacement therapy; and 5) clients with non–life-threatening medical condition(s) that do not require the services of an acute care hospital.

In order to accommodate this increased acuity in patients being treated in this service, the facility must have an affiliation agreement and procedures in place with an acute care hospital that ensures the seamless transfer of the patient to the acute care setting, if clinically necessary.

Required Staff: Must be provided in the facility under the supervision of a Medical Director. All other licensing requirements for medical services and co-occurring services must be followed.

Required Medical Services:

- Full medical assessment.
- Ongoing medical services including medication monitoring.
- Pregnancy test for all women.
- 24 hour nursing services.
- 24 hour access to physician.

Counseling Services:

- Individual counseling: 1 hours/week minimum.
- Group Sessions: 1 hour/week.

Psychoeducation:

- Minimum of two hours per week.

Co-occurring Services included as part of this service:

- Case Management.
- Medication Monitoring.

SUBSTANCE ABUSE TREATMENT SERVICES
CO-OCCURRING SERVICE ENHANCEMENTS

Substance Abuse Treatment Co-occurring Service Enhancements strive to advance the integration of mental health services into client's substance abuse treatment. This initiative provides reimbursement for an array of co-occurring services to be provided as an enhancement to substance abuse treatment services for consumers with a co-occurring mental health diagnosis. Specific services are delivered based on individual need.

Psychiatric Evaluation

Description:
Psychiatric evaluations are meetings between a psychiatrist and a child, adolescent or adult in which the professional tries to glean information necessary to diagnose an emotional disorder. During this interview the psychiatrist collects enough data about the patient, through input from the substance abuse and/or co-occurring evaluation, previous treatment records and consultation with the treatment team, to develop an initial psychiatric diagnosis and treatment plan, including pharmacotherapy.

Who Can Provide the Service?
Psychiatric Evaluation is provided by: MD or DO Certified in Addiction Psychiatry; Board Certified Psychiatrist who is a member of ASAM or experienced with addiction; Board Eligible and ASAM Certified Psychiatrist; MD or DO Board Eligible for Psychiatry with 5 years of addiction experience and ASAM membership; ASAM Certified MD or DO with 5 years of co-occurring mental health disorders experience; Certified Nurse Practitioner-Psychiatric and Mental Health (CNP-PMH), Advanced Practical Nurse-Psychiatric and Mental Health (APN-PMH), and Physician's Assistant (PA) w/Psychiatric and Mental Health certification.

Comprehensive Intake Evaluation

Description:
The Comprehensive Intake Evaluation includes; a full mental status evaluation, a detailed history of psychiatric symptoms, a review & if necessary expansion of the information collected during the ASI, collection and review of previous treatment records, & the completion of relevant assessment tools such as the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) are helpful to clinicians making LOC decisions for the COD client

Who Can Provide the Service?
The Comprehensive Evaluation is provided by: Licensed Clinical Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), Licensed Marriage and Family Therapist (LMFT).

Medication Monitoring

Description:
Medication monitoring is the ongoing assessment, monitoring and review of the effects of a prescribed medication (Medication Assisted Therapy) upon a client. It is as a result of these visits that medications are adjusted, medical tests are ordered, and the client's response to treatment is evaluated. All Addictions and COD treatment facilities must allow for Medication Assisted Therapy for appropriate clients. These clients may be receiving medication(s) prescribed by the primary treatment facility, or by another provider.

Who Can Provide the Service?
Provided by: Licensed MD or DO, Certified Nurse Practitioner-(CNP), Advanced Practical Nurse-(APN) Physician's Assistant- (PA).

Clinical Consultation

Description:
The Consultant meets with an agency's clinical staff in order to advise, counsel or educates those clinicians regarding the diagnosis, treatment, and management of clients in the care of that organization.

Who Can Provide the Service?
A psychiatrist is the preferred consultant in this role. Psychiatrists or clinicians from other disciplines who provide clinical consultation must be licensed or certified to practice as health care professionals, and authorized to render diagnoses according to the DSM for both mental health and substance use disorders. (e.g.: psychiatrist, licensed clinical psychologist, licensed clinical social worker, licensed psychiatric nurse, licensed professional counselor, etc.). A minimum of 5 years' experience in mental health or co-occurring treatment is required.

Case Management

Description:
Case Management is the provision of direct and comprehensive assistance to clients in order for those individuals to gain access to all necessary treatment and rehabilitative services. The clinical case manager (CCM) facilitates optimal coordination and integration of these services on behalf of the client. In addition to connecting clients to these resources, the CCM monitors their client's progress in treatment. The goal of this intervention is to reduce psychiatric and addiction symptoms, and to support the clients' continuing stability and recovery.

Who Can Provide the Service?
Clinical case management services can be provided by the client's primary counselor, or by a staff member designated as CCM for a number of clients. CCM services can be

provided by a health care professional with experience and expertise in service systems, including social service systems, the addictions treatment system, and services for mental health disorders. A minimum of Bachelor's Degree in one of the helping professions, such as social work, psychology, and counseling or LCADC or CADC.

Family Therapy

Description:
Treatment provided to a family utilizing appropriate therapeutic methods to enable families to resolve problems or situational stress related to or caused by a family member's addictive illness.

Who Can Provide the Service?
Family and Individual Therapy must be provided by: Licensed Clinical Psychologist, Certified Nurse Practitioner-Psychiatric and Mental Health (CNP-PMH), Advanced Practical Nurse-Psychiatric and Mental Health (APN-PMH), Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), or Licensed Marriage and Family Therapist (LMFT).

Individual Therapy

Description:
The treatment of an emotional disorder as identified in the DSM through the use of established psychological techniques and within the framework of accepted model of therapeutic interventions such as psychodynamic therapy, behavioral therapy, gestalt therapy and other accepted therapeutic models. These techniques are designed to increase insight and awareness into problems and behavior with the goal being relief of symptoms, and changes in behavior that lead to improved social and vocational functioning, and personality growth.

Who Can Provide this Service?
Family and Individual Therapy must be provided by: Licensed Clinical Psychologist, Certified Nurse Practitioner-Psychiatric and Mental Health (CNP-PMH), Advanced Practical Nurse-Psychiatric and Mental Health (APN-PMH), Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), or Licensed Marriage and Family Therapist (LMFT).

Individual Therapy - Crisis Intervention

Description
The provision of emergency psychological care to a client who is experiencing extreme stress. In order for a difficult situation to constitute a crisis, the stressor(s) must be experienced as threatening, and of an intensity/magnitude that can not be managed by the client's normal coping capacities. The determination that a client is experiencing a

crisis must be made by a licensed clinician. This initial assessment, where clinically indicated, includes evaluation of the individual's potential for suicide, homicide, or other violent/extremely problematic behaviors. In COD treatment settings, the client's potential for relapse and/or decompensation must be determined. The goals of crisis intervention are:(1) Stabilization, i.e. to reduce or relieve mounting distress; (2) Mitigation of acute signs and symptoms of distress; (3) Restoration of the pre-crisis (hopefully adaptive and independent) level of functioning; (4) Prevention (or reduction of the probability) of the development of maladaptive post-crisis behavior (e.g.: relapse and/or decompensation), or of post-traumatic stress disorder (PTSD).

Who Can Provide the Service?

Provided by: MD or DO, Licensed Clinical Psychologist, Certified Nurse Practitioner-Psychiatric and Mental Health (CNP-PMH), Advanced Practical Nurse-Psychiatric and Mental Health (APN-PMH), Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), or Licensed Marriage and Family Therapist (LMFT), Physician's Assistant (PA) , Advance Practice Nurse (APN) ,Certified Nurse Practitioner (CNP)

SUBSTANCE ABUSE TREATMENT SERVICES
MEDICATION ASSISTED TREATMENT SERVICE ENHANCEMENTS

Methadone Treatment

Description: Methadone is a synthetic opioid used medically as an analgesic, and as an anti-addictive medication for use in patients who meet criteria for opioid dependence. Methadone, used for maintenance and/or detoxification is a medication that is provided in combination with substance abuse counseling in a licensed substance abuse treatment facility that is; accredited by a recognized accreditation body, approved by SAMHSA, complies with all rules enforced by the Drug Enforcement Administration (DEA) and is licensed by the Division of Addiction Services.

Required Staff: When prescribed in a substance abuse treatment facility, the following requirements apply:

Medical Director: Licensed in the State of New Jersey as a physician, certification in Addiction Medicine (ASAM, Addiction Psychiatry, or American Osteopathic Association) is preferred. Membership in ASAM is required.

Nursing Director: Registered Nurse (RN) currently licensed in New Jersey with one year of experience in Addictions treatment.

Only physicians, registered nurses, licensed practical nurses or pharmacists may dispense or administer medication in a facility providing opioid treatment services.

Required Medical Services for Methadone Maintenance:

- Full assessment with physical examination at admission and annually thereafter;
- Regular urine drug screens; pregnancy screen at intake for women of child-bearing age; and
- Regular review of medication by physician and prescription adjustments as medically determined.

Required Medical Services for Methadone Detoxification: All physicians are referred to the federal guidelines established through the Center for Substance Abuse Treatment (CSAT) for the minimum requirements:

- During methadone detoxification, medical care and consultation should be available on a 24-hour basis. This care and consultation should be supervised by the physician performing the detoxification protocol;
- Pregnancy testing must be conducted at intake for women of child-bearing age;
- Opioid dependent pregnant clients must receive proper education for the risks of methadone detoxification; and
- Clients must have 24 hour access to a nurse on call.

Counseling Services: At minimum, methadone treatment delivered in a Licensed Methadone Treatment program must adhere to the counseling standards outlined in DAS licensure standards, 10:161B-11, which includes number and frequency of counseling sessions based on the criteria of the Phase System.

- Phase I- At least one counseling session per week
- Phase II- At least one counseling session every two weeks
- Phase III- At least one counseling session per month
- Phase IV- At least one counseling session every three months

Methadone can be administered in conjunction with other clinical services across all levels of care provided by a DAS licensed Substance Abuse treatment program. All counseling requirements must be in accordance with the licensing requirements for that level of care.

Buprenorphine Treatment

Description:
Buprenorphine, in the form of Subutex (buprenorphine hydrochloride) and Suboxone tablets (buprenorphine hydrochloride and naloxone hydrochloride), is used medically for the treatment of opioid dependence.

Detoxification:
Buprenorphine can be used for the medically supervised withdrawal of clients from both self-administered opioids and from opioid agonist treatment with methadone, providing a transition from the state of physical dependence on opioids to an opioid-free state, while minimizing withdrawal symptoms and avoiding side effects of suboxone. The goal of the service is to achieve a safe and comfortable withdrawal from mood-altering drugs and to effectively facilitate the client's entry into ongoing treatment and recovery.

Induction:
Buprenorphine induction (usual duration approximately one week) involves helping a client begin the process of using buprenorphine to manage his or her opioid dependence. The goal of the induction phase is to find the minimum dose of medication at which the client discontinues or markedly diminishes use of other opioids and experiences no withdrawal symptoms, minimal or no side effects, and has no uncontrollable cravings for drugs of abuse, and is stabilized.

Maintenance:
Buprenorphine maintenance, following induction and stabilization, requires maintaining buprenorphine at stable dosage levels for a period in excess of 21 days.

Counseling Services: Suboxone treatment should be administered in conjunction with other clinical services across all levels of care provided by a DAS licensed Substance Abuse treatment program. All counseling requirements must be in accordance with the licensing requirements for that level of care.

Required Staff:
Must be provided by a certified physician in Addiction Medicine who has satisfied qualifications set-forth by the provisions of the Drug Addiction Treatment Act of 2000 (DATA 2000) and the Office of National Drug Control Policy Reauthorization Act of 2006 (ONDCPRA).

When prescribed in a substance abuse treatment facility, the following requirements apply:

Medical Director: Licensed in the State of New Jersey as a physician, certification in Addiction Medicine (ASAM, Addiction Psychiatry, or American Osteopathic Association) is preferred. Membership in ASAM is required. DATA 2000 waiver and appropriate Drug Enforcement Agency (DEA) registration are required.

Nursing Director: Registered Nurse (RN) currently licensed in New Jersey with one year of experience in Addictions treatment.

Only physicians, registered nurses, licensed practical nurses or pharmacists may dispense or administer medication in a facility providing opioid treatment services.

Required Medical Services:

- All physicians are referred to the federal guidelines established through the Center for Substance Abuse Treatment (CSAT) for the minimum requirements;
- A full assessment with physical examination must be conducted at admission and annually thereafter;
- Pregnancy testing must be provided at assessment for women of child-bearing age;
- Opioid dependent pregnant clients must receive proper education regarding the risks of buprenorphine treatment;
- During buprenorphine detoxification, induction and stabilization, medical care and consultation should be available on a 24-hour basis supervised by the physician performing the detoxification or induction and stabilization protocol.
- During buprenorphine detoxification, clients must have 24 hour access to a nurse on call;
- During detoxification, the client must be seen each day for, at minimum, a medical assessment.
- Clients must be instructed to abstain from the use of any opioids for twelve hours prior to the induction phase of buprenorphine treatment; and
- Regular urine drug screens should be performed for all clients.

Naltrexone Treatment

Description:
Naltrexone, in the form of Vivitrol (injectable naltrexone) is a medication administered to support relapse prevention in conjunction with substance abuse treatment and social

supports to consumers with a diagnosis of alcohol abuse or dependence or opioid dependence Vivitrol is an extended-release formulation of naltrexone, an opiate antagonist. Patients should not be actively drinking at the time of the initial nalterxone administration. Naltrexone is indicated for the prevention of relapse to opioid dependence following opioid detoxification.

Induction:
Naltrexone induction involves an initial intramuscular injection administered by appropriate medical personnel (either a Medical Director, Nurse Practitioner, Physician Assistant, Registered Nurse). Liver Functioning Tests (LFT) should be performed as per medical need identified by physician.

Maintenance:
Typical duration of services is a once a month intramuscular injection for 3-6 months.

Counseling Services: Naltrexone treatment should be administered in conjunction with other clinical services across appropriate levels of care provided by a DAS licensed Substance Abuse treatment program. All counseling services must be provided in accordance with the licensing requirements for that level of care.

Required Staff:
When prescribed in a substance abuse treatment facility, the following requirements apply:

Medical Director: Licensed in the State of New Jersey as a physician, certification in Addiction Medicine (ASAM, Addiction Psychiatry, or American Osteopathic Association) is preferred.

Nurse Practitioner: Nurse Practitioner (NP) currently licensed in New Jersey.

Physician Assistant: Physician Assistant (PA) currently licensed in New Jersey.

Registered Nurse: Registered Nurse (RN) currently licensed in New Jersey.

Required Medical Services:

- A full assessment with physical examination must be conducted prior to induction and annually thereafter;
- Pregnancy testing must be provided at assessment for women of child-bearing age;
- LFTs as medically indicated.

SUBSTANCE ABUSE TREATMENT SERVICES
MEDICAL, CLINICAL, AND RECOVERY SUPPORT
SERVICE ENHANCEMENTS

Medical Services

Physician Visit: Reimbursement for physician office visit, new or established patient.

Urine Drug Screen: Reimbursement for process to collect urine to screen for drugs of abuse.

Oral Swab Drug Screen: Reimbursement for process to collect oral fluids to screen for drugs of abuse.

Comprehensive Assessment

A bio-psycho-social assessment of patients entering treatment or transferring to a different contractee. This assessment includes completion of an ASI, completion of an American Society of Addiction Medicine (ASAM) placement criteria, a co-occurring screening, and completion of the NJ-SAMS admission. Members of the patients family and/or significant others may also be involved, *if indicated and authorized by the patient.* The assessment must result in a DSM IV Diagnosis and Level of Care determination, to be used in the client treatment placement and treatment planning. The assessment must produce a written document which is placed in the patient's clinical record. It identifies problems which must be addressed in a written treatment plan, also to be placed in the patient's clinical record.

Continuing Care Assessment

Continuing Care Assessment is a treatment activity that can take place with or without the client present. The primary clinician, working with their clinical supervisor or preferably, the agency interdisciplinary team, reviews client treatment progress and current functioning. During the review a LOCI continuing care evaluation is completed, a treatment plan review is completed and a new plan for the client is developed. All participating members of the team and participating clients must sign a note or treatment plan indicating the review took place and that they participated. This must be in client chart and available for review.

Case Management

The provision of direct and comprehensive assistance to clients in order for those individuals to gain access to all necessary treatment and rehabilitative services. The clinical case manager (CCM) facilitates optimal coordination and integration of these services on behalf of the client. In addition to connecting clients to these resources, the

CCM monitors their client's progress in treatment. The goal of this intervention is to reduce psychiatric and addiction symptoms, and to support the clients' continuing stability and recovery.

Court Liaison

Substance abuse treatment agency staff accompany client to court for required hearing.

Recovery Mentor

A service designed to support the clients' treatment engagement and retention and transition the client from structured treatment to long-term recovery in the community. The Mentor provides emotional support and concrete assistance to enable the client to access and utilize social, medical, legal and other support services. The Mentor coordinates with the treatment contractee and provides outreach, advocacy, and coordination of services. Primarily through role modeling, he/she educates the client about recovery process and how to live a sober lifestyle.

Transportation

A transportation voucher is issued to DAS client for the following allowable trips:

- To and from assessment
- To and from detoxification
- To and from initial meeting with treatment contractee
- To court from treatment facility for scheduled court date

Women with Dependent Children Services

Services including room, board, and childcare designed to support a family-centered approach to care for women whose dependent children accompany them in treatment. May be provided in an ambulatory or residential setting.

DCF 2014 Inventory and Needs Assessment for New Jersey Behavioral Health

A Report by Children's System of Care

Allison Blake, Ph.D., L.S.W.
Commissioner

Inventory and Need Assessment for New Jersey Children's Behavioral Health

Pursuant to New Jersey Statute 30:4-177.63, this is a report to the Governor; the State Senate Health, Human Services and Senior Citizens Committee; and the General Assembly Human Services Committee concerning activities of the New Jersey Department of Children and Families (DCF) with respect to available children's behavioral health services in New Jersey.[1]

The following are the statute's key provisions applicable to the Commissioner of the New Jersey Department of Children and Families:

A. Establish a mechanism through which an inventory of all county-based public and private inpatient, outpatient, and residential behavioral health services is made available to the public;

B. Establish and implement a methodology, based on nationally recognized criteria, to quantify the usage of and need for inpatient, outpatient, and residential behavioral health services throughout the State, taking into account projected patient care level needs;

C. Annually assess whether sufficient inpatient, outpatient, and residential behavioral health services are available in each service area of the State in order to ensure timely access to appropriate behavioral health services for persons who are voluntarily admitted or involuntarily committed to inpatient facilities for persons with mental illness in the State, and for persons who need behavioral health services provided by outpatient and community-based programs that support the wellness and recovery for these persons;

D. Annually identify the funding for existing mental health programs;

E. Consult with the Community Mental Health Citizens Advisory Board and the Mental Health Planning Council, the Divisions of Developmental Disabilities and the Division of Mental Health and Addiction Services in the Department of Human Services, the Department of Corrections, the Department of Health, and family consumer and other mental health constituent groups, to review the inventories and make recommendations to the Departments of Human Services and Children and Families regarding overall mental health services development and resource needs;

F. Consult with the New Jersey Hospital Association, the Hospital Alliance of New Jersey, and the New Jersey Council of Teaching Hospitals in carrying out the

[1] The Department of Human Services has prepared a separate report concerning adult behavioral health services.

purposes of this act. The commissioners shall also seek input from Statewide organizations that advocate for persons with mental illness and their families; and

G. Annually report on departmental activities in accordance with this act to the Governor and to the Senate Health, Human Services and Senior Citizens Committee and the Assembly Human Services Committee, or their successor committees.

Prelude - The Children's System of Care.

The New Jersey Department of Children and Families – Division of Children's System of Care (CSOC) is responsible for overseeing the public system of providers who serve children with emotional and behavioral health care challenges, children under the age of 21 with developmental disabilities[2], and youth up to age 18 with substance use challenges[3]. CSOC is committed to providing these services based on the needs of the child and family in a family-centered, community-based environment. Services available through CSOC are authorized without regard to income, private health insurance or eligibility for Medicaid/NJ FamilyCare or other health benefits programs. Families with private insurance or other means may choose to access services outside of the public system.

The Children's System of Care's primary objectives are to help youth succeed:

- At home, successfully living with their families and reducing the need for out-of-home treatment settings;
- In school, successfully attending the least restrictive and most appropriate school setting close to home; and
- In the community, successfully participating in the community and becoming independent, productive, and law-abiding citizens.

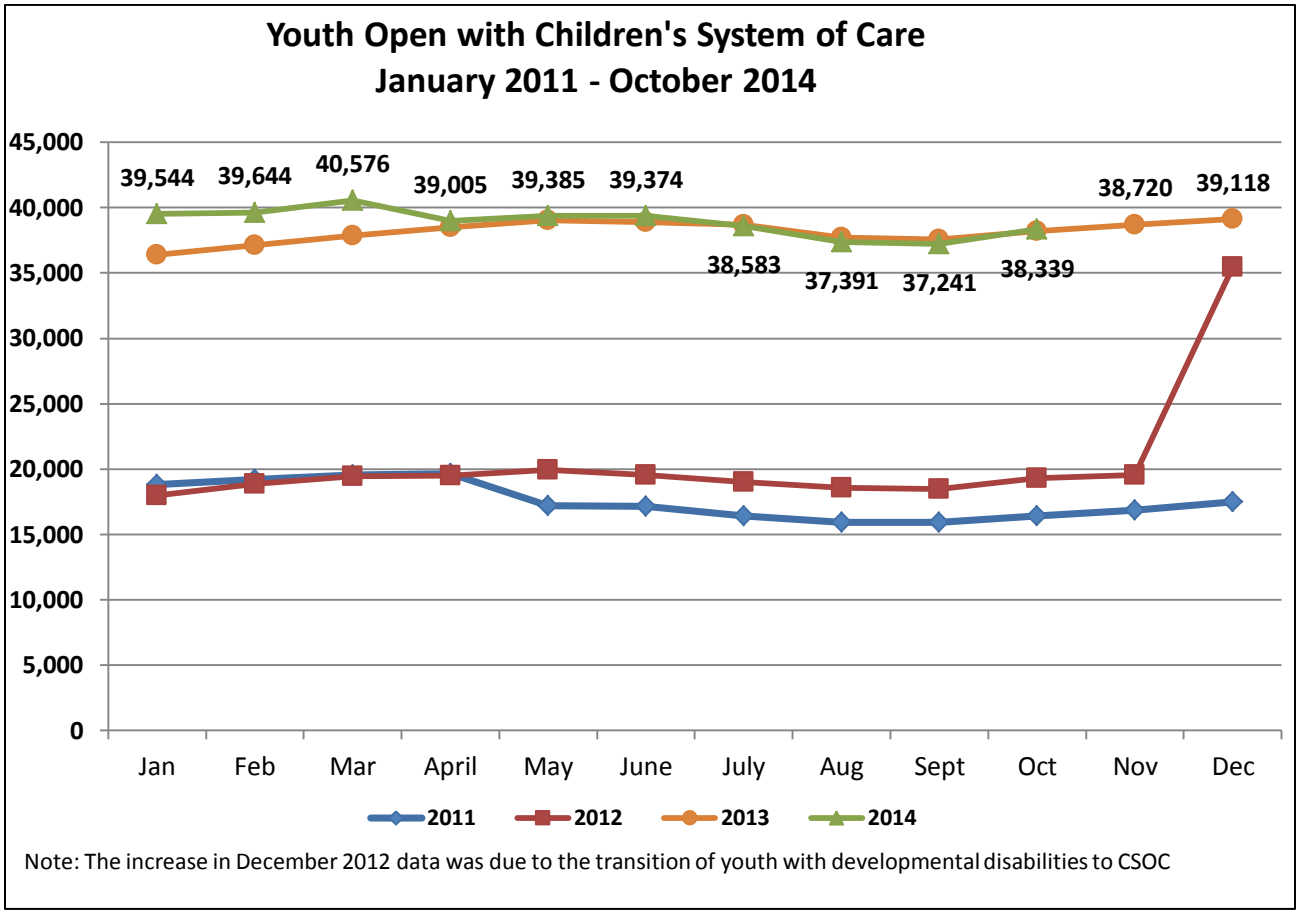
CSOC offers a statewide continuum of care, which includes care management, a mobile response service, peer/family support, in community services (e.g. outpatient and in home therapy), as well as a range of residential services of varying intensities. The single portal for access to all services available through CSOC is PerformCare, the Contracted System Administrator (CSA) for the children's system. For information about services available through CSOC, the public may contact PerformCare at 877-652-7624 or visit http://www.performcarenj.org/. Information about CSOC is available at http://www.state.nj.us/dcf/about/divisions/dcsc/.

[2] As of January 1, 2013, CSOC became responsible for providing all of the services to youth under the age of 21 with developmental disabilities.

[3] As of July 1, 2013, CSOC assumed oversight from the DHS DMHAS of substance abuse treatment programs for adolescents ages 13 to 18.

As of October 2014, there were over 38,000 youth open with CSOC. Figure 1 below shows the number of youth open with CSOC from January 2011 to October 2014.

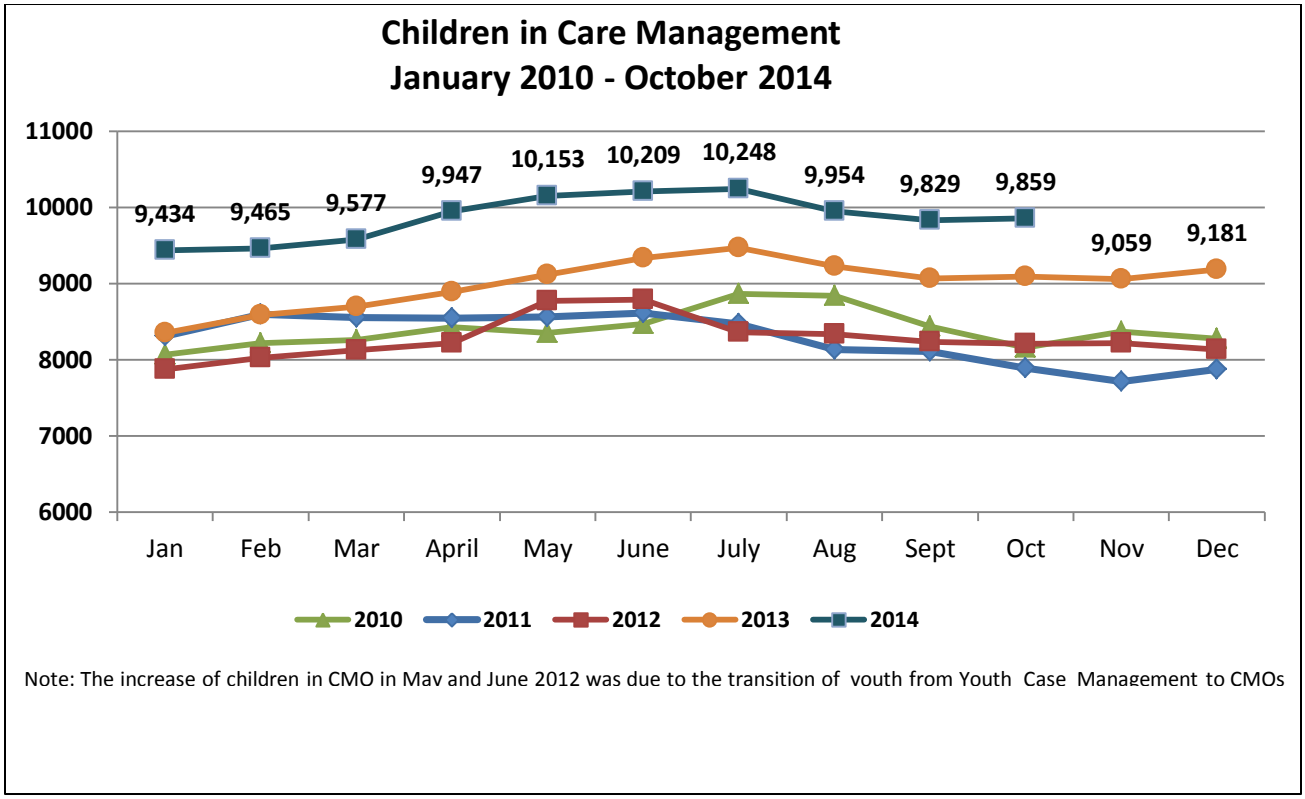
Figure 1



Note: The increase in December 2012 data was due to the transition of youth with developmental disabilities to CSOC

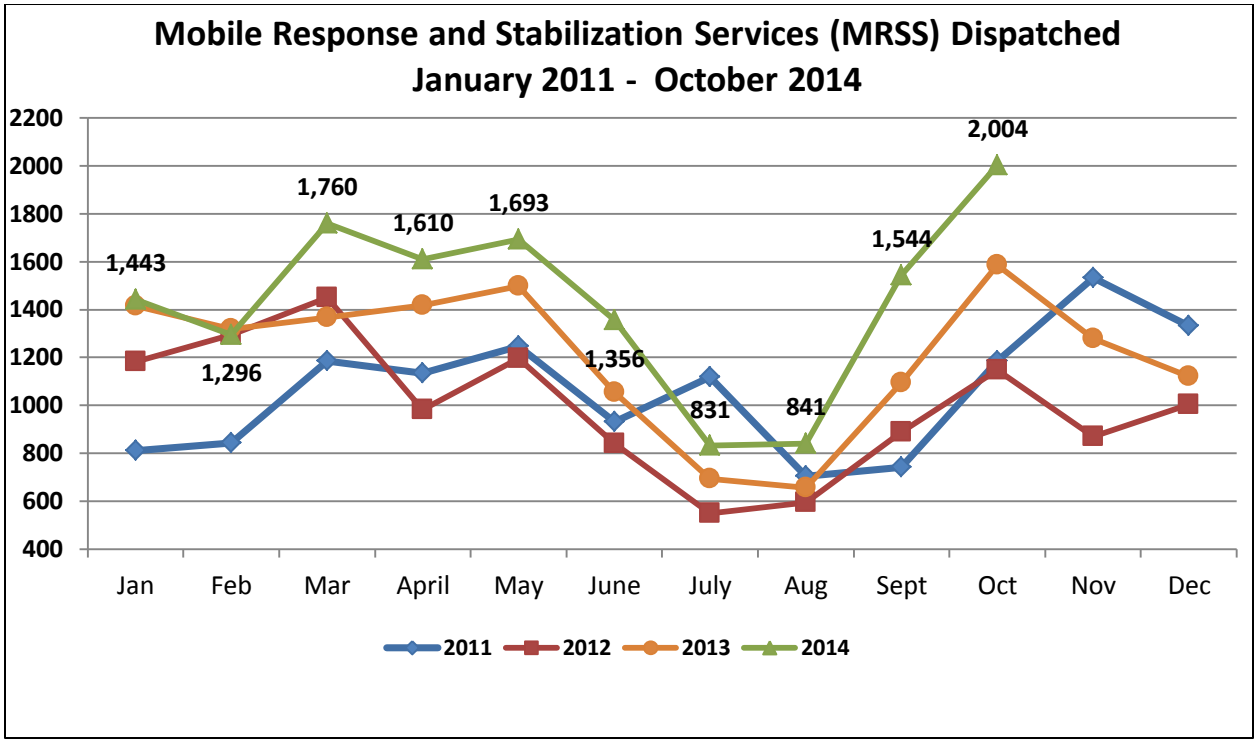
Youth whose needs require moderate or intensive care management services that cross multiple service systems may be eligible for enrollment with a CSOC Care Management Organization (CMO). A CMO is an independent, community-based organization that provides advocacy, service planning, and care coordination. There are 15 CMOs statewide whose catchment areas correspond to the 15 court vicinages. Figure 2 below shows the number of children receiving Care Management from January 2010 to October 2014.

Figure 2



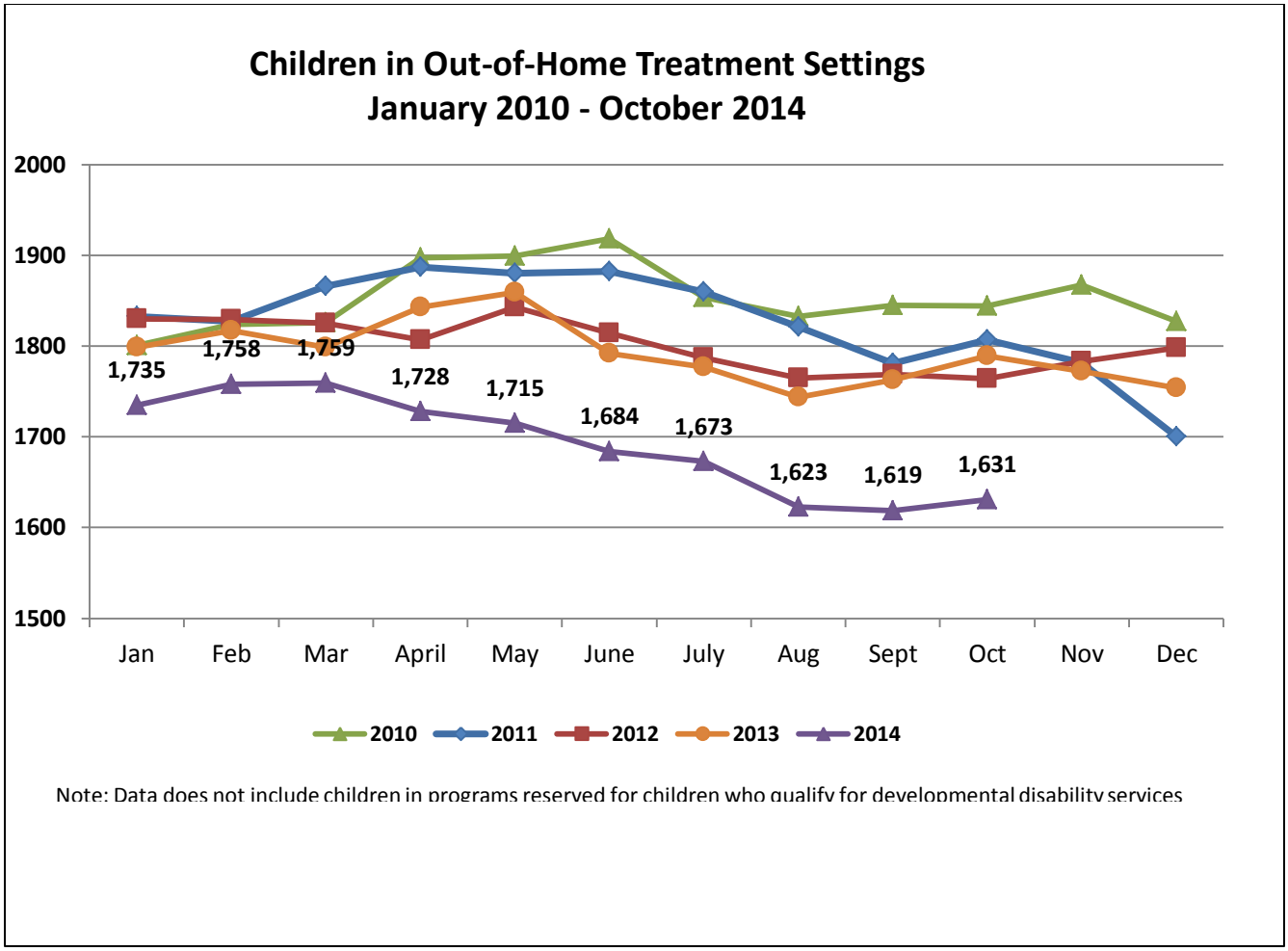
Among the critical resources available through CSOC are Mobile Response and Stabilization Services (MRSS). MRSS are a system of time limited, clinically based interventions available 24 hours a day, 7 days a week, 365 days a year to youth in danger of being removed from their current living arrangements. An initial MRSS intervention can be delivered at the site of the crisis within 1 hour of a request. Follow-up MRSS, which include appropriate service implementation, may last up to 8 weeks. Figure 3 below shows the number of times Mobile Response and Stabilization Services were dispatched from January 2011 to October 2014.

Figure 3



CSOC out-of-home treatment services are available to youth enrolled with a CMO who meet specific clinical criteria. Figure 4 below shows the number of children in out of home treatment settings between January 2010 and October 2014.

Figure 4



For additional CSOC data, please view the Commissioner's Dashboard and the Children's InterAgency Coordinating Council (CIACC) Summary of Activity reports on the DCF Continuous Quality Improvement webpage, http://www.state.nj.us/dcf/childdata/continuous/index.html.

A. Inventory of Children's Behavioral Health Services

An inventory of inpatient, outpatient, and in-state residential behavioral health services for children can be found at http://www.performcarenj.org/families/behavioral/find-prov.aspx.

Children's behavioral health inpatient services, or Children's Crisis Intervention Services (CCIS), are short-term, acute care psychiatric units in community hospitals. CCIS provides crisis stabilization, evaluation, and treatment to youth age 5-17 in need of involuntary commitment or eligible for parental admission or voluntary admission. The typical length of stay for a child in a CCIS unit is less than two weeks. A referral from a psychiatric screening center is the primary way to access Children's Crisis Intervention Services. A list of screening centers in New Jersey is available at http://www.state.nj.us/humanservices/dmhs/services/centers/.

The inventory of children's behavioral health outpatient providers lists Medicaid enrolled providers by county. Outpatient services may be accessed by directly contacting providers.

The programs listed in the inventory of residential treatment services may only be accessed through CSOC. That is, a youth must be enrolled with a CSOC Care Management Organization (CMO) and meet specific clinical criteria. The types of out-of-home or residential programs includes Treatment Homes (TH), Group Homes (GH), Residential Treatment Centers (RTC), Specialty Programs (SPEC), Psychiatric Community Homes (PCH), Detention Alternative Programs (DAP), and Medical Needs Programs (Pregnancy/Diabetes)[4]. The inventory includes the address, gender, age range, and capacity for each program.

In addition to the inventories identified above, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) hosts a Behavioral Health Treatment Services Locator on its website at http://findtreatment.samhsa.gov/. The locator, which has a wide array of search criteria, will identify public and private mental health and substance abuse programs for children and adults in New Jersey and throughout the country. By entering an address, a city, or zip code, members of the public can locate specific types of programs in their vicinity.

Child Substance Use

The array of substance use services available through CSOC includes outpatient, intensive outpatient, partial care, short-term residential, and long-term residential. The list of programs CSOC contracts for may be found on the PerformCare website at http://www.performcarenj.org/pdf/provider/substance/substance-use-provider-list.pdf.

[4] Please see the attached document entitled, *Descriptions of CSOC Residential Programs by Intensity of Service (IOS)* for more information on residential services available through CSOC.

As forecasted in last year's report, the number of substance use treatment programs available through CSOC increased in 2014 with the transition of the South Jersey Initiative (SJI) from the DHS Division of Mental Health and Addiction Services (DMHAS) to CSOC. SJI offers treatment for adolescents from Atlantic, Burlington, Camden, Cumberland, Gloucester, Cape May, Ocean, and Salem counties with substance abuse addictions. SJI provides a continuum of care that includes methadone maintenance, detoxification, residential, halfway house, and outpatient treatment services.

B. Methodology to Estimate Need for Children's Behavioral Health Services

DCF and its system partners employ several methodologies to quantify the use of and need for inpatient, outpatient, and residential behavioral health services throughout the State, including 1) needs assessments and 2) analysis of utilization management data.

As to needs assessments, the County InterAgency Coordinating Councils (CIACCs) are key components in this process. Established by statute[5], CIACCs are county-based planning and advisory groups composed of individuals from government and private agencies that advise counties and DCF regarding children, youth and young adults with serious emotional and behavioral health challenges. The mission of the CIACCs includes working in collaboration with DCF to create a seamless array of services. CIACCs also serve as the counties' mechanism to advise DCF on the development and maintenance of a responsive, accessible, and integrated system of care for youth and their families through the involvement of parents, children, youth and young adults, child-serving agencies, and community representatives. Through enhanced coordination of system partners, CIACCs also identify service and resource gaps and priorities for resource development.

In order to help fulfill their duty to identify service and resource gaps and priorities for resource development, CIACCs are charged with conducting a County Needs Assessment (CNA). The CNA process involves a variety of activities including interviews with community leaders and others affiliated with organizations or agencies, public forums, focus groups, surveys, data analysis, and asset mapping. The results of the needs assessments are provided to CSOC to help inform resource decision-making and allocation at the state and county levels. Using the needs assessments as a guide, CSOC may allocate funds to establish a statewide service or services targeted to specific counties. Each year, DCF also makes community development funds available to CIACCs to help counties procure outpatient or other services to meet mental health needs within a particular county[6].

[5] N.J.S.A. 30:4C-66 et seq.

[6] CIACCs are required to follow the public bidding process used by county government in order to expend Community Development funds.

As noted in last year's report, DCF, the CIACCs, and other partners within the children's system are continuing to adjust to the transition of services for youth with developmental disabilities and services for youth with substance use challenges to DCF. Therefore, CIACCs were not required to submit needs assessments in 2014. DCF is currently exploring an electronic survey, developed by the National Technical Assistance Center for Children's Mental Health within the Georgetown University Center for Child and Human Development that will facilitate the CIACC Needs Assessment process beginning in 2015. This electronic survey will enable DCF to more efficiently gather and effectively utilize stakeholder input. DCF also receives input concerning county needs via Needs Assessments that are conducted by County Human Services Advisory Councils (County HSAC) as well. These comprehensive County HSAC needs assessments are often conducted in lieu of a separate CIACC Needs Assessment.

As to inpatient and outpatient programs, specifically, as noted in the 2012 and 2013 inventory reports, the Comprehensive Medicaid Waiver calls for the CSA for the children's system to assume responsibility for utilization management of these programs. Once the CSA takes on these responsibilities, CSOC will have the ability to quantify the usage of and the need for inpatient and outpatient services, using CSOC's comprehensive management information system. Likewise, the data generated from the agency's management information system will allow CSOC to allocate resources accordingly. Although CSOC does not yet provide utilization management of all outpatient providers, CSOC does ask providers wishing to establish outpatient programs within a particular geographic area to submit documentation that demonstrates the need for that particular service within the designated area.

To quantify the usage of and the need for residential treatment services within the children's system, CSOC utilizes an electronic bed-tracking system jointly developed with the CSA for the children's system. The electronic bed-tracking system, which is part of CSOC's comprehensive management information system, allows CSOC to monitor utilization rates and admission wait times of CSOC-contracted residential treatment programs in real-time. The data generated by the bed-tracking system enables CSOC to determine when there is a need to develop additional residential treatment programs via the public bidding (Request for Proposals or RFP) process. Because of CSOC's ability to closely monitor utilization of its residential services, CSOC is able to develop residential programs as needed, as resources allow.

Finally, using other data generated by its management information system (please see the Prelude for some examples), CSOC is able to determine the current and future needs of CMOs, MRSS providers, and Family Support Organizations (FSOs). Each of these entities plays a critical role in helping children and families achieve better outcomes.

C. Annual Assessment

Utilizing the methodologies identified above, DCF assesses areas of need, both in terms of the types of services and their geographic availability, each year. With the further refinement of these needs assessment methodologies DCF will become even more effective at assessing statewide behavioral health and other service needs.

D. Annual Funding for Existing Child Behavioral Health Programs

For State Fiscal Year 2015, funding directly appropriated to CSOC from State and Federal sources, and the funds contributed by Juvenile Justice Commission for the provision of behavioral services across all service lines totaled $441,475,000. See Table 1 below.

Table 1

Sources of Funding for Children's Behavioral Health Services[7]

Grants in Aid	$254,455,000
Title XIX (Federal)	$145,131,000
Title XXI (State and Federal)	$ 33,504,000
Juvenile Justice Commission	$ 573,000
Substance Abuse Block Grant (Federal)	$ 7,812,000
TOTAL	**$441,475,000**

Table 2 below lists the allocation of funds for children's behavioral health services by service type for State Fiscal Year 2015. Residential programs range from high-intensity hospital-based psychiatric services to low-intensity services like Treatment Homes[8]. Behavioral Assistance and Intensive In-Community therapy are short-term, home-based intensive treatments. Youth Incentive Programs represent CIACC community development funds.

[7] Funds appropriated for developmental disability services are not included. Funds for the administrative funding for Family Support Organizations and the Contracted Systems Administrator are included as they support the system of care.

[8] Please see the attached document entitled, *Descriptions of CSOC Residential Programs by Intensity of Service (IOS)* for more information on residential services available through CSOC.

Table 2

Allocation of funds for Children's Behavioral Health Services by Service Type

Residential	$230,659,000
Care Management Organizations	$ 74,053,000
Family Support Organizations	$ 10,864,000
Mobile Response and Stabilization Services	$ 26,585,000
Behavioral Assistance/Intensive In-Community therapy	$59,425,000
Youth Incentive Programs	$ 3,767,000
Outpatient	$12,340,000
Substance Abuse	$13,552,000
Contracted System Administrator (CSA)	$10,230,000
TOTAL	**$441,475,000**

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

DCF is committed to maintaining close, interactive relationships with DHS and other key stakeholders. Therefore, senior and other CSOC staff regularly attend the combined meetings of the Community Mental Health Citizens Advisory Board and the Mental Health Planning Council to share information about the children's system and discuss issues pertinent to stakeholders. In addition, CSOC staff meets regularly with CIACCs, the New Jersey Alliance for Children, New Jersey Association of Mental Health Agencies, and the New Jersey Youth Suicide Prevention Advisory Council to share information and receive feedback about the children's system. CSOC continues to work closely with both the DHS - Division of Developmental Disabilities (DDD) and the DHS - Division of Mental Health and Addiction Services (DMHAS) since assuming responsibility for providing the services these agencies formerly provided.

F. Consult with the New Jersey Hospital Association, the Hospital Alliance of New Jersey, the New Jersey Council of Teaching Hospitals, and Statewide organizations that advocate for persons with mental illness and their families

Senior DCF management, including CSOC's Director, participates with DHS in regular meetings with the New Jersey Hospital Association, the Hospital Alliance of New Jersey, and other advocates for persons with mental illness and their families. Building upon previous years' efforts, in 2014 CSOC continued to communicate with hospital screening centers and State psychiatric hospitals to address barriers to accessing services through the children's system. CSOC staff also met with other stakeholders including Children's Hospital of Philadelphia, the

Administrative Office of the Courts, and the Division of Mental Health Advocacy within the New Jersey Office of the Public Defender to share information about the children's system and receive feedback with the purpose of improving access to services through the children's system.

G. Summary

Members of the public may access information about children's behavioral health and other services available through the public system of care by contacting PerformCare at 877-652-7624 or by visiting http://www.performcarenj.org/. An inventory of public inpatient, outpatient, and in-state residential behavioral health services for children can be found at http://www.performcarenj.org/families/behavioral/find-prov.aspx. Families with private insurance or other means may choose to access services outside of the public system. A comprehensive inventory of mental health and substance abuse treatment programs for children and adults in New Jersey and nationwide is available on the SAMHSA website at http://findtreatment.samhsa.gov/.

To ensure the children's system remains responsive to New Jersey families, DCF and its system partners employ several methodologies, including needs assessments and data analysis, to quantify the use of and need for behavioral health and other services so that DCF can appropriately allocate resources. Based upon needs previously identified, CSOC opened several additional residential treatment programs in 2014. Based upon current needs, DCF issued several Request for Proposals for additional services in 2014, including residential treatment services for females with co-occurring mental health and substance use challenges; residential treatment services for males with behavioral health challenges; and residential treatment services for males and females with serious emotional and behavioral challenges who require intensive clinical care and 24 hour supervision. In each Request for Proposals, CSOC provides clearly defined clinical criteria about the therapeutic services each program must provide as well as the geographical location each program is to be located to ensure that resources are available where needed.

DCF will continue to look for ways to improve its assessment processes in order to create an even more effective system of care for New Jersey children and families.

Appendix

Children's System of Care - Residential Treatment Programs by Intensity of Service (IOS)

Children's Crisis Intervention Services (CCIS): Psychiatric inpatient hospital services located in community hospitals that provide acute inpatient treatment, stabilization, assessment and short-term intensive treatment.

Intermediate Inpatient Psychiatric Units: Inpatient secure sub-acute psychiatric units located in community hospitals that provide Children's Crisis Intervention Services (CCIS). These units serve youth who require additional inpatient treatment following stabilization in a CCIS.

Intensive Residential Treatment Services (IRTS): Inpatient secure treatment services provided to youth with a wide range of serious emotional and behavioral needs who require 24 hour per day care in a safe, secure environment with constant line-of-sight supervision.

Psychiatric Community Homes (PCH): A community residential facility that provides intensive therapeutic services for youth who have had inpatient psychiatric care and/or children who may be at risk of hospitalization or re-hospitalization.

Specialty Bed Programs (SPEC): Programs that provide intensive residential services for children who are presenting with very specific high risk behaviors including fire setting, assaultive behavior, sex offending behavior predatory or non-predatory, and children who have experienced significant trauma from physical, sexual, or emotional abuse.

Residential Treatment Center (RTC): Programs that provide 24 hour per day care and treatment for youth unable to function appropriately in their own homes, schools and communities, and who are also unable to be served appropriately in smaller, less restrictive community-based settings.

Group Home (GH): Group home services provide up to 24 hour per day care and treatment to youth whose needs cannot be met appropriately in their own homes or in foster care, but who do not need the structure and intensiveness of a more restrictive setting.

Treatment Homes (TH): Programs that provide care and supervision by specially trained parent/caregivers in a family-like setting for typically one or two children with behavioral health needs who require a moderately high level of therapeutic intervention.

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

REVISION REQUEST DETAIL:
Please describe any of the states efforts for outreach to Rural SMI/SED population

SMHA was notified recently that it was awarded a SAMSHA planning grant to certify community behavioral health clinics (CCBHC). SMHA will begin working with at least one dually licensed mental health and substance use provider in a rural county and at least one provider in an urban county so that they will be certified to be a certified community behavioral health clinic in New Jersey. The CCBHC will be a provider of evidenced based mental health, substance use treatment, and health services for children and adults and serve veterans and their families. One of the conditions that New Jersey has accepted in receiving this planning grant is that SMHA will also apply for the SAMSHA CCBHC demonstration grant in October and if awarded the New Jersey CCBHCs will be expected to provide the previously described services effective 1/1/17.

Children's System of Care Services to Rural Youth

The New Jersey Children's System of Care (CSOC) defines a county as "rural" if, according to US Census figures, 25 percent or more of its population lived in rural areas. Using this definition, six New Jersey counties are considered rural, three on the State's southwestern border, and three along the northwestern border. This configuration, along the Delaware River, places rural counties in each region – in the north, Warren and Sussex; in the Central Region, Hunterdon; and in the South, Cape May, Cumberland and Salem. One of the six rural counties is among New Jersey's highest per capita income counties and one is the lowest, illustrating the diverse resources and needs of even this small subset of our 21 counties.

As part of New Jersey's System of Care, a full array of children's mental/behavioral health developmental disabilities and substance use services are available to all rural counties. These services include but are not limited to Care Management Organizations, Family Support Organizations, Mobile Response and Stabilization Services, Intensive In-home services, Children's Partial Care, Outpatient Services, and out of home treatment. CSOC monitors the adequacy and effectiveness of the acute care system in each region.

Planning Steps

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

Narrative Question:

This step should identify the unmet services needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the populations relevant to each block grant within the state's behavioral health system, especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet these unmet service needs and gaps.

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

SAMHSA's Behavioral Health Barometer is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the National Survey of Substance Abuse Treatment Services (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the Behavioral Health Barometers. States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the Healthy People Initiative[18] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

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[18] http://www.healthypeople.gov/2020/default.aspx

Footnotes:

Planning Step 2: Identify the Unmet Service Needs and Critical Gaps within the Current System

Single State Authority on Substance Abuse (SSA)

The SSA has a long tradition of conducting needs assessments to determine overall treatment need for substance abuse treatment, demand and gap, and treatment need and gaps for special populations in New Jersey. Our methodologies also allow us to determine need at the county level. This information is important for the planning and development of new substance abuse prevention and treatment services. Needs assessment data are incorporated into our RFPs for developing new substance abuse and treatment services, are incorporated into funding formulas for distribution to our counties per AEREF legislation and utilized in the Division's applications for federal grants. Various social indicators that have been demonstrated to have a relationship to substance abuse are employed in our relative needs assessment methodology, such as, mortality from alcohol and drug poisoning, treatment admissions, child abuse and neglect, DUI arrests and drug law violations. The SSA utilizes numerous data sources, e.g., national, state, SSA data systems and surveys to inform its need assessment and planning processes.

The SSA uses a variety of methodologies such as large-scale population-based surveys (NJ Household Survey); Middle School Risk and Protective Factors survey; targeted surveys such as Older Adults, Veterans; relative needs assessment; synthetic estimation such as capture-recapture; and social indicator analysis. in order to develop it needs assessment strategies.

Data Sources Used To Identify Needs and Gaps

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

SSA Information Systems

- New Jersey Substance Abuse Monitoring System (NJSAMS)
- Prevention Outcomes Management System (POMS)
- Block Grant Support System (BSS)
- Contract Information Management System (CIMS)
- Driving Under the Influence Tracking System (DUITS)
- Child Protection Substance Abuse Initiative (CPSAI) Module
- Clinician Roster Information System (CRIS)

SSA Surveys

- NJ Household Survey on Drug Use and Health (2003, 2009)
- NJ High School Risk & Protective Factor Survey (2008)
- NJ Middle School Risk & Protective Factor Survey (2007, 2010, 2012)
- Co-Occurring Survey (2008)
- Survey of Older Adults (2012)
- Veterans Survey (2015)

Other SSA Data Sources

- NJ Epidemiological Profile for Substance Abuse (2008)
- County and Municipal Social Indicator Chartbooks (2005,2013)
- NJ Substance Abuse Provider Performance Reports
- NJ Substance Abuse Overviews
- NJ Intoxicated Driving Reports

Other State Data Sources

- NJ DOH Uniform Billing (UB-04)
- Uniform Crime Reports
- NJ Department of Education Student Health Survey (2009, 2011)
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- Youth Risk Behavior Survey (YRBS)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Prescription Drug Monitoring Program
- Overdose Data
- Narcan Reversals (State Police and Department of Health)
- Drug Arrests (State Police)
- Drug Seizures (State Police)
- State Police Regional Operations Information Center (ROIC) reports

Federal Data Sources

- U.S. Census Bureau
- Violent Death Reporting System
- National Survey of Drug Use and Health (NSDUH)
- Treatment Episode Data System (TEDS)
- National Survey of Substance Abuse Treatment Services (N-SSATS)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Fatality Analysis Reporting System (FARS)
- National Vital Statistics System (NVSS): Multiple Causes of Death (Mortality)
- Uniform Crime Reports (UCR): Police Reported Crimes
- Youth Risk Behavior Surveillance System (YRBSS)
- WISQARS
- SAMDHA
- CDC WONDER

All these data sources allow the SSA to examine current data as well as to make comparisons over time for trend analysis. Also, utilizing Federal data allows New Jersey to examine its state performance in comparison to national data.

Data Driven Planning Process

Over the years, the SSA has performed regular statewide needs assessments for substance abuse prevention and treatment. Information from general and special populations surveys combined with treatment utilization data from the New Jersey Substance Abuse Monitoring System (NJSAMS), as well as the application of Geographic Information Systems (GIS) methodology using Arcview for visual data presentations, provides the SSA with data to assess both service

needs and delivery capacities which drive its SAPT Block Grant Application, its statewide strategic planning, and its multi-year county comprehensive planning.

Assessing the well-being of community health through social indicators has been a long-standing concern to the Center for Substance Abuse Treatment (CSAT). To meet this objective, CSAT has encouraged the use of social indicators to assess social and health risks related to substance misuse in order to inform policy makers. CSAT convened a group to draft a road map for such studies in the form of a "*Social Indicators Core Protocol*" to be used by states. Following the social indicators core protocol guidelines provided by CSAT, the SSA developed the *NJ Chartbook of Substance Abuse Related Social Indicators* The Social Indicators Chartbook is intended to identify social and health problems directly or indirectly related to substance use and to aid in the assessment of needs for treatment and prevention services. This is achieved, in part, by using key social indicators outlined in the core protocol by CSAT, and by identifying risk and protective factors affecting health outcomes. Summary analysis of the core indicators is presented using census data, criminal justice data and substance abuse treatment admissions data.

Additional indicators were identified using guidance from three sources: 1) The U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration's Risk and Protective Factors for Mental, Emotional, and Behavioral Disorders Across the Life Cycle; 2) The Community Anti-Drug Coalition's (CADCA) Assessment Primer: Analyzing the Community, Identifying Problems and Setting Goals; and 3) CADCA's Community Assessment Needs Assessment Data Collection Examples of Local Data worksheet. These documents rely on the Center on Substance Abuse Prevention's (CSAP) Strategic Prevention Framework to guide the identification of individual, family, and community factors that are related to substance abuse. Additionally, CADCA's Assessment Guide is specifically concerned with aiding community coalitions during the needs assessment process and in identifying communities to target for prevention initiatives and the organization of the county and municipal social indicators follow CADCA's conceptualization of domains useful in prevention planning.

The specific objectives of the Chartbook are to: 1) Present an objective profile of New Jersey at the state, county, and municipal levels using key social indicators related to substance abuse; 2) Show the effect of substance use and related health consequences in New Jersey at the state, county, and municipal levels; and 3) Provide information to support needs assessment and prevention, as well as treatment planning, at the community level.

At both the state and local levels, the New Jersey substance abuse planning process is designed to employ both quantitative and qualitative data to assess the relative need for alcohol and drug abuse prevention, early intervention, treatment, and recovery support services. It uses both administrative databases prepared by federal, state, and local governments, as well as general and special population and service-provider surveys conducted by DMHAS to engage in "gap" analysis of unmet treatment demand by age, race and sex among New Jersey residents. The household survey is of sufficient sample size to present use data and other general findings at the county level within an acceptable standard error (+ or – 3.8%). The periodic scheduling of surveys and other studies has provided the SSA with the capacity for longitudinal analysis and forecasting to estimate future prevalence of substance abuse treatment need and demand at both state and county levels and by demographic characteristics of subpopulations warranting special surveillance. Analysis of treatment admissions and delivery at the municipal level provides the SSA with the capacity for spatial analysis of unmet treatment demand and access to care. Thus,

analysis of both primary and secondary data sources drives New Jersey's state planning and policy development for behavioral health care.

Needs Assessment: Treatment

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

Over time, the SSA expanded the size of its household sample to 4,200 completed telephone interviews in 1998 and to 14,700 in both 2003 and 2009. The expansion to N = 14,700 provided approximately 700 completed household interviews per county, enough to allow survey data analysis for planning purposes in each county. After the STNAP ended in 2003, the SSA conducted its 2009 needs assessment "family of studies" using SAPT Block Grant funding. The SSA planned a fifth "family of studies" needs assessment program again using the SAPT Block Grant.

The SSA conducts the New Jersey Household Survey of Drug Use and Health (NJ-HSDUH) at five-year intervals using a questionnaire developed by CSAT during the STNAP that is nearly identical to the questionnaire employed for the National Survey of Drug Use and Health (NSDUH). The primary focus is the population distribution of substance use and the population prevalence of substance abuse and addiction. It employs DSM diagnostic criteria of abuse and dependence in combination with "past 12 month" drug use to obtain alcohol and illegal drug treatment need estimates. The questionnaire also asks those with a treatment need about their treatment histories and obtains an estimate of unmet treatment demand which was .47% in 2003 and .46% in 2008-9. Beyond these core elements, the SSA's questionnaire regularly includes sections on tobacco use and gambling behavior.

Typically, the NJ-HSDUH includes one or more special topics, such as the needs of pregnant women in 1993 and 1998, the needs of persons impacted by the 9/11 attacks in NYC in 2003, and in 2009, both substance use among New Jersey Veterans and obstacles to treatment access among persons who need but do not get care. For the 2013-2014 NJ-HSDUH, which was to be the first NJ-HSDUH after the merger of the Divisions of Mental Health and Addiction Services, the SSA planned to include a new permanent section on mental health treatment needs and access to community-based, mental health treatment opportunities and to return to the special topic of substance use among pregnant women.

Plans to conduct the NJ-HSDUH due in 2013-2014 were blocked by Treasury procurement issues. In 2007, the SSA had obtained a waiver from a then newly promulgated OMB rule that would have required, for the first time, a public bidding process before the SSA could contract for the data collection that the survey entailed and this allowed the SSA to conduct the NJ-

HSDUH in 2008-2009. Regarding the 2013-2014 survey, Treasury determined not to grant such a waiver, requiring instead that the SSA develop an RFP that will need to be issued through their department. At best, this will be a two-year process before the RFP will be posted with an anticipated data collection start date of October 2017 and survey results available at the earliest in 2018. As an interim measure until the RFP can be posted, plans are now underway to conduct a scaled-back survey that will only sample at the state level in order to derive our need coefficient.

Surveys of sub-populations not found in the telephone sampling frame have included: tri-annually since 1993, middle school students; in 1998, Medicaid eligible clients in managed behavioral health care, Temporary Assistance for Needy Families (TANF) recipients, adults and youth in the criminal justice system, convicted intoxicated drivers, residents of homeless shelters, women receiving pre-natal care; in 2003, outpatient mental health patients, in 2008, high school students, in 2009, persons relying on mobile cell phones to the exclusion of landlines in their homes and in 2012, a statewide survey of substance use by older adults aged 60 or older.

For the 2003 STNAP contract, the SSA employed techniques of administrative database linkage to evaluate long-term treatment utilization patterns, recidivism, mental health, mortality, hospital discharge histories and access to care. Longitudinal database linkage studies were also conducted for the FFY 2014-2015 program which included the findings from a four-year evaluation of treatment outcomes and social cost/benefit ratios for injecting heroin users receiving medically assisted treatment (methadone and buprenorphine) and, a study of the effectiveness of Vivitrol among alcohol dependent persons participating in the SSA's Driving Under the Influence Initiative (DUII). An updated, social indicators chart book that presents secondary source data, including those from the 2010 census, related to prevention and treatment admissions over multiple years was developed and plans are underway to update the Chartbook in 2016.

Another keystone source of information for need assessment and gap analysis for addiction services is the NJSAMS. The SSA is able to establish the number of persons receiving substance abuse treatment from licensed treatment providers through its mandated reporting of essential client health data to this combined public health disease surveillance and provider-oriented, management information system. By applying the two sample capture-recapture model to multiple years of NJSAMS data, the SSA can estimate the drug treatment need which is not observed in NJSAMS. When combined with findings on alcohol treatment need obtained from the NJ Household Survey, the SSA can estimate both the need and demand for treatment and differentiate between met and unmet treatment demand.

Finally, the county AEREF comprehensive planning process detailed under "Step 1: Assessing the strengths and needs of the service system...." contributes significantly to the SSA's planning for services across the full continuum of care by 1) applying state needs assessment data to the county and municipal level, 2) comparing trends in state admissions with trends in county admissions, 3) analyzing both state and county admission trends by level of care, primary drug, eight special subpopulations, and locational access, 4) and supplementing state-provided data analysis with needs assessment data developed at the community level. The counties obtain local data from 1) key informant and stakeholder focus group data, and 2) quantitative data

produced from locally-funded research or made available to county planners from multiple health and behavioral health care planning initiatives occurring in their counties. The county level planning process is most informative regarding the identification of gaps in the delivery of services and recommendations for system level changes that can close these gaps. In addition to independent local planning and investment in local systems development, the SSA also relies on county level planning to provide "feedback" regarding the functioning of New Jersey's behavioral health care delivery system and policy recommendations regarding improvement of its performance.

In the most recent county planning cycle, 2010-2015, a wide range of service gaps were identified in the county plans beyond the fundamental shortfall in the supply of services at all levels of care. Often access to existing services is hampered by: lack of transportation, particularly in the more rural areas of the state; limits to personal financial capability; struggles with private insurance plans to obtain coverage for short term residential treatment; social stigma associated with seeking treatment; lack of post-acute care recovery services, such as housing, employment, health care, day care, sober recreation, post-traumatic stress care, or case management for persons with little or no recovery capital of their own; waiting lists consequent to the aforementioned shortfall in supply of acute care services; language and cultural differences between providers of care and clients seeking treatment. Gaps in services exist for: adolescent care, residential services for specialized populations, co-occurring treatment, women, medically-assisted service slots, services for pregnant women, access to psychiatric services, and re-entry services for the criminal offender.

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

The new county planning cycle is limited to four years beginning in calendar year 2016 and ending in calendar year 2019. New county comprehensive plans will be certified by DMHAS by the end of 2015. During the planning cycle, each county will be required to report on its progress implementing and measuring the outcomes of each year's objectives. The 2016-2019 planning cycle will require close monitoring of system level changes following upon the implementation of the Affordable Care Act, the state's Medicaid expansion, and the state's move to managed care for substance abuse treatment. These three developments are expected to change the demand for the use of county dollars to subsidize access to care for the medically indigent and this in turn is expected to permit counties to emphasize the development of recovery support services before the expiration of the cycle in 2019.

The SSA also utilizes local input such as this to help guide its overall statewide program development. As some specific examples, the Medication Assisted Treatment Initiative (MATI) has helped improve "access on demand" to medically assisted treatment for opiate injection drug-users in six urban locations. It has also provided 63 units of supportive housing for clients referred through the MATI. As part of its fee-for-service initiatives, the SSA developed a network of providers with "co-occurring treatment capability" to enhance treatment effectiveness

for substance abusing residents with mental health issues. This network helped community advocates realize "one-stop", "treatment on demand", or "no wrong door" access to care. One County noted a service gap for early intervention services and planned for better integration of ASAM Level .5 into Level 1.0 outpatient programs and advocated for the inclusion of Level .5 (Early Intervention) into NJSAMS reporting, which was in fact accomplished.

The SSA is currently receiving technical assistance from CSAT on improving prenatal screening and reducing the incidence of infants who are SEI/NAS through an In Depth Technical Assistance (IDTA) effort concerning its women's programs. A key component of this project involves data coordination among all the system partners who are involved with this issue.

Estimation of the Population in Need of Treatment - The estimated size of New Jersey's 2014 resident adult population in need of treatment for *alcohol* abuse or dependence is 588,857 persons. It is found by applying the proportion in need identified by the 2009 NJ-HSDUH to the U.S. Census Bureau's estimate of New Jersey's resident adult population for 2014. The size of the 2014 adult population needing treatment for *drug* abuse or dependence in New Jersey is 349,996 persons. It is found by applying a procedure known as the two sample capture-recapture method to the count of unique clients receiving drug abuse treatment in 2012 and 2014 as reported in the NJSAMS. This technique was utilized due to under-reporting of illicit drug abuse or dependence observed in the household survey. The sum of these two estimates of treatment need, one for alcohol abuse and one for drug abuse, equals the 2014 New Jersey total substance abuse treatment need or 938,853 persons. Results by county are presented in Table 1.

Table 1

Estimate of Treatment Need for Alcohol and Drug Addiction, New Jersey, 2014					
County	Adult Population 2014[1]	% in Need of Alcohol Treatment	% in Need of Drug Treatment	Total Need for Alcohol and Drug Treatment	Total Need as % of Adult County Population
Atlantic	213,425	11.3	7.3	39,684	18.6
Bergen	710,036	9.0	3.3	87,056	12.3
Burlington	353,175	6.9	4.2	39,076	11.1
Camden	390,156	7.8	6.3	55,057	14.1
Cape May	78,254	8.7	11.4	15,749	20.1
Cumberland	117,906	8.9	8.1	20,100	17.0
Essex	591,946	7.8	5.5	78,556	13.3
Gloucester	220,088	9.3	6.0	33,706	15.3
Hudson	514,750	6.3	5.0	57,846	11.2
Hunterdon	101,176	9.7	7.0	16,931	16.7
Mercer	282,341	13.2	4.9	51,198	18.1
Middlesex	634,966	6.7	3.9	67,412	10.6
Monmouth	491,375	12.3	6.8	94,243	19.2
Morris	376,517	11.8	4.0	59,245	15.7
Ocean	449,647	8.8	5.6	64,498	14.3
Passaic	382,175	5.7	4.1	37,700	9.9
Salem	50,759	7.9	7.7	7,921	15.6
Somerset	241,230	8.5	4.9	32,175	13.3
Sussex	114,896	11.2	5.6	19,308	16.8
Union	400,374	7.5	4.7	48,651	12.2
Warren	84,444	8.3	6.8	12,738	15.1
Total	6,799,636	8.7	5.1	938,853	13.8

Note: The percentages have been rounded up to the nearest tenth and will not reproduce the numbers given in the text.
[1] Source: U.S. Census Bureau, Population Division Annual Estimates of the Resident Population in 2014: based on April 1, 2010 to July 1, 2013 population survey.

Met and Unmet Treatment Demand - Table 2 presents the met and unmet demand for substance abuse treatment as well as the ratio of unmet to met treatment demand, or "gap" in New Jersey by county. It can be seen that of 78,942 individuals who wanted substance abuse treatment, 47,664 received it. This resulted in an unmet demand of 31,278 or a gap of 39.6%.

Table 2:
2014 Met and Unmet Demand

County	2014 Adult Population [1]	2014 Met Demand [2]	Unmet Demand [3]	Total Demand [2 + 3]	Unmet Demand As Percent of Total Demand
Atlantic	213,425	2,760	982	3,742	26.2
Bergen	710,036	2,163	3,266	5,429	60.2
Burlington	353,175	1,893	1,625	3,518	46.2
Camden	390,156	3,766	1,795	5,561	32.3
Cape May	78,254	1,349	360	1,709	21.1
Cumberland	117,906	1,244	542	1,786	30.4
Essex	591,946	4,847	2,723	7,570	36.0
Gloucester	220,088	1,886	1,012	2,898	34.9
Hudson	514,750	3,334	2,368	5,702	41.5
Hunterdon	101,176	697	465	1,162	40.0
Mercer	282,341	1,800	1,299	3,099	41.9
Middlesex	634,966	3,293	2,921	6,214	47.0
Monmouth	491,375	4,420	2,260	6,680	33.8
Morris	376,517	1,759	1,732	3,491	49.6
Ocean	449,647	4,381	2,068	6,449	32.1
Passaic	382,175	2,570	1,758	4,328	40.6
Salem	50,759	409	233	642	36.3
Somerset	241,230	1,331	1,110	2,441	45.5
Sussex	114,896	763	529	1,292	40.9
Union	400,374	2,272	1,842	4,114	44.8
Warren	84,444	727	388	1,115	34.8
New Jersey	**6,799,636**	**47,664**	**31,278**	**78,942**	**39.6**

[1]Source: U.S. Census Bureau. Annual estimate of 2014 resident population based on 2012 and 2013 population survey.

[2] Met demand: The number of adults admitted for treatment in 2014, according to NJSAMS data.

[3] Unmet demand: Percent of 2009 NJ Household Survey estimated adult population who did not receive treatment in the 12 months prior to the interview but who felt they needed and wanted treatment (0.46 %) times the 2014 adult resident population.

New Jersey Statute 30:4-177.63 became effective March 2010 which required the Commissioners of Human Services and Children and Families to: a) establish a mechanism to inventory all county-based public and private inpatient, outpatient and behavioral health services and make the information available to the public, b) establish and implement a methodology, based on nationally recognized criteria, to quantify the usage and need for inpatient, outpatient and residential behavioral health services throughout the state, taking into account projected patient care level needs, c) annually assess whether there are sufficient behavioral health services available, d) annually identify the funding for existing mental health programs; e) consult with various stakeholder groups to make recommendations, f) consult with various NJ hospital organizations and organizations that advocate for mental illness and their families and g) annually report on activities related to this act to the Governor and Senate and Assembly Health and Human Services Committees. An inventory of all NJ licensed substance abuse disorder treatment providers and prevention agencies was made available. Also a table estimating need for alcohol and drug treatment by county was prepared. The SSA submitted its annual inventory and needs assessment to the New Jersey State Legislature in November 2014.

In addition to survey data, the DMHAS addiction research team developed methods for using social indicators to supplement estimates of need obtained through other methods. Because social indicator data are compiled by their primary users and archived for use by others, indicator data are somewhat convenient to obtain, especially when random samples surveys are not feasible to undertake. One such method of social indicator analysis is the Relative Needs Assessment Scale (RNAS), developed by DMHAS researchers, Mammo & French (1996), using social indicators with known correlations to the incidence and prevalence of substance abuse. The scale calculates an index of risk for each jurisdiction of the same size (county, municipal, zip code, etc.) for which the indicators can be obtained. Because the scale is an interval level of measurement that sums to one, scores are comparable and easily interpreted across jurisdictions.

The RNAS methodology has been used since 2003 to estimate the need for the prevention of alcohol and other drug abuse. It was updated in 2008 and utilized to facilitate the evaluation of proposals submitted to DMHAS as part of the State's Substance Abuse Prevention and Treatment Block Grant (SAPT BG) funded prevention RFP. In the current county comprehensive planning process for 2016 to 2019, the RNAS model, updated to include data from the 2010 U.S. Census, will be used to identify areas within counties with potentially high concentrations of people with substance abuse prevention, treatment and recovery support service needs.

Special Treatment Capacity Assessment Initiatives

Geographic Information Systems (GIS) - In 2014, using its licensure database, the SSA mapped the spatial distribution of treatment services across all counties and modalities of care and used this information in its county comprehensive planning. Since that time the SSA routinely uses GIS to map its treatment services in order to guide its planning of services in underserved areas.

Dual Diagnosis Capability - In FFY 2008, the SSA conducted a web-based survey of licensed substance abuse treatment providers to assess provider capacity to serve New Jersey's dually-diagnosed treatment population. The survey was adapted from the Dual Diagnosis Capability in

Addiction Treatment (DDCAT) tool (McGovern, et al., 2006). It was found that among 120 agencies responding, 76.7% did NOT qualify as Dual Diagnosis Capable. NJSAMS data indicate that approximately 40% of New Jersey's substance abuse clients also have a mental health issue, but with 76.7% of substance abuse treatment agencies lacking dual-diagnosis capability, there is clearly a need to develop dual-diagnostic capability among substance abuse treatment providers in order to increase both their referrals to and their acceptance of referrals from mental health treatment providers. In FFY 2011, the SSA converted the survey questionnaire for use among community mental health treatment providers.

The DDCAT survey results were used in the planning and development of the SSA's co-occurring services network (COSN) as well as a statewide, co-occurring learning collaborative that helps individual provider agencies to develop co-occurring capabilities. As noted in Step 1, the SSA has established a co-occurring network of providers for its fee-for-service initiatives.

Workforce Development - As part its on-going responsibility to address areas of concern that affect service access, quality, and outcomes, the SSA provided several educational opportunities to enhance the competency of its addiction and behavioral healthcare workforce. Through its Addiction Training and Workforce Development (ATWD) initiative, the SSA has provided scholarships for initial and renewal/recertification alcohol and drug counseling courses for behavioral healthcare professionals, alcohol and drug counselors, and prevention specialists in the State of New Jersey. All training initiatives also assist prospective alcohol and drug counselors with navigating the credentialing process, exam preparation, internship recruitment, and placement.

To prepare clinical staff to achieve certification or licensure, and to comply with the New Jersey Board of Marriage and Family Therapy Examiners' Alcohol and Drug Counselor Committee continuing education requirements, the Addiction Training and Workforce Development (ATWD) contract was renewed with the New Jersey Prevention Network. The principal goal of this initiative was to provide accessible training opportunities statewide for those entering or presently working in the addiction field. The anticipated outcome was to increase the number of credentialed and licensed employees who provide treatment and/or prevention services. The contractee offered alcohol and drug counseling coursework leading to certification and licensure at eight geographically located training sites across New Jersey. Training opportunities were available to individuals and counseling staff in outpatient, residential, and opioid substance abuse, prevention, and behavioral healthcare treatment programs. Since its inception in 2006-2007, the ATWD has had over 500 students become credentialed as certified alcohol and drug counselors (CADC) or Licensed Clinical Alcohol and Drug Counselors (LCADC).

In addition, the ATWD contractee provided scholarships for individuals to attend Certified Prevention Specialist (CPS) courses. Participants from prevention agencies, county alliances, and other community agencies were eligible to attend classes. The goal of the scholarship program was to increase prevention knowledge and best practices to the field as well as to increase the number of prevention specific professionals in New Jersey.

The SSA continued to build capacity among current licensed clinical professionals through its Memorandum of Agreement with The Rutgers University, Center for Alcohol Studies (CAS)

Education and Training Division. CAS offered highly specialized, one-day professional development seminars throughout the year as well as offering an intensive weeklong summer training program. Topic areas include clinical supervision, cultural competency, trauma informed care, SBIRT, motivational interviewing, and co-occurring disorders. Both the seminars and weeklong program offered training education hours that can be applied towards recertification or renewal for alcohol and drug counselors and behavioral healthcare professionals working within the addiction and co-occurring treatment fields.

To address SAMSHA recommended scopes of practice for alcohol and drug counselors and to create an addiction professional career ladder, CAS offered continuing professional development seminars for bachelor's level students. The initial program was a series of six classes, each comprised of 6 one-day meeting sessions, designed to meet the educational requirements of individuals seeking initial certification. Each class is designed to provide comprehensive education on addictions and issues related to dual diagnosis. Courses emphasize essential skill development to enhance individual's ability to act as effective case managers and counselors. Each series is approved for 36 Continuing Education Units (CEUs) by Rutgers University and 3 academic course credits – which may be transferred to other bachelor's level programs at the discretion of those academic institutions. Courses are part of a certificate program that is approved for initial certification by the New Jersey State Board of Marriage and Family Therapy Examiners' Alcohol and Drug Counselor Committee, and other affiliated behavioral healthcare professional licensure boards.

The School of Social Work, Division of Continuing Education Certificate in Community-based Planning addresses the needs of County Alcoholism and Drug Abuse Directors as well as county Mental Health Administrators (MHAs) to develop professional skills in health care systems planning. Traditionally, counties have played an ancillary role in the purchase and provision of mainly treatment services for their residents. With the implementation of both the federal PPACA Affordable Care Act and the New Jersey Medicaid Waiver plan for managed behavioral health care, county comprehensive plans will have to reflect the impacts of these reforms.

The *Education, Training and Technical Assistance* (ETTA) project is an innovative program developed and designed by DMHAS and the Continuing Education Department of the Graduate School of Social Work at Rutgers University for the purpose of advancing the planning education and training of today's county comprehensive planner. It also provides the planner with technical assistance to apply the training in the course of the 2015-2018 county comprehensive planning process that takes place during 2013 and 2014. Coursework began in June 2013. The curriculum consists of five day long training sessions, coupled with on-line instruction and results in a Certification in Community-Based Planning from Rutgers University. There will be three waves of this education and training, with the first wave involving all 21 County Alcohol and Drug Directors, plus 9 of 21 county Mental Health Administrators.

Medication Assisted Treatment - Data from NJSAMS for Calendar Year 2014 indicates that only 10% of Methadone is planned in treatment for clients, yet heroin and other opiates are the primary drugs of admission for 42% of clients entering New Jersey's addiction treatment system. The development of the MATI is an attempt to help reduce this gap by providing more access to

medication assisted treatment for opiate addicted individuals by offering methadone, as well as suboxone, to clients.

The SSA implemented a pilot program for the alcohol or opioid dependent, Driving Under the Influence (DUI) offender that include medication-assisted therapy using the FDA approved medication Vivitrol (an injectable form of Naltrexone). A comprehensive research protocol was developed and numerous client outcomes are being assessed. The pilot was launched in September 2011. Clients receive the medication for up to six months.

Based on the promising results for this pilot program, the DMHAS funded a third medication-assisted treatment option for the opioid dependent patient in New Jersey: Detoxification and Stabilization, including Vivitrol, delivered to high risk consumers in a residential setting, followed by up to five additional injections in an outpatient setting. Acknowledging that addiction is a medical disorder that postulates client-centered treatment, the purpose of this funding is an additional medication treatment alternative for the opioid dependent patient. This treatment package is an enhanced service for opioid dependent persons who are in need of opioid detoxification and want to remain abstinent without maintenance medications, or for patients seeking medically supervised withdrawal from maintenance medications. The addition of the Stabilization Period in care is to assist the opioid dependent with acute withdrawal during the ten-day, opioid-free period required prior to the first injection of the medication. The patient will then be referred to outpatient treatment for additional injections, treatment, and all the appropriate bio-psychosocial interventions to decrease the likelihood of relapse and assist the person to long-term recovery.

Also, the Division has mandated trainings on medication assisted treatment for treatment providers, incorporated language requiring acceptance of clients on medication assisted treatment into contract requirements, and has provided training for systems partners in Drug Court and Child Welfare on medication assisted treatment. Most significantly, the SSA has incorporated course work requirements in the workforce development initiative described above.

In May 2015, DMHAS submitted an application for federal funding for its three-year Medication Assisted Treatment Outreach Program (MATOP) under the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) Targeted Capacity Expansion: Medication Assisted Treatment-Prescription Drug and Opioid Addiction grant opportunity. DMHAS received notice of award at the end of July. MATOP will provide accessible, comprehensive and integrated care, using evidence-based programs such as medication assisted treatment (MAT), mindfulness based recovery maintenance, smoking cessation and other recovery support services for individuals with an opioid use disorder. Three New Jersey licensed Opioid Treatment Programs (OTPs) will participate in this initiative and provide outreach and other engagement strategies to diverse populations at risk such as incarcerated individuals, pregnant and parenting women, veterans, parents and caregivers involved with the child welfare system, opioid overdose reversals and syringe access program participants. In addition, DMHAS will partner with Rutgers University, Robert Wood Johnson Medical School to provide trainings and webinar series for OTP providers, patients and their families. Trainings and webinar series will focus on increasing understanding of the effectiveness of MAT among patients and providers throughout New Jersey, as well as to

address misconceptions regarding the use of MAT, smoking cessation and mindfulness based recovery maintenance. New Jersey's project will serve 130 unduplicated individuals annually and 390 unduplicated individuals over the entire project period.

In Depth Technical Assistance (IDTA) - In early 2014 the SSA reached out to the NCSACW to request continuation of IDTA to address emergent issues of concern where New Jersey like many other states, has been experiencing an increase in illicit opioid use among women. New Jersey's 2012 treatment data reflected the most commonly used substances among New Jersey's pregnant women include heroin and other opiates. The NCSACW granted an IDTA continuation for a limited scope of work with DMHAS as the lead agency to address NJ's increase in substance using pregnant women, and the associated Substance Exposed Infants (SEI), including those with Neonatal Abstinence Syndrome (NAS). The IDTA continuation involved a Monmouth county walkthrough that included an MAT provider, local hospital, Maternal Health Consortia, the local DCP&P office, and other stakeholders who provide services to substance using pregnant women who reside in Monmouth County revealed both effective practices and unexpected yet significant SEI gaps. As this limited TA came to a close, NJ as a recent SAMHSA Prescription Drug Abuse Policy Academy State was eligible to apply for a unique IDTA offered through SAMHSA's NCSACW to address the multi-faceted problems of NAS and SEI. Since NJ identified significant SEI gaps with the Monmouth county walkthrough, NJ as the lead State agency partnered with DCF and DOH and submitted a successful application for IDTA on SEI and NAS. Multiple State Departments and their Divisions, as well as the provider community, will participate on the IDTA with the goal to strengthen collaboration and linkages across addiction treatment, medical communities, child welfare, providers and other organizations to improve services for pregnant women with opioid and other substance use disorders and outcomes for their babies. A data workgroup has been formed to better coordinate data collection efforts among all the system partners in order to plan next steps to help mitigate this serious problem.

Needs Assessment: Prevention

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

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

been prepared. County level reports was prepared which provide trend information for key indicators.

Implementation of the SSA's first High School Survey was completed in June 2008. It used the same survey instrument as the middle school survey (Pride Survey) and is the first New Jersey report at the county level on 9th through 12th grade youth. The SSA has also been collaborating with the NJ Department of Education (DOE) on its Student Health (High School) Survey and has provided financial assistance for the 2010-2011 and 2013 surveys. While the DOE does not sample at the county level, the findings still provide important information regarding factors protecting and posing risk to adolescents concerning substance use.

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

The SSA also developed the Relative Needs Assessment Scale (RNAS) for alcohol and drug prevention planning in 1995 and updated it in both 2008 and 2013. The RNAS employs social indicators of substance use-related mortality and morbidity and calculates relative risk for each county and municipality, thus, permitting comparisons of relative risk among counties across the state and among municipalities within each county. The RNAS is used to target prevention and treatment resources by location and socio-economic characteristics of at-risk populations; it was utilized in the 2008 and 2014 RFP processes for awarding five-year prevention contracts utilizing SAPT Block Grant funding. In FFY 2014, the SSA provided RNAS indexes down to the municipal level for use in the county comprehensive planning process for 2016 to 2019.

Addictions Prevention Strategic Plan - In 2010, the SSA began an addictions strategic prevention planning process for the use of primarily environmental management strategies. The planning method relied on the full range of DMHAS' available quantitative data for the purpose of identifying meaningful priorities at both the state and community levels for which measurable change could be achieved when prevention efforts employed targeted, evidence-based prevention strategies. The Plan aligns stakeholder group prevention efforts and resources with the identified priority areas and guides prevention decision-making and policy development at the state, county, and provider levels for all DMHAS-funded prevention services through 2016. A draft Addictions Prevention Strategic Plan was distributed to Planning Committee members in August, 2011 and the final plan was completed in the summer of 2012. The plan will be updated during the summer of 2016.

In keeping with the aforementioned purpose of the Plan, the priorities identified were included in the RFP entitled, "Funding for Regional Coalitions to Utilize Environmental Strategies to Achieve Population-Level Change". The primary goals of the RFP were to identify and fund regional coalitions to utilize the SPF and undertake a rigorous needs assessment process to

identify which of the statewide DMHAS prevention priorities identified in the Plan are the most significant in their region. Seventeen coalitions were awarded contracts.

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

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

The SSA continues to actively recruit for new members of the SEOW. This past year has seen the addition of members from the NY/NJ High Intensity Drug Trafficking Area (HIDTA), the Department of Health's Division of Family Health, Department of Military and Veterans Affairs, the NJ Poison Information and Education System (NJPIES), the New Jersey Hospital Association Behavioral Health Group, representatives from the NJ State Police's Regional Operations Intelligence Center, and representation from the Prescription Drug Monitoring Program which became operational in September 2011.

Originally, the role of SEOW was to conduct a statewide prevention needs assessment to recommend a statewide priority for the SPF-SIG project. Beginning in late 2006, the SEOW developed the New Jersey Epidemiological Profile for Substance Abuse, which it submitted to SAMHSA in April 2007. The plan was updated in 2008 and will be updated again during the summer/fall of 2015.

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

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

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

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

The profile served as the basis for recommending prevention priorities to be addressed through the SPF-SIG grant. The SEOW conducted an extensive review of data describing substance use and its consequences available from a multitude of sources. Using prevalence and incidence rates, severity ratings and trends, the SEOW developed a formula incorporating these variables to produce need scores and ranked the needs in order of importance. "Alcohol dependence of 18-25 year olds in the past year", "drug dependence of 18-25 year olds in the past year" and "past month use of illicit drugs by 18-25 year olds" were the three highest ranked indicators. Based on these data, the priority "to reduce the harmful consequences of alcohol and drug use among 18-25 year olds," was selected as the guideline for the SPF-SIG project. It was noted that there are very few prevention programs tailored for the 18-25 year old population. In 2008, the SSA awarded eleven community contracts to implement this prevention priority. As the projects were implemented, most were focused on the harmful consequences of alcohol consumption and in particular, motor vehicle crashes. SPF-SIG funding ended in 2012, after which, most of the SPF-SIG communities received funding (from the SAPTBG) to continue their coalition work by focusing on the priorities identified in the prevention strategic plan.

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

The Division was awarded a SEOW grant from SAMHSA for $180,000. Funding from the SEOW grant, in part made possible the development of a Social Network Analysis Project (analysis of linkages between/among the disparate prevention organizations in New Jersey). Additionally, in 2011, New Jersey received a $561,000 State Prevention Enhancement (SPE) Grant from SAMHSA, which enabled the state to expand its prevention system and make numerous enhancements to the substance abuse prevention infrastructure. New Jersey utilized SPE funding to make numerous enhancements to its prevention infrastructure by: addressing gaps in data regarding older adults and binge drinking rates among young adult women of child bearing age (21-29 years), expanding the capacity of the Prevention Outcomes Monitoring System (POMS - DAS' prevention management information system) to collect data on

environmental strategies and programs, updated its *Chartbooks of Social and Health Indicators*, the information which can be used to identify health problems directly or indirectly related to substance use and to aid in the assessment of needs for prevention and treatment services, and further enhanced the database of all prevention services and programs being delivered throughout the State.

Partnership for Success (PFS) - In October 2013, DMHAS received a five-year Strategic Prevention Framework - Partnerships for Success (SPF-PFS) cooperative agreement from CSAP. The goals of New Jersey's SPF-PFS initiative are threefold: 1) to strengthen and enhance the work of 17 DMHAS-funded regional prevention coalitions; 2) to further develop the prevention data infrastructure and information systems capacity at the state level; and 3) in collaboration with state partners and community stakeholders, to continue work in developing a unified statewide prevention planning and service delivery system. Specifically, New Jersey's SPF-PFS seeks to 1) reduce underage drinking among persons aged 12 to 20; and 2) reduce prescription drug misuse and abuse among persons aged 12 to 25. As additional components of its PFS programming, New Jersey also focuses on unhealthy drinking patterns and prescription drug abuse among adults age sixty and older; and serves military families with prevention education, addressing military community risk levels, striving to mitigate the risk factors, and enhancing the protective factors to support military members and their families in making responsible parenting and individual choices in regards to drug and alcohol use.

DMHAS utilizes SPF-PFS funds for numerous prevention infrastructure developments and enhancements. For instance, New Jersey is taking advantage of emerging technologies to better promote prevention messaging, and has developed a prevention-focused mobile app for iPhone and Android smartphones called "Be the One".

Veteran's Survey - New Jersey is focused on returning Veterans as a priority population for its PFS initiative and other programming. This is another population for which there is limited information. DMHAS has reached out to New Jersey Department of Military and Veteran's Affairs as well as the New Jersey National Guard to solicit their active participation on the SEOW and Advisory Council in light of this priority. DMHAS is collaborating with its partners at Rutgers University to conduct a survey of returning Veterans in order to gather information about behavioral health issues and concerns within this population in New Jersey. We are in the process of finalizing the instrument and will field the survey in the summer of 2015.

Older Adult Survey. The SSA has recognized that information concerning older adults and substance use is lacking, and this was also identified as a data gap by the SEOW. In order to help close that gap, the statewide results have yielded some interesting findings that will help drive planning efforts for this population over two years. An Older Adult Survey was conducted during 2012 utilizing funding from the SPE grant. However, there were insufficient funds for a large enough sample to obtain reliable county level estimates. The goal of the survey for the PFS opportunity is to obtain enough data to create small area estimates of the prevalence of substance abuse and mental illness among older adults in New Jersey. A telephone interview survey will be developed and random digit dialing with a multistage cluster design will be used to generate probability-based samples of the adult population of each New Jersey County or relevant geographic area. Synthetic estimation techniques will then be applied using the results of the

survey and other archival data to create small area estimates of the prevalence of substance abuse for the target population in specific geographic areas (e.g., municipality).

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

Two new modules were developed for POMS during FY 2013: 1) the Strategic Prevention Framework (SPF) and 2) the Environmental Strategies. Training on the SPF module occurred in March 2013 and is now being utilized by the 17 Regional Coalitions. Modifications were made to the Environmental Module, and providers will begin to use the module in the fall of 2015.

County Planning for Treatment and Prevention

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

Further, according to the AEREF enabling legislation, each participating county is required to submit "an annual [county] comprehensive plan (CCP) for the provision of community services to meet the needs of alcoholics and drug abusers."[2]..Further, this plan "shall…demonstrate linkages with existing resources which serve alcoholics and drug abusers and their families." The law also stipulates that counties pay "special attention" to the needs of youth, drivers-under-the-influence, women, persons with disability, workers, and offenders committing crimes related to substance abuse. Thus, the counties are mandated by statute to develop unified, data-informed, comprehensive plans for the coordinated provision of community-based prevention, early intervention, treatment, and recovery support services for all county residents at both state and local levels. The SSA provides counties with quality assurance planning protocols and is responsible to review each CCP to determine: 1) whether the plan complies in form and function with the requirements of Chapter 51 by rationally relating county resources with the needs of county residents, and 2) whether it is designed and developed in a manner consistent with the state's quality assurance standards for county planning.

Local Citizen Advisory Planning Boards - A key component of the county comprehensive planning system is the county Local Advisory Committee on Alcoholism and Drug Abuse (LACADA), an independent, citizen's advisory group. The LACADA is required to develop and present to the County Board of Freeholders the aforementioned CCP for adoption. The

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

LACADA is also required to establish a County Alliance Steering Subcommittee (CASS). The CASS is the county-level planning body for each county's GCADA municipal alliance which, in turn, is a coalition of municipal level residents and other stakeholder volunteers that recommend a set of local prevention priorities to the LACADA based on their own data analyses and prevention service inventories. Municipal alliance plans are coordinated by the CASS with a county's comprehensive plan through a process known as Unification Planning. The SSA works closely with GCADA to prepare for and implement the Unification process. Additionally, the counties are required to allocate approximately 11% of the county AEREF dollars to support prevention education services.

Length of County Planning Cycle - In 2004, the SSA established a three-year planning cycle for the county AEREF program that allowed counties to submit multi-year plans for the period 2006-2008. In 2008, the SSA lengthened the planning cycle to four years from 2009 through 2012, in order to establish the principle that county RFPs for substance abuse services were to be published subsequent to SSA certification of the county comprehensive plan and in accordance with its goals and objectives. In January of 2011, the SSA extended the effective period of the current CCPs to a fifth year, through 2013, in order to coordinate with the scheduled implementation of federal health care reform. As a consequence of the devastating impacts of "Superstorm Sandy" in October 2012, the SSA, in collaboration with the county planners, extended the current planning cycle for an additional year through the end of 2014. An additional 1 year extension was implemented in spring 2014 for reasons related to the storm's impact and the focus of many counties on the implementation of Federal Disaster Relief Funds. Thus, the next CCP will govern the four-year period from January 1, 2016 through December 31, 2019.

SSA Planning Standards - Additionally, in 2008, the SSA established planning processes and quality standards that required: 1) state certification of CCP compliance with all Chapter 51 and the SSA planning requirements as a condition of recommending the release of county AEREF and other state discretionary funding; 2) engagement of community stakeholders in a formal community needs assessment based upon state and local data describing substance abuse treatment needs and gaps in the delivery of services required to meet those needs; 3) a logic model of the interrelationships of needs, goals, objectives, strategies, resource allocations and outcomes for prevention, early intervention, treatment, and recovery services; 4) one system-level change to enhance the local continuum-of-care; 5) an action and resource allocation plan that implements the CCP according to its goals, objectives, strategies and intended outcomes; 6) a draft RFP for the provision of those services that would implement the CCP in accordance with its corresponding planned resource allocation; and 7) establishment of an annual plan implementation and outcomes monitoring procedure to document plan implementation obstacles encountered and corrective actions taken to overcome them.

Thus, the SSA, in collaboration with its partner county governments has established planning standards intended to produce rational, goal-oriented, data-driven county plans for the development of the full continuum of care from primary prevention through recovery support.

The SSA supplies counties with data from the SSA's needs assessment program. For instance, the counties review: a) primary data obtained from the household survey, b) secondary social

indicator data from the county and municipal chart books, c) administrative data from sources like NJ-SAMS and facility licensure . The SSA's County Planning Guidelines also encourage county behavioral health planners to incorporate local perceptions of substance abuse issues and treatment system capacity by means of county focus groups and other encouragements to citizen participation. As previously mentioned, the SSA also provides planning education, training, and technical assistance to the county directors.

Future Developments in the State-County Collaborative Planning Process – For the 2016-2019 planning cycle, the SSA will continue to assist counties with planning data and analyses as well as understanding of federal and state level changes to health care delivery that will affect access to care for their residents. It will continue to help counties identify and implement a greater number of evidence-based prevention education programs and encourage counties to participate in planning environmental approaches to prevention at the county and municipal levels. It will encourage counties to increase their investments in recovery support services in order to help treated individuals maintain the benefits of clinical services, forestall relapses, and when necessary, return to treatment sooner before clinical treatment needs become severe.

System Enhancements

1)Treatment

DUI Vivitrol Pilot - The SSA's goal is to develop a system of care that offers high risk clients the means to enter and sustain recovery. In this effort, the SSA has implemented a pilot program for the alcohol or opioid dependent, DUI offender that includes medication-assisted therapy using the FDA approved medication Vivitrol. A comprehensive research protocol was developed and numerous client outcomes are being assessed. The pilot was launched in September 2011; clients receive the medication for up to six months. There is a follow-up survey six months after the client's last injection. The pilot ended in September 2013 once 100 clients had received the medication. Since results have been promising, Vivitrol has been incorporated as an enhancement in most its substance abuse Fee for Service Initiatives (Drug Court, MAP, SJI, MATI and DUI), moving it into general practice, rather than pilot status.

Interim Managing Entity - In January 2015, the Governor announced that the Division of Mental Health and Addiction Services will develop an interim managing entity (IME) for addiction services as the first phase in the overall reform of behavioral health services for adults in New Jersey. University Behavioral Health Care (UBHC) will be the IME with an implementation date of 7/1/15. The IME will provide as a coordinated point of entry / no wrong door for those seeking treatment for substance use disorders. Clients can either call the IME directly to be screened and receive a warm handoff to a provider, or they can go/call a provider directly to be screened and continue services. The IME will assist clients to find the right provider for their needs and help them navigate the substance abuse treatment network. This will allow the state to manage its resources across payors and across the continuum of care. The IME will be implemented in Phases and will eventually manage substance abuse services for Medicaid, block grant and the most state funded initiatives. Not all addiction services will be managed in the first phase of implementation of the IME.

Payment for Episode of Care - The SSA has explored financing strategies involving payment for an episode of care. Since the SSA has a fee-for-service billing system for several of its treatment initiatives, it has the data available to conduct this analysis. Preliminary work has begun by examining the episode costs for the different initiatives by the level of care initially entered. The analysis has indicated the episode costs vary widely across initiatives even though they start at the same level of care. These data have helped inform the SSA in developing benefit management strategies for high cost services such as residential with the goal of ensuring that individuals get the right service at the right time in the right amount (as per SAMHSA's recommendation) . Maximizing the appropriate use of services in the most cost effective manner, allows the SSA to provide more services to clients in need and helps reduce the treatment gap between met and unmet demand.

Opioid Overdose Recovery Program - A Request for Proposals (RFP) was issued in June 2015 to develop an Opioid Overdose Recovery Program to respond to individuals reversed from opioid overdoses and treated at hospital emergency departments as a result of the reversal. This new two-year initiative funded by DMHAS, the Governor's Council on Alcoholism and Drug Abuse (GCADA) and the Department of Children and Families (DCF) will fund programs in Atlantic, Camden, Essex, Monmouth and Ocean Counties. The Opioid Overdose Recovery Program will utilize Recovery Specialists and Patient Navigators to engage individuals reversed from an opioid overdose to provide non-clinical assistance, recovery supports and appropriate referrals for assessment and substance use disorder treatment. The Recovery Specialists and Patient Navigators will also maintain follow-up with these individuals. Recovery services provided for these individuals should be fundamentally strengths-based. Additionally, they should deliver or assertively link individuals to appropriate and culturally-specific services and provide support and resources throughout the process. It is planned that, at minimum, recovery specialists will be accessible and on-call from Thursday evenings through Monday mornings in the specific locations where funding is made available. This new initiative is planned to commence in fall 2015.

2) Prevention

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

- Reduce underage drinking
- Reduce the use of illegal substances – with a special focus on the use of opioids among young adults 18-25 years of age

- Reduce prescription medication misuse across the lifespan
- Reduce the use of new and emerging drugs of abuse across the lifespan

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

Effective January 1, 2012, the regional substance abuse prevention coalitions were funded to engage community stakeholders to address prevention priorities identified by DMHAS' Prevention Strategic Planning Committee in 2010 and to complement and reflect the first of the SAMHSA's Eight Strategic Initiatives.

The coalitions will intensively collaborate with Municipal Alliances in their region, which are funded and overseen by the GCADA. Coalitions will also coordinate their efforts with those of the nine Federally-funded Drug Free Community Support Programs in New Jersey. This initiative seeks to achieve an enhanced level of communication and collaboration among all groups and organizations that are working to reduce the misuse and the harmful consequences of alcohol and drug use among the citizens of New Jersey.

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

In addition to serving these high-need communities, New Jersey proposes to utilize SPE funding to make numerous enhancements to its prevention infrastructure by: addressing gaps in data regarding older adults and binge drinking rates among young adult women of child bearing age (21-29 years), expanding the capacity of the POMS, the SSA's prevention management information system, to collect data on environmental strategies and programs, creating a Social Indicator Database, updating the *New Jersey State Epidemiological Profile for Substance Abuse*, updating its *Chartbooks of Social and Health Indicators*, the information in which can be used to identify health problems directly or indirectly related to substance use and to aid in the

assessment of needs for prevention and treatment services, and creating a database of all prevention services and programs being delivered throughout the state.

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

Partnership for Success Grant - In May 2013, the SSA submitted a Partnership for Success (PFS) grant to SAMHSA. This grant will target underage drinking and the misuse of prescription medication among 12 to 25 year olds as per SAMHSA requirements. New Jersey has also added an additional priority focused on the misuse of prescription medication among older adults (60 years and above). The grant will also include components related to smoking cessation and addressing the needs of returning military.

Prevention Statewide RFP - A Request for Proposals (RFP) for Statewide Services and Special Projects for Substance Abuse Prevention was released in September 2014 for community-based substance abuse prevention services and two special prevention projects described below. The guidelines and requirements of the RFP were developed by DMHAS in accordance with the DMHAS Substance Abuse Prevention Strategic Plan. Funding for all services is provided by the SAPT Block Grant. Each county in the state was assigned a funding allocation from the total funds available based on its relative need. The funding allocation was determined based on the presence and intensity of social indictors, past 30-day use rates, treatment admission rates, as well as need and risk factors within each county. Bidders responding to the RFP were required to utilize evidence-based programs and address the risk and protective factors specific to the prevention priority as well as the population (e.g. families, middle or high school students, older adults, workplaces, etc.) they propose to serve. In addition, bidders were required to provide quantitative data to substantiate the need for the substance abuse prevention services within the community and population they intend to target. From the 98 proposals that were received, 51 community-based contracts and two special project contracts were awarded totaling $5,700,200.

Prevention Services to Families of Military Veterans - Working with the New Jersey National Guard Family Program and its eight Family Assistance Centers based at armories around the state, the SSA funds the New Jersey Prevention Network to provide programs to serve returning military personnel and their families through two evidence-based programs, Coping with Work and Family Stress and the Strengthening Families Program. Both programs are designed to enhance protective factors to support military members and their families in making responsible parenting and individual choices in regards to drug and alcohol use.

Prevention Services to Gay, Lesbian, Bisexual, Transgendered and Questioning Youth - According to a study by University of Pittsburgh researchers published in the April 2008 issue of *Addiction*[3].the likelihood of substance use by gay, lesbian bisexual, transgendered and questioning (GLBTQ) youth are on average 190 percent higher than for heterosexual youth, the

[3] Marshal, Michael P., Friedman, Mark S., Stall, Ron, King, Kevin M., et. al. (2008). Sexual orientation and adolescent substance use: a meta-analysis and methodological review. *Addiction, 103*(4), 546-556.

SSA funds the North Jersey Community Research Initiative to continue and expand their existing programs for high-risk GLBTQ youth of color by adapting a prevention model developed by the Centers for Disease Control and Prevention, early intervention services, social marketing, and structured recreational activities. A CSAP-sponsored evaluation of the program determined that the program was effective in reducing rates of substance use among participants and that participants were highly satisfied with the services that were provided.

Opioid Overdose Prevention - One of the gaps identified through the SSA's data is the need to engage individuals who have undergone a Narcan reversal to enter treatment. The data clearly demonstrates that most individuals who experience a reversal do not enter treatment. As a result DMHAS is actually developing strategies to reduce this gap.

DMHAS issued a Request for Proposals (RFP) in June 2015 to establish a two-year opioid overdose prevention program. This RFP funded by DMHAS and the Governor's Council on Alcoholism and Drug Abuse (GCADA) will establish three programs commencing in the fall of 2015 in the following regions:

North: Bergen, Essex, Hudson, Morris, Passaic, Sussex and Warren Counties
Central: Hunterdon, Mercer, Middlesex, Monmouth, Somerset, and Union Counties
South: Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Ocean and Salem Counties.

The program is expected to include an educational component, outreach to at-risk individuals, collaboration with interested stakeholders and distribution of naloxone rescue kits. The program will provide education to individuals at risk for an opioid overdose, their families, friends and loved ones to recognize an opiate overdose and to subsequently provide life-saving rescue measures to reverse the effects of an opioid overdose.

State Mental Health Authority (SMHA)

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

The merged SSA/SMHA is better positioned to conduct a joint, statewide and comprehensive behavioral health needs assessment—inclusive of both substance abuse and mental illness within the grant period. One promising data source that will have integrated substance abuse and mental

health survey is the NJHSDUH currently in development Mental Health indicators have been included in the questionnaires of this survey.

Mental Health Promotion, Needs Assessment and Goals

A major initiative currently underway is the development and implementation of a web-based client registry and tracking system to support DMHAS' transformation into a recovery oriented service organization. The new system will provide the ability to more easily create unduplicated statistics on consumers served, as well as to identify service utilization across the mental health system.

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

In the summer of 2014, the SMHA launched an ambitious update of the QCMR system. Beginning with Q1 SFY 2015, providers are now able to submit their QCMR data via a secure website. All contracted providers have been trained in the use of this new system, resulting in more timely, more accurate, and more complete submissions of QCMR data. Improvements to the programming of this system, as well as continued training of QCMR agency users, remain ongoing.

Data Sources - The SMHA has steadily improved its capacity to organize mental health promotion initiatives utilizing prevalence estimates and epidemiological analyses at the state and county levels. The data sources SMHA will continue to utilize in driving the planning for the prevention and mental health promotion initiatives include:

- Annual Demographic Profiles summarized by New Jersey Department of Labor and Workforce Development based upon Census 2010, Intercensal Population Estimates, and Population projection estimates by the U.S. Census Bureau.
- New Jersey State Health Annual Assessment Data, Center for Health Statistics, New Jersey Department of Health (DOH).
- The New Jersey Violent Death Reporting System (NJVDRS), a CDC-funded surveillance system, which records suicide (with known circumstances).
- CDC-funded New Jersey Behavioral Risk Factor Survey, in which mental health modules were implemented (Depression and Anxiety Module, 2010 and 2011; and Mental Illness and Stigma Module, 2012 and 2013 and 2014). The SMHA funded the collection of Mental Health Module in NJBRFS in 2014.
- Mental Health Consumer Satisfaction Survey (MHSIP), Mental Health Statistics Improvement Program.
- New Jersey DOH Uniform Billing from which we can derive prevention quality indicators (using the algorithm provided by AHRQ) to calculate preventive hospitalizations.

- New Jersey DOH Healthcare Facility Licensing data, with which occupancy rates for psychiatric beds in general hospitals are calculated.
- Beds Enrollment Database (BEDS): In May 2012, the SMHA began development on a web-based system (BEDS) which was designed to assist hospital social workers quickly facilitate safe, clinically appropriate and enduring placements of hospital consumers into community settings. In addition, BEDS was designed to assist DMHAS Central Office keep better track of its funded community-based housing resources, and better inform the Division about community-based housing resources (e.g., Supportive Housing, Residential Services/"Legacy Housing", and Medication Assisted Treatment Intervention (MATI) Beds. Currently BEDS is in undergoing pilot use and testing by seven provider agencies and the SMHA's non-forensic state hospitals.
- The Unified Services Transaction Form (USTF) database is an electronic client level database (CLD) registry originally developed in 1978 (and revised in SFY 1990) which still serves as one of the primary sources for populating the URS data tables. In SFY 2015, there were approximately 480,000 records—with each record containing the potential for over 50 separate data fields. Currently the SMHA is undertaking a major revision of the USTF database, and transforming it into a secure, web-based, client reporting system. Pilot testing has been completed by the SMHA's Office of Olmstead, Compliance, Planning & Evaluation, and now awaits final programing by the SMHA's Office of Information Technology. This is expected to be completed in CY 2016. With this updated system, the USTF will require providers to provide the SMHA more time-sensitive client-level data, indicating changes in consumer's status (e.g., Global Level of Functioning, incarceration status, geographic location). Further this new USTF will be scalable so that new program elements can be seamlessly added to the dataset, as such programs are rolled-out by the SMHA.

  The SMHA is able to determine treated prevalence within the publicly funded mental health system through its management information system. The USTF database is a de-identified client registry for individuals seen in state and county psychiatric hospitals, short term care facilities and publicly-funded mental health programs in community mental health agencies. A USTF form is completed for every consumer upon admission, discharge and transfer from a public mental health service provider. The USTF was revised, effective July 1989, to be 100 percent consistent with the MHSIP minimum data set. The USTF provides the state with information regarding treated prevalence within the public mental health system.
- Oracle Hospital Census Database is the central information system used by DMHS for storing client-specific records on consumers admitted into New Jersey's four inpatient adult psychiatric hospitals. To keep up with the flow of consumers entering, and exiting the SMHA's state hospitals, this data is updated on a daily basis by hospital personnel. Because Oracle is scalable, the Hospitals Census database has been modified slightly at each of the SMHA's psychiatric hospitals to meet not only the overarching needs of the SMHA, but to also meet the unique needs of each hospital. The scalable nature of Oracle has allowed the SMHA to also develop modules specific to data requirements imposed by the Olmstead Settlement Agreement, including a "Discharge Planning and Placement" Module designed to track efforts and information relevant to the timely discharge of hospital CEPP (Conditional Extension Pending Placement) consumers. Although Oracle

provides client-level data, this information is aggregated on a daily basis to provide critical reporting at the hospital level as well as the statewide level. The Oracle database is used by the Division on a daily basis for patient management, hospital administration, utilization management, Olmstead-related issues, and reporting of URS data tables 20A and 20B.

- Quarterly Contract Monitoring Report (QCMR) Database collects quarterly, cumulative, program-specific data from each of the service providers contracted by DMHS. QCMR data is provided to the SMHA by 118 separate agencies on 17 different program elements (e.g., Supportive Housing, PACT, Outpatient Services) for roughly 630 separate sub-program elements (e.g., a specific program element, run by specific agency, specific site) on a quarterly basis. The QCMR historically emphasized program-level data, but as the QCMRs data field layouts change over time, increasing numbers data points related to consumer outcomes have been included. Starting in Q1 SFY 2015, the Division successfully migrated the old 'pencil and paper' version of the QCMR to a secure, web-based system[4]. This update of the QCMR data reporting system has significantly improved the timeliness, and accuracy of QCMR data submission, vis-à-vis the user-friendly web-based interface, data input masks, mandatory field settings, and auto-calculated fields. Because the QCMR collects data on a program-by-program basis, it contains no client level data. Instead it collects consumer data in the aggregate. The QCMR provides essential data for many routine reports generated by the SMHA including: Provider Performance Reports (for Supportive Housing and Designated Screening), annual Budget Briefing reports, and planning resources for the annual Consumer Perception of Care Survey. In addition, the QCMR provides reliable information for the majority of ad-hoc reports created by the Division, specifically around the topics of utilization management, provider performance and the geographic distribution of available services.

Needs Assessment - The SMHA has identified the following gaps in service delivery: minority populations, transgender, lesbian and gay populations, persons with dual disorders, consumers with co-occurring medical conditions, persons in dual recovery from substance abuse and mental health disorders as well as those who have past criminal involvement. Due to the high prevalence rate of dual disorders, DMHAS sponsors and funds a small program to provide specialized approaches to starting and running dual recovery groups at Community Wellness Centers. Nine Community Wellness Centers participate in the initiative. Due to the early mortality and medical co-morbidity of the mental health consumer population, Community Wellness Centers have begun to offer free health screenings for cardio-metabolic syndrome by measuring blood glucose levels, weight, blood pressure, and body mass indicator.

Client Level Database - With the development and implementation of the web-based client level database, as well as with the other databases and datasets described above, the SMHA will be able to significantly enhance its planning efforts and capacity for data informed decision making. The SMHA will be able to prepare a comprehensive need assessment inclusive of county based needs, barriers, critical gaps, and reporting on target populations. To enhance this, the SMHA

[4] https://dmhas.dhs.state.nj.us/qcmr/Login.aspx

has acquired GIS technology (ArcView[5]) which will allow for sophisticated statewide analyses of need to be conducted on a county-by-county basis. Such technology allows the SMHA to conduct geographically-informed queries using existing tabular datasets (e.g., US Census data, SMHA client utilization information, etc.).

New Jersey Statute 30:4-177.63 - became effective March 2010 which required the Commissioners of Human Services and Children and Families to: a) establish a mechanism to inventory all county-based public and private inpatient, outpatient and behavioral health services and make the information available to the public, b) establish and implement a methodology, based on nationally recognized criteria, to quantify the usage and need for inpatient, outpatient and residential behavioral health services throughout the state, taking into account projected patient care level needs, c) annually assess whether there are sufficient behavioral health services available, d) annually identify the funding for existing mental health programs; e) consult with various stakeholder groups to make recommendations, f) consult with various NJ hospital organizations and organizations that advocate for mental illness and their families and g) annually report on activities related to this act to the Governor and Senate and Assembly Health and Human Services Committees.

To meet this legislative requirement a methodology was recently developed to determine mental health need for New Jersey utilizing nationally recognized criteria. There are three major approaches that are typically used in assessing the need for mental health services: 1) community surveys (e.g., direct survey, key informant), 2) demand or utilization based methods, and 3) social indicators. New Jersey has chosen to use social indicators, due to its demonstrated practicality, expediency, empirical support and cost effectiveness.

A key assumption with the social indicator approach is that the population at risk of mental illness can be estimated by using demographic data and can substitute for a direct survey of the mental health needs of individuals. A major advantage is that census data and other public data (suicides, divorce, crime statistics, etc.) are readily available. A review by Cagle (1984)[6] suggests that a small set of carefully chosen indicators can serve the purpose for determining need. The current approach is based on epidemiological literature to determine the social correlates of mental illness. Cagle reviewed this approach to assess need for acute psychiatric services in New York State. The New York Office of Mental Health was searching for a "rational" method to determine statewide need for acute psychiatric beds. Interestingly, Cagle's review of the research suggested that there may not be much difference in correlations between social indicators and the need for long term- vs. acute-care services.

The epidemiological evidence was grouped into three categories: low socioeconomic status, marital status indicators and other social factors. The social indicators and their definitions that were used to produce the need assessment for mental health in New Jersey are presented in Table 1 and are partially based on Cagle's work.

[5] http://www.esri.com/software/arcgis/index.html
[6] Cagle "Using Social Indicators to Assess Mental Health Needs", Evaluation Review, 1984, 8 (3), 389- 412.

Table 1 Definition of Social Indicators Used in the RNAS Model to Calculate Mental Health Risk Index for New Jersey Counties	
Low socioeconomic status	
• Poverty [A]	Poor families below the poverty level, 2014.
• No high school education [A]	Number of people age 25 years & over, with no high school diploma, 2014.
Marital status	
• Divorced families [A]	Adults 15 and over in 2014 who were separated or divorced.
• Female householder [A]	Female householder, no husband present with own children less than 18 years, 2014.
• Living alone [A]	Nonfamily householder living alone, 2014.
Environmental and Other Social Factors	
• Unemployment [A]	Population 16 and over unemployed in 2014
• Housing tenure [A]	Ratio of occupied housing which are renter occupied, 2014.
• Population density [B]	County population per square mile, 2010
• Suicide attempts [C]	Non-fatal suicide attempts. Self-inflicted injuries among the10-24 age group resulting in hospitalization (based on 2009-2011 data).
Source: A U.S. Census Bureau, 2009-2013 American Community Survey (5-year estimate). B U.S. Census Bureau: State and County QuickFacts. Last revised 8/5/2015 C New Jersey Department of Children and Families: Updated 2012 Adolescent Suicide Report	

The methodology utilized was the Relative Needs Assessment Scale (RNAS) developed by the DMHAS research team, which has been used for determination of substance abuse treatment and prevention need and has been described in the above section. RNAS provides a single value of the severity of mental health problems for each county with its magnitude demonstrating its relative standing among the rest. This work attempts to standardize the relative occurrence of mental health problems into a scale that segments population counts into proportional shares.

As the research team refines this need assessment methodology, an opportunity to enhance the determination of mental health need will become available with the planned NJHSDUH. Since the Divisions are now merged, there will be a special section added to the survey for mental health, utilizing questions on this topic. This will allow us to develop a coefficient for mental health need that can be applied to estimating the need and demand for mental health treatment in New Jersey. Due to the large sample size of the NJ household survey, it will be possible to assess mental health need at the county level, as is currently done for alcohol and drug need. This

additional methodology will supplement the current RNAS that was developed for mental health. Also the synthetic estimation technique of "capture-recapture" will be explored to assess its utility for improving estimates of mental health need.

The next step will also be to do a gap analysis for mental health as has been done for substance abuse. The gap analysis examines the difference between the "demand" for mental health treatment, which can be derived from the household survey, and the actual number of individuals who are able to receive treatment.

In November 2014, the SMHA submitted its annual inventory and needs assessment of behavioral health services to the New Jersey State legislature.

Data Driven Planning

Consumer Operated Service - In the Fall of 2014 the SMHA began an significant update of the data system used to track consumer operated services, specifically for Community Wellness Recovery Centers (formerly known as "Self-Help Centers") and Recovery Centers (peer run programs specializing in consumers with substance use disorders). This system, the Self Help And Recovery Program (SHARP) will be replacing and improving on the current Self Help Outcomes and Utilization Tracking (SHOUT) system. SHOUT is the outcome-based measurement system based on consumer operated self-help center (SHC)/Consumer Operated Services EBP model and administered by CSP, one of the SMHA's contracted providers. SHARP will be the proprietary software of the DMHAS, thereby allowing the Division to have improved access with the data and its collection. SHARP will build on the strengths of SHOUT in in evaluating performance and fidelity to the SHC model, as well as collect more client specific outcome measures aligned with SAMHSA's Eight Dimensions of Wellness[7] As SHOUT did previously, the SHARP system will provide DMHAS with information on Community Wellness/Recovery Center operations, activities, and consumer participation. SHARP is being developed with full and sustained collaboration with the community of wellness recovery centers and peer advocates.

Peer Recovery Warm Line - The Peer Wellness Warm Line (PRW) is a statewide toll free line operated by the Mental Health Association in New Jersey. Peer Specialists, who are trained in "Intentional Peer Support" and "The Wellness and Recovery Action Plan," staff the call line. By establishing "mental health" as the common ground, the Peer Specialist supports the Caller in talking about their wellness and recovery using the key concepts within the Intentional Peer Support and Wellness and Recovery Models. The Warm Line was recognized nationally in 2012 as the winner of the Mental Health America Innovative Program of the Year Award. In 2012, the PRW answered a total of 12,265 calls.

In addition to tracking quantitative data, the Warm Line also tracks qualitative measure to assess the impact of services on Callers. One goal of the services is to provide Callers with the support and skills to avoid emergency room visits and other more restrictive interventions. Also in 2012, an average of 93% of callers identifying feeling they were in crisis and may need to go to an ER were able to make an alternate plan by the end of the PRW phone contact. Work on the

[7] http://store.samhsa.gov/shin/content//SMA12-4568/SMA12-4568.pdf

"Dimensions of Wellness" is also tracked. Data consistently shows that all eight dimensions are being addressed with PRW Callers, with Emotional Wellness and Social Wellness being the most frequently discussed at 42% and 19%, respectively.

Supported Employment (SE) - Contract performance commitments (Annex A) and subsequent QCMRs provide the number of consumers to whom services are delivered and become employed.

Supported Education (SEd) - Contract performance commitments (Annex A) and subsequent QCMRs provide the number of successfully completed semesters consumers complete.

Justice Involved Services (JIS) - Contract performance commitments (Annex A) and subsequent QCMRs provide the number served by the Services.

Integrated Dual Diagnosis Treatment (IDDT) - The providers that have implemented this service are evaluated every year by the University Behavioral Health Care (UBHC), Rutgers.

Illness Management and Recovery (IMR) - SMHA provides IMR through existing DMHAS-funded partial care and PACT contracted community provider organizations. In addition, IMR has recently, been offered to supportive housing providers. IMR training and technical assistance is provided by UBHC under contract with SMHA. For purposes of Block Grant reporting (and general planning) IMR training data is provided to DMHAS by UBHC.

Involuntary Outpatient Commitment (IOC) - The outpatient commitment law[8] is intended to provide a treatment option in the community for a class of consumers who are not willing to receive treatment voluntarily and will become, in the foreseeable future, dangerous enough because of a mental illness to require supervision, but who are not so imminently dangerous that they need to be physically confined in an inpatient program. This law is an amendment to civil commitment law creating the option to commit to outpatient treatment for persons in need of involuntary commitment to treatment. As of January 31, 2015, 314 persons were served in IOC during SFY 2015. As of February 2015 the SMHA funded (or had issued RFPs) for IOC programs in all of New Jersey's 21 counties.

The roll-out, and utilization of IOC services has received great statewide attention. The SMHA has entered into a Memorandum of Agreement with the Rutgers University School of Social Work for the evaluation of these statutory requirements. This evaluation started in the fall of 2014 and is expected to continue until June 30, 2016. Only the original six IOC programs (serving Burlington, Essex, Hudson, Ocean, Union and Warren Counties) are be the subject of this study. Further, the outpatient commitment law requires that an evaluation on the implementation of involuntary commitment to outpatient treatment be conducted. It is required by the Law that the evaluation covers eight evaluation domains (regarding issues such as recidivism, statewide distribution of IOC court orders, patient responses, etc.).

Veterans Services - Veteran's status data is collected by the SMHA via the USTF database. This dataset is far from definitive—as many provider agencies solicit veteran's status data from

[8] N.J.S.A.30:4-27.1 et seq.

their consumers on an inconsistent basis. The upcoming web-based, client-specific consumer database will remedy this, with business rules and data validation tools that will enhance the collection of veteran status data—with particular emphasis on identifying consumers who were veterans of recent conflicts (e.g., Operation Enduring Freedom and Operation Iraqi Freedom).

Supportive Housing (SH) - Throughout the duration of the Olmstead Settlement (SFY 2010 through 2014), a total of 1,065 placements were targeted for creation, with 695 set aside for individuals on Conditional Extension Pending Placement (CEPP) Status) and 370 set aside to prevent homelessness and/or institutionalization. From 2010 through 2014, the Division created a total of 1,437 placements with Olmstead funding, exceeding its target by 372 or 35%. Of these new placements, 942 were created for consumers designated CEPP and 495 placements were created for consumers at Risk of Hospitalization. By the end of 2015, DMHAS had created an additional 205 Supportive Housing placements, with 160 of these set aside for the discharge of CEPP consumers from state hospitals and the remaining 45 reserved for consumers at risk of hospitalization or homelessness. The continuous creation of Supportive Housing placements is consistent with the Division's paradigm shift from institutionalization to community integration in the delivery of services to its mental health consumers.

Treatment teams currently collect data on the discharge needs of every consumer in the state hospital using the Individual Needs for Discharge Assessment (INDA). Completed at the first (7-day) treatment team meeting and reviewed at each subsequent (30-day) meeting, the INDA examines the consumer's needs for successful discharge, focusing on areas such as Legal, SSPRC/CARP, Finances, Insurance, Level of Care, Challenging Behaviors, Housing Preference & Discharge Interventions, Diagnosis, Medical Needs, Medication Needs, Functional Needs, Substance Abuse, and Community needs. As of SFY 2016, the INDA has been revised as a means of updating the Division's process of involving housing and/or services providers in the process of discharge planning for non-forensic state hospital consumers. It has replaced the Agency Referral and Response Form (ARRF) as the tool by which providers are engaged in the discharge process, and now serves as a shared tool used to document both the hospital treatment team's and the community providers' plans to address the consumer's individual needs for maximized community integration.

DMHAS continues to work on developing a Provider Performance Report for Supportive Housing (PPR SH). The PPR SH contains 17 data elements organized among three domains: program volume indicators, program terminations, and linkages made to other programs. This dashboard report collects annual data for each SH agency and benchmarks it alongside of statewide and regional averages. The report will be shared once it has been reviewed and finalized.

Bed Enrollment Data System (BEDS) - As discussed in the previous section "Mental Health Promotion, Needs Assessment and Goals", BEDS is a secure web-based system designed and administered by the SMHA to facilitate the assignment of consumers from state psychiatric hospitals into safe and appropriate community-based residential settings, in accordance with SAMHSA's Supportive Housing EBP[9], the SMHA's Olmstead Settlement Agreement[10], and the

[9] http://store.samhsa.gov/shin/content//SMA10-4510/SMA10-4510-05-EvaluatingYourProgram-PSH.pdf
[10] http://www.nj.gov/humanservices/dmhas/initiatives/olmstead/olmstead_settlement_agreement.pdf

revised DMHAS Administrative Bulletin 5:11[11]. For purposes of residential placement, BEDS is a real-time system that allows SMHA central office, hospital social worker staff, and community providers to match consumers in need, with available community housing opportunities. For the purpose of data-driven planning, BEDS is a powerful utilization management and planning tool that will allow the SMHA to observe resource utilization, vacancy rates, and the geographic distribution of resources and housing requests. At the time of writing, BEDS is in the pilot stage, in use with the SMHA's state hospital and seven residential providers. It is expected that state-wide implementation will begin in the Fall of 2015.

Homeless Adults/Housing First/PATH - The SMHA contracts with 25 non-profit agencies to operate PATH programs within the state's 21 counties. A small number of PATH programs use PATH funding to directly provide psychiatric assessment and outpatient mental health services. Many PATH providers are Community Mental Health Centers and link their consumers to mental health in their agency outpatient or partial care programs. All PATH programs link individuals to behavioral health and co-occurring services within their communities. Data from the PATH program is collected using the HMIS. This web-based software application stores client-specific information (demographics, needs) of homeless populations. HMIS data is accessed at the SMHA by the program coordinator for Homeless Services.

Acute Care Services - The SMHA uses multiple data sources in monitoring acute care system trends. The QCMR system provides data on basic volume measures (with relation to contract specifications) such as service episodes, numbers of persons served and units of service delivery. The USTF provides data on demographic factors, system use, service needs and diagnosis. By regulation, Systems Review Committee (SRC) data is collected and reviewed monthly by localized county specific committees comprised of acute care providers and governmental staff. These SRC processes include review of trends related to volume, capacity, referral patterns, system flow, length of stay and disposition.

In early 2013 the SMHA convened a meeting of the Designated Screening Center (DSC) coordinators to present the first Provider Performance Report for Designated Screening Centers (PPR DSC). These provider-specific, dashboard-style reports contain 17 separate data elements drawn from the SRC, QCMR and Annex A data sources. The data elements on this PPR are organized by volume indicators, quality measures (e.g., recidivism, frequency transfer delays) and operational costs. These reports also provide aggregate statewide and regional data to allow providers to compare their results across the state and its regions.

Programs for Assertive Community Treatment (PACT) - The SMHA collects data for all New Jersey PACT teams on a monthly and quarterly basis. The quarterly data is submitted via the QCMR. The QCMR collects program/provider specific data for programs contracted by the SMHA. See http://nj.gov/humanservices/dmhas/provider/contracting/contracting_info/qcmr/QCMR_31_PACT.pdf for more details. Seventeen program elements submit their quarterly aggregate data in this manner. The QCMR data is augmented annually by the submission of Annex A data which provides the SMHA with data on expected service levels, and mutually-agreed upon deliverables.

[11] http://www.state.nj.us/humanservices/dmhas/regulations/bulletins/Mental%20Health/5_11.pdf

By regulation, all New Jersey PACT teams are required to have staff with expertise in the treatment of substance abuse disorders and thus, PACT teams shall provide highly individualized dual disorder services for enrollees who have co-occurring mental health and substance abuse disorders. DMHAS anticipates continued targeting of dedicated funding to expand the state's Program of Assertive Community Treatment (PACT). SFY 2013 is the fourth consecutive year in which the statewide PACT capacity has been expanded. In total, since SFY 2010, eleven New Jersey PACT teams have been expanded, with the targeted (maximum) capacity of the program going from 2,002 to the current capacity of 2,082

Anti-Stigma - The Governor's Council on Mental Health Stigma relies on both qualitative and statistical data provided by community partners to identify needs and then craft strategies that address those needs. The Governor's Council on Mental Health Stigma partnered with the state psychiatric hospital staff to celebrate hope, recovery and wellness in recognition of Mental Illness Awareness Week October 7 – 15, 2012. Participants heard speeches on wellness and recovery from families and consumers, were able to tour the treatment malls and see programs, and viewed displays of artwork. For 2013, creative arts festivals will be held at the state hospitals. Community agencies will be invited to attend along with families and consumers.

The Council posted training videos relating to stigma awareness and messages of hope and recovery on its website. It continues to work with DMHAS, the Mental Health Planning Council, and additional stakeholder groups to publicize the suicide prevention lifelines (e.g., 1.800.273.TALK) and the accessible community-based mental health services that can help consumers deal with symptoms leading to suicidality. In addition, the Stigma Council has partnerships with federal and state military and veterans organizations and spearheads initiatives such as the "Life Doesn't Have to Be a Battlefield – Don't Let Stigma Stand in Your Way" campaign. This campaign is designed to increase participation in state mental health services among veterans.

Intensive Family Support Programs (IFSS) - Data regarding the usage of IFSS by minority families has been obtained via individual program monitoring visits, mental health licensing site reviews, IFSS Workgroup meetings and QCMR from NAMI NJ which document the number of referrals to IFSS. In the third quarter of Fiscal Year 2013, a survey was conducted by the SMHA among the 21 IFSS programs in order to determine the volume of minority families being served. The response rate was 100% of the 21 programs surveyed. The total number of families served statewide was 1,665. The results revealed that 1,301 (78.12%) are White, 160 (9.61%) are Black or African American, 125 (7.51%) are Hispanic or Latino, 43 (2.58%) are Asian, 22 (1.32%) are Other or Not Reported, 13 (.78%) are Native Hawaiian or Other Pacific Islander and finally 1 (.06%) is American Indian or Alaska Native. The effort to attract minority families is definitely not lacking although remaining a challenge. Monitoring the efforts of IFSS with regard to minority families shall continue to occur on a regular basis via monitoring visits, Office of Mental Health Licensing Site Reviews and IFSS Workgroup Quarterly Meetings. The SMHA will conduct the next survey of minority families in the third quarter of Fiscal Year 2014.

Older Adults - According to the New Jersey Department of Labor and Workforce Development, the proportion of New Jersey's residents age 65 and older is projected to be 15.96% [12]. The specialized needs of older adults is well known (e.g., medical fragility, ambulatory considerations, increased risks of falls, increased prevalence of depression and social isolation), yet the necessary resources still must be marshaled on an appropriate scale. It is evident that housing opportunities (appropriate for older adults) must be expanded throughout the state. The SMHA contracts Trinitas Hospital to run the Statewide Clinical Outreach Program for the Elderly (S-COPE), a program that services to older adults and individuals diagnosed with a mental illness by improving access to the most integrated settings and treatment appropriate to meet their needs. S-COPE provides clinical consultation and intervention, including: individual client assessments, crisis intervention/stabilization, collaboration with treating primary care physicians & psychiatrists, development of individualized formal treatment plans, development of individualized behavior modification programs, follow up evaluations for effectiveness of recommended interventions, as well as education on mental illness and medications to client and family.

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

Consumer Perception of Care Survey - The SMHA Consumer Perception of Care Survey will continue to be distributed in the summers of 2015 and 2016 to a representative sample of adult consumers of all community-based, non-acute programs. The survey results will be reported in the 2016 and 2017 CMHSBG Implementation Reports. An unmodified version of the Mental Health Statistics Improvement Program (MHSIP) Adult Survey (Draft Version 1.2, February 17, 2006)[13] will be used as the survey instrument, with the addition of ten questions related to primary health, from the Behavioral Risk Factor Surveillance System (BRFSS) survey[14]. Each non-acute mental health program that is administered by an agency by the SMHA, will serve as a sampling stratum. Agency program coordinators will be instructed by the SMHA on techniques of random sampling and bias reduction. Consumers are empowered to participate in this survey with little/no intervention from direct care staff. The results of this survey are expected to be studied and used to guide the SMHA's planning efforts for future initiatives and resource allocation. The information gleaned from these survey efforts will be used to populate the relevant URS Data Tables, as well as inform the SMHA on the quality of community based, state funded mental health services, as perceived by the sample of consumers responding to these surveys.

Use of Statewide and Nationwide Data Sets

The SMHA uses several independent datasets, alongside national and statewide datasets to shed light on goals, priorities and success. Specifically, this constellation of datasets is most commonly used to identify counties that are most appropriate (in terms of need and access to

[12] http://lwd.dol.state.nj.us/labor/lpa/dmograph/lfproj/sptab2.htm.
[13] http://media.wix.com/ugd/186708_3175909b8c1640988e6bee6edf865edd.doc?dn=%22URS_MHSIP_Adult_Survey2.doc%22
[14] http://www.cdc.gov/brfss/questionnaires/pdf-ques/2011brfss.pdf

mental health services) for new community services and RFPs. Additional statewide and county-specific data is obtained from the US Census Bureau (e.g. http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml) to inform comparisons of population density, residential characteristics, racial diversity, unemployment rate, age distribution, household income, poverty levels and other factors helpful in determining need. The New Jersey Department of Labor and Workforce Development also generates important economic and employment data (http://lwd.dol.state.nj.us/labor/lpa/content/njsdc_index.html) which is often used by the SMHA in making inter-county comparisons of economic need. Data on crime statistics in New Jersey is compiled by the NJ State Police, and its reports http://www.state.nj.us/njsp/info/stats.html) are utilized by the SMHA in obtaining a clear picture of county stressors and crime rates.

National data is often examined by the SMHA to shed light on New Jersey mental health efforts, relative to similar states. SAMSHA, through its compilation of URS data tables, and state level detail reports provide useful information in this regard (http://www.samhsa.gov/dataOutcomes/). The National Research Institute (NRI) of the National Association of State Mental Health Program Directors (NASMHPD) is another source that the SMHA consults on a regular basis for national wide mental health data (http://www.nri-inc.org/reports_pubs/). The SMHA regularly receives and reviews the findings of both inter-state and regional mental health reports distributed by The Bristol Observatory and the University of Vermont (http://www.thebristolobservatory.com/pubsformultistaterp.html).

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

Prevalence for Adults with SMI and Children with SED

Prevalence: According to the Federal methodology proposed for estimating the prevalence of SMI, the proportion of adults within the state with a SMI is 3.9%[15].

According to figures released by the United States Census Bureau[16], the 2013 adult population of New Jersey was 6,877,811. The size of the New Jersey child population was 2,033,691. Using the SAMHSA's SMI prevalence rate among persons 18 and older (3.9%) the estimated number of adults with SMI in New Jersey in 2013 was 268,235.

[15] http://www.samhsa.gov/data/sites/default/files/NSDUH148/NSDUH148/sr148-mental-illness-estimates.htm
[16] Source: U.S. Census Bureau, Population Division, March 2, 2015
http://quickfacts.census.gov/qfd/states/34/34033.html

The demand for SMHA-funded community programs for people aged 65 and older has continued to grow in New Jersey. Rising enrollments are consistent with a general increase in the population size of older adult state residents. In 2010, New Jersey had 1,185,993 residents who were 65 years of age or older. In 2011, this population increased to 1,208,360, as reported by the US Census. This represents an increase of 22,367from 2010 to 2011 (an increase of 1.9%). The US Census projection for 2015 is 1,332,800 New Jersey adults aged 65 and older, a projected increase of 10.3% relative to 2011.

In accordance with nationally-accepted definitions, New Jersey currently uses the Federal definition that stipulates that adults with a SMI are persons:

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

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However, we are in the process of developing our own independent definition of SMI which will be piloted with agencies in Calendar Year 2014 prior to full implementation across the system. With the implementation of the Home to Recovery CEPP Plan and the expansion of community capacity, the number and types of community mental health services has grown and diversified in order to meet the needs of the New Jersey's mental health consumers. According to the USTF database, SMHA has served 285,217 unduplicated consumers in community settings—including county hospitals and STCFs in SFY 2011. Although complete FY 2012 USTF data is unavailable at the time of writing, the number of unduplicated consumers served in community agencies, county hospitals and short-term care facilities in the first three quarters of SFY 2012 (spanning the time period between July 1, 2011 and March 31, 2012) is 286,885.

When county hospitals are excluded from tabulation, the SMHA served 276,676 unduplicated adult consumers in community settings (excluding county hospitals), in FY 2011- which was a 2.1% increase from 2010 (270,948).

US Census Bureau Estimates (2010 and 2011) and 2015 Projection of New Jersey								
Year	**Fed %**	**Total Adults**	**Total Adult SMI**	**Fed%**	**Total Children**	**Total Children SED**	**Total**	**Source**

2010	0.054	6,726,680	363,241	0.08	2,065,214	165,217	8,791,894	http://lwd.dol.state.nj.us/labor/lpa/dmograph/est/est_index.html#state
2011	0.054	6,778,345	366,031	0.08	2,042,810	163,425	8,821,155	http://lwd.dol.state.nj.us/labor/lpa/dmograph/est/est_index.html#state
2015	0.054	6,987,264	377,312	0.08	2,036,736	162,939	9,024,000	http://lwd.dol.state.nj.us/labor/lpa/dmograph/lfproj/lfproj_index.html

Unduplicated Adults Served – According to the 2015 URS data table 15a, there were 137,396 unduplicated consumers with SMI served by the SMHA. Of this, 122,610 (89.24%) were served in community settings, (758) 0.55% were served in state inpatient psychiatric hospitals, and (14,028) 10.21% were served in Other Psychiatric Inpatient settings. These proportions are relatively unchanged from 2013 where 117,747 (89.39%) were served in community settings, 910 (0.69%) were served in state inpatient psychiatric hospitals, and 13,068 (9.92%) were served in other inpatient settings.

According to URS Table 2a , 128,557 (40.34%) of the total served by the SMHA in 2015 were ethnic minorities. During this same period 190,097 (59.66%) non-ethnic minorities (e.g., 'white') consumers were served. These proportions changed slightly from 2013 when 152,093 (44.74%) ethnic minorities were served by the SMHA. During that time, 187,844 (55.26) non-ethnic minorities (e.g., 'whites') were served.

The SMHA continues to define SMI as those individuals who score 5 or less on the Global Level of Functioning (GLOF) scale (Carter and Newman (1976). The GLOF scale has 10 levels that provide an overall score integrating separate judgments of consumer functioning on four dimensions: personal self-care; social and interpersonal functioning; vocational and/or educational productivity; and emotional stability and stress tolerance. The SMHA's use of this measure to determine the proportion of persons with SMI served has a slight risk of marginally under-representing the numbers served (as operationally defined by the Federal methodology), however in order to maintain consistency with previous years' results, this definition of SMI is still in use.

Gaps Observed by the New Jersey Behavioral Health Planning Council

The partnership of community stakeholders with the SMHA is critical to the success of the Division. The New Jersey Behavioral Health Planning Council (NJBHPC, a.k.a., "The Planning Council") is the primary (but by no means sole) voice of the community. Through the participation of the Planning Council, and its Advocacy subcommittee, the Division has obtained clear guidance on service needs and gaps within the current system of care.

Nicotine Cessation - Although the SMHA's inpatient psychiatric hospitals officially adopted institution-wide 'smoke free' policies and regulations in 2009[17], nicotine use in, and around community-based, state-funded, behavioral health facilities remains problematic. The prevalence of nicotine use among current and prospective consumers of community-based

[17] See http://www.state.nj.us/humanservices/news/press/2009/approved/20091006a.html

behavioral health services is so endemic that the Planning Council has provided anecdotal feedback to the SMHA indicating that some facilities use their lack of nicotine treatment as a selling point. In other words, providers eager to increase their program census will minimize their anti-nicotine efforts, so as not to discourage potential consumers who use nicotine products. This issue is compounded by the prevalence of non-tobacco based products (e.g., e-Cigs, 'vaping', etc.) that side-step existing tobacco cessation policies, yet still allow users to be negatively impacted by their unfettered use of such nicotine delivery devices. The Planning Council continues to advocate for additional resources and administrative action from the Division to reduce the use of nicotine products, through prevention efforts, education, funding sanctions and corrective policies.

Quality Improvement (QI) - The wide use of evidence-based practices (EBPs) and promising practices across New Jersey's behavioral health system is a known strength. However in order to for the system to sustain fidelity to these practices, to measure change, to illuminate best practices, and to uncover areas for further improvement, the community based system needs to pay sustained attention to Quality Improvement. The Planning Council advocates to the SMHA to promote the use of Quality Improvement measures, and has asked the SMHA to provide agencies with necessary technical assistance needed to improve their QI practices. The SMHA is highly receptive to such requests, contingent on available state personnel, and ongoing projects.

Children's System of Care (CSOC)

CSOC acknowledges the following unmet service needs in the Children's System of Care:

- Meeting the needs of children exposed to trauma;
- Continued need for suicide prevention/postvention services;
- Availability of community based services and supports and in-state, out of home treatment options for youth with co-occurring physical and behavioral health challenges
- Availability of community based services and supports and in state, out of home treatment options for youth with co-occurring mental/behavioral health challenges and developmental disabilities, especially those individuals who function in the lower ranges of developmental disability; and
- Availability of community based services and supports and in state, out of home treatment options for youth with substance use challenges including detox.

Step 2: Identify the unmet service needs and critical gaps within the current system. Please provide a description of how the state plans to meet these identified unmet service needs and gaps.

REVISION REQUEST DETAIL:

1.) The SMHA has identified the following gaps in service delivery: minority populations, transgender, lesbian and gay populations, persons with dual disorders, consumers with co-occurring medical conditions, persons in dual recovery from substance abuse and mental health disorders as well as those who have past criminal involvement.

Gaps in service for those with criminal backgrounds

The NJ Drug Court program is statewide. The SMHA currently receives substantial resources from the Judiciary to pay for substance abuse (SA) services to its drug court population. There are similar efforts to provide substance abuse services to State Parole Board (SPB) parolees and Department of Correction (DOC) inmates on community release through a Mutual Assistance Program (MAP) where resources are allocated from both SPB and DOC to the SSAA. DOC desires a joint community re-entry effort for inmates with SA, mental health and co-occurring disorders who are maxing out. SPB would like to duplicate the MAP for mental health services; however the SMHA has been hampered by rate setting issues which should be resolved soon. The SSAA does not presently have the case management capacity for inreach to DOC inmates in need of SA services in the community; it would require additional resources to accomplish such an effort. Although referrals are made by DOC transitional and mental health services, the ex-offender disconnect from initial community services is extremely high; this requires case management follow-along for the first several months which would require an infusion of funding. As a result of planning legislation, the State SA/MH authority and DOC are collaborating to articulate the SA and MH services within the prisons and the needed efforts to connect inmates to services in the community.

The SMHA funds mental health Justice Involved Services (JIS) in fifteen New Jersey counties. These are essentially criminal justice case management services which link consumers who have been entangled with the criminal justice services to needed treatment, psychiatric rehabilitation and other community supports. Additional resources are needed to establish JIS programs in the remaining six counties. Many of the existing JIS programs need additional staff to handle the increased population of probationers coming from the NJ court system. These JIS programs are the infrastructure to which additional resources can be directed to assist with re-entry from state prison and linkage for SPB parolees to needed mental health services.

Service for LGBT population

Since 1985, The New Jersey Division of Mental Health and Addiction Services (DMHAS) has had the commitment to improve services to individuals from diverse backgrounds, including LGBT. The mechanism to grow further in SMHA's addressing these system needs began with the 2015 reformation of DMHAS' multi-cultural activities into a Multi-cultural Services Group (MSG.) The MSG has developed a process for systems assessment that will begin with all contract agencies surveying their existing planning and service delivery to diverse populations. As SMHA reviews the results of those surveys, areas of gaps in service, and needs for technical assistance (TA) will be identified. Beginning in early 2016, TA groups will be held in the north and south to assist agencies in formulating multi-cultural plans. Those plans will become a part of SMHA's contracting process in FY 2017, and followed up through DMHAS Multi-cultural Training Centers each year to ensure that the plans continue to grow.

The MSG has also developed a Request for Proposal for a consultant on LGBT issues. That consultant will assist in development of technical assistance and training curriculum for use system wide.

2) Gaps Observed by the New Jersey Behavioral Health Planning Council:
Nicotine Cessation: nicotine use in, and around community-based, state-funded, behavioral health facilities remains problematic. The Planning Council continues to advocate for additional resources and administrative action from the Division to reduce the use of nicotine products, through prevention efforts, education, funding sanctions and corrective policies.

The New Jersey Division of Mental Health and Addiction Services (DMHAS) agrees that smoking is the number one preventable cause of death and this is partly responsible for the early mortality that is seen in those with mental illness. The Division has advocated for broad coverage of smoking cessation medications and services for individuals with serious mental illness, and it will continue to do so. We will also continue to promote effective non pharmacological interventions, such as the Learning About Healthy Living Manual, which is being used statewide and nationally, and to support CHOICES, which is a nationally recognized peer to peer intervention. We continue to work with Dr. Jill Williams, both in our hospitals and in efforts to address smoking by offering training on these interventions in the state hospitals and in the community. DMHAS is working with our Medicaid Division to develop Behavioral Health Homes in the community, as these are effective in reducing smoking and in addressing the related health issues.

DMHAS plans to work with Division of Medical Assistance and Health Services to address the availability of services needed to help consumers quit, as we recognize that some smoking cessation medications and some of the non-pharmacological interventions that are needed in behavioral health programs may not be covered by Medicaid. DMHAS also recognizes that some programs allow consumers to use nicotine products, including e cigarettes, and thus get around existing tobacco cessation policies. While restricting smoking in some community programs is not in the Division's control, DMHAS certainly will consider the Planning Council's

recommendations to address the smoking that occurs in licensed programs and residences by administrative action.

3) CSOC acknowledges the following unmet service needs in the Children's System of Care: •Meeting the needs of children exposed to trauma; •Continued need for suicide prevention/postvention services; •Availability of community based services and supports and in-state, out of home treatment options for youth with co-occurring physical and behavioral health challenges •Availability of community based services and supports and in state, out of home treatment options for youth with co-occurring mental/behavioral health challenges and developmental disabilities, especially those individuals who function in the lower ranges of developmental disability.

CSOC acknowledges the following unmet service needs in the Children's System of Care:

1. Meeting the needs of children exposed to trauma

In order to further operationalize the DCF mission of ensuring the safety, well-being and success of New Jersey children and families, the Department of Children and Families has developed a Strategic Plan for the period 2014-16. The plan identifies the priorities to move the system of care along a continuum toward achieving its goal of successful community living for children and families by providing services that are appropriate, individualized in the least restrictive environment and by producing evidence that its service models are effective and fiscally sound. CSOC expansion activities will focus efforts on the following strategic plan priorities: ensuring that contracted services meet the needs of children and families served; moving out-of-home services toward using evidence informed service models; increasing the capacity of treatment programs to improve treatment outcomes; increasing the capacity of CMO staff and the community to recognize and reduce the impact of trauma; and collecting data that helps DCF and its stakeholders to understand the impact of each type of service on children and families. The DCF Strategic Plan is available at: http://www.state.nj.us/dcf/about/welfare/NJDCFStrategicPlan.pdf

CSOC continues to support the need for high quality, timely and focused assessments as a part of the continuum of care available to children, youth and young adults and their families in New Jersey. Biopsychosocial assessments provide critical information from the child, youth or young adult and his or her immediate supports about strengths, needs, preferences, and vulnerabilities and as such, are fundamental to ensuring youth and their families become engaged in the most appropriate type, intensity, and frequency of care. Biopsychosocial assessments are conducted solely by independently licensed clinicians who have been certified by CSOC as possessing the capacity to complete the Information Management Decision Support Needs Assessment, which has been revised to incorporate a trauma-specific module.

CSOC strives to provide children, youth and young adults and their families with the right services, at the right time, for the right amount of time. Through the children's system of care, children, youth and young adults can access an array of evidence based mental and behavioral health treatments, including trauma focused therapies, such as CBT and TF-CBT. In addition, DCF's Office of Child and Family Health has a full-time clinical team that includes a pediatrician, a child/adolescent psychiatrist, and a neuropsychologist.

CSOC provides services to children, youth and young adults and their families up to age 21.The following evidence-based trauma-specific interventions are provided within the NJ children's system of care: Trauma Focused-Cognitive Behavioral Therapy, Cognitive Behavioral Therapy, Post Traumatic Stress Management Training and Psychological First Aid with Ethnocultural, Gender, and Developmental Specificity (PTSM)**;** Advanced PTSM: Response Protocols to Suicide; and, Classroom Based Psychosocial Intervention (CBI) and Traumatic Incident Intervention (TII)

The following trauma-specific workshops are available through the Traumatic Loss Coalitions for Youth program sponsored by CSOC:

- After a Suicide – Guidelines for Schools
- An Introduction to Evidence Based and Best Practice Suicide Prevention Programs for Schools
- Applied Suicide Intervention Skills Training (ASIST) For educators, law enforcement, mental health professionals, clergy, medical professionals, administrators, volunteers, and anyone else who might be interested in adding suicide intervention to their list of skills
- Creating Safe and Respectful Environments
- Crisis Planning for Vulnerable School Populations
- Depression in Children and Adolescents
- Enhancing Your School's Crisis Plan
- Helping a Grieving Child
- Managing Trauma and Loss in Schools For Administrators and Crisis Teams
- Preventing Youth Suicide: Awareness Training For Teachers, Parents, and Non-Mental Health Personnel
- People Skills
- Responding to Grief and Loss
- School Crisis – an Administrator's Guide to Management and Recovery
- Schools and Mental Health-Bridging the Gap in Treating the Whole Child
- School Safety is Every Adult's Responsibility
- Stress, Burnout and Vicarious Trauma
- Suicide Assessment Training for Clinicians and Counselors
- Supporting Adolescents As They Transition from High School
- Trauma and Youth
- Understanding Trauma and Loss in Youth
- Using the School I&RS Team to Support Students with Mental Illness
- Working with Resistant Teens

- Working with Youth with Mental Health Disorders

2. Continued need for suicide prevention/postvention services

New Jersey's lead State agency for youth suicide prevention is the Department of Children and Families (DCF). In March 2011, the New Jersey Youth Suicide Prevention Plan was released by the Department of Children and Families. This New Jersey Youth Suicide Prevention Plan seeks to build on the existing efforts in New Jersey by remaining focused on the risk and protective factors associated with the prevention of suicide in children, youth, and young adults. The plan outlines goals, rationale, and objectives for increasing the prevention effort throughout the state. The plan presents the overall goals for the prevention of suicide and is broken down into ten sections:

New Jersey's Youth Suicide Prevention Plan Goals

1 Improve and expand surveillance systems;

2 Promote awareness that suicide is a preventable public health problem;

3 Develop broad-based support for youth suicide prevention;

4 Develop and implement strategies to reduce the stigma associated with needing and receiving mental health, substance abuse, and suicide prevention services;

5 Strengthen and expand community-based suicide prevention and postvention programs;

6 Implement professional training programs for those who are in regular contact with youth at-risk for self-injury or suicide;

7 Develop and promote effective clinical practices to reduce suicide attempts and completions;

8 Promote access to mental health and substance abuse services;

9 Improve reporting and portrayals of suicide, mental illness, and substance use in the electronic and print media; and

10 Promote and support research on youth suicide and suicide prevention, its dissemination and incorporation into clinical practice and public health efforts.

Traumatic Loss Coalition for Youth

Suicide is the fourth leading cause of death for New Jersey's youth. DCF/DCSOC is dedicated to the prevention of youth suicide. New Jersey's primary youth suicide

prevention program is the Traumatic Loss Coalition for Youth funded by DCF/CSOC. The Traumatic Loss Coalitions for Youth Program at Rutgers -University Behavioral HealthCare is an interactive, statewide network that offers collaboration and support to professionals working with school-age youth. In 1999 the Traumatic Loss Coalitions for Youth Program (TLC) was created to establish TLCs in each of New Jersey's 21 counties and to provide ongoing technical assistance to communities in crisis. The dual mission of the TLC is excellence in suicide prevention and trauma response assistance to schools following unfortunate losses due to suicide, homicide, accident and illness. This is accomplished through county, regional and statewide conferences, training, consultation, onsite traumatic loss response, and technical assistance. The purpose is to ensure that those working with youth from a variety of disciplines and programs have up-to-date knowledge about mental health issues, suicide prevention, traumatic grief, and resiliency enhancement. Since its inception, the TLC has trained thousands of individuals throughout the state with the purpose of saving lives and promoting post trauma healing and resiliency for the youth of New Jersey. The TLC website can be accessed at http://ubhc.rutgers.edu/tlc/

2ND Floor

The New Jersey Statewide youth helpline/hotline, 2nd Floor, is available 24-hours a day, seven days a week to youth and young adults ages 10-24 to help find solutions to the problems they face at home, school, or play. Youth can either call the helpline/hotline, 1-888-222-2228, or access the interactive Web site www.2NDFLOOR.org The helpline/hotline is supervised at all times by a mental health professional. Youth are provided with relevant and appropriate linkages to information and services to address their social, emotional, and physical needs. Calls to the 2NDFLOOR youth helpline/hotline are anonymous and confidential except in life-threatening situations.

2NDFLOOR was accredited as New Jersey's first statewide suicide hotline by the American Association of Suicidology.

NJ Youth Suicide Prevention Advisory Council (NJYSPAC)

DCF continues to fund the NJ Youth Suicide Prevention Advisory Council (NJYSPAC), which was formed under legislation signed into law in January 2004. The 17 members of the Council meet monthly to examine existing needs and services and make recommendations to DCF for youth suicide reporting, prevention and intervention. The Council also advises DCF on the content of informational materials to be made available to persons who report attempted or completed suicides. DCSOC will work closely with the NJ Youth Suicide Prevention Advisory Council to identify ways in which New Jersey can continue to improve our efforts to prevent youth suicides and implement the needed changes as outlined in the State Plan.

3. Availability of community based services and supports and in-state, out of home treatment options for youth with co-occurring physical and behavioral health challenges

CSOC, in coordination with the DHS Division of Mental Health and Addiction Services developed and implemented Behavior Health Homes (BHH) in Bergen and Mercer counties. BHH serve as a "bridge" that connects prevention, primary care, and specialty care, and is designed to avoid fragmented care that leads to unnecessary use of high end services (i.e. emergency rooms and inpatient hospital stays.) The current child family teams are to include medical expertise and health/wellness education for purpose of providing fully integrated and coordinated care for children who have chronic medical conditions. Behavioral Health Home provides services to children with serious emotional disturbance with the goal of improving health outcomes; promoting better functional outcomes (such as increased school attendance); decreasing overall cost, and the cost associated with the use of acute medical and psychiatric services; improving child/family's satisfaction with care; and, improving the family's ability to manage chronic illness.

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 constitutes 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.

4. Availability of community based services and supports and in state, out of home treatment options for youth with co-occurring mental/behavioral health challenges and developmental disabilities, especially those individuals who function in the lower ranges of developmental disability

The Department of Children and Families (DCF) is charged with serving and safeguarding the most vulnerable children and families in the State and ensuring that service delivery is directed towards their safety, protection, permanency, and well-being. On June 28, 2012, the Governor of the State of New Jersey signed P.L. 2012, c. 16, into law. The provisions of that law took effect immediately and transferred responsibility for providing services for person with developmental disabilities under age 21 from the Division of Developmental Disabilities (DDD) within the Department of Human Services (DHS) to the Division of Children's of System of Care (CSOC) within the Department of Children and Families.

CSOC serves children, youth, and young adults with emotional and behavioral health care challenges, intellectual/developmental disabilities, and substance use challenges and their families. CSOC is committed to providing these services based on the needs of the youth and family in a family-centered, strength-based, culturally competent, and

community-based environment. CSOC firmly believes that the family or caregiver plays a central role in the health and well-being of children, youth, and young adults. CSOC involves families/caregivers/guardians throughout the planning and treatment process in order to create a service system that values and promotes the advice and recommendations of the family, is family-friendly, and provides families the tools and support needed to create successful life experiences for their children. CSOC is committed to the development, enhancement and/or expansion of the following: Wraparound services, Care Management Organization services, Mobile Response and Stabilization, Intensive in-home (IIH) clinical and behavioral services, Individual Support Services (ISS), Natural Supports, Family Support Services (Respite, Assistive Technology, Vehicle Modifications), out of home care including Behavioral Health Homes, Group Homes, Specialty Homes, Treatment Homes, and Crisis Stabilization and Assessment Services.

5. Availability of community based services and supports and in state, out of home treatment options for youth with substance use challenges including detox

On July 1, 2013, State-wide contracted Substance Use Providers and South Jersey Initiative Providers serving adolescents age 13 to 18 were transitioned over to Department of Children and Families/Children's System of Care from Department of Human Services/Division of Mental Health and Addiction Services. This transition was a recommendation of the Adolescent Substance Abuse Task Force's final report in December 2009 to integrate all children's services under one division.

Five (5) adolescent long term residential substance use providers, one short term residential provider, ten (10) ambulatory serving both outpatient and intensive outpatient, one (1) partial care provider and eleven (11) South Jersey Initiative ambulatory providers serving both outpatient and intensive outpatient in multiple sites transitioned to Children's System of Care. January 1, 2015 Lighthouse Recovery Center became a Children's System of Care contracted provider, providing long term residential treatment with (27) beds for adolescent males and females.

Effective July 1, 2015 the out of home residential providers began providing co-occurring services to all youth in their programs. The contract deliverables include an increase in clinical services provided by dually licensed clinicians. All Treatment is authorized through PerformCare and all are Medicaid providers. All youth authorized for co-occurring treatment accessing these beds are opened to CMO.

South Jersey Initiative: provides funding for ambulatory substance use services to adolescents male/ female, 13-18 in the eight southern counties.

The agencies identified:

Center for Family Services – Gloucester and Camden Counties

County of Cumberland – First Step

Genesis Counseling – Camden and Burlington Counties

My Father's House – Gloucester County

Preferred Behavioral Health – Ocean County, 4 sites

Lighthouse Recovery Center – Atlantic, Ocean and Camden Counties

SODAT – Burlington, Camden, Cumberland, Gloucester and Salem Counties

Seashore Family Services – Ocean County, 2 sites

Drenk/Legacy – Burlington County, 2 sites

The Wounded Healer – Gloucester County

Village Wrap – Camden County

The State contracted residential providers:

Daytop Village, Pittsgrove – 44 long term beds, male/female

Daytop Village, Mendham – 64 long term beds, male/female

Integrity House, Newark – 20 long term beds, male

Newark Renaissance House – 38 long term beds, male

New Hope Foundation, Marlboro – 22 short term beds, male/female

Straight and Narrow, Passaic - 40 long term beds, male

On January 1, 2015, Lighthouse Recovery Center, Mays Landing – 27 long term beds, male/female

Total = 255 beds Statewide

Ambulatory Providers: all serving adolescents, male/female – 134 IOP/58 OP/18 partial care Statewide

CPC Behavioral Health, Redbank – 6 IOP

Catholic Charities/Trenton – 43 IOP/12 OP

COPE/Montclair – 9 IOP/4 OP

Seashore Family Counseling/Bricktown – 7 IOP/12 OP

Daytop/ Parsippany – 10 IOP/10 OP

Family Connections/West Orange – 18 IOP/8 OP

Genesis/Haddonfield – 11 IOP/4 OP

My Father's House/Gloucester City – 9 IOP/4 OP

Newark Renaissance House/Newark – 9 IOP/4 OP 18 partial care

SODAT/Woodbury – 12 IOP

Lighthouse Recovery Center in Mays Landing also provides six (6) beds for detoxification treatment for adolescents, males/females. The detox services are also authorized through PerformCare.

As part of our continued efforts to integrate substance use services into our system of care, Children's System of Care is pleased to announce the opening of Community Treatment Solutions – Aspen Residence, a five (5) bed co-occurring RTC program for females ages 13 – 17, located at 448 Parkview Drive, Eastampton, NJ 08060. Robin's Nest – Arbor House, 416 Ewan Road, Monroeville, NJ 08343 will be opening the second 5 bed co-occurring RTC late August/early September. These new co-occurring RTC's will provide services to females who present with co-occurring mental health and substance use diagnoses and treatment needs within a trauma-informed framework. Referrals for these 2 programs must go through Youth Link.

11/10/15

CSAP Revision Request:
NJ provided a description of how you addressed a gaps in the data regarding older adults (pg. 168 of 499- under Older Adult Survey); however, Can you please provide data sources used to identify needs within NJ's prevention system?

Can you please describe NJ's primary prevention needs and gaps within the current system?

Planning Step 2: Identify the Unmet Service Needs and Critical Gaps within the Current System

Single State Authority on Substance Abuse (SSA)

Data Sources Used To Identify Needs and Gaps – Throughout the Continuum of Care

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

SSA Information Systems
- New Jersey Substance Abuse Monitoring System (NJSAMS)
- Prevention Outcomes Management System (POMS)
- Block Grant Support System (BSS)
- Contract Information Management System (CIMS)
- Driving Under the Influence Tracking System (DUITS)
- Child Protection Substance Abuse Initiative (CPSAI) Module
- Clinician Roster Information System (CRIS)

SSA Surveys
- NJ Household Survey on Drug Use and Health (2003, 2009)
- NJ High School Risk & Protective Factor Survey (2008)
- NJ Middle School Risk & Protective Factor Survey (2007, 2010, 2012)
- Co-Occurring Survey (2008)
- Survey of Older Adults (2012)
- Veterans Survey (2015)

Other SSA Data Sources
- NJ Epidemiological Profile for Substance Abuse (2008)
- County and Municipal Social Indicator Chartbooks (2005,2013)
- NJ Substance Abuse Provider Performance Reports
- NJ Substance Abuse Overviews
- NJ Intoxicated Driving Reports

Other State Data Sources
- NJ DOH Uniform Billing (UB-04)

- Uniform Crime Reports
- NJ Department of Education Student Health Survey (2009, 2011)
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- Youth Risk Behavior Survey (YRBS)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Prescription Drug Monitoring Program
- Overdose Data
- Narcan Reversals (State Police and Department of Health)
- Drug Arrests (State Police)
- Drug Seizures (State Police)
- State Police Regional Operations Information Center (ROIC) reports

Federal Data Sources

- U.S. Census Bureau
- Violent Death Reporting System
- National Survey of Drug Use and Health (NSDUH)
- Treatment Episode Data System (TEDS)
- National Survey of Substance Abuse Treatment Services (N-SSATS)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Fatality Analysis Reporting System (FARS)
- National Vital Statistics System (NVSS): Multiple Causes of Death (Mortality)
- Uniform Crime Reports (UCR): Police Reported Crimes
- Youth Risk Behavior Surveillance System (YRBSS)
- WISQARS
- SAMDHA
- CDC WONDER

All these data sources allow the SSA to examine current data as well as to make comparisons over time for trend analysis. Also, utilizing Federal data allows New Jersey to examine its state performance in comparison to national data.

Older Adult Survey. The SSA has recognized that information concerning older adults and substance use is lacking. DMHAS realized that planning for statewide prevention services was not as comprehensive as possible in that there was inadequate New Jersey-specific data regarding behavioral health among older adults. The NJ Household Survey on Drug Use and Health includes older adults among its respondents, however, the survey and its focus is not specifically focused on this population. Therefore, this data regarding older adults was identified as a data gap by the SEOW. In order to help close that gap, the statewide results have yielded some interesting findings that will help drive planning efforts for this population over two years. An Older Adult Survey was conducted during 2012 utilizing funding from the SPE grant. However, there were insufficient funds for a large enough sample to obtain reliable county level estimates. The goal of the survey for the PFS opportunity is to obtain enough data to create small area estimates of the prevalence of substance abuse and mental illness among older adults in New Jersey. A telephone interview survey will be developed and random digit dialing with a multistage cluster design will be used to generate probability-based samples of the adult population of each New Jersey County or relevant geographic area. Synthetic estimation

techniques will then be applied using the results of the survey and other archival data to create small area estimates of the prevalence of substance abuse for the target population in specific geographic areas (e.g., municipality).

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

Two new modules were developed for POMS during FY 2013: 1) the Strategic Prevention Framework (SPF) and 2) the Environmental Strategies. Training on the SPF module occurred in March 2013 and is now being utilized by the 17 Regional Coalitions. Modifications were made to the Environmental Module, and providers will begin to use the module in the fall of 2015.

Selecting indicators to describe the consequences of substance use and the consumption patterns associated with those consequences is a critically important aspect of the needs assessment process. The SEOW Epidemiological (Epi) Profile Workgroup identified various dimensions that could describe the extent of a problem, including the size of the problem, its magnitude relative to other states' problems, the severity of the problem's impact on an individual and/or community, trend characteristics, attributable risk to substance abuse, and availability of data. In addition, the Epi-Profile Workgroup identified additional criteria that could impact efforts to address a problem, including capacity/resources, perceived gap between capacity/resources and need readiness (political will/public concern), economic impact, and social impact. The SEOW Epi-Profile Workgroup compiled a list of the data gaps they identified in their process. Some of the data gaps identified by the SEOW Epi-Profile Workgroup included:

- Medical Examiners data - not all counties report to state; need to search for data on presence of AD in system of homicide victims; more collaboration / cooperation between New Jersey State Police and New Jersey Medical Examiners on ALL AOD related deaths
- Secondary cause of death via alcohol data need to be collected
- Pedestrian fatalities and non-fatalities by age and substance need to be collected
- Alcoholic Beverage Commission needs to collect routine statistics on citations, fines, etc.
- Current use of ATOD by high school students
- Prescription usage patterns (misuse/abuse)
- General education referrals to school Substance Awareness Coordinators
- General education referrals to treatment
- High school dropout rate

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's NBHQF. The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at http://www.samhsa.gov/data/quality-metrics/block-grant-measures. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

4. If not, what changes will the state need to make to be able to collect and report on these measures?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Quality and Data Collection Readiness

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

The Single State Authority on Substance Abuse (SSA)

The SSA has several key information systems, described below, that provide information on a variety of levels. Depending on the system, information is able to be reported at the client, program, provider, and encounter level. Information systems exist for treatment, prevention, early intervention, fiscal management, billing, emergency medication, and intoxicated drivers.

NJSAMS. The client level system, known as the New Jersey Substance Abuse Monitoring System (NJSAMS) was developed and implemented by the SSA to be a real-time, web-based substance abuse treatment data collection and reporting system, which was implemented in July 2005. The system is required to be used by all licensed substance abuse treatment providers in New Jersey, regardless of whether or not they contract with the SSA. It collects basic demographic, substance use, financial, clinical and service information on all clients enrolled and served in New Jersey's substance abuse treatment system. Encounter data are collected and reported for services that may have different payers. In 2014 there were 65,574 admissions to treatment. The system consists of numerous modules and contains all the clinical assessments providers are required to complete. There are approximately 464 providers reporting on NJ-SAMS, representing 727 sites; 6,328 users are password-registered.

NJSAMS was developed over time under the initial auspices of the Center for Substance Abuse Treatment (CSAT). The purpose was to develop the state's capacity to use web-based information technology for the collection and reporting of data necessary to meet Federal Performance Partnership Grant (PPG) and the GPRA reporting requirements. NJSAMS was developed in response to the need for: timelier reporting on substance abuse treatment episodes, better monitoring of client outcomes, quality improvement, better client placement, and tracking of treatment through the continuum of care. The NJSAMS website is hosted by the Rutgers University Computer Center under a Memorandum of Agreement with the SSA. It is a secure web-based system designed to collect confidential health information and is HIPAA and 42CFR compliant.

A major IT accomplishment over the past two years was the complete re-architecture of NJSAMS, which was originally written in classic ASP and included numerous webpages making data entry slow. Work began on this project in September 2011 and the new system was launched mid-November 2013. It was programmed in-house. The new system is based on Object Oriented Programming (OOP) specifications, used Microsoft best practices, programmed in C#, developed in a .NET framework and runs on SQL server 2012. A tiered programming design was utilized with a presentation layer for the user interface (UI), a business layer for the business logic and a data access layer for interaction with database. It has a new user friendly interface that utilizes accordion technology. New items have been added to reflect current system issues,

e.g., chronic disease, prescription drug abuse, etc., while old ones were retired. This new system is scalable, i.e., able to handle a growing amount of work in a capable manner, streamlined and fast. The new NJSAMS was migrated to a new faster web server, with additional RAM added. There has been a dramatic improvement in performance and less maintenance in now required due to the new design. It is a totally relational database that has been normalized and no redundancy in data entry. NJSAMS provides encryption in transit, and most recently, has enhanced its security by including encryption at rest.

The NJSAMS includes the latest Addiction Severity Index V.5, the Level of Care Index (LOCI), DSM IV, as well as additional modules that can collect further information on client care and needs. The system is capable of producing the CSAT National Outcome Measures (NOMs) and generates the data needed for Provider Performance Reports which are now made available to all providers directly from the system. Data from NJSAMS are used to fulfill Block Grant reporting requirements and are also submitted quarterly to the Treatment Episode Data System (TEDS). Due to its flexible design, additional data elements or modules can be easily added to meet any new federal reporting requirements or other treatment system considerations.

Some critical new features were added that did not exist in the old system. Basic business processes are now enforced by the system in that an income and program eligibility assessment (known as the DASIE) must first be completed. Another feature that was incorporated was the creation of a data correction utility function to help ensure the creation of only one unique client ID for an individual. The system checks whether information such as name or birthdate doesn't match the social security number provided and the information is corrected when the provider provides proof of the correct information.

Screening, Brief Intervention and Referral to Treatment (SBIRT) Module. DMHAS was awarded a five-year Screening, Brief Intervention and Referral to Treatment (SBIRT) grant in August 2012. A requirement of that grant was to submit GPRA data. A web-based module was developed in order to capture the GPRA reporting requirements required for the grant by the grantee partners. The system was programmed in-house using a .NET framework and certified by CSAP so New Jersey could upload its data to SAMHSA's SAIS system. A test of the web services to transmit the data between DMHAS and SAMHSA was successfully tested. The system was deployed in March 2013. This module has been designed to interface with NJSAMS so not only will the Division have information on all clients who undergo screening and brief treatment, but those who are referred to specialty treatment and the outcomes of that treatment.

Fiscal Intermediary MIS. A Fiscal Agent Billing system contract was awarded to the Computer Sciences Corporation (CSC) through an open competitive bid. This system went live July 1, 2010. The CSC system is a web-based billing system for all of the SSA's fee-for-service (FFS) initiatives: Drug Court, MAP-SPB, MAP-DOC, SJI, MATI, DUII, RRI and the Co-Occurring Network. The amount of funding dedicated to these initiatives is approximately $40 million. All providers that participate in these networks must first obtain an authorization for services in NJSAMS. The information is then submitted via a web service to CSC for approval. Providers submit their claims through the CSC system for payment. Detailed service data is input which includes the CPT code.

CSC and the SSA have developed an automated interface with NJSAMS to link services data reported in NJSAMS which correspond to the claim for payment. This link includes service provider fields, services paid elements (service code, units, dates of service, amount, etc.) and client identifier elements. CSC confirms all information prior to paying any bill and verifies all requests for services through the NJ-SAMS Prior-Authorization Module. Approximately 1 million claims are processed each year. CSC reimburses and/or notifies the agency of claim status within 10 working days of receipt of the bill for all clients. In addition, all the CSC billing data tables, approximately 76, are transferred to NJSAMS on a nightly basis to the SSA's server. This allows the SSA capability to analyze detailed encounter data. This information is easily linked to NJSAMS data so service utilization patterns can be analyzed by client characteristics and levels of care.

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

Numerous reports are included in the system. It is web-based and was developed and tested in-house over a six-month period during CY 2009. All New Jersey substance abuse prevention providers that receive SSA contracts are required to use the system and were trained on it which went live in August 2009. There are 35 providers reporting on POMS with 145 password-registered users.

Currently information about universal strategies (i.e., environmental strategies) is not collected on POMS, which is one of the modifications currently in process. The SSA applied for and received a Strategic Prevention Enhancement (SPE) grant from SAMHSA which provided financial assistance for the effort to add an environmental factors module to the system. This module is currently being revised. A Strategic Planning Framework (SPF) Module was added to POMS, as one of the deliverables for the SPE grant, and has been completed. Prevention providers were trained on this new module which was deployed in March 2013. At the SSA's Technical Review by CSAP in July 2012, the reviewers noted that New Jersey was the first in the nation to implement these modules in its Prevention IT system.

CIMS. The Contract Information Management System (CIMS) is a web-based, paperless contract processing system developed in C# in a .NET environment. When fully evolved, it will follow a contract through its entire life span from the initial RFP through the latest contract renewal, modification, and Report of Expenditures. Provider agencies are able to complete and submit all of their contract actions through CIMS at any location that has internet access. CIMS went live July 1, 2010 for renewal contracts which included the electronic submission of the Annex B (budget). On January 1, 2011 the system went live for the Annex A and Programmatic Requirements.

The four main areas CIMS was designed to address are:

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

Numerous enhancements have been added to the system since January 2011, including the addition of the quarterly Reports of Expenditure, as well as other management reports.

CRIS. The Clinician Roster Information System (CRIS) supports the collection, review, and maintenance of provider agency clinical and medical staff information to ensure that each approved agency site meets licensure requirements for counselor credentialing as required by SSA regulations. Participating agencies are responsible for entering and maintaining up-to-date staff information through an accessible web-based portal. The system also facilitates reporting on systems-wide adherence to licensure requirements. The system was piloted in December 2011 and deployed in January 2012. All outpatient providers are required to use the system and residential providers were encouraged to begin using it prior to the adoption of the SSA's Residential Regulations which occurred in July 2013.

The SSA has a variety of other IT systems which are described below.

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

GEMS can interface with an OTP's third party clinical management methadone dosing software systems through an upload process to eliminate additional data entry regarding dosage and take home privileges. The OTP determines how frequently it will upload the information. It can also be used directly as the dosing information system for those agencies that do not have a third party software system. In the event that a client cannot reach his/her home clinic for treatment, another clinic, with the client's consent, will be able to securely access the needed dosing information from GEMS. Additionally, GEMS has been designed to interface with the NJ-SAMS, which is the SSA's client administrative data system. When an OTP admits a client, key data fields will automatically transfer from NJ-SAMS to GEMS. GEMS was piloted with 12 providers in July 2011 and went statewide in July 2012.

Driving Under the Influence System (DUITS). The DUITS replaced an antiquated Fox Pro 2.6a database LAN application used to manage and report the Division's IDP class scheduling related information. The system was redesigned into a web-based .NET application which went live in

August 2011. There are approximately 400,000 client records and 500,000 violations in the system. The system allows users to enter client, DUI violations and suspension data. It also produces class rosters for Intoxicated Driver Resource Centers (IDRCs), client form letters and management reports, and provides data for the microfiche imaging process. Because the new system uses the same technology and platform as the IDRC Data System, a scripting feature will be added that will allow the automatic transfer of class schedule data between the DUITS and the IDRC system, which is currently accomplished through a file extract and upload process. System improvements were made during FY 2013 such as enhanced reporting features, and implementation of electronic image archive storage and retrieval.

The State Mental Health Authority (SMHA)

Currently the SMHA uses several major data sets, the sum of these provide the SMHA with critical data on the client-level, program-level, and agency level scales.

The Unified Services Transaction Form (USTF) database is an electronic client registry originally developed in 1978 (and revised in SFY 1990) which still serves as one of the primary sources for populating the URS data tables. In SFY 2015, there were approximately 480,000 records—with each record containing the potential for over 50 separate data fields. Currently the SMHA is undertaking a major revision of the USTF database, and transforming it into a secure, web-based, client reporting system. Pilot testing has been completed by the SMHA's Office of Olmstead, Compliance, Planning & Evaluation, and now awaits final programing by the SMHA's Office of Information Technology. This is expected to be completed in CY 2016. With this updated system, the USTF will require providers to provide the SMHA more time-sensitive client-level data, indicating changes in consumer's status (e.g., Global Level of Functioning, incarceration status, geographic location). Further this new USTF will be scalable so that new program elements can be seamlessly added to the dataset, as such programs are rolled-out by the SMHA.

The Quarterly Contracted Monitoring Report (QCMR) Database collects quarterly, cumulative, program-specific data from each of the service providers contracted by DMHS. QCMR data is provided to the SMHA by 118 separate agencies on 17 different program elements (e.g., Supportive Housing, PACT, Outpatient Services) for roughly 630 separate sub-program elements (e.g., a specific program element, run by specific agency, specific site) on a quarterly basis. The QCMR historically emphasized program-level data, but as the QCMRs data field layouts change over time, increasing numbers data points related to consumer outcomes have been included. Starting in Q1 SFY 2015, the Division successfully migrated the old 'pencil and paper' version of the QCMR to a secure, web-based system[1]. This update of the QCMR data reporting system has significantly improved the timeliness, and accuracy of QCMR data submission, vis-à-vis the user-friendly web-based interface, data input masks, mandatory field settings, and auto-calculated fields.

The Systems Review Committee (SRC) Datasets are a series of linked MS-Excel documents submitted monthly from 32 Short Term Care Facilities and 23 Designated Screening Centers. SRC data is compiled monthly by providers on a one-page monthly MS-Excel spreadsheet that is submitted electronically to the SMHA. The SRC dataset provides program/agency-specific data that is the aggregate of each program's consumers served within a given month.

[1] https://dmhas.dhs.state.nj.us/qcmr/Login.aspx

The Oracle Hospital Census Data Base is the central internal information system used by DMHS for storing client-specific records on consumers admitted into New Jersey's five inpatient adult psychiatric hospitals. In order to comply with Olmstead settlement data requirements , a "Discharge Planning and Placement" Module is currently being developed within the Oracle Hospital Census database to track efforts and information relevant to the timely discharge of hospital CEPP (Conditional Extension Pending Placement) consumers—who were the focus of the Olmstead Settlement Agreement. Oracle provides both client-level data, and in the aggregate also provides well as institutional-level (hospital scale) data.

The Bed Enrollment Data System (BEDS)[2] is the SMHA's newest data system, which is currently in the pilot testing phase. BEDS is a secure, web-based data protocol designed to: 1. expedite the timely discharge of consumers from state psychiatric hospitals to appropriate community-based settings, 2. provide utilization management for the SMHA's Supportive Housing and Residential Services programs, and 3. allow enhanced resource tracking of SMHA-funded community-based beds and subsidies. The pilot phase (involving the SMHA's state psychiatric hospitals and seven residential provider agencies) is highly successful. Statewide roll-out of BEDS is anticipated for the Autumn of CY 2015. BEDS provides both consumer-specific data, agency-level data, and program level information.

2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system?

The DMHAS IT systems are segregated, i.e., specific for reporting substance abuse and mental health services data for clients, as well as for programs and fiscal information. The majority of the Division's data collection systems are customized to serve the unique patient, institutional, and administrative needs of both the SMHA and the SSA. The SSA and SMHA individual data systems are all within DMHAS and not part of a larger system. Consumers for whom mental health services are provided are documented within the data systems of SMHA (e.g., USTF, QCMR, Oracle). Alternatively consumers provided with substance use disorder services are documented within the data systems of the SSA (e.g., NJSAMS, CSC Fiscal Intermediary System). There are several extra-Divisional datasets that contain information on both populations which is collected at the Department level (e.g, the Department of Human Services' *Unusual Incident Management and Reporting System* (UIRMS), and interdepartmental level by the Division of Medical Assistance and Health Services's *NJ Medicaid Management Information System* (NJMMIS). Children's data is reported separately by the NJ Department of Children and Families, which is autonomous and administratively separate from the SMHA and the NJ Department of Human Services.

3. Is the state currently able to collect and report on measures at the individual client level?

The SSA can report any of its data at the client level (demographic, clinical, financial, encounter, etc.). Currently it reports on all Treatment Episode Data System (TEDS) items, which includes

[2] https://dmhas.dhs.state.nj.us/BEDS/Login.aspx

the System Data Set (SDS), the Minimum Data Set (MDS) and the Supplemental Data Set (SuDS). The SSA has been reporting TEDS data through NJSAMS for many years.

The SMHA's USTF data system allows for reporting of the draft measures for individual client level reporting. The SMHA reports its Basic Client Information (BCI) and State Hospital Readmissions (SHR) to SAMHSA's contractor, Synectics on an annual basis.

4. If not, what changes will the state need to make to be able to collect and report on these measures?

The SSA does not need to make any changes to collect and report client level data. With the total re-design of the SSA client level reporting system, which was released in November 2013, the system is scalable and additional items that may be needed in the future can be easily added.
This is N/A for the SMHA.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Pregnant Women/Women with Children

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

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

Objective:

Increase number of pregnant women or women with children receiving substance abuse treatment.

Strategies to attain the objective:

• Quarterly Women's Steering Committee meetings with women's treatment providers to discuss issues related to best practices including retention, engagement, access and referrals, systems collaboration, and training needs.
• In an effort to prevent prenatal substance exposure, State Fiscal Year 2015, DMHAS expanded a contract with a community-based provider in Mercer County to provide substance use disorder assessments on pregnant women who screen positive on the Perinatal Addictions Prevention Project (4 Ps). DMHAS and the DHS Office of Autism and Prevention of Developmental Disabilities provided joint funding for this expansion. The Initiative supports Certified Alcohol and Drug Counselors (CADC) who are out-stationed at Health Start clinics and prenatal clinics in Mercer and Middlesex counties. The Initiative combines prevention, screening, early intervention, case management and referral to treatment when appropriate and follow-up. The Initiative includes an evaluation component.
• Implemented service elements from the National Association of State Alcohol/Drug Abuse Directors (NASADAD) "Guidance to States: Treatment Standards for Women with Substance Use Disorders" that emphasize best practice and modified women's treatment provider contracts to include language from the document that addresses the full continuum of treatment services.
• Require programs to provide: family-centered treatment, evidence-based parenting programs, trauma-informed and trauma-responsive treatment using Seeking Safety, Strengthening Families and complete National Center on Substance Abuse and Child Welfare (NCSACW) online tutorials "Understanding Child Welfare and the Dependency Court: A Guide for Substance Abuse Treatment Professionals."
• DMHAS integrated the CHOICES program, an evidence-based intervention designed for women about choosing healthy behaviors to avoid alcohol – exposed pregnancies for use by licensed substance abuse treatment providers serving pregnant and parenting women. This intervention is a contract requirement.
• Awarded In-Depth Technical Assistance (IDTA) from 2008 through 2012 from NCSACW. New Jersey received a customized program of IDTA designed to identify and implement key policy and practice changes based on New Jersey's readiness to change and progression through the phases of IDTA. New Jersey is in discussion with the IDTA team on continuing to build on the foundation established in the prior NCSACW IDTA project by working collaboratively with a NCSACW consultant(s) in a targeted effort to strengthen identification and system response to substance exposed infants (SEI), including those presenting with Neonatal Abstinence Syndrome (NAS) from maternal opioid use.
In early 2014 the SSA reached out to the NCSACW to request continuation of IDTA to address emergent issues of concern where New Jersey like many other states, has been experiencing an increase in illicit opioid use among women. New Jersey's 2012 treatment data reflected the most commonly used substances among New Jersey's pregnant women include heroin and other opiates. The NCSACW granted an IDTA continuation for a limited scope of work with DMHAS as the lead agency to address NJ's increase in substance using pregnant women, and the associated Substance Exposed Infants (SEI), including those with Neonatal Abstinence Syndrome (NAS).

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increase number of pregnant women or women with children receiving substance abuse treatment.
Baseline Measurement:	7865
First-year target/outcome measurement:	Increase percentage of pregnant women or women with children receiving substance abuse treatment in 2016 by 1%.
Second-year target/outcome measurement:	Increase percentage of pregnant women or women with children receiving substance abuse treatment by 2% by the end of 2017. The change in FY 2017 will be measured by calculating the percent difference from 2015 to 2017.

Data Source:

The number pregnant women and women with children from SFY 2015– 2017 will be tracked by the SSA's New Jersey Substance Abuse Monitoring System (NJSAMS).

Description of Data:

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

Data issues/caveats that affect outcome measures::

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.

Priority #: 2

Priority Area: Intravenous Drug Users

Priority Type: SAT

Population(s): IVDUs

Goal of the priority area:

To expand access to comprehensive treatment, including Medication Assisted Treatment (MAT), in combination with other treatment modalities, for opiate dependent individuals, including IVDUs, through mobile treatment units and other innovative approaches.

Objective:

Increase the number of IVDUs who enter treatment and number of heroin and other opiate dependent individuals who enter treatment.

Strategies to attain the objective:

• Referral to specialty treatment from sterile syringe programs operating in New Jersey.
• Providing services in convenient locations, particularly the mobile medication vans, in order to reduce barriers and engage individuals in care as easily as possible.
• Promoting the use of MAT (e.g., methadone, buprenorphine, Vivitrol) for opiate dependent individuals.
• Educating providers and clients about the benefits of MAT.
• Plan to develop a learning collaborative for the Administrative Office of the Courts and drug court providers on the benefits of medication assisted therapy.
• Submission of Federal grant "Targeted Capacity Expansion: Medication Assisted Treatment-Prescription Drug and Opioid Addiction" to expand the use of medication assisted treatment to individuals at risk for heroin/other opiate use.
• Award of an RFP to provide training throughout the state on bystander Narcan administration.
• Award of an RFP to provide recovery support in 5 counties to individuals who present in EDs for a Narcan reversal in order to link them to treatment or other recovery support services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of IVDUs who enter treatment.

Baseline Measurement: 18,571

First-year target/outcome measurement: Increase the number of IVDUs who receive treatment by 1%.

Second-year target/outcome measurement: Increase the number of IVDUs who obtain treatment by 2% by the end of 2017. The change in FY 2017 will be measured by calculating the percent difference from 2015 to 2017.

Data Source:

The number of IVDUs in SFY 2015 through 2017 will be tracked by the SSA's New Jersey Substance Abuse Monitoring System (NJSAMS).

Description of Data:

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

Data issues/caveats that affect outcome measures::

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.

Indicator #:	2
Indicator:	Increase the number of heroin and other opiate dependent individuals who enter treatment.
Baseline Measurement:	30,291
First-year target/outcome measurement:	Increase the number of heroin and other opiate dependent individuals who enter treatment by 1%.
Second-year target/outcome measurement:	Increase number of opiate dependent individuals who enter treatment by 2% by the end of 2017. The change in FY 2017 will be measured by calculating the percent difference from 2015 to 2017.

Data Source:

The number opiate dependent individuals in SFY 2016 and 2017 will be tracked by the SSA's New Jersey Substance Abuse Monitoring System (NJSAMS).

Description of Data:

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

Data issues/caveats that affect outcome measures::

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.

Priority #: 3

Priority Area: Individuals with or at risk of HIV/AIDS who are in treatment for substance abuse

Priority Type: SAT

Population(s): HIV EIS

Goal of the priority area:

To provide funding and increase capacity for the provision of HIV Early Intervention Services (EIS) at designated substance abuse treatment facilities.

Objective:

Increase the number of agencies engaged in the Rapid HIV Testing Initiative in SFY 2016 and SFY 2017.

Strategies to attain the objective:

• Expend 5% of the SAPTBG award for HIV Early Intervention Services (EIS).
• Continue MOA with Rutgers, Robert Wood Johnson Medical School for onsite and mobile rapid HIV testing services.
• Coordinate and provide trainings/conferences in regards to the provision of best practices in HIV testing and counseling services for Department of Human Services (DHS) licensed substance abuse treatment agencies (e.g., motivational interviewing).
• Continue data sharing agreement with the Department of Health (DOH), Division of HIV/AIDS, STDs and Tuberculosis Services (DHSTS).
• Provide de-identified data to DOH to match against their HIV/AIDS database to determine the number of infected or at-risk clients engaged in substance abuse treatment services.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increase the number of agencies engaged in the Rapid HIV Testing Initiative in SFY 2016 and SFY 2017.
Baseline Measurement:	32 sites
First-year target/outcome measurement:	36 sites
Second-year target/outcome measurement:	40 sites

Data Source:

DOH HIV database, NJSAMS and UMDNJ agency listing

Description of Data:

Data on the number of SSA licensed agencies engaged in the Rapid HIV Testing initiative is provided by RWJ Medical School. The change in FY 2017 will be measured by calculating the percent difference from FY 2015 to FY 2017.

Data issues/caveats that affect outcome measures::

None

Priority #: 4

Priority Area: Underage Drinking

Priority Type: SAP

Population(s): Other

Goal of the priority area:

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

Objective:

Decreased past month use of alcohol among persons aged 12 to 20.

Strategies to attain the objective:

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. 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 in their regions.

Environmental Strategies

• Enhance Access/Reduce Barriers – Coordinate a countywide high school PSA Contest on the dangers of underage drinking to enhance access to effective prevention strategies and information.
• 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 – Partner with local law enforcement agencies to coordinate a DWI checkpoint aimed at reducing drunk drivers and to provide information to motorists.
• Enhance Barriers/Reduce Access - Increase compliance checks and enforcement and reporting.
• Enhance Barriers/Reduce Access - Work towards implementing responsible beverage server training in cooperation with local liquor establishments to better train employees on proper identification techniques and reducing sales to underage persons.
• Change Consequences/Enhance Access/Reduce Barriers – Coordinate the efforts of countywide juvenile diversion programs related to underage drinking such as stationhouse adjustments with local police departments.
• Change Consequences/Enhance Skills – Enhance and build capacity within JCC and Stationhouse Adjustment Programs with law enforcement.
• Change Physical Design – Through the compliance check report and GIS mapping, provide municipalities and state alcoholic beverage control with report of how outlet density and location impact alcohol availability to youth.
• Change Physical Design/Enhance Barriers/Reduce Access – Reduce the number of alcohol outlets serving to underage youth through the use of the Compliance Check Summary Report, which will be available for NJ-ABC and all law enforcement agencies.
• Modify/Change Policies – Enhance or create policies related to underage drinking on a countywide level. This will be done through the increase of private property ordinances, enhancement of school policies, policies related to scholarship eligibility or extracurricular activities, and policies related to adult alcohol use at youth-oriented events.

Individual Strategies

• Provide information – Educate parents and youth on the dangers of underage drinking through awareness efforts, workshops, and countywide events. These programs will be provided through county alcohol and drug funding, municipal alliances, New Jersey National Guard Counterdrug Task Force, and other community organizations.
• Provide Information – Educate youth on the dangers of underage drinking through the use of evidence-based middle and elementary school prevention programs, New Jersey National Guard Counterdrug Task Force Fly-In and Drunk Driving Awareness Prevention Programs, Union County Red Ribbon Drug Awareness Event, and other community programs

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 underage drinking.

With assistance from SAMHSA, New Jersey produced an informational video for parents, entitled, "Empowering Parents to Prevent Underage Drinking in New Jersey." The video focuses on the issues and risks related to underage drinking.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Past month use of alcohol among persons aged 12 to 20.
Baseline Measurement:	23.3 percent of the target population reported drinking any alcohol during the month prior to participating in the survey (NSDUH, 2012-2013).
First-year target/outcome measurement:	A reduction of 1% below the baseline measure.
Second-year target/outcome measurement:	An additional reduction of 1% below the first year measure.

Data Source:

National Survey on Drug Use and Health (NSDUH), 2012-2013 State Estimates of Substance Use and Mental Disorders, Alcohol Use in Past Month and Binge Alcohol Use in Past Month among Persons Aged 12 to 20 in New Jersey

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.

Data issues/caveats that affect outcome measures::

None

Priority #: 5

Priority Area: Suicide Prevention Hotline

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

To reduce suicides among New Jersey's residents through the expansion and increased availability of a suicide prevention hotline designed to support New Jersey's residents experiencing mental health crises.

Objective:

Reduce the number of suicide prevention hotline calls originating within New Jersey that are answered by parties outside of New Jersey.

Strategies to attain the objective:

The NJ Suicide Prevention Hopeline is a NJ-based suicide prevention hotline that accepts calls routed by the National Suicide Prevention Lifeline Network (NSPLN). The NSPLN handles suicide-related phone calls from the community. The NJ Hopeline will receive additional calls which 'overflow" from NSPLN. In the event that additional call volume necessitates 'overflow' that cannot be expedited by the NJ Hopeline, then out-of-state Lifeline backup crisis centers will handle any remaining calls. The phone number was launched on May 1, 2013 and is 855—NJHOPELINE (855-654-6735).

The SMHA continues to fund the NJ Suicide Prevention Hopeline, operated by Rutgers University Behavioral Healthcare (UBHC), which is set up to

accept calls from individuals who are seeking information or assistance for themselves or friends or relatives that may be at risk of suicide. The NJ Suicide Prevention Hopeline is a NJ-based suicide prevention crisis hotline that can accept NJ calls routed through the National Suicide Prevention Lifeline Network (NSPLN) in addition to calls coming in through the NJ Hopeline phone number which is 855-NJHOPELINE (855-654-6735). There are currently a total of 5 NSPLN crisis centers, including the Rutgers UBHC NJ Hopeline, operating in NJ. The funding provided to the Rutgers UBHC NJ Hopeline by the SMHA provides the necessary resources for the Hopeline to answer calls 24/7/365 and provide statewide backup to the NJ NSPLN when the other NJ crisis centers are not in operation. The NJ Suicide Prevention Hopeline was launched on May 1, 2013 and since that date has been a major success in ensuring that NJ calls to the NSPLN are now answered in NJ.

Another goal of the NJ Hopeline which continues to be reached is to ensure that hotline calls to the Hopeline are answered by a trained staff person within 12 seconds. The NJ Hopeline also offers communication via text messages and chat and has the capability to “warm transfers” to and from other help and crisis lines. Calls are received from anyone of any age and will be answered by peers, trained volunteers, and clinical staff. If a caller is assessed as being at serious risk of suicide, the caller can be “warm-transferred” to the appropriate local Screening Service or other entity (i.e. DCF children’s program) that can provide emergency or other necessary services for that individual. If appropriate and if a caller agrees, Hopeline staff can also provide “follow up” calls.

Calls are received from anyone of any age and will be answered by peers, trained volunteers, and clinical staff. If a caller is assessed as being at serious risk of suicide, the caller can be “warm-transferred” to the appropriate local Screening Service or other entity (i.e. DCF children’s program) that can provide emergency or other necessary services for that individual.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Reduce the number of suicide prevention hotline calls originating within New Jersey that are answered by parties outside of New Jersey.
Baseline Measurement:	The New Jersey Hopeline began operations on May 1, 2013. In SFY 2014, “NJ Hopeline” suicide prevention hotline answered 98.4% of the calls originating in New Jersey transferred by the National Suicide Prevention Lifeline Network (NSPLN) which can’t be answered by the current active New Jersey Lifeline Crisis Centers (either due to excess call volume or after the Lifeline Crisis Centers’ operating hours). From 5/1/2013 to 8/31/2014, NJ Hopeline handled over 25,000 calls. The call volume it handles has been increasing by month during the same period of time. In SFY 2015, SMHA’s goal is consistent with what was achieved in SFY14. That is 98.4%. NJ Hopeline was contracted to answer 25,200 calls. Between 7/1/2014 and 6/30/2015, the Hopeline answered a total of 25,141 calls. This is an average of 2,095 calls per month.
First-year target/outcome measurement:	In SFY 2016, NJ Hopeline is contracted to provide 25,200 calls.
Second-year target/outcome measurement:	In SFY 2017, NJ Hopeline will answer 25,400.

Data Source:

In October 2013, the SMHA received the first call record dataset from NSPLN for the first quarter of SFY 2014. Every quarter subsequent to that, the SMHA will review the additional datasets provided by NSPLN. In addition, the SMHA will attempt to collect analogous call data from the NJ Hopeline.

Description of Data:

The National Suicide Prevention Lifeline Network maintains data that tracks all calls from their point of origin to the point of where they are ultimately answered. DMHAS will receive this data on a regular basis, and that dataset will form the basis for measuring this performance indicator. The SMHA receives both raw and summary call data from both NSPLN and NJ Hopeline on a quarterly basis. Both datasets include: dates of calls, lengths of calls, call source data, dispositions, and frequencies of all diversion.

Data issues/caveats that affect outcome measures::

The New Jersey Hopeline began operations on May 1, 2013. In the summer of 2013, DMHAS will begin reviewing NSPLN call record data to learn about the format and quality of the data. so the SMHA anticipates the standard operational and data reporting challenges endemic to new institutions. The SMHA is prepared to make best use of whatever data is submitted by both sources.

The total number of incoming calls presented to the NJ Hopeline refers to the number of calls that enter the Automatic Call Distributions System(ACD). Every call that enters the ACD is counted regardless of whether the call is answered or the caller abandons the call. It is anticipated that 97% of the calls presented were answered while 3% of the presented calls were abandoned. NJ Hopeline staff and volunteers make follow up calls. It is anticipated that approximately 17% of callers will have an average of 2.5 follow up calls.

Priority #: 6

Priority Area: Supportive Housing

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Increase opportunities for community living among mental health consumers who currently reside in inpatient settings and for those consumers who are at-risk of being hospitalized and/or homeless.

Objective:

SMHA continues to increase opportunities for community living among mental health consumers by developing additional supportive housing programs, improving referral and vacancy data tracking system, and providing community support services to supportive housing providers.

Strategies to attain the objective:

The SMHA will announce additional RFPs for Supportive Housing Programs which are designed to develop and support community-based programs that promote: housing stability in community settings, engagement with mental health services, regular access to primary health services; community inclusion, and wellness & recovery.

Contracted providers of Supportive Housing will continue to supply the SMHA with data to ensure that desired service levels are achieved.

SMHA staff will monitor the continued development of new Supportive Housing opportunities. Workforce development activities will expand the reach and efficacy of community-based services for consumers receiving Supportive Housing. The development of a referral and vacancy tracking data system—particularly around supportive housing and residential services, 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:	Increased number of individuals served by Supportive Housing.
Baseline Measurement:	In SFY 2013, 5,353 clients were served. In SFY 2014, a total of 5,531 clients were served. The number of consumers served by Supportive Housing in SFY 2015 is estimated to be approximately 5,650.
First-year target/outcome measurement:	The number of consumers served by Supportive Housing in SFY 2016 is estimated to be 5,763, an increase of 2% from SFY 2015.
Second-year target/outcome measurement:	In SFY 2017, a total of 5,878 individuals will be served by Supportive Housing. This number will be an increase of 2% from SFY 2016.

Data Source:

The number of consumers served by Supportive Housing in SFY 2016 – 2017 (and beyond) will be tracked by the SMHA's QCMR database.

Description of Data:

The QCMR Database collects quarterly, cumulative, program-specific data from each of the service providers contracted by DMHS. The current QCMR for Supportive Housing contains 50 data elements. The key data field relevant for this performance indicator is Item 4, "Ending Active Caseload (Last Day of Quarter)". Currently 49 agencies contracted by the SMHA provide QCMR data for Supportive Housing.

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 Supportive Housing will be monitored through contract negotiations and data will be maintained through the QCMR database.

Failure to reach the performance indicator may result in review of agency admission and discharge policies to ensure that the target population receives this service and to ensure that consumers are not discharged prematurely or unreasonably. Failure to reach performance indicators may also result in contract contingencies or termination.

The Division has recently updated its treatment planning process in an effort to facilitate each consumer's successful transition from the hospital into a community setting. Through this new process, the Individual Needs for Discharge Assessment (INDA) has replaced the

Agency Referral and Response Form (ARRF) as a means of assigning each consumer to an appropriate community service and/or housing provider. Assigned provider(s) are involved in the discharge planning process as early as the first (7-day) hospital treatment team meeting. During the initial treatment team meeting and all subsequent meetings (i.e. every 30 days), hospital staff and community providers will engage in a collaborative examination via the INDA of the consumer's needs for and barriers to discharge. Both sides will discuss plans for addressing these needs both within and outside of the institutional setting. The goal of this hospital-community partnership is to ensure a smooth and successful transition of consumers from their treatment inside the hospital into the care of informed providers within the community who are fully prepared to meet their needs and ensure optimal community integration.

Indicator #:	2
Indicator:	Creation of additional community-based supportive housing beds.
Baseline Measurement:	SFY2015, 215 community housing beds have been created. The total number of community-based supportive housing beds created in SFY2015 was 215. Among these beds, a total of 160 were for CEPP population. A total of 45 beds were for at-risk population. There were an additional 10 beds created in SFY2015 for non-specific hospital population. While these placements were not specifically developed for CEPP consumers, they were available to be utilized by CEPP consumers.
First-year target/outcome measurement:	In SFY 2016, the SMHA will develop no fewer than 200 community-based supportive housing beds.
Second-year target/outcome measurement:	The SMHA is not currently able to indicate the number of community-based supportive housing beds that will be created in SFY 2017.

Data Source:

The SMHA has developed the Bed Enrollment Data System (BEDS) which will be used to track the development of community based supportive housing and residential referrals and vacancies. This is a secure, web-based system that has been in the planning stages since 2010, and in development since 2012. In July 2015 the Division launched a pilot exercise for a limited number (6) of residential providers and the Division's three non-forensic psychiatric hospitals. This pilot contains four stages: 1. training and demonstration of the software to pilot participants, 2. the uploading of provider data on their current stock of housing resources, 3. the actual use of BEDS to facilitate discharges of hospital consumers to residential settings, and 4. evaluation of the pilot study & making any necessary changes to the system as indicated by the pilot. At the time of writing the training demonstration sessions were completed, the data uploads have been processed, and the pilot use was launched.

Description of Data:

Current internal SMHA contracting data indicates the state contracting awards to agencies whom create Supportive Housing Beds. Key data indicates the date and amount of the grant award, as well as the date that the housing unit was available to consumers (e.g., "came online").

Data issues/caveats that affect outcome measures::

These new housing opportunities will be specifically earmarked for: 1. those at risk for homelessness and/or inpatient psychiatric hospitalization, and 2. individuals on CEPP status (e.g. individuals who are medically and clinically permitted to be discharged from state/county inpatient psychiatric hospitals but whom are unable to be discharged due to a lack of permanent housing options).

Indicator #:	3
Indicator:	Increased technical assistance activities to be delivered to providers of Supportive Housing (SH). Overview- the SMHA has contracted with the University Behavioral Health Care (UBHC) School of Health-Related Professions (SHRP) to provide technical assistance (TA) for SH providers to facilitate better community integration of consumers of SH services. In SFY 2014, the SMHA contracted with SHRP to provide two separate tracks of community support services (CSS) for SH providers. Track 1 is for SH supervisors, where they will receive TA on how to supervise their staff in their efforts to have SH consumers better integrated into their communities. Track 2 is geared toward direct care providers and provided training in core competencies. Both tracks of TA were conducted in a series of trainings.
Baseline Measurement:	At the beginning of SFY 2015, SHRP completed in depth four months' CSS trainings to 100 supervisors of Supportive Housing throughout the state and started an in depth CSS training series for 120 Supportive Housing direct care workers. In addition, SHRP along with a DMHAS staff person conducted site visits to agencies who participated in the supervisor training series. The purpose of the site visits is to provide the supervisors with technical assistance as they begin to integrate some of the CSS principles they learned into

practice at their agencies. The CSS training consists of 8 modules, each of which is a full-day in length. A CSS overview webinar was provided on February 23, 2015. Executive Directors, Chief Operating Officers were among the individuals invited to participate in the webinar. Sixty-two individuals from supportive housing agencies participated in the webinar. As of June, 2015, 480 individuals participated (and completed) the CSS trainings. From January to June 2015, 40 additional supervisors and 160 direct care staff participated in the training.

First-year target/outcome measurement: CSS training will commence in the Fall (September – December 2015). It is anticipated another 160 individuals will receive training in CSS.

Second-year target/outcome measurement: By the end of fiscal year 2017, it is anticipated another 200 individuals will receive training in CSS.

Data Source:

The exact number of agencies (or personnel) trained by this TA effort will be reported to the SMHA by the training provider (UBHC-SHRP).

Description of Data:

The SMHA anticipates that the TA provider will submit quarterly training reports to the SMHA on a range of outcome indictors such as: number (and dates) of training, the number of agencies that have received the TA, number of personnel participating in training, and number of activities conducted by the TA training communities.

Data issues/caveats that affect outcome measures::

SHRP is completing analysis of readiness assessments (readiness to implement CSS) conducted on our agencies. Agencies completed a self-report form and SHRP conducted on-site reviews as well. Information is being compiled and technical assistance will be provided to agencies the summer of 2015 based on assessed needs (from readiness assessment).

Priority #: 7

Priority Area: Consumer Operated Services

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

To promote wellness and recovery among individuals attending DMHAS sponsored peer-operated community wellness centers (formerly known as self-help centers) throughout New Jersey.

Objective:

To increase consumer participation in wellness and recovery activities provided at DMHAS sponsored community wellness centers statewide.

Strategies to attain the objective:

Provide a wide range of peer delivered wellness and recovery activities at DMHAS sponsored community wellness centers statewide. Encourage participation by publicizing planned activities in monthly activity calendars, discussing at center community meetings, networking with DMHAS community wellness centers, and marketing self-help services with other community service providers.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase consumer participation in wellness and recovery activities.

Baseline Measurement: In SFY 2014, 80% of individuals participating in Consumer Operated Services participated in wellness/recovery activities (i.e. developing Wellness and Recovery Action Plans, which may include enrollment in groups such as Exercise Groups, Anxiety Support Groups, etc.).

First-year target/outcome measurement: In SFY 2015, 83% of individuals participating in Consumer Operated Services are anticipated to participate in wellness/recovery activities.

Second-year target/outcome measurement: In SFY 2017, 85% of individuals participating in Consumer Operated Services are anticipated to participate in wellness/recovery activities.

Data Source:

This performance indicator will be measured through use of the Self-Help Outcome Utilization Tracking (SHOUT) data application. SHOUT is used by 33 DMHAS-funded community wellness centers to track member participation at community wellness centers through a unified, individual record system specifically designed for community wellness centers. Among the 33 DMHAS-funded community wellness centers, three are hospital-based and 30 are community-based.

Description of Data:

Reports are generated on a monthly and quarterly basis to assess performance against contract indicators. To meet the performance measurement objectives, community wellness center staff will input and monitor community wellness center member participation in wellness and recovery activities statewide through the use of SHOUT™. Electronic surveys will be administered annually with community wellness center members and in combination with SHOUT utilization data which will be used to assess performance against the stated indicator.

Data issues/caveats that affect outcome measures::

Differential submission of SHOUT data by the community wellness centers may impact the timing of quarterly reports. Due to the independent nature of the community wellness centers themselves, the completeness and comprehensiveness of SHOUT data is expected to vary considerably from center to center. While participation in consumer-operated services is voluntary, and there will always be consumers in need of one-on-one supports, the ultimate goal is that all consumers will be taking steps toward wellness and recovery using the eight dimensions of wellness. In the long-term, the hope is that the centers will continue to develop more and more offerings, which will lead to the engagement of more consumers in the use of these services.

Priority #: 8

Priority Area: To improve the capacity to recognize and reduce the impact of trauma for all children, youth and young adults receiving services from CSOC

Priority Type: MHS

Population(s): SED

Goal of the priority area:

CSOC becomes a trauma-informed system of care

Objective:

CSOC will continue to increase the number of provider agency staff trained in trauma-focused care.

Strategies to attain the objective:

• DCF conducted a Department-wide needs assessment to measure its capacity to recognize and reduce the impact of trauma for all children, youth and young adults receiving services.
• CSOC will continue to identify gaps in service provision for children, youth and young adults with trauma.
• CSOC Strength and Needs Assessment has been revised to include an enhanced trauma module.
• CSOC in coordination with UBHC-Rutgers will continue to enhance the trauma-focused training curriculum.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: CSOC will continue to increase the number of provider agency staff trained in trauma-focused care.

Baseline Measurement: In SFY 2016 CSOC will develop a baseline measurement of provider agency staff trained in trauma-focused care during SFY 2016-2017.

First-year target/outcome measurement: SFY 2016 will use the same database to measure a specified percentage of change.

Second-year target/outcome measurement: SFY 2017 will use the same database to measure a specified percentage of change.

Data Source:

CSOC will utilize reports generated by UBHC-Rutgers

Description of Data:

Number of provider agency staff trained during given SFY.

Data issues/caveats that affect outcome measures::

None

Priority #: 9

Priority Area: Integration of community-based physical and behavioral health services to children, youth and young adults with chronic medical conditions.

Priority Type: MHS

Population(s): SED

Goal of the priority area:

CSOC will provide Behavioral Health Home (BHH) services to children, youth and young adults with serious emotional disorders with the goal of improving health outcomes.

Objective:

CSOC will increase the number of children, youth and young adults receiving Behavioral Health Home services.

Strategies to attain the objective:

• Each Behavioral Health Home will have the ability to identify, screen and coordinate both primary care and specialty medical care.
• CSOC will develop services and supports to address the needs of children, youth and young adults with specialized treatment needs including, but not limited to: asthma, diabetes, obesity, eating disorder, organic developmental disabilities and/or substance use.
• CSOC will continue to identify gaps in service for children, youth and young adults with specialized treatment needs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: CSOC will increase the number of children, youth and young adults receiving Behavioral Health Home services.

Baseline Measurement: In SFY 2016 CSOC will develop a baseline of the number of children, youth, and young adults receiving Behavioral Health Home services.

First-year target/outcome measurement: SFY 2016 will use the same database to measure a specified percentage of change.

Second-year target/outcome measurement: SFY 2017 will use the same database to measure a specified percentage of change.

Data Source:

Reports generated by the CSA

Description of Data:

The number of children, youth, and young adults receiving Behavioral Health Home services during given SFY.

Data issues/caveats that affect outcome measures::

None

Priority #: 10

Priority Area: Continuation of community-based suicide prevention/postvention services.

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Decrease youth suicide attempts and completions .

Objective:

CSOC/TLC will continue to increase the number of school personnel participating in Suicide Awareness trainings.

Strategies to attain the objective:

The Traumatic Loss Coalition (TLC) for Youth Program at UBHC UMDNJ provides a two-hour Suicide Awareness Training for Educators to fulfill the professional development requirement, in accordance with N.J.S.A. 18A:6-11. A team of clinicians experienced in the evaluation and treatment of children and adolescents with mental health disorders and suicidal behaviors provide this training. The content can be customized to meet the needs of a single school or an entire school district, as well as mental health and social agency staff. On-site school counselors or administrators are included in the presentation to talk about the specific protocols outlined in their school's crisis plan for referring at-risk youth for further evaluation and treatment.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	CSOC/TLC will continue to increase the number of school personnel participating in Suicide Awareness trainings.
Baseline Measurement:	The number of school personnel trained during SFY 2014, which was 1,517, will serve as baseline.
First-year target/outcome measurement:	First year target/outcome is an increase of 5% of baseline. SFY 2016 will use the same database to measure a specified percentage of change.
Second-year target/outcome measurement:	Second year target/outcome is an increase of 5% of SFY 2016 number. SFY 2017 will use the same database to measure a specified percentage of change.

Data Source:

Reports generated by the Traumatic Loss Coalition (UBHC, Rutgers)

Description of Data:

The number of school personnel trained during given SFY.

Data issues/caveats that affect outcome measures::

None

Priority #: 11

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

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

One new priority area under development is the system wide assessment for delivering services to diverse populations.

Objective:

SMHA will use survey results to identify areas of gaps in services to diverse population and needs for technical assistance.

Strategies to attain the objective:

Since 1985, DMHAS has had the commitment to improve services to individuals from diverse backgrounds, including LGBT. The mechanism to grow further in SMHA's addressing these system needs began with the 2015 reformation of DMHAS' multi-cultural activities into a Multi-cultural Services Group (MSG.) The MSG has developed a process for systems assessment that will begin with all contract agencies surveying their existing planning and service delivery to diverse populations. As SMHA reviews the results of those surveys, areas of gaps in service, and needs for technical assistance (TA) will be identified. Beginning in early 2016, TA groups will be held in the north and south to assist agencies in formulating multi-cultural plans. Those plans will become a part of SMHA's contracting process in FY 2017, and followed up through DMHAS Multi-cultural Training Centers each year to ensure that the plans continue to grow.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	$63,658,335		$0	$1,820,833	$199,519,603	$0	$0
a. Pregnant Women and Women with Dependent Children*	$13,000,000		$0	$0	$19,710,824	$0	$0
b. All Other	$50,658,335		$0	$1,820,833	$179,808,779	$0	$0
2. Substance Abuse Primary Prevention	$22,261,972		$0	$4,415,010	$5,544,774	$0	$0
3. Tuberculosis Services	$0		$0	$0	$0	$0	$0
4. HIV Early Intervention Services	$4,637,910		$0	$0	$0	$0	$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention**							
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	$2,200,000		$0	$0	$2,735,623	$0	$0
11. Total	$92,758,217	$0	$0	$6,235,843	$207,800,000	$0	$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

The amount in Row 1a Column E (PW/WDC) on Table 2 has historically been appropriated to the New Jersey Department of Children and Families (DCF), which transferred these funds to the New Jersey Division of Mental Health and Addiction Services (DMHAS) to administer under terms of a Memorandum of Agreement (MOA). In SFY 2016, DCF will administer these funds directly for purchase of comparable

services from the same provider entities; while included in Row 1a Column E, these funds will no longer flow directly through DMHAS in SFY 2016 and beyond.

Pursuant to a CSAT 2013 Technical Review, DMHAS is currently receiving State requested Technical Assistance (TA) from Johnson, Bassin, and Shaw (JBS), which, in part, addresses the review and documentation of methodologies for calculating the Statewide Maintenance of Effort (MOE), moving forward. During the second half of CY 2016, DMHAS will continue to coordinate closely with our CSAT Project Officer and JBS, respectively, regarding the methodology for, and calculation of, the Statewide MOE. As needed, DMHAS will request additional CSAT TA to ensure continued MOE compliance.

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			$0	$0	$0	$0	$0
6. Other 24 Hour Care		$2,356,894	$307,216,098	$0	$176,494,718	$0	$0
7. Ambulatory/Community Non-24 Hour Care		$20,989,836	$271,649,666	$11,490,510	$740,593,998	$0	$0
8. Mental Health Primary Prevention**		$0	$0	$0	$0	$0	$0
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)		$1,297,540	$0	$0	$0	$0	$0
10. Administration (Excluding Program and Provider Level)		$1,297,540	$3,220,412	$995,960	$36,819,636	$0	$0
11. Total	$0	$25,941,810	$582,086,176	$12,486,470	$953,908,352	$0	$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Planned expenditures are based on SFY16.

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

For Child Behavioral Health services herein, Medical Assistance funding is directly appropriated to the Department of Children and Families, as such, expenditures above are inclusive of those resources.

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health	$	$
General and specialized outpatient medical services;		
Acute Primary Care;		
General Health Screens, Tests and Immunizations;		
Comprehensive Care Management;		
Care coordination and Health Promotion;		
Comprehensive Transitional Care;		
Individual and Family Support;		
Referral to Community Services;		
Prevention Including Promotion	$	$

Screening, Brief Intervention and Referral to Treatment ;		
Brief Motivational Interviews;		
Screening and Brief Intervention for Tobacco Cessation;		
Parent Training;		
Facilitated Referrals;		
Relapse Prevention/Wellness Recovery Support;		
Warm Line;		
Substance Abuse Primary Prevention	$	$
Classroom and/or small group sessions (Education);		
Media campaigns (Information Dissemination);		
Systematic Planning/Coalition and Community Team Building(Community Based Process);		
Parenting and family management (Education);		
Education programs for youth groups (Education);		
Community Service Activities (Alternatives);		
Student Assistance Programs (Problem Identification and Referral);		

Employee Assistance programs (Problem Identification and Referral);		
Community Team Building (Community Based Process);		
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental);		
Engagement Services	$	$
Assessment;		
Specialized Evaluations (Psychological and Neurological);		
Service Planning (including crisis planning);		
Consumer/Family Education;		
Outreach;		
Outpatient Services	$	$
Individual evidenced based therapies;		
Group Therapy;		
Family Therapy ;		
Multi-family Therapy;		

Consultation to Caregivers;		
Medication Services	$	$
Medication Management;		
Pharmacotherapy (including MAT);		
Laboratory services;		
Community Support (Rehabilitative)	$	$
Parent/Caregiver Support;		
Skill Building (social, daily living, cognitive);		
Case Management;		
Behavior Management;		
Supported Employment;		
Permanent Supported Housing;		
Recovery Housing;		
Therapeutic Mentoring;		
Traditional Healing Services;		

Recovery Supports	$	$
Peer Support;		
Recovery Support Coaching;		
Recovery Support Center Services;		
Supports for Self-directed Care;		
Other Supports (Habilitative)	$	$
Personal Care;		
Homemaker;		
Respite;		
Supported Education;		
Transportation;		
Assisted Living Services;		
Recreational Services;		
Trained Behavioral Health Interpreters;		

Interactive Communication Technology Devices;		
Intensive Support Services	$	$
Substance Abuse Intensive Outpatient (IOP);		
Partial Hospital;		
Assertive Community Treatment;		
Intensive Home-based Services;		
Multi-systemic Therapy;		
Intensive Case Management ;		
Out-of-Home Residential Services	$	$
Crisis Residential/Stabilization;		
Clinically Managed 24 Hour Care (SA);		
Clinically Managed Medium Intensity Care (SA) ;		
Adult Mental Health Residential ;		
Youth Substance Abuse Residential Services;		
Children's Residential Mental Health Services ;		

Therapeutic Foster Care;		
Acute Intensive Services	$	$
Mobile Crisis;		
Peer-based Crisis Services;		
Urgent Care;		
23-hour Observation Bed;		
Medically Monitored Intensive Inpatient (SA);		
24/7 Crisis Hotline Services;		
Other	$	$
Total	$0	$0

Footnotes:
DMHAS does not collect data in this manner.

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Expenditure Category	FY 2016 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	$31,829,168
2 . Substance Abuse Primary Prevention	$11,130,986
3 . Tuberculosis Services	
4 . HIV Early Intervention Services**	$2,318,955
5 . Administration (SSA Level Only)	$1,100,000
6. Total	$46,379,109

* Prevention other than primary prevention

** 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by CDC, National Center for HIV/AIDS, Hepatitis, STD and TB Prevention. The HIV Surveillance Report, Volume 24, will be used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective FY 2016 SABG allotments to establish one or more projects to provide early intervention services for HIV at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state does not meet the AIDS case rate threshold for the fiscal year involved. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend FY 2016 SABG funds for EIS/HIV if they chose to do so.

Footnotes:

The Substance Abuse Primary Prevention subtotal amount of $11,130,986 listed in Row 2 on Table 4 includes the Prevention Column Total of $9,330,986 listed on Table 5b, plus the Resource Development Prevention Column Total of $1,800,000 listed in the first column of Row 8 on Table 6a. Combined, the planned Primary Prevention Percentage from the FY 2016 SAPT Block Grant Award is 24%.

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Strategy	IOM Target	FY 2016
		SA Block Grant Award
Information Dissemination	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	
Education	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	
Alternatives	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	
Problem Identification and Referral	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	

Community-Based Process	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	
Environmental	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	
Section 1926 Tobacco	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	
Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	
Total Prevention Expenditures		
Total SABG Award*		$46,379,109
Planned Primary Prevention Percentage		0.00 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:
DMHAS has selected the option to complete Table 5b, rather than Table 5a; however, as required, we are reporting the amount spent on

Section 1926 Tobacco, herein, on Table 5a, which as indicated above is $0 for each column.

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award	
Universal Direct	$1,775,600	
Universal Indirect	$2,695,600	
Selective	$1,859,000	
Indicated	$3,000,786	
Column Total	$9,330,986	
Total SABG Award*	$46,379,109	
Planned Primary Prevention Percentage	20.12 %	

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:
The Substance Abuse Primary Prevention subtotal amount of $11,130,986 in Row 2 on Table 4 includes the Column Total of $9,330,986 listed above, plus the Resource Development Prevention total of $1,800,000 listed on the first column of Row 8 on Table 6a. Combined, the planned Primary Prevention Percentage from the FY 2016 SAPT Block Grant Award is 24%.

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Targeted Substances	
Alcohol	þ
Tobacco	þ
Marijuana	þ
Prescription Drugs	þ
Cocaine	¢
Heroin	þ
Inhalants	¢
Methamphetamine	¢
Synthetic Drugs (i.e. Bath salts, Spice, K2)	þ
Targeted Populations	
Students in College	þ
Military Families	þ
LGBT	þ
American Indians/Alaska Natives	¢
African American	¢
Hispanic	¢
Homeless	¢
Native Hawaiian/Other Pacific Islanders	¢
Asian	¢
Rural	¢
Underserved Racial and Ethnic Minorities	¢

Footnotes:

Planning Tables

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award			
	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	$200,000	$150,000	$0	$350,000
2. Quality Assurance	$200,000	$550,000	$0	$750,000
3. Training (Post-Employment)	$0	$0	$0	
4. Education (Pre-Employment)	$0	$0	$0	
5. Program Development	$600,000	$1,700,000	$0	$2,300,000
6. Research and Evaluation	$800,000	$2,100,000	$0	$2,900,000
7. Information Systems	$0	$0	$0	
8. Total	$1,800,000	$4,500,000		$6,300,000

Footnotes:

The Substance Abuse Primary Prevention subtotal amount of $11,130,986 in Row 2 on Table 4 includes the Resource Development Prevention

amount total of $1,800,000 listed on the first column of Row 8 of Table 6a, plus the Column Total of $9,330,986 listed on Table 5b. Combined, the planned Primary Prevention Percentage from the FY 2016 SAPT Block Grant Award is 24%.

Planning Tables

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Block Grant
MHA Technical Assistance Activities	
MHA Planning Council Activities	$47,826
MHA Administration	$1,249,714
MHA Data Collection/Reporting	
MHA Activities Other Than Those Above	
Total Non-Direct Services	$1297540
Comments on Data:	

Footnotes:

Environmental Factors and Plan

1. The Health Care System and Integration

Narrative Question:

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[26] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but “[h]ealth system factors” such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[27] It has been acknowledged that there is a high rate of co- occurring mental illness and substance abuse, with appropriate treatment required for both conditions.[28] Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The Framingham Heart Study produced the idea of "risk factors" and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence–based practices[29] [30] that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[31] Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.[32] In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.[33] Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.[34] Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.[35] In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[36]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[37] Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between mental and substance abuse treatment providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as federally qualified health centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.[38] Use of EHRs – in full compliance with applicable legal requirements – may allow providers to share information, coordinate care and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, care, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[39] and ACOs[40] may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

The Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. Non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.[41] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[42]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[43] Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[44] SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.[45] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or finding a provider.[46] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.[47] It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.[48]

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[49] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, which includes information and resources to help promote health, good outcomes and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[50]

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.[51] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment and recovery support for persons with, or at risk of, mental illnesses and substance use disorders.

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be charged with coordinating care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?
2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?
6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?
7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?
8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?
9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

10. Indicate tools and strategies used that support efforts to address nicotine cessation.
    - Regular screening with a carbon monoxide (CO) monitor
    - Smoking cessation classes
    - Quit Helplines/Peer supports
    - Others_____
11. The behavioral health providers screen and refer for:
    - Prevention and wellness education;
    - Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
    - Recovery supports

Please indicate areas of technical assistance needed related to this section.

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Please use the box below to indicate areas of technical assistance needed related to this section:

- Continued training on Tobacco Cessation EBP's and Promising Practices
- How to include tobacco cessation as part of the treatment plan goals

Footnotes:

1. The Health Care System and Integration

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?

   Currently NJ's Medicaid State Plan covers the following benefits listed in Table 3:

   - Healthcare Home/Physical Health:
     - General and specialized outpatient Medical Services
     - Acute primary care
     - General Health Screens, Tests and Immunizations
     - Comprehensive are management
     - Care coordination and health promotion
     - Comprehensive transitional care (LTSS only)
     - Referral to Community services (LTSS only)
   - Prevention Including Promotion:
     - Screening, Brief Intervention and Referral to Treatment
   - Substance Abuse Primary Prevention:
     - None
   - Engagement Services:
     - Assessment
     - Specialized Evaluations (Psychological and Neurological)
     - Service Planning (including crisis planning)
   - Outpatient Services:
     - Individual Evidenced-Based Therapies
     - Group Therapy
     - Family Therapy
     - Multi-family Therapy
   - Medication Services:
     - Medication Management
     - Pharmacotherapy (including MAT)
     - Laboratory Services
   - Community Support (Rehabilitative):
     - Skill Building
     - Case Management
     - Behavior Management
     - Peer Support
     - Supports for Self-directed Care
   - Other Supports:
     - Personal Care
     - Homemaker

    - Respite
    - Transportation
    - Assisted Living Services
    - Interactive Communication Technology Devices
- Intensive Support Services:
    - Substance Abuse Intensive Outpatient (IOP)
    - Partial Hospital
    - Assertive Community Treatment
    - Intensive Home-based Services
    - Multi-systemic Therapy
    - Intensive Case Management
- Out of Home Residential Services
    - Clinically managed 24 hour Care (SA)
    - Clinically Managed Medium Intensity Care (SA)
    - Adult Mental Health Residential
    - Youth Substance Abuse Residential Services
    - Children's Residential Mental Health Services
    - Therapeutic Foster Care
- Acute Intensive Services:
    - Mobile Crisis
    - Medically Monitored Intensive Inpatient (SA)
    - 24/7 Crisis Hotline Service
- Other:
    - Behavioral Health Home

2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?

   The QHPs network standards are defined by contract and monitored by the Division of Medical Assistance and Health Services. Behavioral health services managed by QHPs are for the IDD/MI and LTSS populations only. Most behavioral health services remained unmanaged within Medicaid and are paid FFS. However, there are plans to move the current FFS behavioral health system into at risk managed care within the next two-three years. At that time, access standards for behavioral health will be established and monitored.

3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.

   The Division of Medical Assistance and Health Services, Office of Managed Care is responsible for monitoring access to MH and SUD services covered by the QHPs.

4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?

The SMHA/SSA has established not anything yet regarding review of complaints or violations of MHPAEA.

5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

   When NJ decided to do Medicaid Expansion, the state used the EHB as the standard for developing and implementing the Alternative Benefit Package (ABP). The primary difference between the ABP benefit and the Medicaid State Plan benefit is the addition of ambulatory and residential substance use disorder services. The state is evaluating the potential to change the Medicaid State Plan to include the ambulatory and residential SUD services covered in ABP so that there is standardization of the benefit in both plans and all members have access to the same benefit.

6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?

   DMHAS has been involved in a variety of efforts to coordinate care in N.J., as its primary responsibilities involve implementation of treatment and prevention services for both mental health and substance use disorders. Individuals who are discharged from state psychiatric hospitals, as well as others with complex needs, receive case management services or are assigned to assertive community treatment teams. While NJ does not have managed care for all of its behavioral health services funded by Medicaid, there are plans currently underway to provide this.

   In January 2015, the Governor announced that the Division of Mental Health and Addiction Services will develop an interim managing entity (IME) for addiction services as the first phase in the overall reform of behavioral health services for adults in New Jersey. University Behavioral Health Care (UBHC) will be the IME with an implementation date of 7/1/15. The IME will provide as a coordinated point of entry / no wrong door for those seeking treatment for substance use disorders. Clients can either call the IME directly to be screened and receive a warm handoff to a provider, or they can go to/call a provider directly to be screened and continue services. The IME will assist clients to find the right provider for their needs and help them navigate the substance abuse treatment network. This will allow the state to manage its resources across payors and across the continuum of care. The IME will be implemented in Phases and will eventually manage substance abuse services for Medicaid, block grant and most state funded initiatives. Not all addiction services will be managed in the first phase of implementation of the IME.

   DMHAS has explored several models of integration, and continues to evaluate the needs of all populations within the behavioral health continuum of care. One initiative is the Behavioral Health Home (BHH). The BHH is a high intensity service targeting those mental health consumers with the most need. While the health home is designed as a high intensity service, there is also a call for integrated care for others. DMHAS is currently working with several technical advisors, exploring how best to test and then implement integrated care in less intensive settings.

7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?

    - DMHAS and NJ Medicaid have been awarded membership in a new learning collaborative for states' developing and implementing programs to integrate primary care, behavioral health, and social services in ambulatory settings. The learning collaborative is led by the National Academy for State Health Policy and will help the team in the design of strategies to support the initiative. The team has envisioned a pilot model that would bring behavioral health in to a primary care setting. DHS has contacted the NJ Department of Health and the NJ Primary Care Association to join the team with the hopes of using the pilot model in FQHCs, CHCs, and other primary care practices.

    - Over the past five years, DMHAS, in partnership with NJ Medicaid and the Department of Health (DOH), has begun the process of integrating primary health care, behavioral health care, and social services. New Jersey has undertaken several initiatives to integrate behavioral health with primary care and social services. Currently, DMHAS has a SAMHSA grant for an SBIRT project, has two counties with behavioral health homes serving adults with severe mental illness and is developing ACOs state wide. The Behavioral Health Home State Plan Amendments will be targeting the serious mentally ill population but plans will expand to the substance use disorder population as well. DMHAS has also offered a learning community and startup funding to prospective providers for health home services. Additionally, several participants are working with their local Federally Qualified Health Care Center (FQHC) and hospitals to advance health home models in their area. Most recently, DMHAS applied for a planning grant from SAMHSA to develop Certified Community Behavioral Health Clinics (CCBHCs). If awarded the planning grant, DMHAS will then prepare a grant to participate in SAMHSA's two-year Demonstration Project for CCBHCs. DMHAS would like to focus on integrating services in the primary care setting and a variety of efforts are underway to bring integrated healthcare to New Jersey.

8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?

    - The Division's strategy is to consider smoking as an addiction, in addition to a healthcare issue. The Division's primary strategy to address nicotine addiction in hospital and community settings has been to produce a toolkit and to promote smoking cessation training that is specifically designed for persons with serious mental illness. Many of the state behavioral health facilities are treating clients for nicotine dependence, and this includes providing medication. DMHAS has established that all state psychiatric hospital be smoke free and assist patients with smoking cessation programs. Smoking cessation treatment is provided in these facilities and then coordinated upon discharge.

- DMHAS through a grant with Rutgers/UBHC offered Tobacco Cessation training to all mental health and substance use disorder agencies. This includes the use of NRT in many forms for consumers and staff, and providing training to agencies on how to incorporate tobacco cessation goals into the treatment milieu for clinical plans. A series of trainings were offered for over period of 24 months, with an extension to the contract for an additional 6 months. Although slower to be addressed by agencies, there is progress in addressing tobacco issues with the consumer.

9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

    - Information pertaining to tobacco use and frequency is addressed in community agencies through the use of a bio-psychosocial or nursing assessments which occur during admission into treatment.

10. Indicate tools and strategies used that support efforts to address nicotine cessation.

    - Regular screening with a carbon monoxide (CO) monitor
    - Smoking cessation classes
    - Quit Helplines/Peer supports
    - Others: NRT such as patches, water, gum, lollipops, etc.
    - DMHAS has made ongoing efforts in conjunction with Rutgers University to address smoking in people with behavioral health issues. These include the development of a toolkit by the university that provides a self -directed cessation intervention. Called *Learning About Healthy Living*, the toolkit recommends screening with a carbon monoxide (CO) monitor and helps individuals to weigh risks and to develop their own plan to quit smoking. Currently, the Division is supporting the university in training consumers if the state's self-help recovery centers to utilize the tool kit. Since 2005, DMHAS has also supported a peer-to-peer tobacco cessation counseling initiative called CHOICES that has gone to every part of the state to educate mental health consumers about the dangers of in a variety of other settings. Both *Learning About Healthy Living* and the CHOICES program have been nationally recognized.

11. The behavioral health providers screen and refer for:

    - Prevention and wellness education;
    - Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
    - Recovery supports.

Please indicate areas of technical assistance needed related to this section.

- Continued training on Tobacco Cessation EBP's and Promising Practices
- How to include tobacco cessation as part of the treatment plan goals

Environmental Factors and Plan

2. Health Disparities

Narrative Question:

In accordance with the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*[52], *Healthy People, 2020*[53], *National Stakeholder Strategy for Achieving Health Equity*[54], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, and people living with HIV/AIDS or other chronic diseases/impairments) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards).[55]

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The top Secretarial priority in the Action Plan is to "[a]ssess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[56]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.[57] This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations.[58] In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the population they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?
2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.
3. Are linguistic disparities/language barriers identified, monitored, and addressed?
4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.
5. Is there state support for cultural and linguistic competency training for providers?

Please indicate areas of technical assistance needed related to this section.

[52] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[53] http://www.healthypeople.gov/2020/default.aspx

[54] http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf

[55] http://www.ThinkCulturalHealth.hhs.gov

[56] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[57] http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208

[58] http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

2. Health Disparities

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?

    - The SSA utilizes the New Jersey Substance Abuse Monitoring System (NJSAMS) to collect information on race, ethnicity (Hispanic origin), gender, primary and secondary languages spoken, date of birth and ASAM level of care for any client admitted to and discharged from substance use disorder treatment. Questions on LGBTQ are not asked. Information on outcome measures is collected at admission and discharge, which includes: abstinence from alcohol, abstinence from other drugs, employment, enrollment in school or job training, number of arrests in prior 30 days, and homelessness.

    - The SSA provides prevention services for Gay, Lesbian, Bisexual, Transgendered and Questioning (GLBTQ) youth. Information on service utilization for this program is tracked through its contract.

    - The SSA conducts targeted surveys using Survey Monkey to garner information for more details on language services. A survey was conducted of Drug Court providers in March 2013 to determine their ability to provide Spanish language services. Nineteen agencies responded, with 51% of the counselors being fluent in Spanish and 42% of the Spanish speaking counselors in an agency being bilingual. Approximately 5% of Drug Court clients required Spanish in order for services to be provided; however, 10% preferred their services to be provided in Spanish. Of agencies who responded, 33% provide drug court materials in Spanish.

2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.

    - DMHAS formed a Multicultural Service Group (MSG) to address issues of quality mental health services that are currently provided; staff credentials, qualifications and training. The MSG mission is to devise strategies that are appropriate to lifestyles, special needs and strengths of New Jersey's diverse minority and cultural groups.

3. Are linguistic disparities/language barriers identified, monitored, and addressed?

    - As noted above, when an issue was identified with Spanish speaking clients participating in Drug Court, a special survey was developed and information provided to the DMHAS Drug Court Coordinator to address. The Multi-cultural Services Group will follow-up on the status of this survey, as well as the status of the use of language banks and materials at the state hospitals.

4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.

- Through a DMHAS RFP process and following the recommendations from the Governors Mental Health Task Force Report, that called for the enhancement and improvement in the delivery of mental health services, which are specifically designed to serve the fastest growing ethnic minority populations in New Jersey, twenty three (23) bilingual/bicultural counselors have been hired who are working in community agencies.

- Annualized funding of $350,000 is provided for prevention, education, treatment, intervention, communication accessibility, and advocacy services for the population of individuals who are Deaf, hard of hearing, and/or disabled. Communication accessibility is coordinated to provide sign language interpreters or Computer Assisted Real-Time Translation (CART) for individuals who were identified as Deaf or hard of hearing seeking substance abuse treatment at any level of care.

- In addition, DMHAS funds services for individuals who are deaf and hard of hearing throughout New Jersey. Behavioral health services for Deaf and Hard of Hearing Services populations are administered by DMHAS services based on region (Northern and Southern). In the northern part of the state these services are contracted by DMHAS to the ACCESS program of St. Joseph's Hospital (Paterson, New Jersey). In the Southern Region, Partial Care and Residential Services for Deaf and Hard of Hearing consumers is provided by South Jersey Behavioral Health Services (Cherry Hill, NJ). Each of these two programs operates independently of each other, and offer slightly different services, yet both are funded by DMHAS.

  The ACCESS program provides community-based specialized mental health services to deaf and hard of hearing consumers in a culturally affirmative environment throughout New Jersey. Services include: psychiatric emergency services; outpatient therapy; partial hospitalization; residential services; consultation; training; and case management services for the Statewide Specialized Inpatient Program (SSIP) at Greystone Park State Psychiatric Hospital.

  Psychiatric Emergency Services for deaf and hard of hearing populations are provided on site by ACCESS during regular working hours and is handled on an on-call basis after hours/weekends/holidays throughout the state. Non-enhanced screening centers are provided telephone consultation from ACCESS. Staff is available twenty-four (24) hours a day, with capacity for videophone and TTY calls. Master's level clinicians are available to enhanced screening centers on a twenty-four (24)-hour basis for on-site assessment. In addition, ACCESS provides the training module on the clinical assessment of deaf individuals in the screener certification series.

  ACCESS is available to provide on-site clinical consultation and liaison services to Short Term Care Facilities (STCF's) to assist in the treatment and discharge planning process for each deaf patient.

Outpatient psychotherapy services are provided to deaf and hard of hearing populations by ACCESS at various locations, including: St. Clare's/Cedar Knolls; Catholic Charities/East Brunswick; Riverview Medical Center/Shrewsbury; Greater Trenton Behavioral Health/Lawrence; Ocean Mental Health/Manahawkin. The staff of the ACCESS program consists of master's level clinicians, deaf and hearing staff, who possess advanced skills in American Sign Language, and who have backgrounds in both deafness and mental health. Qualified interpreter services are also obtained when needed.

In the southern half of the state, DMHAS contracts South Jersey Behavioral Health Resources to provide consumers with residential group home services at their Debra Brown House. The Debra Brown group serves consumers who have both a diagnosed mental illness, and who are deaf or hard of hearing. This facility provides residents with an accessible environment both culturally and with regard to their communication needs. Staff is trained in American Sign Language (ASL) as well as in clinical issues related to deafness. The staff of this facility work individually with consumers to guide each toward their own Wellness and Recovery goals. The Debra Brown House has a capacity of 5.

DMHAS also has a contact with South Jersey Behavioral Health for a program called Regional Resources Center for the Deaf (RRC). The Regional Resources Center Partial Care Program provides barrier-free, comprehensive day treatment services to deaf and hard of hearing individuals with chronic mental illness. The primary goal of the program is to assist participants in developing adaptive functional behaviors and acquiring needed prevocational, emotional and coping skills that will otherwise enhance their ability to achieve and maintain independent community living. The program has a physical capacity for 10 individuals.

5. Is there state support for cultural and linguistic competency training for providers?

- The DMHAS has two (2) Cultural Competence Training Centers that provide onsite technical assistance and resources to develop an individualized cultural competency plan at each agency that focuses on measurable strategies for implementation that impact treatment services for consumers.

Children's System of Care (CSOC)

Within the NJ children's system of care access and/or enrollment in services, types of services received, and outcomes by race, ethnicity, gender and age are tracked by the Contracted Systems Administrator (CSA) management information system.

Within the NJ children's system of care language needs of disparity-vulnerable subpopulations are identified, addressed and tracked by the CSOC CSA, PerformCare. County-wide needs assessments are also conducted on the local level by the Care Management Organizations (CMO) and the County Children's Inter-Agency Coordinating Councils (CIACCs).

CSOC develops plans to address and reduce disparities in access, service use, and outcomes for disparity-vulnerable subpopulations through the following mechanisms:

- having a customized utilization management program for the CSA based on unique local, regional, and programmatic needs;
- employing licensed clinical staff available 24 hours/day,7 days/week with specific experience and training focused on the population being served;
- holding initial and ongoing training regarding program requirements;
- incorporating evidence-based practices and clinical practice guidelines that promote resiliency in children/youth/young adults and families into the review process;
- promoting family-centered, strengths-based, culturally competent planning, and community-based services, natural supports, and active care coordination; and
- using the CSA management information system to capture accurate, real-time data for analysis and identification of opportunities for improvement and right sizing of the children's system of care.

CSOC does not utilize Block Grant funds to measure, track or address to these disparities.

Environmental Factors and Plan

3. Use of Evidence in Purchasing Decisions

Narrative Question:

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including mental health and substance abuse services. Over the past several years, SAMHSA has received many requests from CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance abuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states use of the block grants for this purpose. The NQF and the Institute of Medicine (IOM) recommend that evidence play a critical role in designing health and behavioral health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP[59] is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with (SED). The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[60], The New Freedom Commission on Mental Health[61], the IOM[62], and the NQF.[63] The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[64] SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), and CMS) have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocols (TIPs)[65] are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (CSAT) draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)[66] was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding mental health and substance abuse services.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.
2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
4. Does the state use a rigorous evaluation process to assess emerging and promising practices?
5. Which value based purchasing strategies do you use in your state:
    a. Leadership support, including investment of human and financial resources.
    b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
    c. Use of financial incentives to drive quality.

d. Provider involvement in planning value-based purchasing.

e. Gained consensus on the use of accurate and reliable measures of quality.

f. Quality measures focus on consumer outcomes rather than care processes.

g. Development of strategies to educate consumers and empower them to select quality services.

h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.

i. The state has an evaluation plan to assess the impact of its purchasing decisions.

Please indicate areas of technical assistance needed related to this section.

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[59] Ibid, 47, p. 41

[60] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[61] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[62] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[63] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[64] http://psychiatryonline.org/

[65] http://store.samhsa.gov

[66] http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

3. Use of Evidence in Purchasing Decisions

The SMHA has identified EBP-specific subject matter experts to oversee and monitor the implementation of the state's EBP. Specifically, these subject matter experts oversee the contracts between the SMHA and service providers as well as contracts between the SMHA and the entity under contract to provide training and technical assistance to support the implementation and in some instances proliferation of the EBP. Use of an EBP and its fidelity to the model are measured as progress is made on the training to providers and quality measures of outcome are collected and analyzed to see if desired outcomes or NOMS are modeled. The SMHA collects and analyses outcomes which should assist in future procurement of services. The SMHA through its training and consulting practices, trends emerging EBP and seeks guidance at the national level to address these EBP topic areas. The SMHA uses all available evidences and theories to assist in what EBP and promising practices to follow. On a national level, the SMHA consults with SAMHSA, NASMHPD, National Council on Behavioral Health, HRSA, etc. to address issues of EBP and promising practices.

The SSA's Addiction Training and Workforce Development initiative provides scholarships for staff working in state hospitals and licensed behavioral health agencies to attend specialized trainings to enhance their skills utilizing evidenced based practice. Initial and advanced cognitive behavioral therapy and motivational interviewing classes are offered by the New Jersey Prevention Network, the Rutgers Center of Alcohol Studies, and the Northeast & Caribbean Addiction Technology Transfer Center. Courses include, "The Theory and Practice of Motivational Interviewing," "Advancing the Practice – Motivational Interviewing a New Perspective," and "Motivational Interviewing the Basics." Emphasis is on participants learning evidenced based practice techniques and how to apply them in their clinical work.

Assertive Community Treatment (ACT). The SMHA has identified one individual who is the subject matter expert (SME) for ACT. ACT is available in every county across the state. The SMHA has had the opportunity to expand ACT opportunities over the last five years, enabling expanded ACT teams across the state. In addition the SMHA supports the provision of ACT technical assistance through a designated provider. This entity provides training to new ACT workers and technical assistance to support ACT agencies in operating in a way that preserves fidelity to the ACT model. The SMHA conducts regular reviews of each ACT program's ability to work in fidelity to the model and in rare instances where there have been repeated low scores related to fidelity decisions were made to rebid the service.

Illness Management and Recovery (IMR). IMR is available across the state. The SMHA has identified multiple state staff who together are responsible for the ongoing availability of IMR training for staff in state psychiatric hospitals and staff working in community settings such as partial care and supportive housing. IMR just celebrated its 10th year here in NJ. This year, NJ will kick off a train-the-trainer initiative in IMR. Training is provided by two different entities within one of our state universities.

Supportive Housing. The SMHA has been expanding supportive housing for the last decade. The SMHA is currently undergoing a major training initiative focused on changing the services provided in supportive housing to one that is grounded in psychiatric rehabilitation principles. In

addition, the SMHA is in the process of separating housing from services whereby providing consumers with greater choice on where they live and who provides services to them. The SMHA has developed specialized supportive housing initiatives (such as supportive housing for individuals who are dually diagnosed with a developmental disability and mental illness, supportive housing for individuals who have significant co-existing medical conditions and supportive housing for individuals who have significant forensic histories) based on identified consumer needs. State hospital data is used to help determine the need for such housing and to help determine where to site new housing opportunities.

Similarly, the SSA has developed two supported housing programs when the Medication Assisted Treatment Initiative was launched and has recently made an award to develop a Women's Intensive Supportive Housing (WISH) program.

Integrated Dual Disorder Treatment (IDDT). The Integrated Dual Disorder Treatment (IDDT) model is an evidence-based practice that improves the quality of life for people with co-occurring severe mental illness and substance use disorders by combining substance abuse services with mental health services. It helps people address both disorders at the same time—in the same service organization by the same team of treatment providers.

IDDT emphasizes that individuals achieve big changes like sobriety, symptom management, and an increase in independent living via a series of small, overlapping, incremental changes that occur over time. Therefore, IDDT takes a stages-of-change approach to treatment, which is individualized to address the unique circumstances of each person's life.

IDDT is multidisciplinary and combines pharmacological (medication), psychological, educational, and social interventions to address the needs of consumers and their family members. IDDT also promotes consumer and family involvement in service delivery, stable housing as a necessary condition for recovery, and employment as an expectation for many.

Medication-Assisted Treatment (MAT). The SSA administers a system of care that consistently offers clients the means to seek and sustain recovery. The SSA promotes evidence-based practices that include Medication-Assisted Treatment (MAT) in the management of substance use disorders, specifically opioid and alcohol use disorders. The U.S. Department of Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) defines MAT as the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. MAT is clinically driven with a focus on individualized patient care. Research continues to demonstrate medication, along with behavioral therapies, results in successful outcomes. DHS currently licenses thirty (30) Opioid Treatment Programs (OTPs) that provide methadone treatment services and the SSA funds twenty (19) of these agencies. Six of the thirty licensed programs are funded by the SSA to support its Medication Assisted Treatment Initiative (MATI) which provides both methadone and buprenorphine services in conjunction with required counseling services. The SSA makes Vivitrol (naltrexone) available as an enhancement in all of its Fee-for-Service (FFS) initiatives.

Trauma Informed/Trauma Specific Treatment Services. Given the high prevalence of trauma among women with substance use disorders, licensed treatment providers who provide gender specific treatment and receive State funding and/or Federal Substance Abuse Block Grant Women's Set-Aside must provide trauma informed/trauma specific treatment services using the "Seeking Safety" program. Providers are required to screen all women for trauma using one of the DMHAS recommended evidence based screening tools. This is a SSA contract requirement.

Substance Abuse Prevention. Agencies and coalitions that are funded by the SSA to provide substance abuse prevention programs and services are required to deliver programs for individuals and families that are listed on one of the national registries of evidence-based programs and practices. The specific registries from which providers can select programs are:

- Blueprints for Healthy Youth Development
- US Office of Juvenile Justice and Delinquency Prevention – Model Programs Guide
- SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP)
- Find Youth Info

Screening, Brief Intervention and Referral to Treatment (SBIRT). The SSA has obtained federal Substance Abuse and Mental Health Services Administration (SAMHSA) funding for its NJ Screening, Brief Intervention and Referral to Treatment (SBIRT) Project. NJ SBIRT is an integrated public health approach to the delivery of brief interventions when substance use risk has been identified among adult patients in primary care and community health settings. In NJ SBIRT, a quick and simple screening process identifies patients at risk of substance use issues thus creating opportunities for immediate and brief interventions tailored to address the patients' substance use severity. The types of SBIRT interventions include:

1. Brief Intervention – focuses on increasing patient insight and awareness regarding their substance use and its negative health consequences, and motivation toward behavioral change. BI practice utilizes Motivational Interviewing (MI) as the foundational EBP. MI adaptations are described on SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP).
2. Brief Treatment – is a more structured approach for evoking internally-motivated behavioral change, utilizing Motivational Enhancement Therapy (MET) as the EBP. MET may be delivered as an intervention itself, or used as a prelude to further treatment.
3. Referral to Treatment – is a standard public health practice facilitating patient access to specialized care when indicated.

The effectiveness of Motivational Interviewing (MI) and Motivational Enhancement Therapy (MET) have been repeatedly demonstrated in a variety of clinical and non-clinical settings. Their effectiveness in moderating alcohol and drug use among dependent and non-dependent consumers is also well established. NJ SBIRT is implemented in primary care settings, emergency departments, and soon in family medicine practices.

Children's System of Care (CSOC)

Licensed clinical staff at CSOC, as well as staff at CSOC's Training and Technical Assistance Program, UBHC-Rutgers, disseminate information regarding evidence-based and/or promising practices. Licensed clinical staff at PerformCare, CSOC's Contracted Systems Administrator (CSA), review and authorize the use of evidence-based practices as part of a child, youth or young adult's Individualized Service Plan (ISP). The CSA tracks utilization and outcome measurements of evidence-based practices implemented by CSOC providers.

Information regarding evidence-based and/or promising practices was utilized by CSOC in its purchasing decisions

CSOC arranged for training from the National Improvement Research Network at University of North Carolina at Chapel Hill for CSOC staff, County Inter-Agency Coordinating Councils and System Partners on the implementation of EBPs, assessing community readiness, and maintaining fidelity to the model. Additionally, CSOC contracted with the University of South Florida through its UBHC-Rutgers Training and Technical Assistance Program contract to provide technical assistance and training on evidence-based practice to provider agencies.

CSOC reached out to other states for examples of their policies and guidelines regarding evidence based practices and best practices standards. CSOC received 47 responses to the request. The material received included legislation; state policies and regulations; state practices and guidelines; trainings and Power Point presentations; Requests for Proposals; articles; and, resource material and references for additional information. CSOC Policy Unit staff reviewed the material and developed recommendations for CSOC implementation of EBPs.

Training and Technical Assistance provided by University of North Carolina and University of South Florida; state guidelines, policies and regulations; and, examples of Requests for Proposals were most useful in developing CSOC implementation of EBPs. CSOC synthesized the information received and used it as a foundation for the development and implementation of evidence based programs in the children's system of care.

In order to improve the quality of care provided to the children and families served, CSOC supports the incorporation of evidence-based practices into the work of system partners and providers. A principle strategy for this was to develop a Medicaid reimbursement rate that adequately supports evidence-based practice.

4. Prevention for Serious Mental Illness

Narrative Question:

SMIs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.[67] The "Prodromal Period" is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.[68] In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.[69] The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.[70] [71] This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

****It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Please indicate areas of technical assistance needed related to this section.

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[67] Larson, M.K., Walker, E.F., Compton, M.T. (2010). Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. Expert Rev Neurother. Aug 10(8):1347-1359.

[68] Fusar-Poli, P., Bonoldi, I., Yung, A.R., Borgwardt, S., Kempton, M.J., Valmaggia, L., Barale, F., Caverzasi, E., & McGuire, P. (2012). Predicting psychosis: meta-analysis of transition outcomes in individuals at high clinical risk. Arch Gen Psychiatry. 2012 March 69(3):220-229.

[69] Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J., Norman, R.E., Flaxman, A.D., Johns, N., Burstein, R., Murray, C.J., & Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. Nov 9;382(9904):1575-1586.

[70] van der Gaag, M., Smit, F., Bechdolf, A., French, P., Linszen, D.H., Yung, A.R., McGorry, P., & Cuijpers, P. (2013). Preventing a first episode of psychosis: meta-analysis of randomized controlled prevention trials of 12-month and longer-term follow-ups. Schizophr Res. Sep;149(1-3):56-62.

[71] McGorry, P., Nelson, B., Phillips, L.J., Yuen, H.P., Francey, S.M., Thampi, A., Berger, G.E., Amminger, G.P., Simmons, M.B., Kelly, D., Dip, G., Thompson, A.D., & Yung, A.R. (2013). Randomized controlled trial of interventions for young people at ultra-high risk of psychosis: 12-month outcome. J Clin Psychiatry. Apr;74(4):349-56.

Please use the box below to indicate areas of technical assistance needed related to this section:

The SMHA continues to comply with SAMHSA's requirement that states set aside 5 percent of their Mental Health Block Grant (MHBG) allocation to support "evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders." For New Jersey's SMHA, these funds are to be devoted toward the use of the First Episode Psychosis (FEP) promising practice.

The SMHA is planning an ambitious pilot for identifying and supporting populations at risk of FEP, using an array of interventions including: outreach, family support, peer support, supported education/employment, case management, cognitive behavioral therapy, and medication management for low doses of anti-psychotic medication.

The SMHA would benefit from technical assistance related to FEP practices in general, and from the National Institute of Mental Health's (NIMH's) Recovery After an Initial Schizophrenia Episode (RAISE) program in particular. Such technical assistance would help the SMHA develop

relevant programming, craft appropriate Requests for Proposals (RFPs), evaluation program integrity, and establish outcome measures to track provider performance quality.

The Division's contracted providers would also benefit from technical assistance related to FEP interventions, particular with regard to organizing/hiring relevant staff, clinical training, and supervision necessary to make the FEP promising practice a success.

Footnotes:

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SMIs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.[71] The "Prodromal Period" is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

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MHBG funds must be directed toward adults with SMI or children with SED.

Please indicate areas of technical assistance needed related to this section

The SMHA continues to comply with SAMHSA's requirement that states set aside 5 percent of their Mental Health Block Grant (MHBG) allocation to support "evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders." [1] For New Jersey's SMHA, these funds are to be devoted toward the use of the First Episode Psychosis (FEP) promising practice.

The SMHA is planning an ambitious pilot for identifying and supporting populations at risk of FEP, using an array of interventions including: outreach, family support, peer support, supported education/employment, case management, cognitive behavioral therapy, and medication management for low doses of anti-psychotic medication[2].

The SMHA would benefit from technical assistance related to FEP practices in general, and from the National Institute of Mental Health's (NIMH's) *Recovery After an Initial Schizophrenia Episode* (RAISE) program[3] in particular. Such technical assistance would help the SMHA develop relevant programming, craft appropriate Requests for Proposals (RFPs), evaluation program integrity, and establish outcome measures to track provider performance quality.

The Division's contracted providers would also benefit from technical assistance related to FEP interventions, particular with regard to organizing/hiring relevant staff, clinical training, and supervision necessary to make the FEP promising practice a success.

[71] Larson, M.K., Walker, E.F., Compton, M.T. (2010). Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. Expert Rev Neurother. Aug 10(8):1347-1359.

[1] c.f. http://blog.samhsa.gov/2014/06/17/from-research-to-practice/
[2] See http://www2.nami.org/Content/NavigationMenu/State_Advocacy/Tools_for_Leaders/FirstEpisodePsychosisPrograms.pdf
[3] http://ftp.nimh.nih.gov/health/topics/schizophrenia/raise/coordinated-specialty-care-for-first-episode-psychosis-resources.shtml

Environmental Factors and Plan

5 Evidence-Based Practices for Early Intervention (5 percent set-aside)

Narrative Question:

P.L. 113-76 and P.L. 113-235 requires that states set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age.[72] SAMHSA worked collaboratively with the NIMH to review evidence-showing efficacy of specific practices in ameliorating SMI and promoting improved functioning. NIMH has released information on Components of Coordinated Specialty Care (CSC) for First Episode Psychosis. Results from the NIMH funded Recovery After an Initial Schizophrenia Episode (RAISE) initiative[73], a research project of the NIMH, suggest that mental health providers across multiple disciplines can learn the principles of CSC for First Episode of Psychosis (FEP), and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. The CSC components emphasize outreach, low-dosage medications, evidenced-based supported employment and supported education, case management, and family psycho-education. It also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. Peer supports can also be an enhancement on this model. Many also braid funding from several sources to expand service capacity.

States can implement models across a continuum that have demonstrated efficacy, including the range of services and principles identified by NIMH. Using these principles, regardless of the amount of investment, and with leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state will be able to begin to move their system toward earlier intervention, or enhance the services already being implemented.

It is expected that the states' capacity to implement this programming will vary based on the actual funding from the five percent allocation. SAMHSA continues to provide additional technical assistance and guidance on the expectations for data collection and reporting.

Please provide the following information, updating the State's 5% set-aside plan for early intervention:

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.
2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.
3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.
4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.
5. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

Please indicate areas of technical assistance needed related to this section.

[72] http://samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf

[73] http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm_source=rss_readers&utm_medium=rss&utm_campaign=rss_full

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

5. Evidence-Based Practices for Early Intervention (5 Percent)

Please provide the following information, updating the State's 5% set-aside plan for early intervention:

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.

   In the approved 2014 plan, New Jersey would implement the National Institute of Mental Health's RAISE model utilizing the five percent set aside funds of the Community Mental Health Services Block Grant. Services will be provided to youth and adults aged 15 to 44 years who present with a recent diagnosis (12 months or less) of psychosis spectrum conditions. The First Episode Psychosis (FEP) model in the New Jersey pilot will follow the RAISE model as represented in the Coordinated Specialty Care (CSC) RAISE Implementation Manual including staffing, purpose, training, services and spirit of the model. The New Jersey RAISE model will be altered or modified in comparison to the CSC RAISE model only in the staffing arrangement.

   The New Jersey CSC Service will utilize a team approach that integrates treatment and services. The services that will be provided include evidence-based pharmacological treatment, supported employment and education services, individual and group psychotherapy, case management, and family therapy.

2. An updated description of the plan's implementation status, accomplishments and/any changes in the plan.

   A Request for Proposal (RFP) was being developed for the 2014 - 2015 CMHS BG 5% set-aside. In April 2015, SMHA learned that the original plan which was to roll out the RFP in 2015 had to be changed because any unexpended portion of the 5% set-aside fund in its 2014 plan would not be carried forward after September 30, 2015. SMHA worked closely with the federal officer to revise the plan. Instead of moving ahead with issuing the RFP in 2015, the SMHA's new plan in 2015 is to provide trainings on FEP to mental health service providers who potentially serve the population.

   In FY 2016/2017, a RFP will be issued to fund one provider to implement the Raise model. It is anticipated that the clinical team will be operational near the end of the first year, which is approximately the last quarter of the state fiscal year 2016. The remainder of the 5% set-aside for the state fiscal year 2016 will support building the infrastructure and providing administrative and technical support to the site. The funds will also be used for training in cognitive behavioral therapy, fidelity assessment, and administrative support. New Jersey will also seek technical assistance from SAMHSA, NIH, and possibly other experts in the field.

3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.

   SMHA plans to utilize 5% set-aside funds in 2016 and 2017 Block Grant to fund clinical

teams that will implement the Raise model to serve the population with FEP in New Jersey.

4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.

   A budget is not available at this moment.

5. The state provision for collecting and reporting data, demonstrating the impact of this initiative.

   SMHA will plan the reporting requirements at the time when the RFP is issued.

Evidence-Based Practices for Early Intervention (5 percent set-aside)

REVISION REQUEST DETAIL:

Please submit a general budget for the FY 2016 and 2017 5% set-aside funds by 10/12/2015.

The budget includes three parts. First, trainings on delivery of services on persons with first episode psychosis (FEP) will be provided. Second, a service team will be funded. Next, the remainder funds will be used to cover the administrative cost and technical assistance.

First, informed by the last round of training provided in Fiscal Year 2015, SMHA will allocate an approximate $90,000 for training.

Second, New Jersey Coordinated System of Care Service will utilize a team approach that integrates treatment and services. The services that will be provided include evidence-based pharmacological treatment, supported employment and education services, individual and group psychotherapy, case management, and family therapy. Table 1 presents the staffing composition and budget.

Table 1. Staffing requirement, credentials, and budget

Role	Will provide	Credentials and skills	Salary *	%fte	Budget
Team Leader	Outreach to clients, providers, and family members	Licensed clinician with management skills	66,449	100%	66,449
Psychotherapist	Cognitive behavioral therapy	Licensed clinician	68,000	50%	34,000
Care Manager	Coordinates care	Bachelor level SW	49,087	100%	49,087
Family Therapist	Psychoeducation, preventive counseling, and crisis intervention services	Licensed clinician	52,500	30%	15,750
Supported Employment and Education Specialist	Supported employment and educational services. Ongoing job coaching and support following placement.	Bachelor's level trained employment counselor	42,040	40%	16,816
Pharmaco therapist	Medication management, coordination with primary medical care	Psychiatrist, Nurse Practitioner	100,000	20%	20,000
Peer Support Specialist	Recovery support	Trained and certified peer specialist with lived experience with SMI	40,000	50%	20,000
Subtotal			418,076		222,102
Fringe benefits				40%	88,841
Total					310,943

*estimations based on salary

In summary, the training will cost approximately $90,000. The total annualized cost of one clinical site for one year is anticipated to be approximately $310,943. The remainder of the 5% set-aside after deducting the costs of training and a service team will support building the infrastructure and providing administrative and technical support. The funds will also be used for fidelity assessment and administrative support.

Environmental Factors and Plan

6. Participant Directed Care

Narrative Question:

As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them though the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

6. Participant Directed Care

The New Jersey Department of Human Services (DHS), Division of Mental Health and Addiction Services (DMHAS) is moving from a contracted system of care reimbursement to a Fee-For-Services (FFS) system. The separation of housing and services supports the state's transition to a FFS model. This collaboration with the New Jersey Housing and Mortgage Financing Agency (NJHMFA) will provide a streamlined, one stop resource for individuals served by support service providers to obtain subsidies. This collaboration will offer additional resources for support service providers as well as assist consumers seeking for affordable housing.

Environmental Factors and Plan

7. Program Integrity

Narrative Question:

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 300x–5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 USC § 300x– 55, SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for substance abuse, SAMSHA will release guidance imminently to the states on use of block grant funds for these purposes. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance abuse programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include:(1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?
2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?
3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:
    a. Budget review;
    b. Claims/payment adjudication;
    c. Expenditure report analysis;
    d. Compliance reviews;
    e. Client level encounter/use/performance analysis data; and
    f. Audits.
4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.
5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How does the state ensure block grant funds and state dollars are used for the four purposes?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

7. Program Integrity

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?

   The Affordable Care Act (ACA) has provided additional health coverage options for persons with substance abuse; and, the New Jersey Division of Mental Health and Addiction Services (DMHAS) is proactively partnering with The Division of Medical Assistance and Health Services (DMAHS), the State Medicaid Agency, to ensure that such persons who are Medicaid eligible are appropriately enrolled in order to access needed covered substance abuse services within a framework that ensures Block Grant program compliance and integrity.

   A summary of planning and program development efforts undertaken by the DMHAS in close partnership with DMAHS during SFY 2014-2015, which will be further implemented in phases during SFY 2016 and beyond, follows.

   The DMHAS has begun to implement key elements of the program integrity plan described in the FY 2014-2015 Combined SAMH Block Grant Assessment and Plan developed in 2013. The plan addressed developing a managed behavioral health care partnering agreement to ensure that Block Grant funds are utilized to provide priority treatment and support services for individuals without insurance or for whom coverage is terminated for a short period of time, and to fund these services not covered by Medicaid, Medicare, or private insurance for low-income individuals. In the FY 2014-2015 SAMH Combined Plan, DMHAS described its PI vision to move toward a managed care model which would authorize substance abuse treatment and support services according to income and program eligibility guidelines that:

   - Maximizes utilization of Medicaid reimbursement for state plan services;
   - Maximizes utilization of subsidized QHP reimbursement for covered plan services; and,
   - Reserves Block Grant and other State reimbursement for non-State Plan services for Medicaid enrolled consumers and non-covered QHP services as gap coverage for services not covered by these plans.

   In the interim, the DMHAS has worked to further develop, operationalize, and implement key elements of the managed care model.

   On January 1, 2014, the DMAHS expanded the NJ FamilyCare (NJFC) program in order to offer healthcare to parents, single adults and childless couples ages 19 to 64, with incomes up to 133% of the Federal Poverty Level (FPL). The new federal healthcare law requires the creation of an Alternative Benefit Plan (ABP) for the NJFC expansion population. The ABP includes all NJFC State Plan benefits, as well as some additional substance abuse services.

Governor Chris Christie in his State-of-the-State address for Calendar Year 2015 emphasized the importance of establishing a call line to provide 'one-stop' access for all individuals with substance abuse or for friends and family who are seeking or are in need of resources to obtain treatment and assistance. The opportunity to access addiction services by developing a 'one-stop' access center allows the State to maximize coordinated resources and provide real-time information to consumers and to those entities which provide substance abuse treatment services.

In January 2015, the Division of Mental Health and Addiction Services (DMHAS) announced that the Department of Human Services (DHS) would be partnering with University Behavioral Health Care (UBHC) on the development of an Interim Managing Entity (IME) for addiction services. The IME has been designed to be implemented in phases. It provides 24/7 phone line access availability for all callers, and will subsequently screen consumers to receive an authorized treatment assessment from a network provider. The provider is required to conduct a full consumer assessment, which when provided for a NJFC/Medicaid beneficiary is billable under the applicable CPT procedure code. At the outset UBHC will assist both DMHAS and NJ FamilyCare (FC)/Medicaid with verifying consumer financial eligibility and provider network management activities.

In preparation for the IME implementation, DMHAS has adopted income eligibility guidelines for State and Substance Abuse Block Grant (SABG) funding that aligns with current, Medicaid and QHP subsidy eligibility scales. All consumers will be required to meet income eligibility guidelines to receive State and/or SABG funded services and will be screened for Medicaid enrollment and eligibility. Medicaid will be the payer of first choice for State plan services, however, Medicaid enrolled consumers will also qualify for State and SABG funded services not covered by the state plan. Consumers with potential eligibility will be referred for Medicaid enrollment, and must complete the application process in order to maintain eligibility, if applicable for continued services. Consumers who do not qualify for Medicaid but meet established income and program eligibility criteria will be enrolled in services under the IME, referred for enrollment in a QHP, and must complete the application process in order to maintain eligibility for continued services.

To further prepare for the IME implementation, and to comply with state and federal confidentiality regulations as well as to enable providers to interact with the IME for referrals and authorizations for consumer assessments, every State funded substance abuse treatment provider has been required to sign an Affiliation Agreement. These Provider Network enrollment agreements have been jointly signed during the first half of 2015 between DHS/DMHAS and the State University of New Jersey (Rutgers), on behalf of its UBHC subsidiary and almost the entire current 170 member network of DHS licensed funded treatment providers. These Affiliation Agreements set forth in detail the scope of services and communications to be carried out by each of the three (3) signatory entities, including Billing and Payment, Term and Termination; Relations between the Parties, Governing Law and pertinent legal parameters. The requisite Compliance Statement highlights in detail that "The Parties shall maintain personal health information and records in compliance with federal and state confidentiality laws and regulations, including, but not limited to, the Health Insurance Portability and Accountability Act and the Confidentiality of Alcohol and Drug

Abuse Patent Records". In addition, providers must be enrolled in the NJFC/Medicaid Program as an independent clinic specializing in drug and alcohol treatment services to receive categorical Medicaid fee for service reimbursement.

DMHSA intends to further pursue program integrity assurances through phased implementation of a new managed care initiative under the terms of the Memorandum of Agreement (MOA) with University Behavioral Health Care (UBHC). Titled Interim Management Entity (IME), this DMHAS/UBHC partnership has been designed initially to provide a comprehensive range of access facilitation services to caller inquiries 24/7, as initiated by toll free telephone line that provides instant consumer screening and referral services to Network providers.

Concomitantly DMHAS has implemented changes to the NJSAMS, its online addiction treatment client data collection system, including the DAS Income Eligibility (DASIE) for State and/or BG funding. Providers are required to complete DASIE to indicate a consumer's eligibility for NJFC/Medicaid coverage. Once screened, the IME will authorize a provider assessment of the consumer for admission and treatment to a publically funded Network provider.

On July 1, 2015, DMHAS, NJ FamilyCare/Medicaid, and UBHC jointly launched Phase I of the IME. At that point the IME became the 'one-stop' information and referral authorization service entity for consumer and substance abuse network provider access.

Phase II is targeted for launch in early 2016. At that point the IME will utilize ASAM criteria to authorize addiction treatment placements and continuing care for individuals served through IME managed DMHAS State initiatives, as well as through Medicaid Managed providers for covered services. Many providers are participating in both Networks. IME responsibilities will include limited utilization management activities including treatment authorization and monitoring levels of care. At that point, the IME will provide care coordination as the individual enters and moves through a continuum of care, which will help to ensure continuity of service delivery. Thereafter, in a subsequent phase DMHAS will target the implementation of a fee for service initiative for State and SABG to more closely align with Medicaid fee for service and maximize coordination and program oversight.

2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?

   Each year, the state sends a renewal letter to SA Block Grant funded providers inviting them to submit an online application for a contract to provide a defined set of service modalities (e.g. Drug Free Outpatient Services, Methadone Maintenance). The web based online application system, titled, Contract Information Management System (CIMS) encompasses all the necessary tools for applying for and receiving a contract to provide substance abuse services. These include: Annex A (amount and scope of services to be provided; Annex B (Contract Renewal budget; and Programmatic Requirements, which references the Block Grant supplement that addresses applicable federal compliance requirements to providers

funded with SABG funds. Subsequent to the Application Review process, the final Award Approval letter sent to each contracted provider conveys the amount of SAPT BG funds by FFY Award year, as well as detailed specificity regarding categorical set-aside populations to be served; e.g., treatment slots for Pregnant Women and Women with Dependent Children (PW/WDC).

3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:

In SFY 2016 the state continues to utilize the full range of six (6) categorical Program Integrity activities identified by SAMHSA below to ensure the appropriate use of SA Block Grant funds.

a. Budget review

Each year, the state sends a renewal letter to Block Grant funded substance abuse providers inviting them to submit an online application for a contract to provide a defined set of service modalities (e.g. Drug Free Outpatient Services). The web based online Contract Information Management System (CIMS) includes a contract renewal budget (Annex B) that funded providers must complete. An assigned state contract administrator (CA) reviews the Annex B budget to ensure that proposed costs, and use appropriate, offsetting revenues are consistent with applicable cost principles contained in the Department of Human Services (DHS) Contract Policy and Information Manual and the Contract Reimbursement Manual. In addition the renewal provider must submit manually a Cost Allocation Plan (available online) for their entire organization that illustrates how individual salaries and other cost categories are attributed to DMHAS and all other payers; the plan is also subject to review and approval by the CA prior to contract execution.

b. Claims/payment adjudication

DMHAS is moving toward a Fee-for-Service (FFS) compensation system within this 2-year Block Grant planning period as part of the framework of the IME implementation described above for SABG and State funded providers. This will enable much more precise targeting of the use of Block Grant funds with specific individuals and services.

In addition, DMHAS has maintained a Fee-for-Service payment system for a significant position of its substance abuse treatment and early intervention service initiatives that are not funded through the SABG. This includes eight (8) major initiatives, including three (3) criminal justice initiatives administered through MOAs; and five (5) specialized initiatives funded through State and/or other Federal funds (e.g., SBIRT).

The Computer Sciences Corporation (CSC), the contracted fiscal intermediary, and DMHAS have implemented an automated interface with NJSAMS. It links service data reported in NJSAMS which correspond to the payment claim. CSC verifies all requests for services through the NJSAMS Prior-Authorization-Module and confirms all services payable elements and client identifier elements prior to claims payment.

c. Expenditure report analysis

Continuing into SFY 2016, the majority of Block Grant funded services are provided through cost reimbursement contracts which are compensated on a reimbursement or advance payment basis. DMHAS receives through CIMS quarterly expenditure reports from funded providers and analyzes the reports against the approved contract and governing cost principles, including the subrecipient grant requirements:

Specifically, the following fiscal compliance requirements would be applicable and directly material to the subrecipients: a. Activities Allowed or Unallowed, b. Cash Management, c. Period of Availability of Federal Funds, and d. Procurement.

To monitor Activities Allowed or Unallowed, DMHAS Contract Administrators (CA's) review quarterly subrecipient expenditure reports. If the subrecipient receives funds by cash advance and the subrecipient uses grant money for unallowable activities, the CA will discontinue one or more cash advances. If the subrecipient receives funds by cost reimbursement and the subrecipient uses grant money for unallowable activities, the grant officer will adjust total expenditures, and reimburse the subrecipient for fewer expenditures.

To monitor cash management, DMHAS CA's review the subrecipients' quarterly expenditure reports to observe the usage patterns of the subrecipients. For cash advance recipients that do not utilize the funds they receive, the grant officer will discontinue one or more cash advances. For cost reimbursement recipients, only allowable expenditures will be reimbursed.

To monitor period of availability of federal funds, DMHAS CAs review quarterly subrecipient expenditure reports. The grant period's final expenditure report indicates the amount of funds that have been received, the amount of funds spent, and any remaining balance. If the subrecipient has a balance, the subrecipient must return the balance to the State.

To monitor procurement, subrecipients must budget for equipment purchases when they apply for the grant. Subrecipient purchases must comply with the State's procurement policy.

d. Compliance reviews

In addition to the analysis of expenditure reports cited above, the Grants Monitoring program at DMHAS is responsible for monitoring the contracts and performance of over 200 substance abuse treatment subrecipients. Formal and scheduled onsite visits of 1-5 days in duration are made to recipients of SAPT Block Grant funds a minimum of one (1) time per calendar year. They are conducted by the lead Program Management Officer (PMO), and as needed by additional support personnel, based on the size (e.g. the number of sites) and scope of the program. The Annual Site Visit Report targets six (6) areas of performance: Facility, Staffing, Treatment Records, Quality Assurance, Specialized Services, and Management and Administration (including fiscal). The requisite treatment records review includes a random sample of active client charts and encompasses the provision and availability of clinical and medical services.

At the conclusion of the site visit, the reviewers conduct an exit conference with key subrecipient representatives. After internal DMHAS review and approval, the Annual Site Visit Report is mailed to the subrecipient. The report identifies any areas requiring a plan of correction; and/or the subsequent need to refer unacceptable plans of correction to the DMHAS Performance Improvement Committee.

The Office of Planning, Research, Evaluation and Prevention retains ongoing responsibility for monitoring the programmatic components of about 66 contracts, over half of which receive SABG funds for the provision of primary prevention services to IOM populations. Each subrecipient receives one scheduled, formal site visit per year in addition to two (2) informal site visits conducted by the assigned PMO. The visit, lasting up to a full day, is based on a Formal Site Visit Form that addresses and determines compliance within the performance requirements contained in the Contract Annex A. PMOs also review process data that the subrecipient has submitted on the Prevention Outcomes Monitoring System (POMS), as well as both historical and other pertinent programmatic documentation. In addition, the Program Officer meets with representative program staff to review the program performance information and complete and jointly sign the Site Visit Form. If a Plan of Correction has been indicated as an outcome on the form, based on documented deficiencies, a subsequent meeting is convened at DMHAS with all relevant DMHAS programmatic and fiscal staff to provide guidance and oversight in the development of the plan. The DMHAS Program Office then makes quarterly ongoing site visits to monitor progress on the plan until all identified deficiencies have been ameliorated.

e. Client level encounter/use/performance analysis data

DMHAS executes approximately 150 cost reimbursement contracts per year with community based mental health providers utilizing a mix of State and MHBG funds. DMHAS does not use one (1) specific, standard rate for each modality and unit of service. Rather, each year DMHAS establishes median rates for a wide range of defined service types by conducting a unit cost analysis of budgets (Schedule B) submitted by each agency within the online Budget Matrix system as part of the annual contract renewal process.

Cost is correlated with proposed utilization to develop the median rates; these median rates are used as the basis for final contract negotiations to establish specific provider rates paid for each service. A specific number of units of service, by service type are established within the contract Annex A. Agencies are afforded flexibility with prior approval to provide additional units of service between modalities as long as the contract reimbursement ceiling is not exceeded.

f. Audits

The majority of contract providers have been required to undergo an Annual audit subject to the Single Audit, pursuant to the OMB Circular A-133 requirements including compliance testing and reporting. In SFY 2016 and beyond, providers will be required to comply with 2 CFR 200, titled Uniform Administrative Requirements, Cost Principles and Audit Requirements, which supersedes the OMB Circular A-133, effective 12/26/2014.

4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.

DMHAS has utilized a variety of mechanisms to reimburse for providers for the provision of treatment and support services for substance abuse. The principal mechanism for services funded wholly or in part by the SABG has been the purchase of capacity through the fixed price slot mechanism through cost reimbursement contracts. Concomitantly, DMHAS has increasingly utilized fee for services contracts to pay substance abuse providers for non-Block Grant funded services, particularly within the Criminal Justice arena.

Moreover, under Medicaid expansion, which began on 1/1/2014, the State has recognized the need to enhance program integrity and maximize coordination and joint oversight with the expanded fee for service programs operated by the Division of Medical Assistance and Health Services (DMAHS), the State medical agency.

In the FY 2014-2015 SAMH Combined Plan, DMHAS described its PI vision to move toward a managed care model which would: authorized services according to income and program eligibility guidelines that:

1. Maximizes utilization of Medicaid reimbursement for state plan services; and
2. Reserves Block Grant and other State reimbursement for non-State Plan services for Medicaid enrolled consumers and non-covered QHP services as gap coverage for services not covered by these plans.

In the interim, the DMHAS has worked to plan, operationalize and implement the model.

5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?

DMHAS has provided multiple training opportunities in May-June 2015 in order to prepare providers for the transition to the IME. These trainings included provision of information on completing the Affiliation Agreement to become a Network Provider, and the Service Capacity Management System (SCMS) Account Request Form for authorizing individual users.

6. How does the state ensure block grant funds and state dollars are used for the four purposes?

NOTE: The four purposes being referred to here were included in SAMHSA's 2016/2017 Application Guidance. We have reprinted them immediately below in italics, followed by our four responses, labeled a. through d.

Block grant funds should be directed toward four purposes:

a) to fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time;

b) to fund those priority treatment and support services not covered by Medicaid, Medicare, or private insurance for low-income individuals and that demonstrate success in improving outcomes and/or supporting recovery;

c) for SABG funds, to fund primary prevention; universal, selective, and indicated prevention activities and services for persons not identified as needing treatment; and

d) to collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services and to plan the implementation of new services on a nationwide basis.

a) In early SFY 2016, DMHAS substance abuse contracts will continue to include a provision limiting the use of SAPT funds for non-Medicaid eligibles who meet a means test that represents 350% of the federal poverty level (FPL), as determined by the Division of Addiction Service Income Eligibility (DASIE) module. Beginning as early as 2017, DMHAS plans to implement FFS reimbursement for most SAPT BG funded Treatment providers, utilizing rates consistent with those that are currently under development.

b) In an effort to prepare for this transition to a more comprehensive FFS payment system, DMHAS is nearing completion of a rate setting study and associated budget impact analysis. DMHAS engaged the accounting/consulting firm of Myers and Stauffer (M&S) to develop the rates with significant input from divisional personnel and the provider/consumer communities. DMHAS' goal is to disclose the new rates to providers (including slot funded substance abuse providers) during the summer/fall of 2015 (SFY 2016) and to implement them in SFY 2017. The overall objective of the ongoing study has been to build, from the ground up, rates that are reflective of the full costs to provide services for a wide range of substance abuse and mental health modalities and settings. It is anticipated that the rates will be applicable to both Medicaid and non-Medicaid clients. Key assumptions on the inputs of each service classification were provided to M&S by DMHAS program and policy staff, as well as the provider community, primarily through a series of meetings with experts on the various services. For each level of service, assumptions were compiled on factors such as staffing makeup and credentials, client-staff ratios, fringe benefit rates and non-salary costs. Since the underlying wage and cost assumptions were derived from FY2012 data, an inflation factor was applied to gross costs up to current levels. It is anticipated that the implementation of sound FFS rates will serve as an effective "bridge" between the current unmanaged, mostly contract-based financing structure for mental health and addiction services, and, ultimately, a managed care environment that would be expected to result in improved cost-effectiveness and higher quality health outcomes.

c) DMHAS has consistently allocated over 20% of its annual SAPT BG award allotments to fund primary prevention services within the IOM classification of populations. For the FY 2016 SABG Application, New Jersey has targeted 24% of its projected allotment for implementation of the set-aside, as documented on row 2 of Table 4. See Narrative 9, titled, Primary Prevention for Substance Abuse for additional programmatic detail.

d) DMHAS provides funding support for the ongoing data collection systems necessary to provide performance outcomes measurement. The treatment data collection system is known as the New Jersey Substance Abuse Monitoring System (NJSAMS) and the prevention system is known as the Prevention Outcomes Management System (POMS).

NJSAMS data are submitted quarterly to the Treatment Episode Data System (TEDS), which are used by SAMHSA to prepopulate the six (6) Treatment NOMs Tables in the Block Grant Annual Report based on Calendar Year data.

The NJ Prevention Outcomes Management System (POMS) was designed to collect basic process and demographic information, as well as outcome data, about substance abuse prevention services provided in New Jersey. The POMS collects data on the number and demographics of people served by education and training activities. Those are the domain-based programs and they serve selective and indicated populations.

Environmental Factors and Plan

8. Tribes

Narrative Question:

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the 2009 Memorandum on Tribal Consultation[74] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.
2. Describe current activities between the state, tribes and tribal populations.

Please indicate areas of technical assistance needed related to this section.

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[74] http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:
New Jersey does not have any federally recognized tribal governments or tribal lands within its borders.

Environmental Factors and Plan

9. Primary Prevention for Substance Abuse

Narrative Question:

Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.
- Education builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.
- Alternatives provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- Problem Identification and Referral aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment.
- Community-based Process provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning
- Environmental Strategies establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.

States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- Universal: The general public or a whole population group that has not been identified based on individual risk.
- Selective: Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated: Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data- driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs.

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or an equivalent planning model that encompasses these steps:

1. Assess prevention needs;
2. Build capacity to address prevention needs;
3. Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;
4. Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and
5. Evaluate progress towards goals.

States also need to be prepared to report on the outcomes of their efforts on substance abuse- related attitudes and behaviors. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data driven substance abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

Please consider the following items as a guide when preparing the description of the state's system:

1. Please indicate if the state has an active SEOW. If so, please describe:
    - The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
    - The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
    - The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).
2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. Please describe if the state has:
    a. A statewide licensing or certification program for the substance abuse prevention workforce;
    b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
    c. A formal mechanism to assess community readiness to implement prevention strategies.
5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.
7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.
8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.
9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?
10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

9. Primary Prevention for Substance Abuse

Please consider the following items as a guide when preparing the description of the state's system:

1. Please indicate if the state has an active SEOW. If so, please describe:
   - The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);

   The state has an active SEOW that meets ten times a year. The New Jersey State Epidemiological Outcomes Workgroup (SEOW), which is comprised of staff from various state and county level departments, and statewide provider agencies and organizations, collects and analyzes epidemiological data to assess the magnitude of substance use related consequences and substance use patterns related to these consequences. It examines the incidence of substance use and examines intervening variables. The aim is to profile population needs, resources, and readiness to address the problems and gaps in service delivery.

   The SEOW then utilizes the Strategic Prevention Framework (SPF), to analyze data in these categories:
   Consequences and social costs of substance use and addictions;
   Consumption levels and prevalence of substance use;
   Causal factors (i.e., risk and protective factors) that predict population prevalence.

   For each of the three categories above, criteria are then applied to guide decision making and establish statewide priorities. These rating criteria included:
   Frequency/rates of consumption
   Severity of consequences
   Data trends
   Prevalence of risk & protective factors
   Other recent research

   - The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).

   New Jersey's SEOW routinely reviews data from various data sources, including:
   National Survey on Drug Use and Health
   New Jersey Risk and Protective Factor Survey (for middle schools)
   New Jersey Risk and Protective Factor Survey (for high schools)
   New Jersey Student Health Survey
   New Jersey Household Survey on Drug Use and Health
   Youth Risk Behavior Surveillance System
   New Jersey Older Adult Survey on Drug Use and Health
   County Prevention Plans, including Municipal Alliance Plans
   New Jersey Substance Abuse Treatment Monitoring System

New Jersey Coalition and Partnerships for Success Grantee Strategic Plans
The President's National Drug Control Strategy
SAMHSA Strategic Plan
Strategic Plans from other States

- The populations for which data are collected:

New Jersey's SEOW collects data for the following populations:
Middle school students
High school students
College students
Adults
Older adults
Veterans and their families
GLBTQ youth

On numerous occasions, the SEOW identified many indicators for which data were not available, due to a variety of reasons. One of the top data gaps identified was the lack of information on the older adult population. Among the reasons cited for that data gap were lack of data, low accessibility of data, inadequate technology for data tracking and the capability to aggregate data in more meaningful and useful configurations. The SEOW endorsed the continuation of research on this population relating to substance use and mental health issues. In addition, national research suggests the number of adults with a substance use disorder will increase by more than 250% from 2002 to 2020.

An Older Adult Survey was conducted during 2012 utilizing funding from New Jersey's SPE grant. However, there were insufficient funds for a large enough sample to obtain reliable county level estimates. Therefore, a project of NJ's Partnerships for Success is to obtain enough data to create small area estimates of the prevalence of substance abuse and mental illness among older adults in New Jersey. A telephone interview survey has been developed and random digit dialing with a multistage cluster design will be used to generate probability-based samples of the adult population of each New Jersey County or relevant geographic area. Synthetic estimation techniques will then be applied using the results of the survey and other archival data to create small area estimates of the prevalence of substance abuse for the target population in specific geographic areas (e.g., municipality).

New Jersey is focusing on returning Veterans as a priority population for its PFS initiative. This is another population for which there is limited information. The SEOW has reached out to New Jersey Department of Military and Veteran's Affairs as well as the New Jersey National Guard to solicit their active participation on the SEOW and Advisory Council in light of this priority. DMHAS is also collaborating with its partner at Rutgers University to conduct a survey of returning Veterans. They will provide the design and approach for obtaining an adequate statewide sample.

2. Please describe how needs assessment data are used to make decisions about the allocation of SABG primary prevention funds.

In late 2012, DMHAS completed its Substance Abuse Prevention Strategic Plan. One purpose of the plan is to guide the development and implementation of new programming, and to evaluate its prevention goals as a means of guiding the organization's actions and decision-making with respect to prevention activities. Additionally, the Plan is a roadmap for statewide DMHAS-funded prevention activities, designed to effect population-level change across the life span, prevent misuse of substances and reduce the harmful consequences of alcohol and drug use.

One prominent goal of the prevention strategic planning process was to identify data-driven priorities to guide the development of prevention programming and the allocation of fiscal and other resources. The planning process factored in issues such as current system capacity, feasibility and the probability of affecting change. The priorities identified were: Reduce underage drinking; Reduce illegal drug use; Reduce medication misuse/abuse; and Reduce use of new and emerging drugs of abuse.

Additionally, based upon its analysis, the Assessment Work Group identified underserved populations in need of enhanced services targeted to their unique needs: 1) Older adults, 2) Members of the military and their families, 3) College students – including students at 2-year colleges and 4) Individuals with special needs.

Accordingly, all DMHAS-funded prevention programming is focused on addressing the priorities listed above. The 17 regional coalitions focus on these priorities as do the agencies that provide individual and family curricular-type programs in their communities. DMHAS-funded entities utilize the SPF process to identify which of the priorities present the most significant problems in their regions or communities. Providers and coalitions utilize the SPF process to identify which of the priorities present the most significant problems in their regions or community. This year, the Municipal Alliance Program of community-based, volunteer-operated coalitions funded by the Governor's Council on Alcoholism and Drug Abuse (GCADA) also adopted the DMHAS prevention priorities to guide their Alliance programs.

DMHAS has identified seventeen coalition regions in New Jersey. These regions were selected based the "Prevention Needs Assessment Using Social Indicators: State of New Jersey Substance Abuse Prevention County Level Needs Assessment, 2008". The "Prevention Needs Assessment" utilized archival data of social indicators to develop composite indices of risks to estimate the need for prevention services among New Jersey's 21 counties. Criteria included population, substance abuse treatment admissions and rates within the region.

3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?

   Based upon its review of the Assessment Work Group's findings and its exhaustive analysis of substance abuse prevention capacity in New Jersey, the Prevention Strategic Plan Capacity Work Group encouraged DMHAS to support, preserve, and enhance the current statewide

prevention infrastructure – particularly DMHAS-funded programming. Further, the Planning Committee encouraged mechanisms be established that better ensure that the two primary statewide prevention systems (DMHAS and GCADA) collaborate effectively with each other so that the power of the volunteer Municipal Alliance System is strengthened in its capacity and effectiveness. The Capacity Committee also suggested that the County Alliance Steering Subcommittees (CASSs) need to be supported in their ability to effectively preserve, support, and guide and direct the Municipal Alliances.

The Planning Committee also noted that DMHAS' prevention planning would benefit from a closer alliance with its partners, particularly the GCADA and the County Drug and Alcohol Directors. These three entities could enhance collaboration on prevention planning, implementation, and evaluation efforts to ensure the best use of limited public resources. A recommendation is to share core functions such as a centralized database to better ascertain capacity by building on the SEOW activities and other mechanisms. Based upon this recommendation, DMHAS, GCADA, and County Drug and Alcohol Directors have formed a Unification Planning Workgroup in order to effectuate a successful, collaborative, non-duplicative prevention planning process in the coming years.

In order to increase the capacity and competency of New Jersey's substance abuse prevention workforce and other stakeholders to effectively plan, implement, evaluate and sustain comprehensive, culturally relevant individual and environmental prevention strategies and programs, DMHAS follows SAMHSA recommendations to:

- Expand prevention workforce Strategic Prevention Framework (SPF) capacity building opportunities throughout the state and among traditionally underrepresented populations and communities
- Continue to develop and enhance workforce knowledge of and capacity to implement environmental prevention strategies.
- Increase the preparedness and readiness of the New Jersey prevention system to effectively implement prevention programming and strategies as they relate to health care reform.
- Attract, develop and retain a diverse, high quality, adaptable prevention workforce.

4. Please describe if the state has:
   a. A statewide licensing or certification program for the substance abuse prevention workforce;

In New Jersey, the Addiction Professionals Certification Board oversees the Certified Prevention Specialist (CPS) International Certification and Reciprocity Consortium (IC&RC) Reciprocal Credential. Requirements for the credential are:

- 120 Hours of pre-approved coursework (see Coursework Requirements and Verification pages). Appropriate college credit can be used toward CPS coursework. College courses will be approved at the Board's discretion. All other CPS coursework must have prior approval from The Certification Board. Courses must have been completed within the past 10 years.

- A minimum of a Bachelor's degree in a Human Services related field from an accredited institution.
- Copy of Degree and Transcript must be attached to application. Subject to Board Approval.
- Two (2) years of full-time experience (i.e., 4,000 hours) in at least one of the Five Domains of Prevention (see page 6). This requirement also contains a 120 hour Practicum completed within 2 years of the date of the application
- Successful completion of the ICRC (International Certification and Reciprocity Consortium (IC&RC) Prevention Written Exam. See the Certification Boards website for testing dates and details.
- 50 hours of Prevention related education is required every two years to maintain the CPS credential.

All DMHHAS-funded substance abuse prevention providers or coalitions are required to employ at least 1 staff person who has earned the Certified Prevention Specialist Credential. The applicant must live or work in New Jersey a minimum of 51% of the time.

b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce;

The DMHAS Addiction Training and Workforce Development Program was created to enhance and diversify New Jersey's addiction workforce. One of the goals of the program is to increase credentialed professional staff employed at substance abuse prevention agencies by offering Certified Prevention Specialist (CPS) training opportunities. Eligibility for the program is based on the following criteria:

1. Priority will be given to individuals working towards completion of their CPS.
2. Individuals accumulating work or volunteer experience in the field of substance abuse prevention.
3. After completing coursework, individuals agree to take the additional steps to become certified, which include successfully completing a written exam.
4. Participation and progress in training will be documented by each scholarship recipient as well as NJPN (based on information provided by the student.)
5. Scholarship recipients must have their supervisors' approval to attend courses and agree that NJPN may communicate with their agency regarding their progress towards certification.
6. Scholarship recipients will give NJPN the authority to access the results of the CPS written exam in order to monitor progress towards certification.
7. Scholarship recipients will be eligible for a limited number of free classes, based on funds available and the demand for scholarships.

c. A formal mechanism to assess community readiness to implement prevention strategies.

DMHAS-funded providers and coalitions are required to utilize the Strategic Prevention Framework planning process and to submit a strategic plan that describes the manner in which they undertook the SPF and the results or "product" of each of the 5 steps. DMHAS and its colleagues at the Rutgers University School of Social Work and the New Jersey

Prevention Network provide guidance to awardees in the appropriate use of the SPF – particularly the assessment and capacity sections, in which awardees assess community readiness to implement prevention strategies.

5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?

   As previously mentioned, in 2012, DMHAS issued its five-year prevention strategic plan that focuses statewide prevention efforts on specific data-driven priorities for which measurable change can be achieved at the state and regional levels. The plan is organized according to the Strategic Prevention Framework.

   The Assessment Work Group, co-chaired by a DMHAS staff member and a community representative, reviewed and analyzed New Jersey population-based substance use epidemiological and archival data. The data findings were summarized and presented to the Planning Committee. The SEOW provided a significant portion of the data, such as the New Jersey Epidemiological Profile for Substance Abuse and other resources utilized by the Assessment Work Group. The Assessment Work Group reviewed and summarized a myriad of data from various sources.

   Utilizing the SPF, the Assessment Work Group analyzed data in three categories:
   - Consequences and social costs of substance use and addictions;
   - Consumption levels and prevalence of substance use;
   - Causal factors (i.e., risk and protective factors) that predict population prevalence.

   For each of the three categories above, criteria were applied to guide the decision making process and establish the statewide priorities. These rating criteria included:
   - Frequency/rates of consumption
   - Severity of consequences
   - Data trends
   - Prevalence of risk & protective factors
   - Other recent research

   The Assessment Work Group then developed and used the following criteria to further refine the selection of prevention priorities:
   - Substances most commonly used/abused that impact the greatest numbers of New Jersey residents.
   - Substances that lead to the most severe consequences for the greatest numbers of New Jersey residents.

   Information on readiness and system capacity, such as the current resources of the prevention system at the state, county, and local levels was then applied to the prioritization process to identify new recommendations.

As a result of these findings, DMHAS determined that the most effective means of addressing these priorities at the statewide-level was through the use of a coordinated combination of environmental strategies and programs along with evidence-based individual and family curricular programs. Accordingly, it allocated block grant funding to develop a system of 17 regional coalitions that are utilizing the SPF process to identify which state priorities are of the greatest concern in their region – and implement environmental programs and strategies to address those priorities. Additionally, funding was allocated to provide individual and family programs – to be delivered concurrently with the work of the coalitions. Coalitions and programs coordinate their efforts in addressing the DMHAS-identified prevention priorities.

6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.

   As previously mentioned, the DMHAS Prevention Strategic Plan was completed in 2012 and will guide prevention funding and programming through 2017. All SABG-funded prevention programs and coalitions in New Jersey are required to address the prevention priorities identified in the strategic plan:
   - Reduce underage drinking
   - Reduce illegal drug use
   - Reduce medication misuse/abuse
   - Reduce use of new and emerging drugs of abuse

7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.

   Numerous entities in New Jersey fulfill the responsibilities of an evidence-based workgroup. The SEOW by means of its ongoing data collection and analyses provides input regarding appropriate programs and strategies to address identified needs. DMHAS contracts with the New Jersey Prevention Network (NJPN) and the Rutgers University School of Social Work to provide personalized training and technical assistance to grantees on all aspects of the Strategic Prevention Framework, program evaluation, identification of appropriate evidence-based programs and strategies. Below is a brief description of the services provided by NJPN and Rutgers. The complete list is far more extensive:

   - Keep abreast on current and emerging trends and developments in the behavioral health prevention field – particularly as it relates to research on population-based programs and strategies
   - Using data and information from the grantees' needs and capacity assessments assist the grantee in developing and/or updating a strategic plan that defines the grantee's vision and goals for their program or coalition.

- Facilitate and/or support each grantee in implementing its project in accordance with the five-step Strategic Prevention Framework (SPF) model, and in accordance with the grantee's strategic plan as approved by DMHAS.
- Assess each grantee's adherence to the SPF five-step process.
- Develop procedures and instruments for the collection and evaluation of additional data to more comprehensively assess needs of grantees and coalitions.

DMHAS and the Governor's Council on Alcoholism and Drug Abuse (GCADA) recently convened a working committee that includes representation from GCADCA, DMHAS, County Alcohol and Drug Abuse Program Service Directors, County Municipal Alliance Coordinators, Rutgers and NJPN that review the current Regional Coalition Needs Assessment and planning process, the County Alcohol and Drug Services Planning Process Guidelines and the pending Municipal Alliance Planning Process to ensure a synchronized approach that recognizes the importance of each component while assuring that each discreet process supports the others.

8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.

New Jersey funds both individual/family and environmental programs and strategies with block grant dollars. The individual/family programs utilize evidence-based curricula such as: Strengthening Families, Life Skills, I Can Problem Solve, and Incredible Years – among many others. Parameters for prevention contracts for individual/family programs include the following: 1) contractees are required to provide services according to the risk and protective factor domains identified and prioritized by the County Planning Committee for the county in which each agency is located 2) contractees are required to utilize an evidence-based curriculum, 3) contractees are also required to have a Certified Prevention Specialist (CPS on staff to provide supervision and program oversight, and 4) to use DMHAS' Prevention Outcomes Management System (POMS) to report monthly program activities as well as program outcome measures to the Division.

As indicated previously, DMHAS also funds a statewide system of 17 regional prevention coalitions that are utilizing the SPF process. The coalitions are using environmental programs and strategies to address underage drinking and other DMHAS-identified priorities in their regions. The coalitions are intensively collaborating with Municipal Alliances in their region, which are funded and overseen by the GCADA. DMHAS coalitions also coordinate their efforts with those of the nine Federally-funded Drug Free Community Support Programs in New Jersey. This initiative seeks to achieve an enhanced level of communication and collaboration among all groups and organizations that are working to reduce the misuse and the harmful consequences of alcohol and drug use among the citizens of New Jersey.

DMHAS funds both individual/family and environmental programs and strategies in order to deliver a comprehensive array of prevention programming to assure that communities as well as the individuals and families who live and work in those communities have access to

prevention programs and services that can have an impact at all levels of the individual/family and community life.

Specific examples of funded programs and services, according to strategy are:

1) Information Dissemination:

Prevention Services Resource Centers – specific to their communities - developed and operated by numerous coalitions and agencies. These centers provide an array of informational materials and directories of available services to parents, educators, and others.

Media and awareness campaigns – also offered by numerous coalitions and agencies. Provide information about topics such as Social Host and Private Property Ordinances, or up to the minute information about new or emerging drugs of abuse.

Speakers Bureau – agencies and coalitions provide staff to provide informational presentations on a variety of topics related to prevention for community and faith-based groups, schools, fraternal organizations, and others.

Public Service Announcements – agencies and coalitions are able to collaborate with the Partnership for a Drug Free New Jersey in the development of PSAs as a means of providing information on prevention topics, volunteer opportunities, etc.

2) Prevention Education

Individual and Family Curricular Programs – described in more detail above. Funding for these programs constitutes a significant portion of DMHAS' prevention services' budget. These programs focus on addressing the risk and protective factors associated with the DMHAS prevention priorities. Additionally, providers coordinate the delivery of these programs with the work of their regional coalition.

DMHAS has recently developed a prevention project in collaboration with researchers and clinicians at University Behavioral Health Care at Rutgers University. The project focuses on children between the ages of 8-11 with identified conduct disorders and includes an intensive clinical component delivered in conjunction with the 14-week Strengthening Families Program.

Both DMHAS and Rutgers recognize that conduct disorders in youth are a significant predictor of the development of substance use disorders in adolescence and adulthood and have a distinctly negative impact on children's academic achievement and adult life outcomes, and high personal and societal costs.

In that a number of personality characteristics and psychological variables are known to influence the development of substance use disorders in at-risk youth, DMHAS and Rutgers recognize the need to identify, create and deliver innovative, quality services to those

children at increased risk for the development of substance use disorders with the hope that these interventions will forestall or prevent their development.

3) Alternative Activities – providers do not make extensive use of this strategy.

Recreational Activities – coalitions and agencies provide substance-free activities such as movie nights, trips to sporting events, dances, volunteer opportunities, etc.

4) Community Based Process

Assessing Community Needs/Assets - consistent with DMHAS' commitment to the use of the SPF, these activities are ongoing and conducted statewide. Examples are: using data to determine the needs for prevention services by identifying at-risk populations, communities, or geographic locations and determining priorities for service delivery, problem statement development, organizational/fiscal/leadership capacity assessment, readiness assessment, cultural competence assessment, service gap analysis, external factors/barriers to success, etc.

Evaluation Services – also previously described, DMHAS provides technical assistance to agencies and coalitions on all manner of evaluation-related topics, such as services conducted to evaluate progress towards meeting goals and/or objectives and eventually, program success, working with evaluation teams, developing evaluation tools and instruments, collecting evaluation data, conducting data analysis, reviewing effectiveness of policies, programs and practices, developing recommendations for quality improvement, preparing evaluation reports and updates, etc.

Technical Assistance – DMHAS contracts with the New Jersey Prevention Network for these services, delivered to agencies and coalitions that are intended to impart technical guidance to prevention programs, community organizations, and/or individuals that will strengthen or enhance prevention activities. Examples are: assistance with the strategic prevention framework process, addressing cultural responsiveness, programmatic quality assurance and improvement, effectively implementing programs and services.

5) Environmental Approaches

DMHAS' system of 17 regional prevention coalitions utilizes environmental strategies exclusively. Some examples of their work are:

Alcohol Restrictions at Community Events – the coalition that serves Hunterdon and Somerset Counties worked with event planners to prohibit attendees from bringing alcoholic beverages from outside to a large community-wide event. Previously, attendees were free to bring unlimited amounts of alcohol. As a result alcohol-related problems were frequent and widespread.

Sticker Shock – numerous coalitions utilize this program. Most recently, the coalition in Sussex and Warren Counties placed over 1,000 stickers displaying the legal consequences of purchasing and providing alcohol to minors were on packaged goods in an effort to reduce

underage youth access to alcohol. Stickers were placed on boxes of multi-packs of beer, wine and other alcoholic beverages.

Social host and private property ordinances – all 17 regional coalitions have increased the number of municipalities in their region that have enacted these ordinances

Transportation from college campuses to local bars – coalitions in Mercer and Passaic counties have worked with local bars to get them to discontinue providing van transportation for happy hour and other special events from campus to the establishment.

6) Problem Identification and Referral

DUI education and awareness program – two prevention agencies, by means of a contract with their county-based Intoxicated Driver Resource Center, provide structured prevention education programs intended to change the behavior of youth and adults who have not been court mandated to attend.

9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?

   In order to avoid supplantation of funds, prevention contractees must certify that: DMHAS funds will not supplant expenditures from other federal, state, or local sources or funds independently generated by the contractee.

10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?

    DMHAS utilizes its Prevention Outcomes Management System (POMS) to collect the following process data for individual and family programs: gender, age, race/ethnicity, curriculum, dates the service was provided, CSAP strategy, and total number of sessions attended.

    These data are analyzed to assure that agencies are serving the appropriate population, delivering the correct number of sessions, and enrolling the appropriate number of individuals or families in the program. Also, the data allow DMHAS to determine if the individuals who enroll in the program are reflective of the community in which the program is being delivered.

11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?

    DMHAS, other state departments and divisions collect data by means of several statewide surveys administered at the middle and high school as well as at the community level. Additionally, as mentioned earlier, DMHAS will collect data from special populations by

means of its Older Adults and Veterans' surveys. Outcome data collected in these surveys include:

- Alcohol: past 30 day and lifetime use, binge drinking
- Prescription drug misuse – past 30 day and lifetime
- Consumption patterns – alcohol
- Consequences of alcohol and illegal drug use and prescription drug misuse – motor vehicle crashes, arrests, ER visits, violent behavior, suspension/expulsion from school
- Perceived risk of alcohol and drug use
- Parental attitudes regarding alcohol and drug use
- Retail availability of alcohol

These data are used to modify or change the prevention priorities if necessary and to identify target communities for prevention services and programs.

Environmental Factors and Plan

10. Quality Improvement Plan

Narrative Question:

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

In an attachment to this application, states should submit a CQI plan for FY 2016-FY 2017.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

• CMS' QAPI (Quality Assurance Performance Improvement) and how to integrate this new process
• Conducting thorough and credible root cause analyses
• Developing Plans of Correction that Work
• Integrating Systems Change

Footnotes:

New Jersey Division of Mental Health and Addiction Services
Quality Improvement Plan
FY 2016 – FY 2017

"Quality is never an accident; it is always the result of high intention, sincere effort, intelligent direction and skillful execution. It represents the wise choice of many alternatives." Willa A. Foster

DMHAS Mission

DMHAS, in partnership with consumers, family members, providers and other stakeholders, promotes wellness and recovery for individuals managing a mental illness, substance use disorder or co-occurring disorder through a continuum of prevention, early intervention, treatment and recovery services delivered by a culturally competent and well trained workforce.

DMHAS Vision

- DMHAS envisions an integrated mental health and substance abuse service system that provides a continuum of prevention, treatment and recovery supports to residents of New Jersey who have, or are at risk of, mental health, addictions or co-occurring disorders.
- At any point of entry the service system will provide prompt and easy access to appropriate and effective person-centered, culturally-competent services delivered by a welcoming and well trained work force.
- Consumers will be given the tools to achieve wellness and recovery, a sense of personal responsibility and a meaningful role in the community.

DMHAS Values

DMHAS' work is driven by its values. Staff with the Division and its partner agencies value:

- consumers' dignity and believe that services should be person-centered and person-directed;
- the strength of consumers, their families and friends because it serves as a foundation for recovery;
- the commitment of its partner agencies to professionalism, diversity, hope and positive outcomes;
- evidence-based practices that show consumer-informed and peer-led services improve and enhance the prevention and treatment continuum; and
- the public trust and believe that it is essential to provide effective and efficient services.

INTRODUCTION

The Division of Mental Health and Addiction Services is committed to continuously improve the quality and safety of services and supports delivered to adults in New Jersey's behavioral health

system. This commitment is incorporated into all aspects of the Division's activities: Strategic Planning, Resource Allocation and Performance Improvement Activities.

The Quality Improvement Plan describes the approaches, processes and mechanisms used to ensure New Jersey's mental health and addiction system is meeting its goals. We do this based upon the principles of continuous quality assurance/performance improvement. Many of our approaches to improved service delivery are data-driven; meaning, we rely on valid and reliable data to identify and track critical outcomes and performance measures to ensure their effectiveness.

Continuous quality improvement is not something performed by an individual or a group of individuals----it is a part of our everyday activities. Senior Leaders have committed to excellence in performance and quality improvement through Strategic Planning activities. Division-wide priorities have stakeholder input with continuous communication regarding our status. In addition to Division-wide priority setting by Senior Leadership, units also set priorities to initiate their own improvement activities based on documented need within their work unit.

The Quality Improvement Plan for the Division of Mental Health and Addiction Services focuses on those indicators that systematically measure the achievement towards the Division's Mission, Vision, Values, Strategic Plan and special initiatives. The following criteria are used to base priority for measurement:

- High risk
- High-volume
- Problem prone
- Sentinel events
- Processes related to consumer needs, expectations, and satisfaction
- Strategic goals
- Special Initiatives
- Resource availability, The Operating Budget
- Regulatory Compliance
- Staff and Staffing Issues

DMHAS has processes which are tracked at the state psychiatric hospital level and several clinical initiatives which are being done in collaboration with the state psychiatric hospitals and the community. Each state psychiatric hospital has a Quality Improvement Plan and all community agencies licensed by DHS are required to have a Quality Improvement Plan.

PURPOSE

The purpose of the Division of Mental Health and Addiction Services' Quality Improvement Plan is to continuously improve New Jersey's system of behavioral health that will lead to

improved quality of services and outcomes for individuals, families and communities. A key component of this is the collection of data that will inform policy and measure program impact. This plan demonstrates the Division's activities to assess and improve key processes and outcomes to enhance provider efficiency and effectiveness in achieving service objectives. In addition, the plan is utilized to enhance the Division's operational practices that ultimately affect services delivered to mental health and substance abuse consumers. Components of the plan include:

1. Determination of priorities for improving systems, processes, and consumer safety and satisfaction.
2. Identification of a framework for improving and sustaining performance of Division-wide systems and processes through a planned systematic approach of plan, design, measurement, analyzes and improvement of services provided.
3. Support of the concept that, through collaboration, systems will be more effective, staff will have greater skills, and patient outcome components will be improved.
4. Ensure that the best possible care and services are provided within available resources, while being consistent with the mission, vision, values, goals and objectives, and plans of the organization.

GOAL

The primary goal of the Quality Improvement Program is to continually and systematically plan, design, measure and assess and improve the performance of key functions and processes involved with the delivery of services and supports to adult behavioral health consumers and patients. The Quality Improvement Plan provides a framework and motivation for improvement of consumer health outcomes and customer satisfaction by design of effective, organization-wide processes followed by measurement, assessment, and improvement of those processes.

To achieve this goal, the Quality Improvement Plan strives to:

- Assess the needs of consumers, patients and other key stakeholders;
- Incorporate quality planning throughout the state psychiatric hospitals and provider agencies and;
- Provide a systematic mechanism for state hospitals, provider agencies, individuals, Division Offices, committees and workgroups to function collaboratively in their efforts toward performance improvement

OBJECTIVES

- To establish data systems that will allow scientific measurement of the improvement processes, outcomes of the actions taken and reporting this information by aggregate or individual analysis

- To continue to provide staff education regarding the principles and tools of Continuous Quality Improvement
- To provide criteria for identifying and prioritizing improvement
- To involve all services, staff and stakeholders in improvement activities
- To synthesize information obtained from performance outcome data when determining priorities for improving systems/processes
- To provide the framework for planning, directing, coordinating and improving consumer care and consumer safety for psychiatric and addiction services for Inpatient, Outpatient, and Partial Programs and behavioral/rehabilitation services for Residential programs.
- To support the design of new processes, assist in the implementation, determine criteria for assessment of effectiveness

THE QUALITY MODEL

The Division of Mental Health and Addiction Services utilizes various techniques to determine what should be measured and how it should be measured. In addition, data is regularly assessed and decisions made regarding improvement activities. This process includes the PDC(S)A cycle: Plan, Do, Check/Study, Act which is described below pictorially and in a narrative.

Plan–Do–Check/Study–Act Process

1. **Plan** - Recognize an opportunity and plan a change.
2. **Do** - Test the change. Carry out a small-scale study.
3. **Check/Study** - Review the test, analyze the results and identify what you've learned (how do they compare with the predictions).
4. **Act** - Take action based on what you learned in the study step: If the change did not work, go through the cycle again with a different plan. If you were successful, incorporate what you learned from the test into wider changes. Use what you learned to plan new improvements, beginning the cycle again.

MEASUREMENT/ TOOLS and TECHNIQUES

Any number of tools and techniques can be used for this including flowcharting, cause and effect diagrams, consumer surveys, self-assessment, audits and statistical process control.
Examples of tools include:

- flowcharting

- statistical process control (SPC)
- Pareto analysis
- cause and effect diagrams
- consumer surveys

Examples of techniques include:

- benchmarking
- cost of quality
- quality function deployment
- failure mode effects analysis
- design of experiments

SCOPE OF THE PERFORMANCE IMPROVEMENT PROGRAM

The National Behavioral Health Quality Framework was used as a guide in the development of the Division's Performance Improvement Program. By doing so, this ensures consistency with Federal efforts. The scope of the Quality Improvement Plan covers all aspects of the organization which provide services and supports. In addition to quantitative data, the Division tracks qualitative data including programmatic improvements using stakeholder input, inclusive of individuals in treatment and recovery and their families. The Division engages stakeholders through its frequent meetings with various stakeholders and inclusion of stakeholders in its strategic planning activities and attending stakeholders' meetings and conferences such as the COMHCO (Coalition of Mental Health Consumer Organizations) conference. Such meetings include the Behavioral Health Planning Council (includes family members, consumers, providers, and representatives from the Division and other Departments), Quarterly Stakeholder meeting, Quarterly Addictions Medical Directors meetings, Citizens Advisory Council, and the Addictions Professional Advisory Committee (meets every other month).

Specific monitoring activities are listed below and will be described in more detail in this section. The Performance Measures that were selected to be monitored will be listed at the end of the applicable section.

- Strategic Plan Performance Measures
- Suicide Prevention
- Addictions Treatment and Services
- Contracted Agency Performance
- Critical Incidents
- Sentinel and Adverse Clinical Events
- Mortality
- Response to Emergencies
- Complaints and Grievances

- Consumer Satisfaction
- Hospital-Based Inpatient Psychiatric Services (HBIPS)

STRATEGIC PLANNING

Key areas were assessed as critical for the Division's Strategic Plan and are reported on quarterly to Senior Leadership. Performance Measures have been developed for each of the key areas:

Development of an Interim Management Entity (IME) for Addiction Services

Performance Measures:

- 90% of Members score their satisfaction with IME at average or above average
- 50% of IME Providers score their satisfaction with IME at average or above average

Community Support Services

Performance Measure:

- 90% of individuals retain their supportive housing placement 1 year or longer

Community Re-Integration

Performance Measures:

- The percent of state hospital CEPP census will decline for all 3 regional hospitals (APH – 30%, TPH – 20%, GPPH – 20%)

Community/Clinical Services and Processes-the measurement of this strategic initiative for this plan year is specifically focused on decreasing the morbidity and mortality of consumers with severe and persistent mental illness and substance use and measurement will begin in year 2

Performance Measures:

- Increase by 20% above baseline the number of mental health consumers in the community screened for tobacco use, diabetes and metabolic syndrome
- Increase by 20% above baseline the number of substance use consumers screened for tobacco use
- Increase the number of treatment plans by 20% above baseline that address tobacco use, diabetes and/or metabolic syndrome for mental health consumers in the community who screened positive

Competency and Training

Performance Measure:

- Increase the number of individuals trained as behavioral health peer providers

SUICIDE PREVENTION

Using 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action as a guide, the DMHAS finalized the NJ Adult Suicide Prevention Plan in 2014. There are four specific objectives that are the current focus:

Goal #5: Strengthen, develop, implement, and monitor effective suicide prevention programs that promote wellness and prevent suicide and related behaviors.
Goal #7: Provide training to community and clinical service providers on the prevention of suicide and related behaviors.
Goal #8: Promote suicide prevention as a core component of health care services.
Goal #9: Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicide and suicidal behaviors.

Performance Measures:

- Reduce the Number of Suicide Attempts in NJ
- Reduce the Number of Suicides in NJ

ADDICTIONS TREATMENT AND SERVICES

Addictions treatment and services performance measures relate to prevention of adverse outcomes.

Performance Measures:

- Reduce the number of opioid-related deaths
- Reduce the number of opioid overdoses
- Reduce the percentage of addictions' consumers who smoke
- Increase the number of people on medication assisted treatment

CONTRACTED AGENCY PERFORMANCE

Contract monitoring/utilization review occurs both in addictions and mental health programs.

Addictions

Contracted addictions agencies have one formal contract site visit each calendar year. More frequent reviews are conducted on as needed basis for agencies identified as needing additional technical assistance or monitoring in response to identified deficiencies, technical assistance needs, or special contract requirements. The Annual Site Visit Monitoring Review Form addresses a minimum of five issues: Facility, Staff, Treatment or Service Records, Quality Assurance, Specialized Services, and Other Contract-Specific requirements.

Provider Performance Reports (Substance Abuse)

Provider Performance Reports are made available to all addiction treatment provider agencies. These reports were first produced in 2006 and are issued twice a year for the fiscal and calendar year. The reports were emailed to over 300 providers; however, in 2014 they were programmed to be generated automatically by the SSA's IT system, NJSAMS. Providers can download their reports upon sign-in.

The provider report includes: 1) statewide admission and discharge treatment data and agency specific treatment data for key variables, 2) admission and discharge data by level of care for each specific agency, and 3) State Outcomes Measures (SOMs) for each level of care an agency provides in comparison to statewide averages and peers. In order for agencies to compare their performance relative to other agencies, percentile scores are computed for each outcome measure. They compare 1) the change in performance between discharge and admission and 2) the level of performance at discharge. Statewide outcome data are also presented so an agency can compare its performance to the state.

The outcomes in these reports include: abstinence from alcohol, abstinence from drugs, employment, enrollment in school/job training, criminal justice involvement, homelessness, and retention in substance abuse treatment. A measure on the percentage of clients successfully completing their treatment plan is also included. In addition, county aggregate performance reports are produced that provide Local Advisory Councils on Alcoholism and Drug Abuse (LACADAs) and the County Alcohol and Drug Directors with profiles of the strengths and weaknesses of local systems of care. Statewide performance reports are also produced for the fiscal and calendar year and are posted on the DMHAS website.

These performance reports are one strategy that DMHAS has adopted in its continuous quality improvement efforts to help improve services to clients. The SOMs are one way to monitor client outcomes, help direct system improvements and achieve better accountability. These reports are also used by the provider to inform their continuous quality improvement efforts.

Mental Health

Agencies are required to submit data quarterly (called Quarterly Contract Monitoring Reports – QCMRs) to the Division of Mental Health and Addiction Services. This data is critical to assess agency performance with their respective contracts. Agencies that do not meet the service utilization level for which they are contracted are closely monitored to determine patterns of underutilization.

Regional staff oversees the implementation of the contracts to ensure that service commitments are met and that agencies are compliant with DHS/DMHAS program standards, state & federal statutes, as well as other applicable rules and regulations, policies, procedures and protocols.

Staff also monitors agency operations to assure that services are delivered within the context of a recovery oriented and culturally competent system. By conducting triennial reviews with the Department of Human Services' Mental Health Licensing Unit.

In addition, the Fiscal Office reviews variance reports (both dollar and percent) to identify any variances not explained by the accompanying narrative provided by the agency. Variances that exceed 10% +/- are assessed to determine if the impact is noteworthy given the overall size of the contract provider. If so, these variances are brought to the attention of the regional offices for their input and potential follow-up with the provider.

Systems Review Committee Dataset(s)

The Systems Review Committee (SRC) Datasets are a series of linked MS-Excel documents submitted to the SMHA on monthly basis from 32 Short Term Care Facilities (STCF) and 23 Designated Screening Centers (DSC). The Systems Review Committee was created by legislative mandate[1] in 2010 which requires the division (among other tasks) to: monitor the acute care system, conduct utilization management, identify gaps, and conduct data analysis.

For analytical and administrative purposes, DSC dataset is handled separately from the STCF dataset, although both share great similarities in reporting protocol, functionality, and purpose (hence, we refer to both sets of information collectively as the SRC dataset). The SRC data is compiled monthly by providers on a one-page monthly MS-Excel spreadsheet that is submitted electronically to the SMHA. The SRC dataset provides program/agency-specific data that is the aggregate of each program's consumers served within a given month.

Due to the large number of data points (>50) found on each datasheet, the comprehensiveness of the data, and the geographic coverage of the information , this dataset provided the Division and stakeholders with a range of valuable information on a regular basis. In addition to being the "go to" resource for monitoring the acute care system across the state and within each county's System Review Committee, the SRC is also used regularly ad-hoc reporting on a regular basis.

Provider Performance Reports (Mental Health)

Provider Performance Reports (PPRs) for mental health agencies are designed to be 'data dashboards' that display how key variables of a given agency compare to statewide and regional measures of central tendency. Currently mental health PPRs have been developed for a small number of program elements, specifically Supportive Housing and Designated Screening. For each program element, the PPR contains approximately 20 data elements and calculations drawn from different datasets including the QCMR, the SRC, the Annex A and the Annex B. These data elements are organized into the domains of "Volume", "Quality" and "Cost". By having a single dashboard that pulls data from several distinct data sources, the reader can gain a quick and comprehensive summary of how a given provider's program element compares to statewide

[1] NJAC 10:31-5.1 "Acute Care System Review" , NJAC 10:31-5.2 "Composition of the systems review committee", and NJAC 10:31-5.3 (a)

measures of central tendency, each region of the state (i.e., North, Central, South), and how that agency compares to others. The SMHA is in the process of acquiring additional human resources needed to expand provider performance reporting.

CRITICAL INCIDENTS

The addictions' community may call the Department of Human Services, Office of Licensing-Special Operations/Addiction Services to report incidents and these are entered into the Department of Human Services' (DHS) Unusual Incident Reporting Management System (UIRMS). The unit which is responsible for this resides with the Department of Human Services. Incidents and data are reviewed at this level for addictions' community incidents and jointly with DHS and DMHAS.

Community mental health agencies directly report incidents to the Division's Unusual Incident Coordinators for their respective county. These incidents are entered into the DHS' Unusual Incident Reporting Management System. Aggregate data reports are shared with the community agencies. Specific demographic and other detailed information related to deaths is kept in an Access database for trending and analysis purposes.

All incidents require an investigative follow-up report. Some incidents are also referred to other DHS units for further investigation; these include allegations of abuse, neglect, exploitation, operational issues and other incidents as deemed by the Department of Human Services.

SENTINEL and ADVERSE CLINICAL EVENTS

All state psychiatric hospitals are required to conduct root cause analyses for any hospital sentinel event that falls under The Patient Safety Act or The Joint Commission sentinel event policy. The Division of Mental Health and Addiction Services' Patient Safety Act Oversight Committee reviews each root cause analysis.

- Patient Safety Act events are reported within 24 hours of the event.
- Root Cause Analysis is received by the Division within 45 days.
- Root Cause Analyses are assessed for thoroughness and credibility.

MORTALITY

The Division collects data related to deaths which occur with mental health consumers, both in the state psychiatric hospital system and community. Cause of death and demographic information is obtained for each death reported. The Division plans on instituting prevention to decrease the incidents of early death in our consumers. This includes suicide risk assessment training and suicide prevention as well as interventions related to physical health such as smoking cessation and metabolic syndrome tracking and monitoring.

RESPONSE TO EMERGENCIES

Response to emergencies is dependent upon the type of emergency:
DMHAS has a Disaster and Terrorism Branch that has the capability and authority to deploy certified Disaster Response Crisis Counselors (DRCC). DRCCs can be deployed for any crisis or emergency as determined by the Disaster and Terrorism Coordinator or at the request of the DMHAS Assistant Commissioner or the DHS Commissioner. In addition, the Disaster and Terrorism Branch is home to a multi-disciplinary Training and Technical Assistance Group (TTAG) which has the capacity to provide on-demand training for mental health professionals in the wake of disaster to further increase the state's capacity to address the psychosocial needs of the community.

Assistant Division Director for Community Services, the DMHAS Assistant Commissioner and the Commissioner for the Department of Human Services are available 24/7 should the need arise to contact them and they are individually handled as the situation warrants. All DMHAS Executive Staff are available via cell phone in the case an emergency warrants contacting them.
For community emergencies involving consumers receiving methadone treatment, there is a system called Guest and Emergency Medication System (GEMS), which will allow consumers to receive their medication at any available methadone clinic in New Jersey. In addition, there is a Disaster Coordinator in this Office who assists methadone clinics with the activation of their COOP Continuity of Operations Plan (COOP) and provides support using GEMS, if needed.

COMPLAINTS AND GRIEVANCES

Community Addictions Agencies

For purposes of this section, term complaints and grievances is used interchangeably. The addictions' community may call the Department of Human Services, Office of Licensing-Special Operations/Addiction Services to report any complaints or grievances and these are handled through the DHS Office of Program Integrity and Accountability Unit (OPIA).

Mental Health Agencies

Mental health community complaints and grievances which come into the Division are referred to the Regional Offices to work with the providers and consumer to resolve these issues. The complaint and grievance procedures are outlined below.

Each consumer is made aware of the existence of a complaint procedure and second, non-emergency contacts. Under all circumstances, consumers not accepted for services are informed immediately of the State-wide advocacy services available to them. Agency Directors designate a staff person to function as Agency Ombudsperson on as needed basis. The responsibilities of the Agency Ombudsperson:

- To receive consumer complaints;
- To act an advocate for consumers who make complaints; and
- To attempt to negotiate resolutions of issues raised by consumers (complaints shall be investigated and negotiated within five working days) /grievance processes.
- Submit a written report of findings, resolutions and/or recommendations to the Agency Director and to the consumer within seven working days of the complaint. If the complaint has been resolved to the consumer's satisfaction, the grievance process shall end at this point.

Most complaints and grievances are resolved at the treatment provider/agency level. The consumer may request review by the Agency Director. The Director shall make the final Agency-level decision regarding the complaint, in a due process manner, as quickly as possible. If the complaint has still not been resolved to the consumer's satisfaction, the consumer may request a review by the County Mental Health Board. The County Mental Health Board, through its Administrator, shall receive and review complaints referred from Agency Directors within five working days. The County Mental Health Board shall make its findings and recommendations known to the Agency Director and consumer within seven working days of the complaints.

If the consumer is not satisfied with the recommendation of the Board, or the Agency's response to these recommendations, the consumer may request review by the Division.

Consumers may request a review by the Division directly, and in confidence, at any time. However, consumers are encouraged by the Division to seek an Agency-level review first and will be asked to justify the omission of an Agency or a County-level review. The Division will advise the Agency and the County Mental Health Board of all complaints received directly, unless the consumer, on notice, refuses to consent to such a disclosure.

The Division may convene a Professional Review Committee, when needed, consisting of an interdisciplinary team appropriate to the subject of the complaint. The designees shall receive and review complaints referred by consumers within five working days and shall submit a written report of its findings and recommendations to the Assistant Commissioner within two more days.

The Assistant Commissioner shall review this report and submit recommendations to the Agency Director and the consumer within seven working days. The Division shall determine if any formal State remediation/funding compliance action is necessary based on the Agency's response to these recommendations.

CONSUMER SATISFACTION

State Psychiatric Hospitals

As a recovery-oriented system, the hospitals strive to be inclusive and collaborative as well as to instill hope to patients. As expressed in the Division of Mental Health and Addictions Services' Transformation Statement, each participant in the mental health system -- patients, primary support persons, hospital staff, and community providers -- is empowered and holds distinct and valuable knowledge and experience. One way of obtaining input from patients is through an Inpatient Consumer Survey developed by National Association of State Mental Health Program Directors (NASMHPD)/ Research Institute, Inc. (NRI).

Survey Domains

- Clients Perception of Outcomes
- Clients Perception of Dignity
- Clients Perception of Rights
- Clients Perception of Participation
- Clients Perception of Environment
- Clients Perception of Empowerment

Dissemination of Surveys

The survey is disseminated to 100% of the patients just prior to discharged or mailed to them with a self-addressed stamped envelope after discharge as well as to all patients remaining in the hospital at their annual review. Patients are assisted with completion of the 27 question survey only if they ask for assistance. Completion of the survey is voluntary and anonymous.

Survey Results

Survey data is used for performance improvement. Quarterly reports are received from NRI and each hospital reviews and assessed the aggregate data in each domain and takes corrective action to improve performance.

Mental Health Community

Consumer satisfaction with the services provided by DMHAS contracted mental health agencies is measured via the Annual *Consumer Perception of Care Surveys* which provides consumers with an avenue in which to report their reactions to the services that they are receiving, and a mechanism through which DMHAS may evaluate itself and its contracted providers.

The DMHAS Annual Consumer Perception of Mental Health Care Survey provides the Division with a consistent set of measures by which it may look at the degree to which consumers feel well-served by contracted providers, and to the extent that consumers are satisfied with the

overall level of care furnished by the Division. Due to the standardized nature of the survey format, DMHAS may look back longitudinally at these results to observe change through time.
The DMHAS Annual Consumer Perception of Care Survey is a self-reporting tool consisting of no fewer than 62 items on various topics shaped to convey consumer's reflections of their current mental health service, treatment, assessments of their primary health and basic demographic information. The core of the survey instrument is the *Mental Health Statistics Improvement Program's (MHSIP) Adult Survey*[2]--used it in its entirety (48 questions), supplemented by ten questions related to primary health, from the Behavioral Risk Factor Surveillance System (BRFSS) survey[3] . These tools are recommended for use by the National Association of State Mental Health Program Directors (NASMHPD) Research Institute, Inc. (NRI). The consumer survey dataset yielded by the survey instrument provides perspective in addressing:

*What are some of the basic demographics of the consumers of mental health services?
*Is there a difference between agencies with relation to reported satisfaction?
*Does satisfaction differ between domains of responses?
*What is the overall response of consumers to our mental health services?
*What are the average responses from consumers about mental health service?

Survey Domains

These MHSIP questions are aggregated into eight analytical 'domains. These domains are General Satisfaction; Access to Services; Quality & Appropriateness of Services; Participation in Treatment Planning; Outcomes (effectiveness of services received), Functioning Outcomes (overall social skills and symptom reduction), Social Connectedness and Legal Challenges (response to clinical justice programs in NJ).

Dissemination of Surveys

Each year prospective respondents are randomly selected (among their cohorts enrolled in the same program element, administered by the same provider) to be given the optional and anonymous survey questionnaire.

Survey Results

The Annual Consumer Survey yields helpful data for the URS Data Tables and the National Outcome Measures. These results are reported to the NJ Behavioral Health Planning Council for comment, review and discussion.

In addition, a wealth of additional inferences are gleaned from the Consumer Survey data—depending on Division imperatives and available research resources. A partial list of the

[2] See http://www.nri-inc.org/#!urs-forms--info/c1xvm
[3] See http://www.cdc.gov/brfss/questionnaires/pdf-ques/2011brfss.pdf

phenomena brought into greater clarity with the survey results include: demographic composition (i.e., age, gender, race, ethnicity, marital status) of mental health consumers, composite 'strength' of responses (e.g., to what extent consumers 'strongly' agree with survey statements), response rates per county, response rates per program elements, mean domain scores by county, mean domain scores by program element.

Since 2011, the Annual Consumer Perception of Care Survey of Mental Health Services has been distributed to a stratified random sample of consumers in all non-acute, community-based settings. (Prior to 2011, this survey was distributed annual to the entire population of consumers receiving services from one specific program element.) Going into its fifth year of data collection on this cross-program basis, the SMHA is excited that this dataset can be now looked at from a historical perspective, allowing to SMHA to look at how consumer attitudes on program elements, providers and the system-at-large have changed over time.

HOSPITAL CORE MEASURE DATA SET (HBIPS)

Specific to state psychiatric hospitals, the Division collects data from the hospitals on Core Measures for the NRI Behavioral Healthcare Performance Measurement System (BHPMS) which are sent to NRI and then to The Joint Commission and then some of the measurement data is sent to The Centers for Medicare and Medicaid Services (CMS). These core measure sets fulfill the ORYX reporting requirements for The Joint Commission. HBIPS core measures that describe five areas from the initial admission screening process, four content areas from the continuing care plan and antipsychotic medications post-discharge. These measures include:

- HBIPS 1: Screening for Violence Risk to self or others, Substance Use, Psychological Trauma History, and Strengths
- HBIPS 2: Hours of Physical Restraint Use
- HBIPS 3: Hours of Seclusion Use
- HBIPS 4: Patients Discharge on Multiple Antipsychotic Medications
- HBIPS 5: Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification
- HBIPS 6: Post Discharge Continuum of Care Plan Created
- HBIPS 7: Post Discharge Continuum of Care Plan Transmitted to Next Level of Care Provider upon Discharge

The hospitals also collect data regarding Comfort Care to indicate if the patient is on comfort measures only as this population is excluded from the data collection.

GLOBAL POPULATION MEASURES

Specific to state psychiatric hospitals, the Division collects additional data from the hospitals for the NRI Behavioral Healthcare Performance Measurement System (BHPMS) which are sent to NRI and then to The Centers for Medicare and Medicaid Services. The data collected is related

to substance use screening and tobacco use screening and treatment. Also collected is data related to patient influenza immunization status. These measures include:

- SUB-1: Alcohol Use Status Screening
- TOB-1: Tobacco Use Status Screening
- TOB-2: Tobacco Use Treatment Practical Counseling
- TOB-2a: Tobacco Use Treatment FDA-Approved Cessation Medication Provided or Offered
- IMM-2: Influenza Immunization

EVALUATION and CONTINUOUS IMPROVEMENT

Performance measurement data is reported at Senior Staff Meetings once a quarter by data owners. Senior Leaders have an opportunity at this time to discuss opportunities for improvement. For data which is outside of our expected performance standards and an action plan is devised and implemented by the data or process owner and measurement continuously occurs. If the action plan has resulted in improvement then action plan continues and becomes part of regular processes. If the action plan does not result in improvement, the action plan is reviewed to ascertain if it was implemented as designed or if there needs to be a different action plan developed.

The DMHAS Quality Improvement Plan is, itself, continuously being evaluated and revised as necessary, but at least every two state fiscal years. The evaluation summarizes the goals and objectives of the Division's Quality Improvement Plan, the quality improvement activities conducted during the past year, including the targeted process, systems and outcomes, the performance indicators utilized, the findings of the measurement, data aggregation, assessment and analysis processes, and the quality improvement initiatives taken in response to the findings. Based upon the evaluation, actions are developed to improve the effective of the Plan.

PerformCARE

Quality Improvement Plan

Care Coordination

Outlier Management

Utilization Management

2014

PerformCare

Quality Improvement Plan

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SECTION I- INTRODUCTION

A. Mission & Philosophy and Continuous Quality Improvement (QI) Process

The System of Care Partnership for Continuous Quality Improvement reflects PerformCare's mission to help people get care, stay well, and build healthy communities. Committed to ensuring youth and families receive quality care and services that promote wellness, the model is designed to systematically monitor and evaluate the quality of care and services delivered by the NJ Children's System of Care (CSOC) encompassing system partners. We utilize proven approaches to measure performance; identify opportunities for improvement, and develop protocols to ensure best practices. The Quality Improvement Program implements processes commonly used in healthcare and incorporates National Committee for Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC) health accreditation standards in its design and operation as well as standards based on state regulations, clinical best practices and ethical guidelines.

The QI Program, which includes Care Coordination, Outlier Management and Utilization Management, creates structures to inform the system and key stakeholders whether we make a difference in the lives of youth and family served. We apply QI expertise and System of Care values and principles in providing timely, efficient, and effective services for youth with behavioral health, substance use, developmental disabilities, and co-occurring needs including physical health needs.

B. Stakeholder Model

We recognize the importance of partnering with our key stakeholders in the design and implementation of our QI program because definitions and perceptions of quality vary. Involvement of key stakeholders, including providers, parents, and youth is critical for an effective quality improvement program that reflects the system's goals and objectives. PerformCare develops solutions and partnerships to improve health care for youth and families with behavioral health needs and developmental disabilities and encourages ongoing collaboration with stakeholders to increase access to appropriate, timely and effective care. The PerformCare QI program values the role stakeholders play in the identification of areas for improvement, strategies to achieve improvement and determination as to whether improvement has been achieved and sustained.

PerformCare's Quality Improvement Committee design is based upon diverse membership representing internal and external key stakeholders encompassing providers, parents, advocacy groups, Division of Children's System of Care (CSOC) leadership, and all levels of PerformCare associates.

C. Goals and Objectives

PerformCare implements the mission of the CSOC to support youth with emotional and/or behavioral challenges and needs, and their families/caregivers by providing them with behavioral healthcare and other ancillary services appropriate to their needs, at the appropriate level of service, and for the appropriate length of time. The goal of CSOC is to enable youth to remain at home, in school, and in the

community. PerformCare, as the Administrative Service Organization (ASO), systematically monitors and evaluates to ensure services are:

- Clinically appropriate and accessible,
- Individualized
- Strength-based
- Provided in the least restrictive setting appropriate to the needs of the youth
- Family guided with families engaged as active participants at all levels of planning and service delivery
- Community based, coordinated and integrated with the focus of services, management, and decision-making responsibility resting at the community level
- Culturally competent
- Protective of the rights of youth and their families
- Collaborative across child serving systems, involving mental health, child welfare, Juvenile Justice and other system partners who are responsible for providing services and supports to the target population.

D. Responsibility for the QI Program

The Medical Director and Director of Quality Management have the authority and responsibility to ensure that all QI findings, conclusions, recommendations, actions taken, and results are reported to appropriate individuals within PerformCare, including the Executive Director, senior management, and department managers/supervisors for use in daily operations and to ensure a focus on quality. Within PerformCare operations, the Director of Quality Management ensures that information generated through QI activities is used to improve quality throughout the organization. Toward this end, the Director of Quality Management has sufficient resources to access data necessary that supports measurement of quality improvement actions. The Director of Quality Management is also responsible for system integration efforts so that the QI Program and its objectives are realized throughout the organization, including clinical (utilization/outlier), financial / claims (encounter), and care coordination functions.

The Medical Director is responsible for medical policy pertaining to the quality of behavioral healthcare. The Medical Director is the designated behavioral healthcare practitioner with overall oversight of the QI Management Program. The Medical Director, who is a Board Certified Psychiatrist, is an active participant in the QI Committees. The Medical Director provides clinical consultation as needed, and retains the final authority for recommendations for medical necessity and appropriateness or quality of care decisions.

E. Scope of the QI Program

The QI program encompasses administrative and clinical operations managed by PerformCare, contract performance metrics, service delivery, and outcomes. PerformCare shall provide a QI Work Plan based

on performance from the previous year. The plan, divided into Care Coordination, Outlier Management and Utilization Management, shall be specific and include quantitative and qualitative measures of performance, along with quarterly and annual targets for performance.

The QI Work Plan shall include measures, such as:

- Call Center performance in answering calls
- Disposition of triage screening
- Timeliness of services
- Decision-making processes for appropriate care determinations
- Service utilization including trends
- Outliers, length of stay in each service
- Population disparities
- Provider Network adequacy
- Family satisfaction & perception of care
- Costs of services
- Attainment of outcomes by service line and system-wide, including clinical and functional outcomes and system-wide outcomes
- Complaints, reconsiderations, denials and appeals
- Customer service
- Eligibility processing

Within each of these areas, quality indicators to monitor and evaluate are identified and the methodology, time frames, and performance standards by which indicators are measured are outlined. Indicators help monitor service provision and allow a review of a full range of demographic groups, treatment settings, and types of services.

Time frames for indicators may include any of the following:

- Continuous, ongoing monitors;
- Time increment period (e.g. monthly, quarterly, annually)
- Upon occurrence;
- Concurrent review; and
- Retrospective review

Consistent with Children's System of Care requirements, QI activities will also address:

- Achievement of Quality Strategic Initiatives for specialized waiver programs geared to the co-occurring developmentally disabled and mentally ill (DD/MI); autism spectrum disorders (ASD); and serious emotionally disturbed (SED) youth populations and specific Medicaid amendment services such as Behavioral Health Home
- Needs assessment and service utilization for Family Support Services

- Timely and appropriate management of the eligibility determination process for functional developmental disabilities
- Compliance in managing timely notification to families
- Call center operations that address triage and information and referral
- Targeted care coordination for special youth populations

SECTION II QUALITY IMPROVEMENT OPERATIONS

PerformCare shall utilize the Quality Improvement Steering Committee as the forum for reporting progress and delivery of service in the achievement of strategic initiatives.

A. Complaint Management

PerformCare provides a complaint resolution process for consumers receiving services through CSOC. PerformCare has established a fair and uniform process for families to resolve complaints at the lowest administrative level consistent with CSOC requirements.

A complaint is defined as dissatisfaction regarding an actual or alleged circumstance about provision of service, quality of care, timeliness of service, and or the appropriateness of provider performance. A complaint may be about any provider within the NJ Division of Children's System of Care including PerformCare.

A youth, family member, or authorized representative may file a complaint. A complaint is also accepted from a provider, advocate, or government official. Information on how to file a complaint is available on the PerformCare website and in the Youth & Family Guide.

The complaint is managed by a Quality Improvement Coordinator who contacts the complainant to determine the nature of the complaint and steps taken to address the issue. She/he will reach out to the individual for whom the complaint is about to inquire about the circumstance and details surrounding the complaint. The role of the Quality Department is to conduct an inquiry, attempt to "fact find", and attempt to facilitate a timely and effective resolution of the issue.

There may be situations where the complaint must be escalated to the respective CSOC Service Line Manager, (i.e. Family Support Organization, Mobile Response and Stabilization) and/or Executive associates. Examples of situations warranting escalation to the state include allegations of misconduct, ethical violations, and fraud and abuse.

B. Reconsiderations & Appeals

PerformCare has established a fair and uniform process for youth/ parents/ guardians to resolve appeals known as "reconsiderations" to families beginning at the lowest administrative level consistent with CSOC requirements and accreditation standards. PerformCare makes available to youth/parents/guardians and providers on behalf of youth with the consent of youth/parents/guardians

the right to appeal decisions of a denial of a service. The appeal process applies to those services that are denied, reduced, or terminated based upon medical necessity determination.

The definition for a denial of service is the determination by PerformCare that an admission, extension of stay, or other healthcare service has been reviewed and, based on the information provided, does not meet the clinical requirements for medical necessity, under the Clinical Criteria established by CSOC. These Clinical Criteria are made available on the PerformCare website**.**

The appeal process is written and communicated in the Youth & Family Guide posted on the PerformCare website. Written appeal policies and procedures are available, upon request, to any youth/parent/guardian, provider, or facility rendering service. Youth/parents/guardians are informed of their right to appeal and where to obtain information about the appeal process in writing when notified about a denial of care decision. Providers may reference the PerformCare website for information about the appeal process. The term "provider" includes those facilities or organizations required to obtain authorization for payment through PerformCare.

PerformCare utilizes a two (2) step process whereby the family seeking the reconsideration may provide additional information and that the first step includes an additional review by the original clinician making the denial. If the clinician does not overturn the original decision the case is forwarded for a second level review by a licensed independent practitioner that has not reviewed the case previously. The outcome of the review is sent in writing to the family. The family has the option to bypass the internal process through PerformCare and seek an appeal directly through the Medicaid Fair Hearing process for Medicaid covered services, for example care management services or CSOC for non-Medicaid covered services, such as for Family Support Services. If the family elects the latter option, PerformCare shall automatically implement the internal process for reconsideration and supply any records for the external review.

C. Continuous Monitoring of Performance Metrics

Continuous monitoring of performance metrics is achieved through the management of the Payment Voucher and the Annual QI Work Plan, including the Annual Care Coordination Plan, Outlier Management Plan and Utilization Management Plan, with oversight by the Quality Improvement Department. The Payment Voucher consists of documentation that lists required performance metrics. It is submitted on a monthly basis along with supporting reports reflecting demonstration of these requirements. The voucher is reviewed by the Executive Director prior to submission. The Payment Voucher includes Administration, Clinical Services, Member Services, Quality, and MIS; and contains important metrics such as calls, service plan reviews, reconsiderations, mailing and notices, customer service, MIS operations, and specific activities.

PerformCare utilizes a scorecard reporting model that encompasses contract performance metrics. This is submitted quarterly to the Quality Improvement Steering Committee (please see page __ for committee structure). QI associates monitor those measures in relation to expected thresholds and forward the data to the respective department head when performance is not satisfactory. That

individual develops a Corrective Action Plan, monitors the progress and reports back to the internal QI committee regarding the effectiveness of the intervention(s).

D. Call Monitoring & Documentation Audits

The Quality Department oversees the monitoring of calls recorded through the Call Center operations and the completion of documentation audits for utilization management. Call monitoring and documentation audits are conducted by the Member Services and Clinical Operations. The Quality Department monitors compliance with contractual requirements, quality standards, accreditation requirements, audit requirements and internal protocols.

Performance indicators pertaining to calls include but are not limited to professionalism, respect and courtesy, providing correct information, making sure the caller is aware of next steps or what next to expect, determining the correct the call resolution status, and recording the call properly, and specific protocols for handling registration, providing community information and referrals, and providing options for service providers.

Documentation audits are conducted to ensure proper medical necessity is recorded as per required protocol and that the clinician properly applied the clinical criteria for the requested service.

E. Quality of Care Concerns

Associates report any potential Quality of Care concern to the Quality Department. Issues are logged and reviewed. If action is required, the issue is referred to the appropriate department head. Issue resolution including expected timeframes is reported to the senior management quality improvement meeting. The Quality Department ensures timely resolution and effectiveness.

F. Policies and Procedures

PerformCare has established policies and procedures which complement QI priorities and concepts as outlined in this QI Program Description. In addition, the QI Program has been developed to be consistent with the philosophy and policies of the corporate office. All PerformCare policies and procedures are updated as needed in response to new information and improvements identified during the QI process. New and updated QI policies and procedures are reviewed and approved by the Executive Director, Medical Director, Director of Clinical Operations, Director of Operations, and the Director of Quality Management.

G. Confidentiality

Information and documentation regarding youth and families, including clinical records and provider /member specific data and reports are considered confidential. PerformCare maintains policies and

procedures relating to confidentiality requirements and protocols. These policies and procedures are based upon and consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) guidelines and applicable state regulations to insure that Members rights related to confidentiality are fully protected. No member-identifiable information is provided to any QI Committee. Proprietary business information, including financial performance, should also be treated as confidential information by QI Committee members and not shared with any outside individual or entity. All PerformCare associates, consultants, and committee members are required to sign a confidentiality statement prior to participating in any meetings or activities. Associates are expected to learn, understand, and adhere to confidentiality policies and procedures.

H. Documentation

All QI activities detailed in this Program Description are consistent with prescribed formats and maintained for review by PerformCare management associates, and contract or state oversight individuals.

Information is provided to these groups to the extent that the law allows and within the bounds of the rules and conditions that protect the confidentiality of PerformCare Members. The Director of Quality Management is responsible to ensure consistency in documentation format of all QI activities and to maintain all documentation according to the following:

- The complete scope of QI activities[1] are documented in monthly, quarterly, semi-annual or annual reports as described throughout the standards in the QI Work Plan
- The Director of Quality Management maintains a comprehensive file of all such documentation for all previous review periods
- Steering Committee, Senior Management and sub-committee meeting minutes
- Data from specific and continuous quality improvement activities, including clinical and administrative indicators and performance improvement projects
- Identified quality of care issues and follow up activities
- Complaint and grievances

I. Delegation of Quality Improvement Program Activities

PerformCare does not delegate any QI Program activities. In the event that PerformCare delegates any of these functions to another entity, such as a subcontractor, PerformCare will ensure the following:

- There is a written description of the delegated activities. This description will include the delegate's accountability for these activities and the frequency of reporting to PerformCare.
- PerformCare's program has written policies and procedures monitoring and evaluating implementation of delegated functions and verifying the quality of care provided.

[1] There are separate program descriptions for Care Coordination, Outlier Management and Utilization Management.

- There is evidence of continuous ongoing evaluation of delegated activities including approval of the entity's annual QI Program Description and Work Plan and regular specified reports.
- State oversight officials or representatives have been advised of this delegation.

J. Resources

PerformCare is responsible for ensuring there are adequate resources to operate the QI Program. To this end, the Director of Quality Management and the Director of Clinical Operations, in coordination with the program's Executive Director are responsible for the development and submission of a staffing model. The model will include provisions for sufficient material resources and the provision for necessary education, experience, and/or training to effectively carry out QI Program activities.

SECTION III CARE COORDINATION, OUTLIER MANAGEMENT, UTILIZATION MANAGEMENT

A. Introduction

PerformCare's Care Coordination, Outlier Management and Utilization Management programs are designed to ensure that youth and families receive the right services at the right time for the right length of time, and that behavioral health and other ancillary services are individualized and incorporated into the overall service and permanency plans for youth involved in multiple service systems. PerformCare accomplishes this through the following mechanisms:

- a customized UM program for the ASO based on unique local, regional, and programmatic needs;
- licensed clinical care coordinators available 24 hours/day,7 days/week with specific experience and training focused on the population being served;
- a review process that incorporates evidence-based practices and clinical practice guidelines that promote resiliency in youth;
- promoting family-centered, strengths-based, culturally competent planning, and community-based services, natural supports, and active care coordination; and
- accurate, real-time data for analysis and identification of opportunities for improvement.

Care Coordinators, the Director of Clinical Operations, the Medical Director, and other professional PerformCare associates participate in determining when a youth's situation necessitates services. Providers submit an Individualized Service Plan (ISP) based on a thorough initial and ongoing clinical assessment of the youth's needs. The ISP must represent an appropriate intensity, duration, and frequency of services most clinically appropriate to the youth's needs and have a reasonable likelihood of successfully stabilizing and/or improving the youth's ability to remain in his/her home, school, or other community setting, or to transition from intensive services to community-based services.

The ISP is reviewed by the Care Coordinator, to ensure consistency with the youth's history; presenting problems; DSM-IV-V diagnoses; strengths and needs; requirements for comprehensive, coordinated, integrated services; and adherence to best practice standards and clinical practice guidelines. Efforts are

made to obtain all necessary information and consultation occurs with the treating provider as appropriate.

B. Call Center

PerformCare facilitates access to care for children/youth/young adults with emotional and/or behavioral challenges through a 24/7/365 telephonic single point of access. Family members who call speak with a licensed mental health clinician who assesses the youth's intensity of service need and links him/her to medically necessary services using guidelines approved by CSOC. A Care Coordinator Supervisor supervises the Care Coordinators and works with local system of care service providers to make sure the linkage between family and provider works smoothly.

C. Triage

The Care Coordinator conducts a telephonic screening with the family or young adult that addresses pertinent information pertaining to emotional functioning, risk behaviors, substance abuse, daily functioning, and current involvement with treatment providers and determines the youth's need for behavioral healthcare services and level of urgency. Level of urgency ranges from immediate need where police intervention or psychiatric hospitalization is recommended, to high needs requiring crisis stabilization, or moderate needs requiring an authorization for a comprehensive clinical assessment, to low needs where a referral to outpatient or other community based support service is indicated.

D. Care Coordination

PerformCare maintains a care coordination system that ensures covered services are available and accessible to youth when and where the individual needs them. PerformCare provides care coordination which consists of providing assistance in making referrals, linking to community based services, authorizing court ordered services, and application to other support oriented services such as Family Support Services for youth determined eligible for functional developmental disability. Targeted care coordination that prioritizes the needs of special youth populations, such as youth involved with child welfare or juvenile justice, and youth with substance use, developmental disabilities, and co-occurring physical health is provided.

Care Coordinators assist families in addressing any barriers to services and educating them about resources available in the community.

E. Service Authorization Process

Medically necessary, timely services are essential to the goals of safety and the provision of quality care and delivery of services at the most appropriate intensity of service. Initial and continued care authorization reviews are carried out by the Care Coordinator. Reviews are conducted through documentation review of the electronic medical record, telephonically, or through retrospective reviews. The review process is based on several sources of data and information, including, but not limited to:

- provider documentation in the electronic medical record describing written plans for behavioral healthcare services.
- discussion between Care Coordinator and provider during telephonic review, where applicable
- interaction that occurs electronically between the Care Coordinator and provider when requiring further information

Information reviewed and utilized by the Care Coordinator to determine appropriate intensity of service (IOS) needs includes:

- Initial & subsequent assessments using the John Lyons Adolescent Strength & Needs tools.
- Specialized assessment modules for developmental disabilities, substance use, and physical health
- DSM-IV-V Diagnoses
- Individual Service Plan (ISP)
- Diagnostic Formulation.
- Biopsychosocial Assessment.
- Current Clinical Presentation.
- Continuing Service Planning and Discharge Planning.
- Current Progress Notes, where available
- Documented Medical and Psychiatric Treatment, where applicable
- Documentation of Service Integration with Primary Care Physician, other treating providers, agencies involved with the youth and family, and community resources.

In order for the Care Coordinator to approve a service request, the Care Coordinator must take into consideration the following:

- Business rules (if available) approved by the NJ Children's System of Care (CSOC) for review of services which support the current service plan and promote family-centered, strengths-based, culturally competent planning, and community-based services, natural supports, and active care coordination.
- The documented outcome of the Child Family Team (CFT) meeting in the integrated record.
- CSOC approved clinical criteria
- Administrative eligibility requirements established by CSOC

F. <u>Clinical Criteria</u>

The UM program relies on the clinical criteria that is established and approved by CSOC for each service line. The clinical criteria delineate the admission, discharge, exclusion, and continued stay criteria for each service line and service level of care. PerformCare clinical leadership provide feedback about the clinical criteria and is regularly reviewed and updated as indicated. Through the participation in the UM Sub-committee providers also have the opportunity to provide input to ensure the criteria is written as intended in identifying those youth characteristics and needs that would best be served by the various levels of care and services. Through the forum of the UM sub-committee the clinical criteria is reviewed

minimally on an annual basis to ensure criteria remain relevant, valid, and consistent with literature pertaining to the determination of medical necessity.

By applying medical necessity criteria, the Care Coordinator determines the following:

- The youth is being treated at the least restrictive, least intensive and most clinically appropriate intensity of service required by his/her condition and level of functioning
- Current and requested treatment and ancillary services are consistent with the youth's complexity and severity of needs
- The youth is responding or can reasonably be expected to respond to the prescribed plan of care
- Behavioral healthcare services continue to meet medical necessity

The annual UM Work Plan delineates the frequency of medical necessity reviews and types of assessments and service plans for which medical necessity is applied.

Clinical criteria are posted on the PerformCare website.

G. Clinical Consultation

The Medical Director provides clinical consultation as necessary. The Medical Director oversees the utilization management review process for determination of medical necessity healthcare services. The Medical Director provides clinical oversight to the clinical reviewers and monitors determinations through the application of inter-rater reliability, record audit documentation, and regularly scheduled case review meetings.

All care determination decisions are made by qualified behavioral health professionals to include the Medical Director, Director of Clinical Operations, and licensed clinical Care Coordinators.

H. Best Practices

PerformCare clinical leadership will ensure data interpretation and the use of medical necessity criteria are used to inform reviewers of best practice approaches in the field of behavioral health. Current research in the field, clinical practice guidelines published by professional organizations, such as the Agency of Healthcare Research & Quality, Behavior Analyst Certification Board, and guidelines established by licensing and accrediting bodies will be referred to in the development of medical necessity criteria and practice standards.

The UM sub-committee will serve as a resource in the development of these practice standards. Upon request by the Steering Committee, the UM sub-committee will be responsible for researching, analyzing, and consolidating pertinent information related to practice standards, resulting in recommendations to PerformCare on the adoption of specific clinical practice guidelines and the measurement of provider application with adopted clinical practice guidelines, where applicable.

SECTION IV PERFORMANCE IMPROVEMENT

A. Quality Committee Structure

The CSOC Partnership for Continuous Quality Improvement model is carried out through the deployment of a Quality Steering committee and two (2) subcommittees composed of internal and external stakeholders dedicated to identify and implement improvement initiatives. These committees are scheduled monthly and have the capacity to convene time limited focused work groups to address specific projects. The Steering Committee is comprised of CSOC executive leadership and service line managers and PerformCare executive associates, and serves in an oversight capacity for monitoring performance metrics and quality of service delivery. This committee: establishes annual goals and objectives; sets priorities for improvement; reviews reports and recommendations received by sub-committees; and applies findings for improvement or change in policy, practice, and service delivery. The Steering Committee is used as a forum to dialogue with CSOC about quality findings as well as feedback received from internal and external stakeholders, including the identification of new or expanded needed services that promote wellness. The Director of Quality Management chairs this committee and is responsible to ensure the QI Work Plan is carried out as designed and approved.

The Utilization Management (UM) sub-committee is composed of various stakeholders representing CSOC, PerformCare, families, advocacy groups, and providers. This committee is charged with monitoring and evaluating the provision of services encompassing the application of clinical criteria for determination for level of care, delivery of services, family participation, and the transitioning of youth from various levels of care. Examples for improvement addressed by the UM sub-committee include improving quality of assessments, implementing standard practice guidelines and promising practices, creating informed consent models, and family education. The Director of Clinical Operations chairs this committee.

The Outcomes Management sub-committee is responsible to create a system-wide outcomes management program that encompasses outcomes for the individual youth, program and statewide level. This committee is also composed of external stakeholders representing providers for both community and out of home treatment settings. This committee is charged with delineating actual outcomes, developing protocols for implementing and collecting data, overseeing outcomes related to reporting, and to utilize best practices for outcomes management to assess the value and benefit of services to youth and families. The Medical Director co-chairs this committee with the CSOC Deputy Director.

Specific outputs for the committees include

- Delineate performance measures, benchmarks, and thresholds/targets
- Review and analyze data findings
- Identify, implement, measure, and standardize improvement initiatives
- Create report cards for selected indicators of performance for external distribution
- Design, implement, measure, and evaluate specific Quality Strategic Initiatives as assigned

- Conduct an annual evaluation of the sub-committees activities & achievements
- Assess existing measures and determine where to refine, standardize, or expand
- Determine methodology for administration of instruments, where applicable

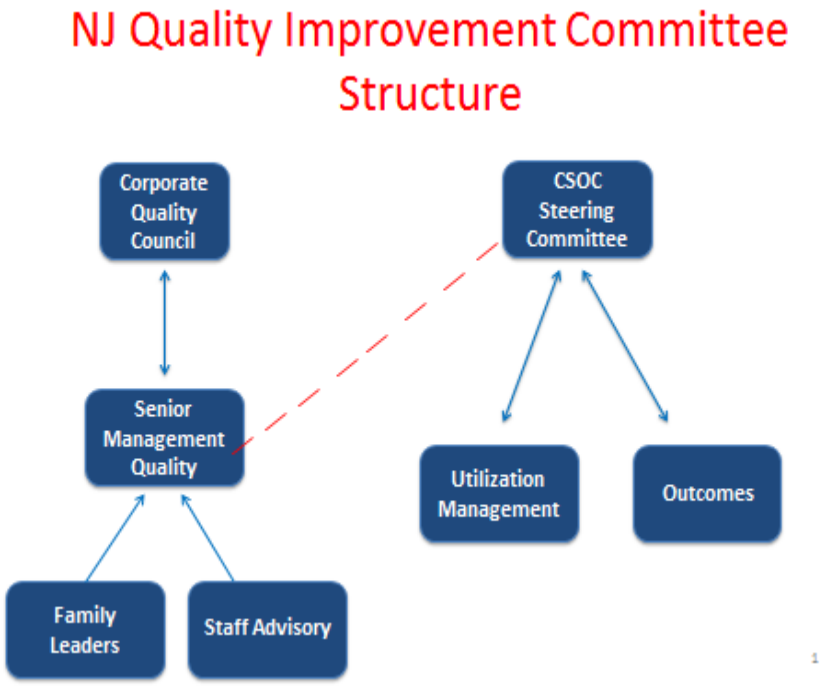
B. **Internal Quality Forums/Corporate Reporting**

PerformCare has commissioned the formation of an internal Quality Advisory Group composed of various associates to identify areas for improvement, make recommendations for change, and evaluate the effectiveness of action taken. This group reports to the Senior Management Quality Meeting who approves any recommendations and the Executive Director assigns responsibility for any improvement activities or corrective action plans. The Senior Management Quality meeting meets monthly to review Quality of Care concerns, compliance, and other internal quality related issues.

Improvement teams, comprised of PerformCare associates who are subject matter experts, are formed and empowered to identify pertinent issues and develop realistic action plans that result in improved efficiencies, outcomes, and overall customer satisfaction.

Our Family Leaders Group for PerformCare, a group of parents and caregivers, meet quarterly and offer valuable feedback about service needs and operations. The group helps ensure that children and families are informed of System of Care services and benefits and how to access care. Family Leaders have an essential role in ensuring our communications are responsive to the needs of the families and youth we serve.

PerformCare associates representing senior management report QI activities and findings to the corporate Quality Council on a quarterly basis.



C. Annual Work Plan

The Director of Quality Management is responsible to develop an Annual Work Plan that identifies the QI activities and reports which is presented to the QI Steering Committee on a monthly basis. The annual Work Plan encompasses administrative and clinical services managed by PerformCare; key metrics about new service lines; findings from utilization management reviews, outlier management, provider performance metrics; and sub-committee reports and presentations.

The Steering Committee oversees ongoing measurement and monitoring to ensure contract compliance, provision of quality care, identify and implement improvements to the care delivery system, and monitor progress as changes are applied.

D. Performance Improvement Projects

Performance Improvement Projects (PIP's) promote continuous quality improvement, supporting organizational and system efforts to maintain and refine delivery of services. PIP's are data driven focused studies in response to System of Care identified needs and issues related to quality of care. Using a systematic approach to assessing and revising processes that impact the quality of services provided, the Plan - Do -Study -Act (PDSA) model is utilized for performance improvement projects. Projects are designed to ensure the following, "S.T.E.E.P. Analysis" dimensions of performance:

- Safety – avoid injury from the care that is intended to help
- Timeliness – reduce waits and harmful delays
- Effectiveness – provide services based on scientific knowledge to all who could benefit and refrain from providing services to those not likely to benefit (avoiding overuse and underuse, respectively)
- Efficiency – avoid waste
- Equitability – provide care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, socioeconomic status
- Person centeredness – provide care that is respectful of and responsive to the individual preferences, needs and values.

Recommendations for QI improvement projects are documented on the "Quality Improvement Project form" and include: an Aim Statement, methodology for implementation and evaluation, Team responsible for the implementation and prescribed timeframes for reporting the status of the project with a projected completion date. This is submitted to the Quality Steering Committee for consideration and approval. The Steering Committee also ensures approved projects receive the required support for successful implementation. Approved projects are incorporated into the annual QI Work Plan. Improvement projects geared to address internal operations are reported to the senior management quality forum.

Improvement teams or identified individuals are responsible to report periodic progress measurements to the Steering Committee. Upon completion the Steering Committee will decide whether to periodically measure performance to assess if the improvement has been sustained.

SECTION V SAFETY and OUTLIER MANAGEMENT

The QI Program is designed to monitor and improve quality of care over a range of behavioral and physical health service delivery areas from point of initial triage throughout the duration of services. Youth safety is a critical priority. As an example of this commitment to youth safety, particular attention is given to the implementation of the following prospective safety activities at point of triage when we are handling an actual call with a family:

- Regular screening for life threatening emergencies and rapid triage of calls
- Referral to psychiatric screening services and request for police dispatch for youth presenting in danger for self or others
- Referral to child welfare Central Registry for potential neglect or abuse

Further safety review is conducted through utilization management processes by licensed Care Coordinators who regularly review Strength & Needs ratings within the various assessment tools and monitors whether the responsible clinician or care manager has addressed these safety needs in the youth's Individual Service Plan (ISP). In the event these safety needs are not addressed in the ISP the PerformCare Care Coordinator indicates the identified safety factor and electronically notifies the individual submitting the ISP. Examples of safety factors reviewed through the review process include

- Suicide ideation or attempt
- Self injury requiring medical intervention
- Physically assaultive to a parent or other authority figure
- Psychiatric hospitalization
- Mental health screening
- Victim of human trafficking
- Threat to harm others
- Victim of bullying

PerformCare routinely runs various aggregate reports to identify the prevalence of various risk factors and needs of youth that are used for provider education, practice improvement, and service development.

Through the use of anomaly management PerformCare provides an automated system for treatment providers to identify and manage outlying service utilization. The MIS uses service utilization data to identify a youth with individual anomalies who are at a pre-determined number of standard deviations from or below the mean for service utilization in the particular service category or for an array of pre-selected strengths and needs.

The goal of outlier management is to identify youth who may be under or over utilizing services and to notify the treatment provider to ensure services are congruent with youth needs.

SECTION VI OUTCOMES

A. <u>Scope</u>

PerformCare provides an Outcomes Management and System Measurement Program that assesses, monitors, and reports the attainment of positive outcomes, including clinical and functional, and system-wide outcomes.

Outcomes are measured by youth, service line, and system-wide. Performance is measured for the System of Care as a whole and for each agency or program individually. Outcomes shall be analyzed in relation to services utilized by each youth and the impact of those services in real time. Performance data is made available to providers to support clinical decision-making on an individual youth level as well as assess and monitor operations on a collective program level.

B. Provider Dashboards/Profiles Reporting

Dashboard reports consist of essential performance measures to assess and monitor service line operations. Performance measures address dimensions of census and capacity, wait time, service utilization, length of stay, outcomes, and various measures specific to service line operations.

Examples of outcomes captured and reported through the dashboards include the following:

- Readmission
- All Authorizations after Transition from the Case Management entity
- Living Situation
- Assessment Score Improvement
- Reason for Discharge

C. Youth Specific Outcomes Management

PerformCare provides an outcome monitoring system designed for providers to enter and store youth needs, such as risk behaviors, behavior and emotional symptoms, and functional information in the MIS database. Data and information entered electronically generates real time reports to treatment and service providers that measure change in quantifiable terms over time during the course of treatment and service delivery. Outcomes information is designed to inform clinical decision-making, i.e. to make placement decisions, plan treatment, and improve quality of care. Reporting data is designed to support providers with their treatment decisions by combining an organized and efficient outcomes monitoring system tied to timely data reporting on youth progress.

Examples of outcomes captured and reported from CANS assessment tools include the following:

- Emotional & psychiatric symptoms
- Behavioral functioning
- Living environment
- Safety and risk
- Family functioning & strengths
- Daily functioning

D. Youth & Family Outcome Perspective

In conjunction with CSOC and system partners, PerformCare elicits information about outcomes from the perspective of the youth and family through satisfaction and follow up outcome surveys. Outcome information is collected telephonically, by mail, and in-person by care management entities and treatment facilities in the community.

Use of self-rater assessment tools during the course of service delivery is also very useful in that it offers the perceptions of parents and the youth's self-report to both supplement and cross validate clinical assessment. The data can be a valuable tool to help service providers more effectively assess whether the youth is making progress and to revise the service plan as needed. Ultimately, use of self–rater findings facilitates the determination of appropriate service utilization ensuring that only what is needed is provided and not too little, as in the case of underutilization, or too much as in overutilization.

Examples of outcomes elicited from youth and families include:

- Daily functioning
- Satisfaction with treatment
- Family ability to manage the youth
- Family ability to advocate and arrange for service

PerformCare makes the Adaptive Behavior Assessment System (ABAS) assessment tool available to families applying for developmental disability of their youth when a functional assessment is not available through the educational system. The ABAS measures functioning in the seven (7) life areas required to demonstrate substantial functional limitations to support the application for eligibility.

E. Predictive Modeling

Predictive modeling is using the knowledge of youth outcomes on a large scale and being able to predict a projected path of progress based upon designated descriptive predictor variables. This allows a clinician and or treatment team to determine a projected course of treatment that is aligned over time based upon the experience of similar youth with similar characteristics. PerformCare Care Coordinators apply this knowledge when conducting admission and continued stay reviews for determining appropriate intensity of service and the identifying need for enhanced care coordination for complex care needs of youth.

PerformCare utilizes existing accumulated Strength & Needs data as the basis for predictive modeling. Predictor variables include age, family factors, previous history, co-morbidity, and complexity. Youth identified with high risk predictor variables are reviewed for to ensure intensive services are authorized.

SECTION VIII MEMBER EDUCATION & INFORMATION

A. Website

PerformCare utilizes the organization's Website as a vehicle for member education regarding behavioral health, developmental disability and substance use services including the role PerformCare plays in linking families to care. The website informs families about accessing services through the call center,

eligibility for services, and serves as the gateway to the Family Portal. The portal provides one means for families to apply for developmental disability eligibility. The Youth & Family Guide, described below under "Rights & Responsibilities" contains essential member education. This document, located on the website, is referenced in each authorization letter mailed to families.

The website is organized and geared to the needs of families, youth, and providers.

B. Community Representation and Attendance

Our "Family Leaders for PerformCare" consists of families representing youth with behavioral health, substance use and developmental disabilities that meet with PerformCare's Executive Director on a quarterly basis. The Executive Director elicits feedback from parents and caregivers and the family perspective on PerformCare operations and the NJ Children's System of Care. Family Leaders disseminate current information about PerformCare and the System of Care to the general community and various advocacy groups serving youth and families.

Additionally, Family Leaders have been added to the QI stakeholder committees.

PerformCare's management team regularly attend and present updates to Family Support Organizations (FSO), Family Councils and the Children's Inter-Agency Community Council (CIACC) who in turn are responsible to disseminate information to the community at large.

C. Member and Provider Experience & Satisfaction

Seeking feedback about families and providers experience and satisfaction in their interactions with PerformCare and delivery of service with the CSOC is a top priority to ensure they are satisfied with the service they have received and that is has been helpful in meeting their needs. Families and providers are an important source of information and ideas regarding services and systems improvements. PerformCare supports and facilitates suggestions, feedback, and input into QI activities using the following:

- Participation in formal quality improvement committee meetings that meet regularly
- Telephone surveys made to new families registering youth applying for services to inquire about their experience in speaking with Call Center representatives
- Mailed satisfaction surveys sent to families inquiring about satisfaction and degree to which services helped the youth and family
- Targeted surveys to community organizations or system partners assessing their experience with PerformCare
- Feedback received directly from family members from our Family Leaders group, community events, emails, phone calls
- Surveys geared to providers seeking feedback about their experience and satisfaction in contacting the Service Desk
- Participation in CSOC Service Line meetings to address any concerns or suggestions

- Following up with families regarding whether they are satisfied in the resolution of complaints or appeals

D. Member Rights and Responsibilities

PerformCare is committed to ensuring that youth and families, referred to here as "Members" are treated in a respectful, helpful, and courteous manner at all times. Our policy on Member Rights and Responsibilities is based upon respect, dignity, and recognition of privacy and cultural sensitivity. PerformCare recognizes the importance of safeguarding and communicating member rights to ensure they are properly safeguarded and effectively communicated. Processes and structures are in place to allow for fair and timely attention to grievances and are part of the quality improvement program to monitor and elicit consumer experience about the grievance process. Member rights and responsibilities address the following areas:

- Members are informed about services
- Members receive notification about services
- Members have appeal rights when disagreeing with a decision about care
- Members have a process for making complaints about any system partner

E. Youth & Family Guide

The rights and responsibilities are summarized in the "Rights and Responsibilities Policy" found in the Youth & Family Guide and on the PerformCare website, and available to all Members, providers, and the public. Members are informed about the Youth & Family Guide at the time of initial registration. The Youth & Family Guide is written at a fifth (5^{th}) grade reading level and is also available in Spanish. Family input is solicited for content, tone, and readability.

The Youth & Family Guide informs members how to access services, emergency or crisis services, and about what covered services are available; information about benefits, how to file a complaint or appeal, and privacy information and any limitations involving family/caregivers or providing information for adult persons who do not want information shared with family members, including ages of consent for behavioral health and substance abuse information.

F. Complaints & Grievances

All Members are ensured the right to complaint and grievance actions through the Complaint and Appeal process through the Quality Improvement Department. The following activities ensure proper oversight of complaints and grievances:

- The Director of Quality Management has oversight responsibility for maintaining complaint and appeal procedures and ensures timely notification and resolution for Members.
- Designated quality improvement associates receive complaints and grievances speaking with families directly to understand the nature of the complaint or grievance and to assist parents

and caregivers in understanding each step of the process and expected time frames for resolution

- A report summarizing each complaint and the associated resolution is sent to CSOC on a monthly basis
- Reports summarizing complaints and appeals are regularly distributed by the Director of Quality Management to the CSOC Quality improvement Steering Committee
- Any allegations of provider misconduct or ethical behavior, and any quality of care concerns are brought to the attention of the respective CSOC Service Line Manager and CSOC Manager of Community Services.

The complaint and grievance system is accessible to associates, providers, and other stakeholders to identify concerns/problems and disputes.

Member Service Specialists and Care Coordinators are able to explain the process and are trained annually on complaints and grievances.

PerformCare uses complaint and grievance data to improve the quality of its systems and services both internally and externally within the provider community. The Steering Committee reviews reports for significant trends and, when appropriate, determines a written plan for remedial/corrective action to be developed and implemented according to procedures.

G. Written Notification

Members receive written notification about services that are authorized. Written correspondence is also sent whenever services are denied, reduced, or terminated, which includes the reason, and appeal rights and instructions.

SECTION XII EVALUATION

A. Annual Evaluation

The QI evaluation is an annual evaluation of the prior year's quality improvement, care coordination, outlier management and utilization management activities including achievements and recommendations for the following year. This process includes updating the QI Plan and developing a new annual Work Plan that is submitted to the CSOC Executive Leadership for approval.

The Work Plan shall also include new initiatives established by CSOC that may include new services and changes to existing services, actions, and time frames for each quality improvement project.

10. Quality Improvement Plan (Additional Information)

Children's System of Care (CSOC)

The DCF Strategic Plan can be accessed here:

http://www.state.nj.us/dcf/about/welfare/NJDCFStrategicPlan.pdf

The DCF 2013-2014 DCF Today (Accomplishments) Report can be accessed here:

http://www.state.nj.us/dcf/documents/about/NJDCF.Annual.Report2014.PDF

The DCF CQI Data Reports can be accessed here:

http://www.state.nj.us/dcf/childdata/continuous/

Environmental Factors and Plan

11. Trauma

Narrative Question:

Trauma [75] is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems [76]. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing “business as usual.” These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed approach consistent with “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach”. [77] This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma [78] paper.

Please consider the following items as a guide when preparing the description of the state’s system:

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?
2. Describe the state’s policies that promote the provision of trauma-informed care.
3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

Please indicate areas of technical assistance needed related to this section.

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75 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

76 http://www.samhsa.gov/trauma-violence/types

77 http://store.samhsa.gov/product/SMA14-4884

78 *Ibid*

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

11. Trauma

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?

   There is no policy in place mandating trauma screening or assessment. DMHAS Trauma Informed Workgroup has reviewed both screening and assessment tools as recommended in the CSAT Tip 57: Trauma Informed Care. The screening tools that are recommended for use throughout the mental health and addictions system of care have been circulated throughout all DMHAS contracted agencies under the signature of the Assistant Commissioner. The Trauma Informed Care Work Group has also developed recommendations for trauma assessment tools and those will be circulated to all agencies in June 2015.

2. Describe the state's policies that promote the provision of trauma-informed care.

   NJDMHAS has not issued policies. Rather than development of documents that outline policies, we have chosen to promote Trauma Informed Care on an ongoing and active way throughout all of our agencies in the form of tool kits, action steps and ongoing information and technical assistance. From those projects, we have already noted many agencies designating Trauma Champions to assist in their development of agency based plans. The Division has also devoted a large section on its website to Trauma so that agencies can download and utilize any information generated for them by the Trauma Informed Care Work Group: http://www.state.nj.us/humanservices/dmhas/initiatives/trauma/.

   Given the high prevalence of trauma among women with substance use disorders, licensed treatment providers who provide gender specific treatment and receive State funding and/or Federal Substance Abuse Block Grant Women's Set-Aside must provide trauma informed/trauma specific treatment services using the "Seeking Safety" program. Providers are required to screen all women for trauma using one of the DMHAS recommended evidence based screening tools. This is a contract requirement.

   DMHAS has disseminated the following completed projects over the last year:
   - State Trauma Definition
   - Position on Trauma Informed Systems
   - Blueprint for Action
   - Guidelines for Agency Assessment of Staff Competencies
   - TA packages for agencies on Trauma Centered Values and Guiding Principles, and Development and Use of Comfort Rooms
   - Universal Trauma Screening

3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?

In addition to the above activities, the Trauma Informed Care Work Group is embarking on recommendations for EBPs, and is actively beginning the curriculum development for training packages. DMHAS uses the Adverse Childhood Experiences results as a model and framework to communicate the impact of trauma throughout the lifespan. We have chosen ACEs as one of the assessment instruments that will be recommended to all of our agencies in June 2015. We have individuals on the Trauma Informed Work Group from other state initiatives and departments including children's services through elder.

4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

NJDMHAS is planning a trauma event to highlight resiliency and some of the state of the art techniques in use for trauma currently. It is important to us that staff understand how to communicate messages of hope and healing, as the majority of individuals in our care have trauma histories.

As part of our next steps, DMHAS would like to have one staff person in each of our state psychiatric hospitals become certified trauma specialists to assist in planning and implementation of clinical program as well as staff debriefing and wellness programs.

We are actively training staff throughout the system on Mental Health First Aid as an evidence based practice; not for the trauma content within that method, but because of the compassion, decrease in stigma, the common language and the systematic and consistent plan it provides for engagement, interaction and resolution of distressing situations - all of which is vital in communicating and intervening with individuals who have trauma. We are teaching the foundation of safety through consistent, predictable and compassionate interaction. It is vital that all of our staff offer safety by behaving in the same manner: from food service, psychiatry, intake, to case managers. DMHAS has trained almost 3000 staff from our agencies since May of 2014.

The Trauma Informed Care Work Group is developing training modules at present that will communicate the basics of trauma, life span issues, clinical interventions, supervision, administrative needs for cultural change, staff issues such as vicarious traumatization.

We are looking into offering and linking to web based trauma training that is currently in existence.

Children's System of Care (CSOC)

The mission of the Department of Children of Families (DCF) is intentionally broad: In partnership with NJ's communities DCF will ensure the safety, well-being and success of NJ's children and families. DCF has the largest workforce directly interacting with children and families who are amongst our most vulnerable and have experienced the most complex trauma-related challenges. There is a growing awareness across disciplines about the need for systems working with traumatized children to be trauma-informed. Likewise, there is a call for child protection systems to be trauma-informed. As such, the primary goal of the DCF is to improve outcomes for children and families and to position all who interface with and support the work of CSOC to understand, prevent and mitigate the impact of trauma that children, youth and young adults and their families experience.

In order to further operationalize the DCF mission of ensuring the safety, well-being and success of New Jersey children and families, the Department of Children and Families has developed a Strategic Plan for the period 2014-16. The plan identifies the priorities to move the system of care along a continuum toward achieving its goal of successful community living for children and families by providing services that are appropriate, individualized in the least restrictive environment and by producing evidence that its service models are effective and fiscally sound. CSOC expansion activities will focus efforts on the following strategic plan priorities: ensuring that contracted services meet the needs of children and families served; moving out-of-home services toward using evidence informed service models; increasing the capacity of treatment programs to improve treatment outcomes; increasing the capacity of CMO staff and the community to recognize and reduce the impact of trauma; and collecting data that helps DCF and its stakeholders to understand the impact of each type of service on children and families. The DCF Strategic Plan is available at: http://www.state.nj.us/dcf/about/welfare/NJDCFStrategicPlan.pdf.

CSOC continues to support the need for high quality, timely and focused assessments as a part of the continuum of care available to children, youth and young adults and their families in New Jersey. Biopsychosocial assessments provide critical information from the child, youth or young adult and his or her immediate supports about strengths, needs, preferences, and vulnerabilities and as such, are fundamental to ensuring youth and their families become engaged in the most appropriate type, intensity, and frequency of care. Biopsychosocial assessments are conducted solely by independently licensed clinicians who have been certified by CSOC as possessing the capacity to complete the Information Management Decision Support Needs Assessment, which has been revised to incorporate a trauma-specific module.

CSOC strives to provide children, youth and young adults and their families with the right services, at the right time, for the right amount of time. Through the children's system of care, children, youth and young adults can access an array of evidence based mental and behavioral health treatments, including trauma focused therapies, such as CBT and TF-CBT. In addition, DCF's Office of Child and Family Health has a full-time clinical team that includes a pediatrician, a child/adolescent psychiatrist, and a neuropsychologist.

CSOC provides services to children, youth and young adults and their families up to age 21.The following evidence-based trauma-specific interventions are provided within the NJ children's system of care: Trauma Focused-Cognitive Behavioral Therapy, Cognitive Behavioral Therapy, Post Traumatic Stress Management Training and Psychological First Aid with Ethnocultural, Gender, and Developmental Specificity (PTSM)**;** Advanced PTSM: Response Protocols to Suicide**;** and, Classroom Based Psychosocial Intervention (CBI) and Traumatic Incident Intervention (TII).

The following trauma-specific workshops are available through the Traumatic Loss Coalitions for Youth program sponsored by CSOC:

- After a Suicide – Guidelines for Schools
- An Introduction to Evidence Based and Best Practice Suicide Prevention Programs for Schools
- Applied Suicide Intervention Skills Training (ASIST) For educators, law enforcement, mental health professionals, clergy, medical professionals, administrators, volunteers, and anyone else who might be interested in adding suicide intervention to their list of skills
- Creating Safe and Respectful Environments
- Crisis Planning for Vulnerable School Populations
- Depression in Children and Adolescents
- Enhancing Your School's Crisis Plan
- Helping a Grieving Child
- Managing Trauma and Loss in Schools For Administrators and Crisis Teams
- Preventing Youth Suicide: Awareness Training For Teachers, Parents, and Non-Mental Health Personnel
- People Skills
- Responding to Grief and Loss
- School Crisis – an Administrator's Guide to Management and Recovery
- Schools and Mental Health-Bridging the Gap in Treating the Whole Child
- School Safety is Every Adult's Responsibility
- Stress, Burnout and Vicarious Trauma
- Suicide Assessment Training for Clinicians and Counselors
- Supporting Adolescents As They Transition from High School
- Trauma and Youth
- Understanding Trauma and Loss in Youth
- Using the School I&RS Team to Support Students with Mental Illness
- Working with Resistant Teens
- Working with Youth with Mental Health Disorders

Environmental Factors and Plan

12. Criminal and Juvenile Justice

Narrative Question:

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one third meet criteria for having co-occurring substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.[79]

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance use disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.[80] [81] Rottman described the therapeutic value of problem-solving courts: "Specialized courts provide a forum in which the adversarial process can be relaxed and problem-solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs." Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[82]

Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

Please consider the following items as a guide when preparing the description of the state's system:

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?
2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?
4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

Please indicate areas of technical assistance needed related to this section.

[79] http://csgjusticecenter.org/mental-health/

[80] The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman,2000.

[81] A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs, U.S. Department of Justice, Renee L. Bender, 2001.

[82] Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.* Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

12. Criminal and Juvenile Justice

Please consider the following items as a guide when preparing the description of the state's system:

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?

   Individuals who are involved with the criminal justice system and who are seeking mental health and or substance abuse services are typically assisted with enrollment in Medicaid, SSDI or SSI if eligible. This is often accomplished by the provider the individual has come to services for. Individuals who are served by the SMHA's Justice Involved Services, which includes case management, are always assisted with enrollment. Recently, the SMHA/SSA has met with the Division of Family Development, the DHS division responsible for signing individuals up for Family Care, to establish a process to conduct Presumptive Eligibility for Medicaid. This initiative will be ongoing throughout the summer and fall of 2015. It will allow provider agencies and their certified staff to presumptively enroll individuals in Medicaid and follow-up to assist in the making that permanent. The vast majority of those individuals involved with the courts and seeking mental health or substance abuse services are within the Federal poverty guidelines.

2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?

   Those individuals incarcerated in the county jails while waiting for their dispositions are screened for medical, psychiatric and substance abuse issues upon admission. Those individuals needing medication will be seen by a psychiatrist associated through the jails behavioral health services, some of which are more robust than others. The SMHA has made efforts to increase the communication between the jails and mental health service providers whose consumers are incarcerated so that services can resume upon release. All of these efforts increase the likelihood that a defendant will receive services.

   The SMHA's Justice Involved Service Providers (JIS) all have a presence in the county jails and receive referrals of defendants with mental illness (MI) and co-occurring mental illness and substance abuse disorders (COD) who have not been adjudicated or sentenced yet. In this case, both screening and case management services are provided. Substantial portions of the JIS caseload are referrals from the adult probation departments just before or soon after sentencing. They are assessed for mental illness as criteria for participation and for needed mental health services which they are linked to.

   The SMHA has a limited number of projects that provide screening and service connection for mental illness and or co-occurring disorders within the municipal and superior courts systems themselves. A mental health professional is available to municipal court staffs who believe that a defendant is presenting with significant emotional issues. After screening for MI or COD, if the defendant has a mental illness, he or she is linked to behavioral health treatment and support services. Another form of this diversionary intervention has the

Prosecutor's Offices taking the initiative to identify defendants in conjunction with defense council, families or others. The JIS or other case management entity screens for MI and or COD and provides the linkage to treatment, health services, housing, employment and other social services. If the defendant successfully sticks the treatment plan, their charges may be dismissed or downgraded.

The SSA and the Administrative Office of the Courts partner to operate New Jersey's statewide Drug Court. The Drug Court's Substance Abuse Evaluators conduct a comprehensive clinical assessment on all Drug Court applicants once they are found legally eligible for Drug Court. As part of the substance use assessment they also conduct a mental health screening and refer participants to mental health professionals for a full evaluation, as needed. The substance abuse evaluation, in conjunction with using ASAM criteria inform the courts and SSA treatment providers with the appropriate level of care needed.

3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?

The SMHA does not provide any form of treatment, either mental health or substance abuse with a county or state correctional facility. The SMHA's JIS services provide assessment, pre-release planning, case management and successful linkages for defendants and offenders with MI and COD who are incarcerated in the County Jails either as a diversionary effort to secure and earlier release so the defendants can receive treatment in the community or assists individuals who have served their time and are transitioning back to their communities. To a lesser extent, there have been coordinated efforts with the state prisons in assisting with transitioning or securing needed mental health services.

The SMHA also collaborates with the State Parole Board (SPB) in working to assist in parolees receiving needed mental health services. There is a formal transitional/supported housing program for parolees with mental illness in the Camden area. The SMHA and SPB have created a Mutual Assistance Program (MAP) for parolees who need substance abuse services. The SPB provider's financial resources to the SMHA who then purchases the appropriate treatment services for the parolee.

In 2010, the SMHA participated in a Chief Justice initiative to more closely align the courts with the SMHA and needed mental health services. The effort, called the Interbranch Advisory Committee on Mental Health Initiatives was made up of mental health, law enforcement, prosecutor, public defender, adult probation and courts staff. The Committee produced a report in 2012 with specific recommendations which was later accepted by the New Jersey Supreme Court. The Chief Justice, in the fall of 2014, appointed an Implementation Committee to begin to operationalize recommendations from the report. The SMHA co-chairs this committee with the Judiciary.

The SSA is working collaboratively with the Department of Corrections (DOC) and local county correctional facilities to establish regulations that allow for licensed therapeutic prison-based substance use treatment. This effort is the result of legislation passed by the

New Jersey Legislature and signed by the Governor which calls for the SSA and the DOC to work collaboratively to plan for and provide substance abuse treatment similar to that provided in the community but that would be provided within the walls correctional institutions to inmates who have been screened and assessed as having substance use disorder. A workgroup made up of representatives of the SSA including licensing authority, DOC and local county jails are working to promulgate regulations for licensed substance abuse treatment and facilitate its availability behind the walls.

4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

   The most robust cross training has been the establishment of Crisis Intervention Team (CIT) training in a number of the counties in New Jersey. This collaborative police based intervention began in 2007 in one county and has spread to five additional with other counties beginning the process of establishing a county wide CIT training. CIT has involved municipal, county, transit and university law enforcement as well as dispatch and other first responders. Mental health emergency service staff as well as JIS and other case managers have participated. The SMHA funded a CIT Center for Excellence in 2009 that assists and facilitates the development of local CIT trainings. The Office of the Attorney General has collaborated with the SMHA on this initiative.

   Staff from the SMHA has been invited by the Administrative Office of the Courts to provide education on mental health to new Superior Court judges on several occasions. SMHA staff has also provided training and information sharing with a number of municipal courts. The Chief Justices Interbranch Advisory Committee previously cited had a number of cross training and educational initiatives recommended that are presenting planned for.

Juvenile Justice

Currently, youth in juvenile detention facilities are eligible for Medicaid or New Jersey FamilyCare (S-CHIP) only after adjudication and referral to a non-secure setting. Coverage expansion for the juvenile justice system under the Affordable Care Act has not yet been determined.

Protocol for Court-Ordered Assessment of Children with Emotional and Behavioral Health Needs (14 Day Plan Protocol)

In the course of proceedings involving juvenile delinquency matters or family crisis petitions, the court may learn that the child involved exhibits behavior suggesting a need for emotional, behavioral, or mental health services. When this becomes apparent at any point in court proceedings, the court may order DCF to submit a service plan to the court within 14 days (14 Day Plan) that assesses the needs of the child and the family and details how those needs may be met.

Attached is the Protocol for Court-Ordered Assessment of Children with Emotional and Behavioral Health Needs (14 Day Plan Protocol) between the DCF Children's System of Care (formerly the Division of Child Behavioral Health Services) and the New Jersey Judiciary, Family Division.

Biopsychosocial Assessments

The NJ regulations for juvenile detention facilities require that all youth entering Detention must receive the MAYSI (Massachusetts Youth Screening Instrument) within 24 hours of admission. CSOC and JJC developed a process that permits juvenile detention centers to request a Biopsychosocial clinical evaluation on any youth that may score on the MAYSI regarding possible mental health concerns.

When a court-involved youth held in a county juvenile detention facility is ordered by a Family Court judge into an out-of-home treatment facility, the youth must be transitioned from the juvenile detention center as quickly as possible. To effectively accomplish this, it is critical that youth for which a congregate care placement is contemplated be identified as early in the court involvement as possible. The New Jersey Department of Children and Families' (DCF) Children's System of Care (CSOC) has implemented an easily accessed clinical assessment process for any youth in a county juvenile detention center that may have behavioral and/or mental health issues. Clinical assessments, which a have a turn-around time of five business days, can be requested by the Social Services staff at the detention center. To accomplish this, CSOC developed a tracking system for children in county detention centers for whom a congregate care placement is being considered. The contracted system administrator's (CSA) management information system was modified to incorporate information about detention status for system-involved children. The information in the CSA management information system identifies children for whom proactive placement is initiated.

The DCF CSOC is represented on the New Jersey Council for Juvenile Justice Improvement. Diversion and the Reentry processes are being addressed by the Access to Treatment and Racial Disparities sub-committees of the Council. Formal recommendations will be presented to the full Council by the individual sub-committees.

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

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

Special Case Review Committee

The Special Case Review Committee (SCRC) reviews those juveniles, both male and female, who present multi-system needs/issues and the need for special attention or advocacy. Included are: those who appear to have developmental disabilities; those who need placement by DCF/DCP&P due to court orders for diversion or aftercare, special presenting problems, and/or homelessness; and those who are being referred or are accepted by DCF/CSOC.

The Office of Special Needs oversees the SCRC, in terms of intra- and inter-agency planning. It is chaired by the Special Needs Assistant. Members include representatives from the DCP&P Central, Middlesex, Union and Camden offices, the JJC Juvenile Parole and Transitional Services (JP & TS) Pre-Release Teams, Regional Court Liaisons/designees, the JJC Child Study Teams, JJC community residential homes, and the New Jersey Training School at Jamesburg (NJTS), Juvenile Medium Security Facility (JMSF), and the Juvenile Female Secure Care and Intake Facility (Hayes Unit) Social Services Departments.

Meetings are held twice a month, for northern and southern regional cases respectively. Referrals are primarily made from the Reception and Program Review committees, from the Reception and Assessment Center (RAC) the New Jersey Training School (NJTS), and Juvenile Female Secure Care and Intake Facility. However, youth may be referred by any source identifying a special need for advocacy and planning, including the Institutional Classification Committees, JP & TS staff, court liaisons and supervisors and program staff.

In addition to this population of JJC/DCP&P involved juveniles, DCP&P maintains an existing Memoranda of Understanding (MOU) with JJC. This MOU stipulates that DCP&P has the responsibility to plan for ***any homeless*** juvenile pending discharge from JJC. The Special Needs Review Committee will identify those juveniles and make referrals to DCP&P via State Centralized Screening (SCR) when appropriate for homeless juveniles not known to DCP&P or those juveniles whose DCP&P cases are closed. In cases where a juvenile with an open DCP&P case is pending discharge and known to be homeless, it is expected that the DCP&P worker is already engaged in permanency plans.

When JJC juveniles have permanency **and** treatment needs that require the intervention of CSOC, the JJC Special Needs Review Committee will work with CSOC and DCP&P to make appropriate referrals prior to time of discharge. In circumstances where CSOC is unable to facilitate a timely permanency plan in accordance with mandatory release dates, DCP&P will be expected to effectuate the most appropriate contingency plan until such time that a more feasible plan is developed. Care Management Organization (CMO) involvement is inclusive in this agreement when appropriate.

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

Attached is the DCF CSOC "Protocol for Supervision of Juvenile Probationers Court-ordered to Attend and Complete a CSOC Specialty Services Program." This protocol was approved in 2012 by the following: NJ Juvenile Probation Managers; NJ Conference of Chief Probation Officers; CSOC Representative for Specialty Programs; NJ Juvenile Committee of Family Presiding Judges; and, the NJ Conference of Family Presiding Judges.

DCF/CSOC funds the Technical Assistance Center through University Behavioral Health Care Rutgers, the State University to provide training statewide. CSOC, through the UMDNJ Training contract, offers training to all children's system of care providers free of charge. The following courses are available on a regularly scheduled basis throughout the year:

- Risk Assessment and Mental Health
- Crisis Intervention for At-Risk Youth
- Crisis Assessment for Parents and Caregivers
- Crisis Cycle
- Developing and Managing the Family Crisis Plan
- Safety Issues Working in the Community
- Youth Behavior, Diagnosis and Intervention Strategies
- Risk Assessment and Mental Health
- Domestic Violence: An Introduction to Domestic Violence
- Working with Challenging and Aggressive Adolescent Behaviors
- Working with Traumatized and Aggressive Youth
- MRSS Orientation – Crisis Response Protocol (Day One)
- MRSS Orientation – Crisis Assessment Tool (CAT) and Developing the

- Individualized Crisis Plan (ICP)
- MRSS Orientation – Crisis Response Protocol (Day 2)
- Understanding Child Abuse and Mandatory Reporting Laws
- Youth Gang Involvement in NJ
- Substance Use and Abuse: Youth with Co-Occurring Developmental and Mental Health Challenges
- Substance Abuse 2: A Closer Look – Family and Addiction

In addition, CSOC staff provides training on working with individuals with behavioral health challenges to staff of the Juvenile Justice Commission.

NEW JERSEY JUDICIARY, FAMILY DIVISION
AND
DEPARTMENT OF CHILDREN AND FAMILIES, DIVISION OF CHILD BEHAVAVIORAL HEALTH

PROTOCOL FOR COURT-ORDERED ASSESSMENT OF CHILDREN WITH EMOTIONAL AND BEHAVIORAL HEALTH NEEDS (14 DAY PLAN PROTOCOL)[1]

April 11, 2008

I. BACKGROUND

The New Jersey Department of Children and Families (DCF) is by statute the government entity responsible for services and supports for children in need of protection, permanency and emotional, behavioral and mental health services. DCF oversees various services for children and families to ensure children's safety, permanency and well-being and to help families and children through social, emotional and other problems that could result in family disruption.

DCF encompasses two agencies of concern in the present matter: the Division of Youth and Family Services (DYFS) and the Division of Child Behavioral Health Services (DCBHS). DYFS has statutory responsibility for youth and families for whom safety and permanency concerns are evident. DCBHS is responsible for the emotional and behavioral health needs of youth. DCBHS is ensures, through contracted providers, that services are delivered through family centered planning and community based treatment for children driven by clinical assessment and determined need. It is the imperative of all DCF services that youth are served in their communities, with fortified connections to family. Best practices and overwhelming data demonstrate attending to the behavioral health needs of youth in a family-centered, community-based model maximizes positive change and reduces the likelihood of readmission to services to recidivism with the court. Typically, DCBHS recommends community-based treatment services to the court, including other community based treatment programs and informal supports, rather than out-of-treatment options.

In the course of proceedings involving juvenile delinquency matters or family crisis petitions, the court may learn that the child involved exhibits behavior suggesting a need for emotional, behavioral, or mental health services. When this becomes apparent at any point in court proceedings, the court may order DCF to submit a service plan to the court within 14 days (14 Day Plan) that assesses the needs of the child and the family and details how those needs may be met.

This document sets forth a protocol delineating the roles and responsibilities of DCF and the court in ordering, completing, and executing 14 Day Plans. This protocol is applicable to all cases involving children and families in need of mental health assessments and is consistent with the protocol issued by the Administrative Director of the Courts on May 17, 2005 regarding mental health assessments of juveniles in detention. This protocol was collaboratively developed

[1] Revised to reflect the new statute limiting disclosure clinical information prior adjudication.

and has been endorsed by the Conference of Family Presiding Judges. The language of the protocol was jointly prepared by the Judiciary and DCF in order to accommodate recent organizational changes at DCF.

II. PRINCIPLES

The Judiciary and DCF have agreed to the following principles concerning the evaluation of children and families with apparent emotional or behavioral health needs.

A. Judiciary

1. Under ordinary circumstances, when seeking to identify emotional or behavioral health needs, the court should order only DCF to prepare the 14 Day Plan and to identify service needs. The court should generally resist the temptation to identify more specific case management entities within DCF, (e.g., DCBHS, DYFS, CMO, YCM, Value Options, etc.) The court should avoid ordering DCF to conduct specific and multiple assessments when ordering the 14 Day Plan such as psychological, psychiatric, and neurological recognizing that the determination of an appropriate evaluation is a clinical activity in and of itself.

2. The court's initial order should not specify a presumed level of care. This protocol works best when DCF, through its use of clinically licensed practitioners, exercises its function by identifying needs and provide the court with an appropriate proposed plan on the basis of those needs.

3. In cases in which out-of-home treatment is clearly required, the court should order the development of a plan that provides for DCF out-of-home treatment, rather than specify a particular treatment facility or presumed level of care.

4. In a situation in which the court has ordered out-of-home treatment but the case manager suggests another viable option exists to meet the needs of the child and family, the court should consider either modifying its order or allowing concurrent pursuit of both the court-ordered plan and the suggested alternative. While the court maintains the final authority to determine the proper disposition, the court should give fair consideration to proposed plans that provide for community based services (rather than out-of-home treatment options), so long as the issue of the community safety is addressed.

B. DCF

1. The DCF Court liaison is responsible for communications between the court and DCF and its component divisions. A DCF Court liaison had been designated in each county and is responsible for reviewing court orders and routing each such court order to the appropriate agency.

2. The 14 Day Plan must specify the level of need and the services that will be required and include a specific time frame for the initiation of services.

3. If case management entities have difficulty engaging a youth and/or family in developing the 14 Day Plan, staff must immediately notify the court of the situation while continuing to pursue development of a response to the court's order to the extent possible. The court may

compel the parents or child to cooperate or may direct completion of the plan without their cooperation.

4. On the rare occasion that a court order contradicts a clinical decision, the order must be recognized as an exception and nevertheless be aggressively pursued. Thus, DCF authorizes staff of DYFS and DCBHS contractors and providers listed below to comply with the provisions of the court order as they relate to out-of-home treatment settings. It is the responsibility of the assigned staff to take steps to ensure compliance with the order of the court.

III. PROCEDURES

The Judiciary and DCF, through its management contractors and service providers (see below), have agreed to the following procedures concerning the evaluation of children and families with apparent emotional or behavioral health needs.

DCBHS contractors include:

- Contracted System Administrator (CSA) – Coordinates the care needs of children and their families across all child-serving systems.

- Youth Case Management (YCM) – Provides case management services for children and families with moderate behavioral and emotional health needs. In Camden, Essex, and Middlesex counties, YCM services are provided by the Youth Advocacy Program or the Detention Alternative Program (YAP/DAP). YCM is also an authorized referral source for out-of-home treatment settings.

- Care Management Organization (CMO) – Provides individual case management for children and youth with complex behavioral and emotional health needs.

A. Judiciary

To refer children and families with emotional and behavioral health needs for services in the context of determining and exercising the Courts imperative to ensure community safety :

1. Judges should order the completion of a 14 Day Plan and forward the order to the DCF Court Liaison.

2. Court staff will share available information with the appropriate case management entity as determined by the DCF Court Liaison.

3. The court will enforce parental participation if necessary.

4. The court will give serious consideration to any alternative plans proposed by the appropriate case management entity that address the needs of the child as well as the concerns of the court.

B. DCF Court Liaison

The DCF Court Liaison will review the court order and route the order to the appropriate case management entity based on the following criteria:

1. The DCF Court Liaison will transmit court orders with referrals for protection and permanency issues where DYFS has current involvement with the child's family to the DYFS Local Office, where a DYFS worker will prepare the 14 Day Plan.

2. The DCF Court Liaison will transmit court orders with referrals for emotional or behavioral issues—but with no protection or permanency issues—to the YCM supervisor to prepare the 14 Day Plan.

3. In the cases where the court order includes referrals for both protection/permanency and emotional/behavioral needs, the DCF Court Liaison will transmit the court order to the appropriate DYFS Local Office where a DYFS worker will prepare the 14 Day Plan.

4. In some cases, the court will order DCF to effect an out-of-home placement at the inception of the 14 Day Plan. The DCF Court Liaison will direct these cases to the appropriate DCF entity for preparation of the 14 Day Plan.

C. Youth Case Management (YCM)/Care Management Organization (CMO)

The case management agencies contracted by DCBHS, Youth Case Management (YCM) and Care Management Organization (CMO), should observe the following procedures:

1. The YCM/CMO supervisor or designee reviews the referral received from the DCF Court Liaison,
assigns the child and the family to a youth case manager, and notes in the record that a delinquency charge is pending. The DCBHS contracted case management entity will send a letter to the attorney representing the juvenile indicating the contracted case management entity's involvement with the family. The case manager assigned will register the child and family with the Contract Systems Administrator (CSA) by calling the CSA Customer Services Representative at 1-877-652-7652.

2. YCM/CMO will complete the Presumptive Eligibility process with the child and family.

3. YCM/CMO will complete the Needs Assessment and develop a Service Plan to meet the needs of
the child/family and arrange for appropriate services when necessary.

4. YCM/CMO will contact the Family Court and gather information necessary to complete the Needs
Assessment.

5. Prior to the adjudication of delinquency or finding of guilt, YCM/CMO will submit the Service Plan

to the attorney representing the juvenile within 14 days. However, an attorney representing a juvenile, with the juvenile's consent, may disclose the Service Plan and other such reports or records prior to the adjudication of delinquency or finding of guilt. See *N.J.S.A.* 2A:4A-60.3

6. YCM/CMO maintains primary responsibility for the completion of the Needs Assessment; the planning process will not depend exclusively on the information provided by the court.

7. YCM/CMO will coordinate the Service Plan process and arrange for delivery of services to the child.

8. YCM/CMO can seek assistance from the court if there is a lack of parental cooperation.

9. YCM/CMO will respond to any specific orders or directions from the court.

10. YCM/CMO will electronically submit the Needs Assessment and the Service Plan to the CSA for review and authorization after review and approval by the court.

11. YCM/CMO will use the "One Tab" Service Request Form and will enter any additional information regarding the Service Plan into Progress Notes, the DCF case record system.

12. YCM/CMO will have responsibility for implementation of the Service Plans for children and families with moderate needs. When YCM/CMO continues providing services to a child and family, the CSA will authorize YCM/CMO services for a period of no more than 90 days.

13. When YCM determines that the child and family require a higher level of case management services, YCM will contact the CSA and request that the child be referred to the CMO for case management services. If the CMO is not available, the YCM will retain responsibility.

14. YCM in conjunction with the Family Team, as designated by YCM, may request an extension of youth case management services beyond the initial 90-day authorization via an electronic submission of a Strengths and Needs Assessment and an updated Service Plan within two weeks prior to the authorization expiration date.

15. Whenever DCF services are part of a disposition, the case management entity must notify the court or probation if services are being terminated, for whatever reason.

D. Contracted Systems Administrator (CSA)

CSA, which determines appropriate level of care and authorizes appropriate services for children, adolescents and their families across all child-serving systems, should observe the following procedures.

1. CSA will register the child, check eligibility, and enter the authorization(s).

2. CSA will authorize 14 units of services for a period of time not to exceed 90 days from the date of registration.

3. CSA will give the YCM access to the child's Absolute-MIS case record at the time of registration.

4. CSA will review the Clinical Evaluation and Needs Assessment and call the YCM with any questions.

PROTOCOL FOR SUPERVISION OF JUVENILE PROBATIONERS COURT-ORDERED TO ATTEND AND COMPLETE A DCSC SPECIALTY SERVICES PROGRAM

The following protocol was developed in a collaborative work group comprised of representatives from the Department of Children and Families/ Division of Children's System of Care, Specialty Service Providers and the Judiciary Probation Division. It is recognized that Specialty Services Programs address particular treatment needs of youth whose needs are beyond the "traditional" complement of services. These youth, who may be ordered into such programs by the Family Court as a condition of Probation, exhibit sexual aggression, fire-setting, extreme violent behaviors and effects of complex trauma. Cooperation and understanding between the treatment providers and Probation Officers is crucial to the youths' successful reintegration with their families and communities. This protocol addresses key areas of initial and on-going communication between probation, the families, and the treatment providers to ensure a unified approach in addressing the needs of these youth during placement and in aftercare planning.

1. **Conditions of probation, which include the special condition to complete the treatment program, must be explained to the juvenile and parent/guardian and signed by all. If the juvenile goes to the program directly from detention, the shelter or an alternative detention program, the assigned Probation Officer (PO) must make arrangements to have the conditions explained and signed as quickly as possible.**

2. **Within 5 business days of the juvenile's entrance into the program, the PO must contact the program either by phone or e-mail to exchange contact information. All program contact information should be entered into CAPS. The program should be provided the phone numbers and e-mail addresses for the assigned PO and Supervisor as well as the address for correspondence/payments (including CAPS Case #). The PO should ensure that the program has the court order, signed conditions of probation, and any other court documents needed for the placement. The program should include Probation on consent forms that are signed at the time of admission and should notify Probation of all Child Family Team meetings and upcoming home visits and forward copies of all progress reports to the PO. The Child Family Team consists of the youth and the adults in that youth's life who will assist in the success of the treatment plan including but not limited to the parents/guardians, clinician, PO, and care manager.**

3. **The assigned PO should consult with the Youth Case Manager during Probation Intake in order to gather additional information about the juvenile/family situation. The initial home inspection should be completed before the juvenile comes home for their first visit.**

4. **The program or DCF care manager will provide the parent/guardian with the name and phone number of the treatment provider for their child. During the initial supervision contact, the assigned PO should ensure that the parent/guardian has this information. Parents should be encouraged to participate in the treatment protocol which normally includes Child Family Team meetings, scheduled visits to the program, and may include home visits for their child.**

5. **It should be stressed to the parent/guardian by both Probation and the Care Manager that the PO will work in collaboration with the youth, parent/guardian, and program to achieve a successful outcome. It should be explained that the PO may take part in Child Family Team meetings, will receive progress reports; will be apprised of behavior (both positive and negative) and will be notified of home visits. The parents/guardian should be advised that the PO will also maintain contact with them while their child is in placement. The PO may conduct a home visit when the probationer is home from the program on a home pass. Parents should be encouraged to report all behaviors, positive and negative, to probation following a**

home visit. While the probationer is in program, home inspections and home visits may be conducted as determined by the supervision plan.

6. **The parent/guardian should be advised that they may contact the PO/supervisor if they have concerns that cannot be addressed with the program or during Child Family Team meetings.**

7. **A minimum of once per month, per Outcome-Based Supervision Standards, the PO must monitor and document the probationer's progress. Every effort should be made to visit the program in-person but contact should also be made via telephone contacts to the treatment provider. Routine and on-going contact with the program ensures that interaction with Probation is not triggered by non-compliance rather it is an ongoing collaboration to achieve a positive outcome for that juvenile.**

8. **Every effort should be made for POs to attend the Child Family Team meetings in-person. When personal attendance is not possible, the PO should utilize video or phone conferencing or the assistance of a proxy PO as appropriate.**

9. **Probation should make every effort to assist program staff. This includes collaborating with assigned program staff to reward the probationer for progress and to counsel the probationer to come into compliance. While the juvenile is in placement, the PO may also assist by securing needed documents, contacting the parent/guardians, verifying or assessing the residence, or assisting to contact community agencies.**

10. **The PO is the point of communication between the program and the Courts. The PO will ensure that the Judge is apprised of issues as appropriate. The program will send all correspondence to the PO and not directly to the Judge unless otherwise ordered by the court. If a youth has a scheduled Court date on open charges, the correspondence is also sent to youth's defense attorney.**

11. **It is expected that program staff will address problem behavior by utilizing their approved interventions and sanctions. The PO should be kept informed of behavior and follow-up plans, however the PO should not be expected to file a VOP or request a bench warrant to have the probationer removed. In some circumstances, the PO, after consulting with the supervisor, may suggest an Administrative Review as an effort to address problem behavior. An Administrative Review is a formal scheduled meeting in the Probation office with the juvenile, parent/guardian, program treatment provider, probation officer and supervisor/manager. The purpose of the Administrative Review is to clarify expectations and consequences and to give the juvenile an opportunity to correct problem behavior. The program will transport the juvenile to and from the Probation office. If the program treatment provider is unable to attend the Administrative Review in-person, he or she should be available via conference call.**

12. **A decision will be made through the Child Family Team whether or not the juvenile can continue to be maintained at that program. Before any decisions are made regarding the placement status however, the provider must first follow the DCSC protocol ("No Eject/No Reject") to determine that all clinical interventions have been tried. If it is decided by the Child Family Team that a different program is needed, a Transitional Joint Care Review (TJCR) will be completed by the program and submitted to contract systems administrator (CSA). The care manager will enter a progress note stating they are in agreement with the TJCR. This will place the youth back on the Youth Link "bulletin board" pending transition to the next program.**

The program is expected to maintain the probationer in their program until an alternate program is secured.

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13. **If the probationer commits a new offense, the law enforcement officer filing the complaint will follow the normal procedure for detention. The next business day, the program will notify the PO of the new offense and any pertinent details surrounding the incident. If the offense did not meet detention criteria, the PO should not automatically be expected to request a bench warrant to have the probationer removed; rather the situation will be reviewed in consultation with the Child Family Team members and in consideration for the safety of the probationer, program staff, other program participants and members of the community.**

14. **If the probationer leaves the program without permission and his/her whereabouts are known to the program staff and parent/guardian, the PO should be notified immediately and every effort should be made to return the youth to the program. If the youth is not returned or refuses to return and the program decides to discharge the youth per Medicaid regulations, an incident summary will be forwarded to the PO. A VOP or court review may be requested depending on the circumstances.**

15. **If the probationer leaves the program without permission and his/her whereabouts are unknown to program staff and parent/guardian, the program will immediately make reasonable attempts to locate the juvenile by contacting family and known associates, utilizing the assistance of the Youth Case Manager, CMO, DYFS, UCM or other authorities. If the youth has not returned or cannot be located within 3 hours, the program should follow protocol for reporting the youth as a missing person and should also notify the PO at that time. Upon notification, the PO may make additional reasonable attempts to locate the juvenile. The program will forward an incident summary report to the PO by the next business day. If the youth's whereabouts remain unknown at the time the PO receives the incident summary report, a VOP will be filed and a warrant will be requested at that time.**

16. **It should be noted that the Transitional Joint Care Review (TJCR) is also utilized when a juvenile has completed a particular program and is clinically appropriate for a step-down placement. The supervising PO should be involved in the team meetings for this discussion.**

17. **The aftercare planning should begin a minimum of 90 days before release. The PO should be actively involved in aftercare planning, not limited to: identifying community resources; assessing the most current living situation; linking with the school; and developing a case plan consistent with identified aftercare needs and safety plans and ensuring that Megan's Law registration requirements are met. Upon discharge, program staff will supply the PO with a copy of the Discharge Summary and Aftercare Plan, including dates of any appointments which have already been scheduled. A Probation reporting date should be established prior to discharge and incorporated into the scheduled appointments. Upon the probationer's return to the family, the supervision level should be "CLOSE" for a minimum of 30 days in order to support the Aftercare Plan and assist the probationer to make a positive adjustment. The PO/supervisor will assess the youth's progress after 30 days to determine the appropriate supervision level. Specialized supervision cases will remain at close supervision. Coordination may also be made with the local multi-disciplinary team to support the juvenile's needs and the availability of resources.**

Approved: Juvenile Probation Managers 3-27-12
Approved: Conference of Chief Probation Officers 3-28-2012
Approved: DCSC representative Specialty Programs 4-17-12
Approved Juvenile Cmte of Family PJs 6-5-2012
Approved Conference of Family Presiding Judges 6-13-2012

Environmental Factors and Plan

13. State Parity Efforts

Narrative Question:

MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment - and to comply with MHPAEA. Guidance was released for states in January 2013.[83]

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.[84]

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. SMHAs and SSAs should collaborate with their state's Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Please consider the following items as a guide when preparing the description of the state's system:

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?
2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?
3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

Please indicate areas of technical assistance needed related to this section.

[83] http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf

[84] Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. Psychiatric Services. 60(12) 1589-1594

Please use the box below to indicate areas of technical assistance needed related to this section:

DMHAS requests technical assistance for the training of state staff and contracted agencies in the intersection of federal parity laws in the context of mental health treatment being one of the 10 Essential Health Benefits mandated by the Affordable Care Act. Technical assistance for consumers, as beneficiaries of health insurance, is also requested and will include information about health insurance benefits and the need to understand these benefits in order to best manage their wellness and recovery.

Footnotes:

13. State Parity Efforts

Please consider the following items as a guide when preparing the description of the state's system:

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?

   Grants from SAMSHA for purposes of education and communication of both public and private sector stakeholders would allow for greater, broader and more effective communication of the MHPAEA benefits for purposes of better behavioral health integration and parity. The combination of the MHPAEA, the ACA and the New Jersey Mental Health Parity Law (generally, N.J.S.A. 17:48-6v; N.J.S.A. 26:2J-4.20) allows for expanded mental health treatment opportunities, though the public is not always aware of the greater treatment access these particular set of laws has created.

   In addition to the legislation, New Jersey Medicaid made application to CMS for a state plan amendment to assure that there is parity with the benefit plans for substance use and other mental health services as part of the movement to managed care in the state of New Jersey. The communication of this vital initiative is usually through Medicaid newsletters and through regular meetings with stakeholders such as the managed care organizations, the Medical Assistance Advisory Council, consumer groups and interagency workgroups of which DMHAS is lead member. Funding for additional messaging and educational forums would allow for presentation to the larger community and assist with access to services.

2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?

   DMHAS sponsors three regional consumer constituency meetings on a regional basis with the executive management and the Special Assistant for Consumer Affairs. These meetings are held with the purpose of creating a dialogue between our consumer clients and the policy and decision-makers at DMHAS. A section of each monthly meeting is dedicated to educating consumers about topical issues that impact their lives. Over the course of the past 18 months, we have had a continuous dialogue about parity and improved access to mental health and substance abuse services. We have also dedicated conversations on the importance of accessing preventative care for the first time in many individuals' lives. This has been very powerful and exciting initiative to see roll out.

   New Jersey does coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of MHPAEA, most specifically to address the types of benefit packages that would be available. Examples of such policy and operational coordination are primarily through New Jersey Medicaid and are supported by DMHAS.

3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

New Jersey does coordinate across public and private sector entities primarily through its Medicaid agency. There are regular stakeholder meetings with the managed care organizations in Medicaid which provide both behavioral health and primary care benefits and there are regular meetings with the Department of insurance with private insurance entitles for policy, access and operational coordination. Additionally, advisory organizations like the Medical Assistance Advisory Council, the Governor's Council on Mental Health Stigma, and the Governor's Council on Drug and Alcohol Abuse provide education and public awareness and information on how to access benefits through Medicare, Medicaid and through health management organizations as other private sector insurance. Parity information is also available through these organizations as well.

Please indicate areas of technical assistance needed related to this section.

DMHAS requests technical assistance for the training of state staff and contracted agencies in the intersection of federal parity laws in the context of mental health treatment being one of the 10 Essential Health Benefits mandated by the Affordable Care Act. Technical assistance for consumers, as beneficiaries of health insurance, is also requested and will include information about health insurance benefits and the need to understand these benefits in order to best manage their wellness and recovery.

Environmental Factors and Plan

14. Medication Assisted Treatment

Narrative Question:

There is a voluminous literature on the efficacy of FDA-approved medications for the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for medication-assisted treatment of these disorders is described in SAMHSA TIPs 40[85], 43[86], 45[87], and 49[88]. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?
2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?
3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

Please indicate areas of technical assistance needed related to this section.

[85] http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939

[86] http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214

[87] http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131

[88] http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380

Please use the box below to indicate areas of technical assistance needed related to this section:

• TA on Criminal Justice and MAT

Footnotes:

14. Medication Assisted Treatment

Please consider the following items as a guide when preparing the description of the state's system:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?

    - DMHAS currently contracts with four licensed Opioid Treatment Programs in five specific counties to provide education and training to lay-persons responding to an opiate overdose, and to distribute naloxone in intranasal or injectable form to those who are trained. Kits containing the naloxone antidote are being distributed to attendees at the training sessions. A new RFP for a similar service was released in July, known as the Opioid Overdose Prevention Program, is regionally based and will cover all counties in New Jersey.

    - DMHAS continues to work with hospitals/emergency departments to formulate a procedure of how to refer individuals who were reversed from an opioid overdose (following administration of Naloxone) to substance abuse treatment.

    - DMHAS to continue to collaborate among multiple State Departments and Divisions on GCADA's "Addiction Does Not Discriminate" campaign.

    - DMHAS to continue to work on New Jersey's Opioid Epidemic Strategic Plan with the Attorney General's Office, Department of Health, Division of Medical Assistance and Health Services, Department of Children and Families and Juvenile Justice Commission.

    - Some OTPs classify their programs as their 1) Methadone Program and their other program as their 2) Drug-Free Program. Having this break-down or the term used "Drug-Free" is stigmatizing and possibly this term should be refrained from being used moving forward, especially if we are promoting MAT as a best practice.

    - The Division publishes the following language in its Requests for Proposals (RFPs) for contract funds.

      "If the contract(s) resulting from this RFP includes drug treatment services, then the contract awardee must have in place established, facility-wide policies that prohibit discrimination against consumers of prevention, treatment and recovery support services assisted in their prevention, treatment and/or recovery with legitimately prescribed medication(s). These policies must be in writing in a visible, legible and clear posting at a common location accessible to all who enter the facility.

      Moreover, no consumer admitted into a treatment facility, or a recipient of or participant in any prevention, treatment or recovery support services, shall be denied full access to,

participation in and enjoyment of that program, service or activity, available or offered to others, due to the use of legitimately prescribed medications.

Capacity to accommodate consumers who present or are referred with legitimately prescribed medications can be accomplished either through direct provision of services associated with the provision or dispensing of medications and/or via development of viable networks/referrals/consultants/sub-contracting with those who are licensed and otherwise qualified to provide medications."

- All women's treatment contracts have the following Annex A requirements.

  (1) Medication-Assisted Treatment (MAT) is the standard of care for pregnant women with opioid addiction (Treatment Improvement Protocol 43, Chapter 13). Opioid-addicted pregnant women should not undergo opioid detoxification because of risk to the fetus. The contractee shall ensure that pregnant women are immediately provided with or referred to comprehensive medication assisted treatment which decreases medication complications, improves pregnancy outcomes, and encourages fetal stability and growth.

  (2) MAT shall be continued throughout the pregnancy and arrangements shall be made for women who wish to continue to remain on MAT. All women will be given timely access to prenatal care either by the program or by referral to appropriate healthcare providers (provide documentation in woman's file)

  (3) The contractee shall ensure that **priority** admission to the program will be given to IV using, pregnant women and parenting women.

2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?

   - DMHAS will continue to participate in the Opioid Data Study Team whose focus is on identifying, using, and building upon existing data related to opioid use and misuse. From outcomes collected, the State may be able to implement programming in places where trends are showing higher opioid usage.

   - DMHAS will continue to collaborate with the New Jersey State Police and other State departments to utilize fusion center mapping to track the number of heroin seizures and naloxone administrations occurring in specific geographic areas.

   - DMHAS will continue MAT presentations and meetings with Drug Courts, County Prosecutors and others in the criminal justice fields to discuss the benefits of MAT for this specific population.

   - The SSA has successfully established several learning communities to enhance the treatment provider's delivery of critical substance abuse services such as a co-occurring mental health and substance disorders. The SSA is in the process of establishing a

Medication Assisted Treatment Learning Community (MATLC) to increase the opioid treatment providers, and other MAT provider's awareness of best practices, appropriate clinical profiles, MAT delivery and reporting. This is particularly important since legislation was recently passed which would require New Jersey Drug Courts to allow participants to graduate who are on MAT. The MATLC would invite MAT providers to participate and gather initially bi-monthly to share information, learn from experts and each other.

3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

- Continue contracting or funding the Medication Assisted Treatment Initiative (MATI) which incorporates the use of both Methadone and Buprenorphine for those individuals with an opioid use disorder.

- Continue to fund and support the Vivitrol Enhancement Package through our FFS initiative which incorporates and encourages the use of Vivitrol for opioid use and alcohol use disorders.

- Continue meeting with physicians at the OTPs and other substance abuse treatment programs on a quarterly basis to discuss the latest evidence based practices that exist and how to best implement them throughout the State.

- In May 2015, DMHAS submitted an application for federal funding for its three-year Medication Assisted Treatment Outreach Program (MATOP) under the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) Targeted Capacity Expansion: Medication Assisted Treatment-Prescription Drug and Opioid Addiction grant opportunity. DMHAS was awarded this grant with a start date of August. MATOP will provide accessible, comprehensive and integrated care, using evidence-based programs such as medication assisted treatment (MAT), mindfulness based recovery maintenance, smoking cessation and other recovery support services for individuals with an opioid use disorder. Three New Jersey licensed Opioid Treatment Programs (OTPs) will participate in this initiative and provide outreach and other engagement strategies to diverse populations at risk such as incarcerated individuals, pregnant and parenting women, veterans, parents and caregivers involved with the child welfare system, opioid overdose reversals and syringe access program participants. In addition, DMHAS will partner with Rutgers University, Robert Wood Johnson Medical School to provide trainings and webinar series for OTP providers, patients and their families. Trainings and webinar series will focus on increasing understanding of the effectiveness of MAT among patients and providers throughout New Jersey, as well as to address misconceptions regarding the use of MAT, smoking cessation and mindfulness based recovery maintenance. New Jersey's project will serve

130 unduplicated individuals annually and 390 unduplicated individuals over the entire project period.

Please indicate areas of technical assistance needed related to this section.

- TA on Criminal Justice and MAT

Environmental Factors and Plan

15. Crisis Services

Narrative Question:

In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises.

SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises[89] ,

> "Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports being used to address crisis response include the following:

Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning
- Psychiatric Advance Directives
- Family Engagement
- Safety Planning
- Peer-Operated Warm Lines
- Peer-Run Crisis Respite Programs
- Suicide Prevention

Crisis Intervention/Stabilization:

- Assessment/Triage (Living Room Model)
- Open Dialogue
- Crisis Residential/Respite
- Crisis Intervention Team/ Law Enforcement
- Mobile Crisis Outreach
- Collaboration with Hospital Emergency Departments and Urgent Care Systems

Post Crisis Intervention/Support:

- WRAP Post-Crisis
- Peer Support/Peer Bridgers
- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

Please indicate areas of technical assistance needed related to this section.

[89]Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

15. Crisis Services

Early Intervention Support Services (EISS)

DMHAS now funds eleven Early Intervention Support Services (EISS) programs at an approximate annual cost of $11.5M. These programs serve as urgent mental health community clinics that provide rapid access to short term, crisis intervention and stabilization services to persons with a serious mental illness. EISS serves individual who are 18 years of age or older and offers crisis intervention services outside of the hospital emergency department setting.

A broad range of recovery-oriented services are offered including: comprehensive bio-psycho-social assessments; including an assessment of individuals' needs related to pharmacologic treatments; Medication Prescription, Administration and Education; short-term individual psycho-therapy; Family therapy; Wellness Recovery Action Plans (WRAP) and short term case-management

After-office hour and weekend access, an ability to accommodate "walk-ins" and expedient access to staff with psychiatric prescriptive privileges are critical program characteristics. Further, the program's ability to 'keep the front door open' while avoiding waiting lists for services is paramount.

DMHAS believes that intervention accessed earlier in the crisis cycle and earlier in the course of illness can improve consumer and system outcomes, increase community tenure, decrease the potential for trauma, lower costs for consumers, families and service providers, positively impact the utilization of hospital emergency rooms and allow for better consumer and system outcomes.

During 2014, the state's EISS programs delivered 10,737 episodes of care, with these episodes ranging from one contact (assessment and referral) to 30 days of comprehensive crisis stabilization services.

Mobile Crisis Outreach

Via regulation and contract, DMHAS' Designated Screening Service programs offer mobile crisis outreach. Certified screening staff conducted 9607 community outreaches during state fiscal year 2014. Additionally, 478 mobile outreaches to jail settings and 395 to nursing/assisted living facilities were conducted.

Involuntary Out-patient Commitment

In 2009, the state's civil commitment law was amended, allowing for involuntary commitment to mental health care in an out-patient setting. This outpatient commitment status is intended to provide a treatment option in the community for a class of consumers who are not willing to receive treatment voluntarily and will become, in the foreseeable future, dangerous enough because of a mental illness to require supervision, but who are not so imminently dangerous that they need to be physically confined in an inpatient program. After three solicitations, DMHAS

now supports fifteen operational Involuntary Out-patient Commitment (IOC) programs at an annualized cost of approximately $5.3M.

Involuntary Outpatient Commitment (IOC) programs coordinate community based mental health services for individuals, who are court ordered into mental health treatment. IOC programs enroll individuals who have been adjudicated by a court as meeting the legal standard for involuntary commitment to outpatient treatment. These programs offer: Court ordered out-patient based mental health treatment; Assistance with linking with community based mental health services; Monitoring of adherence to the court ordered plan; Ongoing assessment of clinical progress; Interface with the judiciary including transportation to court hearings and contact with the presiding judge, as needed.

During state fiscal year 2014, 351 persons were enrolled in the six then operational IOC programs. Since eight of the fifteen programs reference above became operational during the fall of 2014, DMHAS anticipates this figure increasing significantly for state fiscal year 2015. In fact, through January 31, 2015, 314 persons have been enrolled in IOC during the first seven months of the current fiscal year.

Children's System of Care (CSOC)

Mobile Response Stabilization Services (MRSS)

MRSS-Initial 72 hours

Mobile Response and Stabilization Services are available 24 hours a day, seven days a week, to help children and youth who are experiencing emotional or behavioral crises. The services are designed to defuse an immediate crisis, keep children and their families safe, and maintain the children in their own homes or current living situation (such as a foster home, treatment home or group home) in the community.

The goals of Mobile Response Initial Services are as follows:

- rapidly respond to any non-immediate life threatening mental health crisis reaction and/or youth with escalating emotional and/or behavioral health needs
- provide immediate intervention to assist children/youth and their parents/caregivers/guardians in de-escalating behaviors, emotions and/or dynamics impacting youth life functioning ability
- Prevent/reduce the need for care in more restrictive settings e.g. inpatient psychiatric hospitalization, detention, etc. by providing timely community based intervention and wrap around service delivery/resource development.
- Effectively engage, assess and plan for appropriate interventions to minimize risk, aid in behavior stabilization, and improve life functioning, allowing the child/youth to remain in, or return to, his/her present living arrangement, functioning in school and community settings, and maintain least restrictive treatment setting.
- Facilitate the child/youth's and the parent/caregiver/guardian's transition into identified supports, resources and services post Mobile Response Initial Services including but not limited to Mobile Response Stabilization Management Services, Care Management Services, outpatient services, evidence based services, community based supports and natural resources.

More detailed information is available at the following link:
http://www.performcarenj.org/pdf/provider/clinicalcriteria/mobile-response-serv-72-hrs.pdf.

MRSS-Up to 8 Weeks

Mobile Response Stabilization interventions provide parents/caregivers/guardians with short-term, flexible services that assist in stabilizing children/youth in their home/community setting. Interventions are designed to maintain the child/youth in his/her current living arrangement, to prevent repeated hospitalizations, to stabilize behavioral health needs and to improve functioning in life domains, as identified. Interventions at this level of care include the delivery of a flexible variety of services through the development of a comprehensive and coordinated Individual Crisis Plan (ICP). Children/youth, based upon need, enter Mobile Response Stabilization Services following the completion of the Mobile Response Assessment and the development of the ICP by the Mobile Response Team during the first 72 hours.

Interventions may include, but are not limited to, crisis intervention, counseling, stabilization bed services, behavioral assistance, in-home therapy, intensive in-community services, skill building,

mentoring, medication management and/or parent/caregiver/guardian stabilization interventions. Mobile Response Stabilization Services are managed and monitored by the Children's Mobile Response Stabilization Services Agency and pre-authorized and reviewed by Perform Care, the Contracted Systems Administrator. Mobile Response Stabilization interventions can be delivered for up to eight weeks. Use of these interventions will vary by setting, intensity, duration and identified needs. The objective of Mobile Response Stabilization Services would be to ultimately defuse the current crisis and help link the youth and family with longer-standing therapeutic resources which are consistent with their treatment needs. This may involve linking the family with services outside of the CSOC system, such as Division of Developmental Disabilities, Autism specialized services, or community based therapeutic nursery programs, where available.

More detailed information is available at the following link: http://www.performcarenj.org/pdf/provider/clinicalcriteria/mobile-response-serv-8-wks.pdf.

Environmental Factors and Plan

16. Recovery

Narrative Question:

The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.

Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of health (access to quality health and behavioral health treatment), home (housing with needed supports), purpose (education, employment, and other pursuits), and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Drop-in centers
- Peer-delivered motivational interviewing
- Peer specialist/Promotoras
- Clubhouses
- Self-directed care
- Supportive housing models
- Recovery community centers
- WRAP
- Evidenced-based supported
- Family navigators/parent support partners/providers
- Peer health navigators
- Peer wellness coaching
- Recovery coaching
- Shared decision making
- Telephone recovery checkups
- Warm lines
- Whole Health Action Management (WHAM)
- Mutual aid groups for individuals with MH/SA Disorders or CODs
- Peer-run respite services
- Person-centered planning
- Self-care and wellness approaches
- Peer-run crisis diversion services
- Wellness-based community campaign

employment

SAMHSA encourages states to take proactive steps to implement recovery support services, and is seeking input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Recovery is based on the involvement of consumers/peers and their family members. States should work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

Please consider the following items as a guideline when preparing the description of the state's system:

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?
6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?
11. Describe how the state is supporting the employment and educational needs of individuals served.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Technical assistance from Rutgers on Learning About Healthy Living Smoking Cessation, how to engage diverse populations (racial, ethnic, LGBT, Trauma, etc.)

Assisting provider agencies to change current business practice so that they are prepared to operate in a fee-for-service, reimbursement contract model.

Footnotes:

16. Recovery

Please consider the following items as a guideline when preparing the description of the state's system:

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?

   Definition of Recovery
   Executive Order #78 defines Recovery as a "deeply personal, unique process of changing one's attitudes, values, feeling, and goals, skills or roles. It is a way of living a satisfying, hopeful, and contributing life even with the limitations cause by mental illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness." (Anthony, 1993)

   According to A. Kathryn Power, "The key messages of transformation are that treatment works, evidence-based practices yield better results, and recovery is not only possible, but is the expected outcome of treatment."

   A recovery-oriented system is one based on the belief that recovery is in fact possible. A recovery-oriented system recognizes the potential inherent in all consumers. It values and seeks to build upon individuals' strengths. The system ensures access to effective and timely treatment, rehabilitation, crisis intervention, on-going peer and other natural support services that promote meaningful lives, the attainment of valued roles, and true empowerment. A recovery oriented system offers hope, is culturally competent, accountable, and is sagacious in its use of resources. Consumers experience transformation on a personal level and take personal responsibility for their lives.

   SAMHSA has delineated four major dimensions that support a life in recovery:

   - Health: overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way;
   - Home: a stable and safe place to live;
   - Purpose: meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and
   - Community: relationships and social networks that provide support, friendship, love, and hope.

   Recovery Values
   The following guiding values and principles continue to shape New Jersey's mental health system and guide our system as we move forward with our transformation efforts.

   - The system is grounded in a ***Recovery orientation.***

- All services are ***Welcoming***, there is no wrong door.
- ***Consumers and their families drive the service needs*** based on wellness and recovery.
- ***Access*** to services promote ***Continuity of Care.***
- Services are ***Culturally Competent.***
- Services are ***Integrated and Collaborative.***
- Services are held ***Accountable, Cost Effective and Monitored*** at the local level.
- ***Stigma will no longer be tolerated*** and education and awareness regarding mental illness and mental health will be increased and at the forefront of our mental health system.
- The system emphasizes ***Evidence-Based and Best Practices, Quality of Care, and Outcomes.***

Hiring People in Recovery Leadership Roles

DMHAS has a special assistant for consumer affairs, who is a member of the DMHAS Executive Staff, a peer support specialist, and an Addictions Consumer Advocate, who is also a member of Executive Staff, within the Office of Planning, Research, Evaluation and Prevention. We are planning on expanding peer delivered services in all four state psychiatric hospitals. Currently, we are developing a formal proposal to recruit and hire a full-time peer supervisor to oversee these services and to ensure that the leadership at the state hospitals provide the necessary supports to make this initiative successful.

Strategies Using Person-Centered Planning, Self-Direction and Participant-Directed Care

The peer support specialists, for our new initiative, will be trained in person-centered planning, self-direction and participant-directed care and will ensure that patients are educated on these strategies. This will create the desired paradigm shift from a patriarchal system to an empowerment-based system. We intend to hire one peer per hospital who will have the experience and ability to participate in the development and evaluation of recovery programming in order to ensure that interventions meet the needs of individuals as they prepare for discharge into community life.

State Hospital Treatment Planning Activities

- Families are encouraged to become active participants in the treatment and discharge planning process for their family member with a serious mental illness. It also specified that families be made aware of significant events involving their loved one while in the hospital.
- Patients are provided the opportunity to develop a psychiatric advance directive to guide the treatment team to their individual wishes when they are not able to make the choice.
- A newly revised Individual Needs for Discharge Assessment (INDA) and revisions to the Treatment Planning process have been made to provide an opportunity for providers to participate in the development of the INDA and participate in treatment planning with the goal of enhancing community tenure. If additional funding for support services is requested, DMHAS has asked that the provider discuss the requests during the team meeting.

Shared Decision-Making

FY 2013 saw DMHAS collaborate with UMDNJ's Center for Excellence in Psychiatry in developing a shared decision-making tool related to taking medications. This tool has been piloted at our state hospitals and has been reviewed by consumer stakeholders and revised accordingly. The document was available for wide dissemination in on July 1, 2013. In FY '14, the tool became even more widely distributed to community groups of consumers as well as to family members and to providers. Anecdotally, there was a great deal of positive feedback about the "Sharing Decisions About Medications" tool from consumers although they still found it very difficult to have their issues addressed given the brevity of the psychiatric appointment.

- In FY '15, DMHAS' Medical Director, Robert Eilers, MD, MPH, presented this shared decision making tool, with tips and guidelines on how to work with your prescriber using the tool, at the Annual Statewide Consumer Conference held in May, 2015. Dr. Eilers' gave the keynote presentation followed by a workshop on the same subject; emphasizing that providers must be educated and sensitized to the issues that consumers struggle with related to taking psychotropic medications and must be willing to accept consumers as equal partners in the treatment team.
- The Division is exploring "best practice approaches" to empower consumers to make the most informed decisions about their health, well-being and their treatment options and care. In FY '14, the Division sponsored a Statewide Conference on Shared Decision-Making, where Pat Deegan, Ph.D., presented her tools for assisting and supporting consumers in being true partners in managing their own care. It was a very positive and powerful presentation as Pat Deegan is a person in recovery and developed these tools using her lived experience.

Recovery Library

The Recovery Library is a very rich repository of wellness and recovery information on just about any topic related to the challenges consumers face in trying to get well. The Division is currently contracting with Pat Deegan Associates in order to provide access and training to the Recovery Library at all of the 35 - community-wellness and recovery centers. In addition to covering the costs of the subscriptions to the service, the Division will provide three days of training by Pat Deegan in order to optimize the use of the materials accessible in the Recovery Library. Although not fully developed as of yet, there will be an outcomes component built into this project to measure utilization and to also capture the impact of the availability of these tools on consumers' recovery/management of symptoms. A team will be working to develop this aspect of the project prior to its implementation.

WRAP

Partial-Care regulations required that the agencies make assistance available for consumers who wish to develop a WRAP (Wellness, Recovery, Action Plan). A WRAP is a recognized best practice tool that focuses on prevention. There are a number of specialized WRAPs for Veterans, people with co-occurring disorders, people with developmental disabilities, weight loss, etc. The WRAP helps the individual focus on the day-to-day in order to maintain their wellness. This plan assists the person develop an awareness at the earliest possible point in time when things are not going well and what interventions can be taken to get back on track.

Recovery Plan

With regards to addiction services, the Division sponsors Recovery Coaches to assist consumers in our Recovery Centers. The Recovery Coach assists consumers to develop their Recovery Plan. The Recovery Plan assists the individual to identify goals within nine life domains: recovery from use/abuse, living and financial independence, employment, and education, relationships and social support, medical health, leisure and recreation, independence from legal problems and institutions, and spirituality and mental wellness. Recovery Coaches are trained to assist the individual to identify goals and strengths, skills and resources. Families are encouraged and welcome to participate. Together, they identify barriers and problems, and develop plans to utilize strengths and skills to remove the barriers with a goal of overall family wellness.

Recovery Services and Supports (i.e. Peer Support, Recovery Support Coaching, Center Services, Supports For Self-Directed Care, Peer Navigators, Consumer/Family Education, Etc.

The state plan discusses its implementation of various recovery supports such as: peer support, recovery mentors, Wellness and Recovery Centers (with recovery coaching available on a voluntary basis), recovery housing, supported housing, supported education, supported employment, and peer specialists in Emergency Rooms for individuals who have overdosed and been reversed by Narcan (Naloxone). These peer specialist will work in-tandem with a Bachelor's level peer navigator.

There are a variety of Peer Support Initiatives that are State sponsored and funded through DMHAS such as Peer Support Groups and 33 consumer-run community wellness centers. They offer effective, evidence-based and best practices to ensure consumer goals are attained. Tools that teach and promote person-centered, individualized recovery planning are made available to center participants. A competent peer workforce is employed and sustained at each center. Services are culturally responsive and many are co-occurring capable to meet the vast need for these services and emphasize a life in the community for everyone.

DMHAS received federal funding for Peer Recovery Support Coaching and State dollars to train Peer Supportive Housing Staff in the Peer Wellness Coaching Model.

DMHAS funds and supports a state-funded Warm Line that incorporates the Intentional Peer Support (IPS) Model as well as WRAP Planning. The Warm Line is fully staffed by peers and is accessible on holidays, weekends and other times when traditional services are not available.

The Division funds three Peer Crisis Respite Centers. Each center has a bed capacity of five and provides a very warm, welcoming, home-like environment that is conducive to recovery. Within each respite, staff have been thoroughly trained in best practice approaches in the delivery of peer support. In FY '15, the Ocean County Peer Respite served 75 guests; the New Brunswick Respite served 109 guests, and the Passaic County Respite, which did not open until mid-July due to contracting issues, has served 68 guests. Each of the peer respites is following the progress of the guests once they leave. This information is being tracked and

will be presented to the leadership of DMHAS later in the Fall 2015 to evaluate the efficacy of the service.

Consumer/Family Education

Family to Family – The NAMI New Jersey Family to Family Education Program is a free 12 week course for family caregivers of individuals with severe mental illness. The course is taught by trained family members. All instruction and course materials are free to class participants. Over 300,000 family members have graduated from this national program. This program significantly improves a family's ability to cope with an ill relative's mental disorder, according to an NIMH-funded study published in June 2011 in Psychiatric Services, a journal of the American Psychiatric Association.

Hearts and Minds - The Hearts and Minds Program was developed by NAMI to start a national conversation about the role of self-care, preventative cardiac care, and advocacy for integrated medical care for consumers of mental health services. This recovery and wellness oriented initiative assists consumers within the self- help centers and consumer support groups in becoming more aware of cardiac health and provide education on how to live healthier lifestyles, including better nutrition, exercise and overcoming addictions, and confronting society's stigmas.

DMHAS currently funds Intensive Family Support Services (IFSS) Programs in every county for family members and significant others to provide coping skills and support in dealing with loved ones living with serious mental illnesses. IFSS programs are based in wellness and recovery principles and educate families on mental illness, treatment options, the mental health and addictions system, and skills useful in managing and reducing symptomatic behaviors of consumers living with mental health and/or addictions issues. IFSS programs offer services in psycho education groups, family support groups, single family consultation, respite activities, and referral service. IFSS programs receive input and feedback from family members via a variety of mechanisms such as satisfaction surveys, service preference forms and level of concern surveys.

DMHAS also funds and supports the use of Family Companions through the Family Support Organization (FSO) in some of our county screening centers.

DMHAS has a Family Monitoring program at our state hospital where families are trained and supported as outside entities to monitor and evaluate the environment and programmatic services at our state hospitals.

The Division has been working with Rutgers University Technical Assistance Center on the development of a self-directed, individualized tool kit called "Your Wellness Counts". This tool kit has distinct modules on Overall Wellness, Shared Decision-Making, Medication, Nutrition, Metabolic Syndrome, Exercise, and Smoking. This tool kit will be able to be used both in the state psychiatric hospitals and in the community, individually or as part of a group program. Already mentioned is the Sharing Decisions About Medication tool.

2. How are treatment and recovery support services coordinated for any individual served by block grant funds?

Pregnant Women/Women with Children

DMHAS licensed substance use disorder treatment providers receiving Block Grant Women's Set Aside funding are required to provide recovery support services before treatment, as an adjunct to current treatment and at discharge from treatment. Providers are required to link each woman with recovery supports and ensure that treatment planning includes follow-up services to prevent relapse. Treatment planning must indicate coordination with other services and resources to include continuing care for pregnant, postpartum and parenting women. Additionally, providers are required to assist women with housing supports and assistance by linking them to transitional, permanent and/or supportive housing, and to enhance the skills necessary to maintain safe and sober housing.

DMHAS in State Fiscal Year 2015 developed two new services for treatment and recovery supports for providers receiving Block Grant Women's Set Aside funding. DMHAS issued a Request for Proposal (RFP) for appropriate supportive housing and services for pregnant and/or parenting women with substance use disorders who are homeless or at risk of homelessness and being discharged from or have successfully completed residential treatment in a DHS licensed substance use treatment facility in the past 30 days. This RFP was for the development of Women's Intensive Supported Housing (WISH) team to provide case management and supportive services to women and their children. The WISH Program combines permanent supportive housing and a support team who will coordinate the continuum of care in the DMHAS outpatient substance use disorder treatment system. The overall goal of the program is to promote long-term recovery, personal growth, and the positive well-being of involved children. The team will also provide supplementary services, often lacking in traditional residential treatment, that help women both retain their housing and make best use of community resources that foster drug free living. WISH combines the benefits of wraparound services with those of supportive housing and is available to ten (10) consumers and their children. DMHAS awarded one (1) provider

Substance Exposed Infants and Neonatal Abstinence Syndrome

NJ has experienced an increase in opioid and other substances during pregnancy, and increase in Substance Exposed Infants (SEI) and Neonatal Abstinence Syndrome (NAS). DMHAS in State Fiscal Year 2015 has partnered with the DHS Office for the Prevention of Developmental Disabilities for a joint initiative to expand an existing program where Certified Alcohol and Drug Counselors (CADC) are outsourced at the Health Start Clinics in several counties. Pregnant women who screen positive on the 4P's Plus are referred to the CADC for assessments. This Initiative offers substance use-related education, screening, and assessment for substance use disorders, referral to substance use disorder treatment, mental health counseling services, case management services, and referrals to a variety of community-based help programs/agencies for at-risk pregnant women in support of healthy pregnancy. An evaluation component is also attached to this Initiative.

3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?

   All peer delivered services in New Jersey have in their mission to be accepting, warm and welcoming. Most consumers with "the lived experience" have been victims of stigma and discrimination at some point in their lives. When consumers come together for various trainings or meetings, there is typically great diversity represented in terms of ethnicity, race, sexual orientation, trauma history, gender and age as well as co-occurring disabilities such as substance use disorders, and developmental disabilities. In general, most consumer groups are accepting of differences and exercise great empathy for others. However, there is an expressed need for training in how to best serve the various diverse populations in order that people feel that their specific needs are being addressed. There is a plan to have the Community Wellness Centers work with our two cultural competency centers on strategies for delivering these services.

   The Division was awarded a transformation-transfer initiative (TTI), through NASHMPD grant to support the development of a New Jersey-specific curriculum to train forensic peer bridgers. These are peers with criminal justice involvement in recovery who are trained to work with other individuals with criminal justice involvement who are currently institutionalized in a hospital, jail or prison, and establishes a relationship of trust and assists those individuals with developing a plan for a successful transition into community life. The peer bridger follows that individual into the community and assists them with developing the necessary community supports to achieve success in the community.
   The NJ Adult Suicide Prevention Advisory Council has representatives from all over New Jersey including specific populations such as LGBT, veterans, individuals with trauma history, racial and ethnic groups, people involved in the criminal justice system, older adults, etc. Because suicide touches so many lives DMHAS believes that it is important to get these stakeholders' input with the developing our action steps and outcome measures.

4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?

   DMHAS received a grant through NASMHPD which has allowed for our collaborating partners to develop and implement a Supervisor Manual for Program Supervisors to fully integrate Peer Wellness Coaching into the service delivery system. The Certified Recovery Support Practitioner (CRSP), the Peer Wellness Coach Certification and the Psychiatric Rehabilitation Counselor (CPRP) are eligible to bill Medicaid under Community Support Services (CSS) for peer providers.

   The Addiction Professionals Certification Board, Inc. of New Jersey (APCB) has expanded their Chemical Dependency Associate Certification (CDA) to include specific aspects of the CRSP curriculum dedicated to peer support for co-occurring individuals. This new certification will be called "CDA Peer Support" and is intended to provide addiction peer

support that can be Medicaid billable. There are currently trainings being provided for the CDA Peer Support credential at our two state funded Recovery Centers. Additionally, the CDA Peer Support credential will count toward 50% of the Certified Alcohol and Drug Counselor (CADC) certification that APCB also issues and maintains. Finally, there has been a grassroots movement to create private recovery centers in New Jersey that are not funded by DMHAS. These recovery centers are using the nationally recognized Connecticut Community for Addiction Recovery (CCAR) Recovery Coach Academy curriculum specific to addiction peer recovery support.

A Recovery Mentor certification is available through the Addiction Professionals Certification Board of New Jersey. Individuals must complete 72 hours of addiction training and 2,000 experience hours in a pre-approved facility.

As part of its Strategic Workforce Development Plan, DMHAS is collaborating with the Addiction Professionals Certification Board of New Jersey to promote a peer credential specific to addiction recovery entitled, "Chemical Dependency Associate/Peer Recovery Support." DMHAS intends to offer scholarships for individuals working in DMHAS licensed treatment centers to attend the training.

Another goal of the Strategic Plan is to train professionals and stakeholders system-wide on the value of the peer workforce. Additionally, DMHAS trained staff on the Eight Dimensions of Wellness. We will continue to focus training with staff and providers on the Eight Dimensions of Wellness and train providers and staff on support services, and rehabilitation approaches to treatment utilizing practices to reduce risk factors.

A formal technical assistance request was approved by SAMHSA for training on Supervisory Practices for clinical peer supervisors in the three regions of our state. This training will be the first skill-based initiative provided to peer supervisors on how to best support and supervise peers in the workplace.

5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?

   The Division has moved forward with its Community Support Services State Plan within which peer delivered services can earn federal financial participation as a part of CSS. State appropriations support other peer delivered services such as wellness coaching and Peer Outreach Support Teams (POST) and other such roles for which consumers are uniquely qualified.

   DMHAS has developed a promising practice model through several grant initiatives funded by SAMHSA and made available through the National Association of Mental Health Program Directors, NASMHPD, for Peer Wellness Coaching. This model has received national attention for excellence and we have been able to demonstrate positive outcomes related to health and wellness.

DMHAS also utilizes the Self-Help Outcomes Utilization Tracking (SHOUT) System at the Community Wellness Centers to enhance and expand reporting criteria that ensures accountability for how services are being utilized. It is in the process of redesigning this system which will be called the Self-Help and Recovery Program (SHARP) that will capture information on outcomes and the dimensions of wellness. It will be a web-based .Net system. The addictions recovery centers will also report into the new system.

The State completed a five-year evaluation study of its Medication Assisted Treatment Initiative (MATI) which was conducted by the National Center on Addiction and Substance Abuse (CASA). One component included an evaluation of the supported housing program that was part of this project. Supportive housing clients had lower than average hospital emergency department costs and inpatient hospital costs in comparison to a matched control group of MAT patients who did not enter supportive housing,[1] there was a 20% increase in reunified families as parents regained custody of their minor children, and both heroin use and IDU significantly decreased from baseline after clients moved into supportive housing.

Our state-wide peer recovery warm-line utilizes the "Intentional Peer Support" (IPS) model and all people who answer the phone are trained in this model. Callers to the warm-line are out-reached to determine if a crisis has been averted and data regarding these outcomes is collected and aggregated for reporting to the Division.

Guests to the Crisis Peer Respites receive 'best practices peer support services" during their stay at the Centers. They are given an assessment at the time of admission and at discharge as well as at several points post-discharge. This outcome data is also collected, aggregated and reported to the Division.

6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).

   Involvement of individuals in recovery from serious mental illness and addiction and their families is critical to New Jersey's wellness and recovery-oriented system of care. Consumers and families are actively encouraged to participate in various advisory groups, committees, workgroups, meetings and the request for proposal (RFP) process:

   <u>Planning</u>

   - A significant percentage of the Behavioral Health Planning Council is comprised of primary consumers and family members. They have direct input into the planning, delivery and evaluation of consumer-operated services funded by Block Grant dollars, which accounts for approximately $12M of mental health and $47M of substance abuse prevention and treatment funding. The combined New Jersey Community Mental Health Citizen's Advisory Board and the Behavioral Health Planning Council consist of more than 50% of their membership as family and

[1] Statistical significance of the differences could not demonstrated due to the small sample.

consumers. This Council continues to recruit consumers and family members of individuals in recovery with co-occurring and addiction disorders to enhance membership and to be more aligned with the changes at the federal level as well as the state level with the merger of the state's Divisions of Mental Health and Addiction Services in July 2010.

- The NJ Adult Suicide Advisory Council's membership not only includes representatives from advocacy groups, but also includes consumers and family members who have been affected by suicide in their lives. This Council incorporates representatives from various specific populations such as: State Police, LGBT, racial minorities, ethnic minorities, Veterans, those involved in prison system, physicians, primary care, etc. Their role is to develop deliverables and outcome measures for the State's Adult Suicide Prevention Plan.
- Families and consumers played and continue to play a key role in the Division's strategic planning activities. The Stakeholder Communication Workgroup, a subset of the Strategic Planning Priorities is composed of Division staff, consumers, family members and providers. This workgroup's focus in how to integrate family, consumer and provider needs and concerns into the Division's activities and how to communicate the Division's initiatives and strategic plan to the community at large.
- The SMHA's Statewide Consumer Advisory Committee (SCAC) is a diverse group of emerging leaders throughout the state who are experiencing recovery in their own lives. They are committed to having open, honest and compelling discussions with the leadership of the DMHAS around what a recovery and wellness-oriented system is about and what it is not. The SCAC has been greatly instrumental in working with the DMHAS on many aspects of the Transformation including focus groups to identify outcomes and other elements of service delivery. In addition, SCAC members have been used as consultants for subcommittee work, as trainers and for curriculum development for socialized DMHAS-sponsored initiatives, and as advisors for proposal reviews. The SCAC has been integrally involved in the completion of Federal Mental Health Block Grant consumer satisfaction survey, and also makes recommendations back to the SMHA on all issues affecting the quality of life of consumers living in New Jersey from housing to medication co-pays to access to employment-related services. The SCAC meets once per month in each of the three regions of the state. SCAC meetings are frequently used to provide important input into specific DMHAS-sponsored projects and initiatives. SCAC makes recommendations to DMHAS on all issues affecting consumers such as: housing, transportation, medication, co-pays, employment opportunities, etc. The Regional Coordinators in each of the three regions of the state now attend monthly SCAC meetings to inform and educate consumers about relevant DMHAS activities, events and initiatives. They encourage and solicit consumer input into DMHAS initiatives as well as entertain questions, concerns and issues raised by consumers at monthly meetings.
- The SSA's Citizens' Advisory Council (CAC) is comprised of consumers representing the voices of New Jersey residents at risk for, struggling with, or otherwise affected by the chronic disease of addiction. The CAC supports education, prevention, intervention, treatment, and recovery from addictive disorders and the elimination of associated stigma. The CAC meets monthly, represents the voice of

addictions consumers, and provides guidance and recommendations to the SSA regarding recovery oriented service delivery in furthering its mission to strengthen and expand recovery services by linking the Division with consumers and advocating for needs and interests of individuals, families, and communities. The CAC identifies policy and program priorities, researches and takes official positions on relevant issues of concern to consumers, and provides consumer representation and input on various committees. The CAC helps creates a bridge between DMHAS and the community of addiction treatment and recovery consumers and their families.

- Families play an integral role in each of the 21 County Mental Health Advisory Boards which meet on a monthly basis.
- The State Family Support Services Plan for Persons with a SMI convenes three regional family working groups which meet on a quarterly basis.

Leadership Roles

DMHAS employs two consumer advocates to strengthen consumer participation in the planning, delivery and evaluation of mental health services and one consumer advocate for addiction treatment and prevention services. One of these is full-time and her role is to develop and monitor consumer-operated services statewide. As the Special Assistant for Consumer Affairs she is a member of the DMHAS executive staff, where she has the opportunity to participate in DMHAS policy and decision-making on a management level. Another consumer is a part-time consumer peer advocate who is responsible for participating in new service development. She reviews and scores each new RFP released by DMHAS and is present at all staff reconciliation meetings where decisions are made regarding funding awards by providers of proposed services. The Division also employs an addictions Recovery Advocate who is a member of Executive Staff and has a critical role in decision-making. The peer advocate and addictions consumer advocate actively participate in DMHAS-sponsored subcommittees dealing with newly developing DMHAS initiatives.

Delivery of Services --- Public Consumer and Family Organizations and Networks

- New Jersey has a strong, active network of public consumer and family member organizations and programs, including but not limited to: Roads to Recovery Consumer-Operated Transportation Services, Leadership Training Academy, The Learning and Recovery Center of Wildwood, Consumer Advocacy Partnership, COMHCO (The Coalition of Mental Health Consumer Organization), The Institute for Wellness and Recovery Initiatives, Consumer Connections CORE Training, Certified WRAP (Wellness Recovery Action Plan) Training, Certified Wellness Coach Training, Chemical Dependency Associate for Peer Support (CDA Peer Support), CHOICES-a smoking cessation program active in state hospitals and self-help centers across the state, Hearing Voices, CPA (Consumer Providers Association), NAMI (National Association of Mental Illness) of NJ, NAMI Connection, NAMI NJ en Espanol, CAMHOP-NJ (Chinese Mental Health Self-Help Group), NJ Self-Help Group Clearing House, and Mental Health Association of NJ (MHANJ).
- A key component of New Jersey's transformation initiative has been the conversion of the 30 community-based self-help centers into thirty community wellness centers. In order to support and understand this change in model, the Assistant Commissioner

initiated focus groups with representatives from all thirty centers in each of the three regions of the state to identify key elements of a community wellness center; the potential strengths to the model; how this model will impact the lives of persons served; and how the Division can support the work of the centers so that they become an even stronger and more integral part of New Jersey's stem of care. A support plan, developed out of the brainstorming from the focus groups, will be produced in the Fall of FY '16 for review. The goal is improved collaboration with the traditional system and peer-operated services.

- The Advisory Committee to the Alcoholism and Drug Abuse Program for the Deaf, Hard of Hearing and Disabled meets on a quarterly basis to ensure quality substance abuse treatment services are provided to individuals identified as Deaf, hard of hearing or disabled in the community. The Committee is comprised of individuals from statewide disability, substance abuse and social service providers, including five state staff in addition to five members who are identified as Deaf, Hard of hearing or disabled and two public members with an interest in substance and co-existing disabilities. The SSA has a contract with an agency to offer communication access to individuals who are Deaf and/or hard of hearing via interpreter services or Communication Assisted Realtime Translation (CART) services at up to eight recovery support meeting groups held weekly statewide (this includes AA, NA, sober house meetings, etc.)
- The state is currently working on strengthening the role of mental health consumers in treatment and recovery planning, shared decision-making and directing their ongoing care and support. DMHAS has greatly expanded the number of peer providers in designated screening centers, on supportive housing services and on PACT Teams. New RFPs released by DMHAS require the hiring of peer providers to newly funded programs. They receive training in best and promising practices such as Intentional Peer Support, WRAPs, and Psychiatric Advance Directives (PADs). The peer providers deliver these services to service recipients of these programs. They frequently provide education and training to fellow staff on these practices leading to a more participatory process in treatment planning.

<u>Service Development</u>

- Consumer input is an integral part of new service development and consumers are utilized in the RFP review process. Their feedback is solicited by DMHAS and incorporated into DMHAS decision-making. Consumers receive a stipend for each proposal that they review as well as receive compensation for participating in a consumer and family feedback session. Consumers and family members comment on the strengths and weaknesses of each proposal reviewed. This information is shared and considered at staff reconciliation meetings prior to the scoring process.

<u>Monitoring and Evaluation</u>

- Families fulfill an important role in the planning and development of mental health services for consumers, their families and significant others. The SMHA has designated the New Jersey Chapter of the National Alliance on Mental Illness (NAMI NJ) to administer the State Family Support Services Plan for Persons with a SMI. This Plan, which is reviewed and revised every three years, identifies the needs, goals and family

priorities for the provision of family support services as well as recommending strategies for outreach and coordinated delivery of support services. The SMHA closely monitors the implementation of the State Family Support Plan via quarterly reports, regular meetings with the Executive Director of NAMI NJ and other documentation as requested.

- The state actively includes consumers and family members in the Patient Services Compliance Unit which conducts on-site reviews in all state psychiatric hospitals. Review teams include one consumer and one family member. The process includes a review of therapeutic program, unit observations, patient care and staff development.
- In accordance with New Jersey Administrative Code (NJAC) 10;190, consumer and family member participation is also required during on-site reviews of community mental health agencies conducted by Department of Human Services' Office of Licensure.
- Families play a key role in the Division of Mental Health Licensing's Tri-annual review each IFSS Program. During this inspection, volunteer families submit to a face to face interview and results are shared with agency administration.
- Concerned Family Groups at all three acute state psychiatric hospitals conduct monitoring visits of the hospital in their catchment area. Observations and recommendations are conveyed to hospital administration including the Chief Executive Officer via quarterly meetings. These Family Monitors use a standardized tool to monitor and evaluate the environment and programmatic activities at these hospitals.

7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

   The DMHAS provides support and funding to over $10 million dollars in peer-operated services. These services provide innovative approaches to wellness and recovery. Some of these initiatives include: peer-operated self-help centers/wellness centers; recovery centers; financial literacy services; consumer-operated transportation services; dual recovery groups; advocacy for consumer parents; and a whole host of other promising practice peer-operated services.

   One such funded program, CSPNJ (Collaborative Support Programs of New Jersey), is a large state-wide organization which provides services such as hospital and community-based self-help centers; community wellness centers; recovery centers; financial services including free tax return preparation and budgeting; supportive housing services; self-help groups; and systems advocacy. This organization is represented at key stakeholders meetings sponsored by DMHAS and is responsible for influencing service delivery statewide. This organization has partnered with DMHAS on the development and implementation of a Peer Coaching Model which has received national recognition. DMHAS has supported and funded the Peer Wellness Coaching Model through incorporating it into the delivery of supported employment and supportive housing. This is a National Model which has been replicated by several other states.

   As the DMHAS works to integrate mental health and substance abuse services, the need to utilize recovery mentors remains crucial to sustained client wellness. With the advent of healthcare reform, these types of services are expected to be reimbursable, and accordingly the Division plans to include addiction recovery mentors as part of a recovery oriented

system of care. DMHAS is working to create a Medicaid reimbursable addictions recovery mentor certification. This certification will consist of a pre-existing curriculum for the Chemical Dependency Associate (CDA) certification combined with material from the Certified Recovery Support Specialist (CRSP) curriculum to create a CDA Peer Support curriculum that will be eligible for Medicaid billing.

At the SSA's two recovery centers (Recovery Center at Eva's Village and Living Proof Recovery Center), all the addictions and/or co-occurring services are specific to the needs of the individuals. Services can include referrals to recovery oriented treatment, peer support, interpreter services, access to housing, employment assistance and child care. Wellness activities support recovery and include recreational activities and self-help advocacy. In addition, the Recovery Coach is a new role that functions between the professional and the sponsor. Recovery Coaches are consumers who have made significant progress in their personal development and are experientially credentialed and trained as peer specialists to assist others to achieve their recovery goals. Recovery Coaches are from the community and trained in cultural competence to ensure sensitivity to the needs of the individual and the family members. Recovery Coaches work with individuals across multiple pathways of recovery, provide outreach to the community, link people to professional treatment and to communities of recovery, assist with the development of their Recovery Plan, and provide long-term, stage-appropriate recovery education and support that meet the individual and family needs.

DMHAS also provides funding and support to a statewide peer advocacy organization COMHCO (Coalition of Mental Health Consumer Organizations). They are funded to hold monthly meetings on advocacy issues directly impacting services to consumers of mental health services. They also sponsor one Statewide Conference which is attended by several hundred consumers from various advocacy groups from throughout the state. The DMHAS Assistant Commissioner participates in the conference by providing an overview of DMHAS sponsored initiatives. Staff from the DMHAS management team frequently serves as workshop presenters. The advocacy organization is also included as key stakeholders who provide direct input into DMHAS policies, procedures and initiatives.

As previously described the Intensive Family Support Service (IFSS) Programs in each of New Jersey's 21 counties include family support groups, respite activities and referral/services linkage.

The SMHA also contracts for Acute Care Family Support Programs in 12 counties. These programs serve families with an adult member who is experiencing a psychiatric crisis and is being assessed in a Designated Screening Center or Affiliated Emergency Service. Staff, many of whom are family members themselves, are designed to provide on- site support to the family while their loved one is being assessed, educate them as to what to expect in an acute care setting, including the commitment process, and to link them to existing family support services in the community. The SMHA carefully monitors the performance of the Acute Care Family Support Programs.

8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.

   The Division currently measures the community outreach efforts of all of the self-help and community wellness centers through the Quarterly Contract Monitoring Reports (QCMRs). Reported are units of service, new consumers served, the unduplicated count and average daily attendance.

   Path Providers outreach to homeless individuals in the streets, at shelters, at Feeding centers, woods, drop in centers and self-help centers. As well as other places where homeless individuals are known to congregate (under bridges, fields wooded areas, parks, local public accessible restaurants, train stations, library's public buildings, subways public agencies. They work to develop a trusting relation and engage individuals into an array of services that meet their physical and mental health needs. Path providers offer water, food, blankets, and hygiene kits during their engagement process. The goal of the path providers is to link individuals to need services.

9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.

   Statewide and Hospital Wellness Committees

   Consumers in the state hospitals participate at state hospital Wellness Committees as well as the Statewide Hospital Wellness Committee, which is co-chaired by DMHAS' Medical Director. The purpose of these committees is to proactively address metabolic syndrome and other risk factors associated with the increased medical co-morbidity of mental health consumers and the shortened life-span of consumers.

   Shared Decision-Making

   DMHAS contracts with Rutgers and together developed a Shared Decision-Making Tool for consumers and providers to use for medication appointments. The tool provides the opportunity for consumers to prepare for appointments with their prescriber, thereby empowering the consumer to be more proactive in decisions regarding psychotropic medications.

   Workshops/Training Related to Wellness

   - In Spring of FY '15 a large state-wide training was sponsored by the Division to promote the implementation of the newly adapted "Learning About Healthy Living" manual at the Community Wellness and Recovery Centers. A follow-up telephone survey was administered to agencies in attendance at the training to identify impact of the training on their programs. Twelve (12) centers committed to starting ongoing Learning About Healthy Living groups and the other 12 centers expressed interest in starting groups if provided with additional information or technical assistance.
   - DMHAS along with Rutgers University are developing a self-directed manual for consumer use individually or as part of a group program called "Your Wellness Counts". This modularized manual covers topics the following topics: Overall Wellness, Shared Decision-Making, Health Eating, Moving More, Metabolic Syndrome, Medications, and

Smoking Cessation. The manual has already been piloted once and is in the editing stage with technical writers.

Tobacco Cessation

- Tobacco cessation programs are held quarterly at both state funded recovery centers and are part of the grant requirements. The Living Proof Recovery Center has nutritional classes weekly as well as yoga and meditation classes. Eva's Village provides their co-occurring population with dual recovery support groups and also has workshops on nutrition, daily exercise and individuals in recovery have access to a full service medical clinic.
- C.H.O.I.C.E.S. (Consumers Helping Others Improve their Condition by Ending Smoking) is made up of a group of peers that are invited into the centers to do presentations on Smoking Cessation. They have made more than 1000 site visits to behavioral health programs and residences in all 21 counties of NJ. This has allowed them to talk to more than 33,000 consumers who smoke to give them important education and feedback about the dangers of smoking and need to seek treatment to try and quit. They use a carbon monoxide meter and the members are faced with the hard truth of how much residue from cigarettes is in their lungs. Consumers generally take it hard when the meter shows a high reading of carbon monoxide. It forces them to think about what they are doing to their overall health by smoking. The goal is to increase awareness of the importance of addressing tobacco use and to create a strong peer network that encourages mental health consumers to make a positive healthy lifestyle change by addressing smoking and tobacco use.

Community Wellness Centers

New Jersey's Community Wellness Centers offer a great deal of support for their memberships around the 8 Dimensions of Wellness. These Wellness Dimensions have evolved to become the primary focus of the centers' activities. The physical dimension is central due to the health and lifespan disparity of the mental health consumer population that takes advantage of the services at these centers; but all of the eight dimensions are incorporated in to the day-to-day activities and events offered to members who chose to participate.

Wellness coaching is offered at some sites where there are regular sessions with a peer coach to work on specific areas of the Wellness Dimensions, especially focusing on physical health, like exercising three times a week, riding a bike, walking around the neighborhood or following an exercise video, changing eating habits (adding more vegetables and fruits, eating less red meat), and prepping homemade meals in advance and making extra food to freeze and eat at a later time, in place of store-bought frozen meals. Members may have replaced fast food lunches with salads and many now cook baked foods instead of fried food options. Some centers provide weekly/daily meals for members and prepare them from healthy recipes and offer salad on the side or fresh fruit for dessert instead of pastry or cookies. They even offer sugar-free options to people with diabetes such as sugar-free ice cream or sugar-free cookies.

Centers work with individuals in developing personal WRAP plans or WRAP plans for Weight Loss using the Copeland model. Some have chosen to do WRAP Scrap, where scrapbooks are used instead of a form. The WRAP plans are visually crafted, as well as having some narrative. Some centers have brought in nutritionists to assist individuals who have chosen to work on goals related to eating a healthier diet or incorporating healthier food choices in to their lives. Other centers offer Nutrition Education, and some help teach members how to pick healthy options when eating out in a restaurant.

Multiple centers have YMCA/gym memberships and members regularly attend the gym and improve their overall physical fitness through increased physical activity. The memberships are open, so that it is not specific to a select few, and many individuals can take advantage of the services. Most centers have exercise equipment and members are welcome to use the equipment when the centers are open. Some centers have walking clubs, where members go on walks near their locations. Several centers visit farm markets or flea markets regularly, especially in warm weather where members can group together, shop indoors/outdoors, and do a lot of casual walking while they shop.

They address cardiovascular function, weight loss and can improve a person's self-esteem and self-efficacy. All centers have scales to help monitor consumers' weight. The centers also offer nutrition groups and help them to prepare healthy meals, where members can learn to read product labels, use less salt in foods, and monitor calories. Some Community Wellness centers have sponsored health screenings, where they check things like blood pressure, BMI, screen for diabetes and even do HIV testing. Many centers had facilitators and managers attended a DMHAS sponsored Learning about Healthy Living Training, where they gained knowledge about the dangers of smoking. Managers took this information back to their centers and now do regular groups on smoking cessation. Some of the members have cut back on the amount of cigarettes they smoke a day, some have stopped and others continue to try to quit.

Wellness Learning Collaborative

DMHAS is currently working to sponsor a Wellness Learning Collaborative to educate and inform the mental health community and the primary care community about the risk factors that contribute to poor health outcomes of mental health consumers. Shared decision-making will be one of the key topics of the Learning Collaborative once it is established.

Cardiovascular Risk

Hearts and Minds is another initiative that DMHAS funds and sponsors. Through this training program, the consumers are presented with research which has demonstrated that people living with severe psychiatric conditions may have an increased risk of heart disease and related health conditions. NAMI New Jersey's Hearts & Minds program is an hour-long live presentation focusing on inner and outer wellness for people living with a mental illness. Hearts & Minds seeks to raise awareness and provide information on: medical self-advocacy, smoking cessation, addictions, healthy eating, exercise, and diabetes. The program is free to any facility or group throughout the state and includes goal setting and exercise and food journals.

Wellness

- New Jersey is fortunate to be the home of the CSP-NJ Wellness and Recovery Institute's Annual Wellness Conference that literally draws in several hundred interested consumers, providers, scholars and family members both within and outside the state to share state-of-the art knowledge about practices and research about wellness and behavioral health. Because it is so highly educational and interactive, DMHAS allows earmarked' "Wellness Dollar funding" to be used for consumers from the centers to attend the event. The conference sells out early every year and offers people a variety of seminars throughout the one day event, as well as, a general assembly with key note speakers discussing a host of Wellness topics. Collaborative Support Programs of NJ is a DMHAS funded agency that oversees many of the Self-help centers in the State. One of the highlights of this agency is the monthly printing of the Words of Wellness newsletter. The newsletter offers support and information on a number of informative topics covering all of the eight Wellness Dimensions. Many consumers, who have incorporated wellness practices in to their own lives successfully, contribute inspiring stories of hope and healing to the newsletter to help reach others in their journey towards wellness and recovery.
- Informed Choices is a DMHAS funded initiative provided by CSPNJ. It includes: Making Informed Decisions about your Medications, Your Treatment, and Your Wellness Options. The mission is to help people in their recovery journey make choices for themselves that will improve their quality of life. It provides support for free choice and teaches alternative approaches to wellness. Informed Choices recommends ongoing support from a health care professional. The purpose is to provide education, support, and information so people have a good balance of treatment and support that works best for them. It is meant to help consumers so they are better able to choose what is best for their wellness. Its goals are to develop skills in making informed treatment decisions, build knowledge about a variety of ways to get and stay well, learn how to ask questions about treatment, write a personal wellness plan, learn about systems change and advocacy to make that change happen.
- Community Wellness Centers help individuals develop skills in all areas of the Eight Dimensions of Wellness. Particular emphasis is placed on improving a consumer's physical health around that particular wellness dimension. The goal is to help reduce the disparity of mental health consumers dying 25 years younger than the general population. DMHAS is proud of the goals of all the centers who work hard to maintain and improve upon the physical health of the membership. Through the work of the New Jerseys various mental health initiatives they provide positive opportunities for people living with a mental illness, and allow them to not just live, but thrive in the community of their choice.

10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?

DMHAS continues to take a pro-active role in moving consumers to less restrictive settings. Since SFY 2013, DMHAS has developed 1,337 new housing opportunities. This includes

supportive housing subsidies and support services plus housing subsidies for individuals receiving Assertive Community Treatment. The DMHAS plans on developing an additional 200 housing opportunities with state appropriations and to work with the NJ Housing and Mortgage Finance Agency to implement recently awarded HUD Section 811 Project-Based Rental Assistance vouchers.

These housing opportunities were made available to individuals in state psychiatric hospitals ready for discharge and to individuals who are homeless, at risk of homelessness or at risk of hospitalization. In addition, some of the housing subsidies were made available to individuals in board and care and residential health care facilities. The state currently has a Home to Recovery (Olmstead Plan) to address the needs of individuals who need housing and opportunities to move into least restrictive settings. The DMHAS has developed a variety of supportive housing initiatives to best meet the needs of individuals coming out of state hospitals (e.g., supportive housing to serve individuals dually diagnosed with a mental illness and developmental disability, supportive housing to serve individuals with a significant forensic history, and supportive housing to serve individuals who have significant primary health issues.

What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a supportive community?

The Division continues to publish RFPs for Supportive Housing, as well as PACT expansion with rental subsidies funded for each consumer. Most contracts awarded are for services being provided in a scattered-site housing models. All proposals are required to explain services they propose to provide to improve community inclusion/tenure as well as provide for opportunities for socialization, improving natural supports, and how they will promote full integration (housing, employment, money management, self-advocacy, social contexts, etc.) of persons served. Providers' proposals receiving maximum scores are expected to work with consumers to explore interests, prior experiences and options for social activities. Staff looks for interest related clubs or hobby organizations, spiritual organizations, community musical, art or theater organizations or other socialization/recreation/education opportunities that matches consumer interests. Consumers are encouraged to explore their neighborhoods, self-help centers, assisted to learn public transportation routes, get library cards, and become active members of their community. Programs offer and help to arrange for specific social activities such as cooking lessons, hosting small dinners and creating opportunities for consumers to socialize with family members or friends. Consumers are expected to be linked with primary healthcare providers in the community, and encouraged to improve physical health care (smoking cessation, increased physical activity, improved nutrition, etc.). Reassurance, support, role modeling, assistance, and monitoring are provided. Attempts are made to identify and use personal strategies that match consumer hopes and desires for health and wellness. Proposals are required to explain how education and employment activities will be explored. High scoring proposals involve consumers in activities that provide meaning and purpose, including employment, education or volunteer activities. Interest and skill inventories are completed and consumers identify desired objectives for occupational enhancement, such as volunteer work, training, or competitive employment. At the same time, high scoring proposals will discuss assistance with

behavioral support plans that will help to minimize any risk and assure safety for the consumer and others. Programs encourage individuals to develop alternative strategies for responding to internal or external stimuli and provide access to counseling and treatment of mental health needs to ensure continued community tenure.

11. Describe how the state is supporting the employment and educational needs of individuals served.

    DMHAS have supported employment programs in all 21 counties with a minimum of two Full-time staff. The DMHAS supported employment agencies provide support to individual diagnosed with mental health disorder and co-occurring disorder to participate in the competitive labor market, helping them find meaningful jobs and provide ongoing support. The goal is to improved employment outcomes. Services include placing consumers in competitive employment, providing rapid job search, fully integrate their wellness and recovery goals in the employment goals and providing benefits counseling. As of July 1, 2015, the community agencies will be doing an "in-reach" into the state psychiatric hospitals with the goal to improve employment outcomes for individuals discharged from the state hospitals.

    DMHAS also has supported education in four (4) regions within the state providing services in 13 out of the 21 counties. The programs provide education services for individuals with severe psychiatric disability whose education was interrupted as a result of their psychiatric symptoms. The community agencies provide supports and services to individuals in recovery as they work towards achieving their academic goals.
    All of our supported employment and education providers receive technical agencies through the DMHAS contracted training and consultation initiative with Rutgers University School of Health Related Professions and Mental Health Association in New Jersey.

    Please indicate areas of technical assistance needed related to this section.

    Technical assistance from Rutgers on Learning About Healthy Living Smoking Cessation, how to engage diverse populations (racial, ethnic, LGBT, Trauma, etc.)

    Assisting provider agencies to change current business practice so that they are prepared to operate in a fee-for-service, reimbursement contract model.

Children's System of Care (CSOC)

The Children's System of Care adopted by DCF/CSOC was developed through the joint efforts of families, providers, advocates, and other stakeholders across the state. It is based on basic principles designed to create a children's service delivery system that:

- increases access to services and supports.
- empowers parents and guardians in seeking care and positively impacting the system to improve it.
- assures the ability of families to share their ideas, concerns, needs, and suggestions.
- enhances the integrity and quality of family and community life.

Through an organized system of care, CSOC is committed to providing emotional and behavioral health care services that are:

1. clinically appropriate and accessible, without regard to income, private health insurance or eligibility for Medicaid/NJ FamilyCare or other health benefits programs;
2. individualized, reflecting a continuum of services and/or supports, both formal and informal, based on the unique strengths of each youth and their family;
3. provided in the least restrictive, most natural setting appropriate to meet the needs of the youth and their family;
4. family-driven, with families engaged as active participants at all levels of planning, organization, and service delivery;
5. community-based, coordinated, and integrated at the community level with the focus of services as well as management and decision-making responsibility resting at the community level;
6. culturally competent, with agencies, programs, services, and supports that are responsive to the cultural, racial, and ethnic differences of the populations they serve; and
7. protective of the rights of youth and their families.

CSOC views children and their families as full partners in the development of their individualized service plans and in assessing progress toward their own outcomes. CSOC is committed to providing services based on the needs of the child, youth or young adult and their family in community-based, family-centered environment. CSOC services are coordinated through one entity and are based on a single, strength-based Individual Service Plan (ISP) developed with the family for the child, young adult and their family.

Link to Health and Wellness Resources are available on the PerformCareNJ website: http://www.performcarenj.org/families/health-wellness.aspx.

Within the children's system of care Family Support Organizations (FSO) are system partners within the NJ Children's System of Care. FSOs are nonprofit, county-based organizations run by families of children with emotional and behavioral challenges. FSOs work collaboratively with the Care Management Organizations, Mobile Response and Stabilization Services, the Contracted System Administrator, state agencies and provider organizations to ensure that the system is open and responsive to the needs of families and youth. The FSO provides peer support, education, advocacy and system feedback to families. They ensure that the key values

of the Children's System of Care are upheld. FSOs are directly funded through CSOC. Meetings between CSOC management and FSO Executive Directors are held on a monthly basis. CSOC staff serves as the liaison to the FSOs. Additional information regarding Family Support Organizations can be accessed here: http://nj.gov/dcf/families/support/support/.

Located within each county, Children's Inter-Agency Coordinating Councils (CIACCs) were created by statute to serve as the mechanism in each county to develop and maintain a responsive, accessible, and integrated system of care for children with emotional and behavioral challenges and their families, through the involvement of parents, consumers, youth and child serving agencies as partners. The CIACCs provide a forum where the system of services for children with emotional and behavioral challenges is developed, reviewed, revised and/or redirected, through collaborative decision-making process with DCF to promote optimal services provided in the least-restrictive, but most appropriate setting possible. Each CIACC completes an annual county needs assessment to determine how DCSOC community development funds should be allocated within that county. Additional information regarding the CIACCs can be accessed here: http://www.state.nj.us/dcf/providers/resources/interagency/.

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead

Narrative Question:

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated arrangement appropriate and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to Section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office of Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

17. Community Living and the Implementation of Olmstead

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.

   The overarching theme of the SMHA's Olmstead plan is transition to the community to the most integrated setting with services wrapped around those served to provide the supports needed for a fulfilling life in the community that is driven by the individual's wishes and personal preferences. Since the rollout of Supportive Housing in SFY 2006, the SMHA has developed over 2400 supportive housing opportunities for individuals who are transitioning from a NJ state psychiatric hospital to the community. As an evidence based service that has housing first principles at its core, supportive housing has been the primary housing model that the SMHA has developed since this time and to date. Understanding that individuals have specific and at time complex service needs, the SMHA has refined its development of supportive housing programs over the years to include programs that service individuals with a co-occurring issues such as a developmental disability, medical condition and legal history. The SMHA has also developed since SFY2009 more than 600 supportive housing opportunities for individuals in the community who are at risk of hospitalization or homelessness. Additional services have been implemented in recent years to enhance the transition of individuals from state psychiatric hospitals to the community and to divert hospitalizations. Most notable are the creation of a consumer operated self-help centers on the grounds of each of NJ's three regional state psychiatric facilities, Early Intervention and Support Service (EISS) programs and Peer Operated Crisis Diversion programs. The on grounds self-help centers assist individuals in gaining skills around wellness and recovery action planning, as well as providing a venue to engage with peers residing in the community who share their inspirational recovery stories. The EISS programs, which are funded in more than half of NJ's 21 counties, provide short term intensive individualized services to those who are in crisis and may otherwise resort to an inpatient hospitalization in the absence of the EISS services and supports. There are currently three peer operated crisis diversion programs funded by the SMHA in NJ. These programs are strategically located in the Northern, Central and Southern regions of the state, making them accessible to many of NJ's residents. A cornerstone of these programs is that at least 50% of each program's staff must be peers in recovery. Like a traditional respite program, the peer operated respite programs offer a residential setting with private rooms that is available 24/7 for individuals in crisis to go as an alternative to hospitalization. The intensive services and supports that are provided offer the individuals served the opportunity to de-escalate a crisis situation and in most instances return to their natural living circumstances. The SMHA funds peer operated community based self-help centers in all of NJ's 21 counties. Individuals attend or become members of a self-help center as a means of support and receiving wellness services from individuals with a shared experience. The SMHA also funds supported employment programs in all of NJ's 21 counties. New supported employment programs were awarded in

more than half of NJ's counties during SFY15. As a pilot initiative, supportive employment programs are being asked to engage individuals at the state hospitals to assist them with their community employment goals and to facilitate access to job opportunities upon discharge.

2. How are individuals transitioned from hospital to community settings?

   The SMHA transitions individuals from state psychiatric hospitals to community based settings and service providers in a variety of ways. Individuals admitted to a NJ state psychiatric hospital who are not otherwise engaged with a service provider are assigned to an Integrated Case Management Services (ICMS) program provider. There are ICMS programs funded by the SMHA in all 21 of NJ's counties. ICMS is responsible for engaging individuals during their hospitalization and assuring linkage to appropriate community based services at the time of discharge. Such service linkages include, but are not limited to, mental health, primary care and addictions treatment as appropriate. The SMHA funds residential and supportive housing programs in each county to serve individuals who are being discharged from the state psychiatric hospitals. Individuals choose a housing program with a vacancy based on their preferred geographic region, as well as their specific service needs. For example, the SMHA funds supportive housing programs that serve individuals with a co-occurring medical condition, co-occurring developmental disability and a history of legal issues. The selected program meets with the individual as soon as possible to begin the engagement process. The program continues to meet with the individual throughout the remainder of the hospitalization, and assist the individual with leasing a supportive housing apartment, selecting and purchasing furniture, activating utilities and other activities associated with having a residence ready for discharge. Thereafter, the program staff provide case management and other support services to assist the individual with accessing appropriate services and entitlements where applicable. The SMHA also works in concert with other Divisions within the Department of Human Services to link individuals to appropriate eligible services. For example, the SMHA works closely with the Division of Developmental Disabilities to facilitate discharges to group residences that are funded under the Community Care Waiver. Programmatic and financial eligibility are assessed and documented collaboratively to expedite discharge to an available residence of the individual's choosing.

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

   As indicated above, since the rollout of Supportive Housing in SFY 2006, the SMHA has developed over 2400 supportive housing opportunities for individuals who are transitioning from a NJ state psychiatric hospital to the community. As an evidence based service that has housing first principles at its core, supportive housing has been the primary housing model that the SMHA has developed since this time and to date. Understanding that individuals have specific and at time complex service needs, the SMHA has refined its development of supportive housing programs over the years to include programs that service individuals with a co-occurring issues such as a developmental disability, medical condition and legal history. The SMHA has also developed since SFY2009 more than 600 supportive housing opportunities for individuals in the community who are at risk of hospitalization or homelessness. Additional services have been implemented in recent years to enhance the

transition of individuals from state psychiatric hospitals to the community and to divert hospitalizations. Most notable are the creation of a consumer operated self-help center on the grounds of each of NJ's three regional state psychiatric facilities, Early Intervention and Support Service (EISS) programs and Peer Operated Crisis Diversion programs. The on grounds self-help centers assist individuals in gaining skills around wellness and recovery action planning, as well as providing a venue to engage with peers residing in the community who share their inspirational recovery stories. The EISS programs, which are funded in more than half of NJ's 21 counties, provide short term intensive individualized services to those who are in crisis and may otherwise resort to an inpatient hospitalization in the absence of the EISS services and supports. There are currently three peer operated crisis diversion programs funded by the SMHA in NJ. These programs are strategically located in the Northern, Central and Southern regions of the state, making them accessible to many of NJ's residents. A cornerstone of these programs is that at least 50% of each program's staff must be peers in recovery. Like a traditional respite program, the peer operated respite programs offer a residential setting with private rooms that is available 24/7 for individuals in crisis to go as an alternative to hospitalization. The intensive services and supports that are provided offer the individuals served the opportunity to de-escalate a crisis situation and in most instances return to their natural living circumstances.

4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

   Currently there is no litigation nor settlement with or between DMHAS and the United States Department of Justice.

5. Is the state involved in a partnership with other state agencies to address community integration?

   As indicated above, the SMHA works in concert with other Divisions within the Department of Human Services, as well as other Departments within the state, to link individuals to appropriate eligible services. For example, the SMHA works closely with the Division of Developmental Disabilities to facilitate discharges to group residences that are funded under the Community Care Waiver. Programmatic and financial eligibility are assessed and documented collaboratively to expedite discharge to an available residence of the individual's choosing. The SMHA collaborates regarding individuals' entitlement needs with the Division of Medical Assistance and Health services, which is the Division within the Department of Human Services that oversees NJ's Medicaid program. From the aforementioned Community Care Waiver program to Managed Long Term Services and Supports (MLTSS), the SMHA and DMAHS collaborate at a systems level and regarding individual circumstances in an effort to facilitate transition to the most integrated setting to meet each individual's needs. The SMHA collaborates with the Department of Children and Families to coordinate services within the children's system of care for young adults who are aging in to the adult system.

   In January 2015, the Department of Human Services/the Division of Mental Health and Addiction Services launched a partnership with the New Jersey Housing and Mortgage Finance Agency (NJHMFA, http://www.nj.gov/dca/hmfa/), to administer housing subsidies

for consumers receiving services from the Division. NJHMFA is undertaking the following tasks on behalf of the Division: Housing Search Assistance, Landlord Recruitment, Housing Inspections, Subsidy Processing, Rental Subsidy Administration, and Tenant/Landlord Inquiry Resolutions. The ultimate goal of this partnership is to increase community-based living, and enhance community tenure for consumers recently recovering from and/or at-risk for homelessness and/or placement in inpatient psychiatric settings.

Environmental Factors and Plan

18. Children and Adolescents Behavioral Health Services

Narrative Question:

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.[90] Most mental health disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[91] For youth between the ages of 10 and 24, suicide is the third leading cause of death.[92]

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[93] Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with more than 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or substance use disorders and co-occurring disorders and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.[94]

According to data from the National Evaluation of the Children's Mental Health Initiative (2011), systems of care[95]:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance

use, and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?
6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?
7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

Please indicate areas of technical assistance needed related to this section.

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[90] Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

[91] Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[92] Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[93] The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

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[95] Department of Health and Human Services. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions: Joint CMS and SAMHSA Informational Bulletin. Available from http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

18. Children and Adolescents Behavioral Health

Children's advocates had long identified a need for fundamental structural reform of New Jersey's System of Care for children with emotional and behavioral disturbances and their families. Initially, like virtually every other state, a number of child-serving systems, each with its own mandates, perspective, and priorities, had responsibility to serve these children. Children and families entered services through many different doors (child welfare, mental health, juvenile justice, education and the courts), often with similar needs for behavioral health and other community support services. The access route generally defined the problem and the services available. This, in turn, tended to define treatment goals and objectives based on the mandates and priorities of the specific child-serving system. The available services within these systems were then organized as programs, requiring children to fit the program's structure rather than structured to meet the individual needs of the child and family.

In 1990 with the creation of the Youth Incentive Program (YIP) and the elimination of state operated inpatient beds for youth under the age of 11, YIP stressed community-based, family-centered services and a decreasing reliance on inpatient care and out of home placement. Progress towards a better system continued and was supported by a dramatic reworking of the Child Welfare System; the result of a lawsuit initiated in 1999 a settlement agreement filed in 2003 and a modified settlement agreement in 2006. In November 1999 New Jersey's child mental health System of Care received a System of Care grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) for Burlington County (Burlington Partnership).

In 2000, New Jersey (NJ) began a major statewide reform initiative to restructure the system for delivering services to children, youth and young adults up to age 21 with behavioral health needs and their families into a single System of Care, coordinated and integrated at the local level, focused on improved outcomes for children and their families. By 2006 the System of Care had been fully implemented in every NJ County.

Recognizing the continued need for improvement within a 'system of care' is essential as the need for mental health services by those 'youth' within the child welfare system continually grows; New Jersey's CSOC has continuously sought to improve services and supports. New Jersey is one of the only states whose child welfare reform plan included a statewide restructuring which resulted in creation of a specific department to house all child/ family based structures. The Department of Children and Families (DCF) in July 2006 became the first cabinet agency whose mission was devoted exclusively to serve and safeguard the most vulnerable children and families in the state.

Included in the DCF were the Division of Youth and Family Services (DYFS), Division of Child Behavioral Health Services (DCBHS) as well as other divisions and entities. The mandate of the DCBHS was to serve children and adolescents with emotional and behavioral health care needs and their families. DYFS primary mandate was investigating/ protecting children from abuse and neglect while also working towards securing permanency for those children without primary caregivers. This restructuring of the DCF resulted in a new DYFS "case practice model" that would ensure better planning and coordination between DYFS and DCBHS. Throughout 2006

and 2007 the DCBHS continued to seek input through focus groups, public hearings and an independent assessment from the University of South Florida to address improvements to the system. During 2007 and 2008 and based upon the major recommendations received, the DCBHS began the process of planfully rolling out these system improvements.

Further reorganization and realignment of service delivery in DCF began in July 2012 when services provided to children with developmental disabilities were transferred from the New Jersey Department of Human Services-Division of Developmental Disabilities (DHS-DDD) into the DCF-newly constituted Division Children's System of Care (CSOC), formerly DCBHS; as well as the transfer of addiction services for adolescents up to age 18 and those ages 18-21 already under the protective supervision of DCF's-newly constituted Division of Child Protection and Permanency (DCP&P), formerly DYFS, or receiving behavioral health services through the DCF's COSC were transferred from the DHS's-Division of Mental Health and Addiction Services (DMHAS) to the DCF.

Effective July 1, 2013, DCF's Contracted Systems Administrator (CSA) began authorizing youth who meet specific criteria to receive substance use treatment (SAT) services from a limited number of providers who are contracted with the DCF, NJ CSOC. In January 2014, CSOC substance abuse treatment resources were expanded to include both South Jersey Initiative (SJI) adolescent treatment services as well as detoxification services for adolescents from the ten identified counties impacted by Superstorm Sandy.

This reform initiative required an organized CSOC with a foundation of core values and guiding principles.

Core Values

- Family driven
- Youth guided
- Individualized and community based
- Culturally and linguistically competent
- Evidence based

Principles

- All children who need services should receive the same accessibility to services.
- Availability and access to a broad, flexible array of community-based services and support for children, and their families and caregivers, to address their emotional, social, educational and physical needs, should be ensured.
- Services should be individualized in accordance with the unique needs of each child and family.
- Services should be guided by a strength-based, wraparound service planning process and a service plan that is developed in true partnership with the child and family.
- Services should be delivered in the least restrictive settings that are clinically appropriate.
- Treatment outcomes for children and families should be quantifiable

System Requirements

The CSOC continues to include components that support this structural reform of service organization, management, and delivery, requiring the following system components:

A Contracted System Administrator (CSA) facilitates and supports utilization management, care coordination, quality management, and information management for the statewide system of care. In this administrative support role, it provides DCF, the CMO and other system partners with the information needed to manage the Individualized Service Plans (ISPs) process toward quality outcomes and cost effectiveness. The CSA is the single point of access to services for New Jersey children with behavioral, emotional, intellectual, developmental, and/or substance use needs. (http://www.performcarenj.org/about/index.aspx - current DCF-funded CSA)

Mobile Response and Stabilization Services (MRSS) are available 24 hours a day, seven days a week, to help children and youth who are experiencing emotional or behavioral crises. The initial 72 hour services are designed to defuse an immediate crisis, keep children and their families safe, and maintain the children in their own homes or current living situation (such as a foster home, treatment home or group home) in the community. MRSS up to 8 weeks provide parents/caregivers/guardians with short-term, flexible services that assist in stabilizing children/youth in their home/community setting.

Care Management Organizations (CMOs) organize and coordinate community-based services and informal resources through face-to-face care management at the local level for individual children and families with multi-service needs and multi-system involvement.

Family Support Organizations (FSOs) provide direct peer support and assistance to children and families from family members of children with current or past system involvement.

Access and Eligibility

Access

The CSA partners with the CSOC as the single point of entry for all children, adolescents and young adults *(up to age 21)* who are in need of behavioral health, or developmental and intellectual disability, or certain substance abuse treatment services. All services are voluntary. The System of Care includes a broad range of services to support the needs of children with complex challenges. Generally speaking, these services fall into one or more of the following categories:

Urgent and emergency crisis response and stabilization.
Care Management.
In-home services (intensive in home/intensive in community).
Substance use treatment services.
Out-of-home treatment.
Support for families and caregivers.
Youth involvement and peer support

CSA staff is available 24 hours a day, 7 days a week to provide individualized care to eligible children. Access to services in the CSOC is *only* through the CSA and may consist of referral to CMO, FSO, MRSS or other in-home and in-community programs.

Access to services provided under the Children's System of Care (CSOC), such as Care Management Organization (CMO) or Mobile Response and Stabilization Services (MRSS), requires a completed Medicaid application. In doing so, the family may be found eligible for Medicaid as secondary insurance, or the child may be approved for state funds that cover the cost of certain behavioral health services to supplement the private insurance benefits.

Eligibility

In general, youth who are eligible for services through the CSA are primarily between the ages of 5 and 21 (up to his or her 21st birthday), reside in the State of New Jersey and have an emotional or serious mental health or behavioral need. Special consideration for services is given to children under the age five. Eligibility for CMO services for child/youth/young adult include but are not limited to:

- those receiving services from the CSOC and are not eligible for Medicaid or NJ FamilyCare;
- those individuals determined by the DCF, or its designated CSA, to require CMO services due to any one or any combination of the following:
- Serious emotional or behavioral health needs resulting in significant functional impairment which adversely affects his or her capacity to function in the community
- His or her CSOC assessment indicates a need for the intensive level of case management services provided by a CMO
- He or she is involved with one or more agencies or systems, including, but not limited to: DCP&P; Crisis/emergency service providers; Department of Human Services or Department of Children and Families provider agencies; JJC; or The court system;
- A risk of disruption of a current therapeutic placement exists;
- A risk of a psychiatric readmission exists; or
- A risk of placement outside the home or community exists, except for:
- Foster care placement, unless one or more of the conditions in (a)2i through v above are also present.

A Youth and Family Guide is available in English online at
http://www.performcarenj.org/pdf/provider/youth-family-guide-eng.pdf
A Youth and Family Guide is available in Spanish online at
http://www.performcarenj.org/pdf/provider/youth-family-guide-span.pdf

Clinical Criteria

The Clinical Criteria for the various services available are located on the CSA's website at http://www.performcarenj.org/provider/clinical-criteria.aspx

Populations Served

Serious Emotional/Behavioral Disorders

"Seriously emotionally/behaviorally challenged' means a youth exhibiting one or more of the following characteristics: behavioral, emotional or social impairments that disrupt the youth's academic or developmental progress and may also impact upon family or interpersonal relationships. This disturbance shall have also impaired functioning for at least one year or the impairment shall be of short duration and high severity. (NJAC Title 10:191-1.2)

Youth with emotional/behavioral disorders must be in need of services that are not typically provided through primary health insurance (typical services include outpatient individual therapy or partial hospitalization) and must meet the specific eligibility rules for each service type.

Substance Use
"Substance use/dependence" means a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances including alcohol, tobacco and other drugs. There may be repeated failure to fulfill major role obligations, repeated use in situations in which it is physically hazardous, multiple legal problems and recurrent social and interpersonal problems. For the purpose of this chapter, substance abuse and substance dependence also means other substance-use related disorders as defined in the DSM-V. (NJAC Title10:161A-1.3)

Youth age 13 up until their 18th birthday may qualify for substance use treatment services through PerformCare. Youth who are 18 years-old may also qualify for CSOC substance use treatment services **IF** they are actively in high school or actively pursuing their education **AND** would be best served in an adolescent program.

The Substance Use Treatment Provider List identifies which providers serve 18 year-olds. If a youth turns 18 (or 19 if admitted at age 18) while receiving services in a contracted SUT program, PerformCare will continue the authorization until the youth is ready for transition to another level of service. At the time of completing their current course of treatment, youth will be transitioned to DMHAS for substance use treatment services. Further information is available online at: http://www.performcarenj.org/provider/substance/index.aspx

Developmental-Intellectual Disability
Youth with intellectual/developmental disabilities must first be determined "Developmental Disability (DD) eligible" in order to receive services. The application is available on the CSA website at http://www.performcarenj.org/families/disability/determination-eligibility.aspx

for youth up to their 18th birthday. Individuals/families who don't have access to the Internet, can call the CSA at 1-877-652-7624 and an application will be mailed. Youth who were determined DD eligible by the NJ Division of Developmental Disabilities do not have to reapply in order to receive services in the Children' System of Care.

Strengths and Needs Assessment (SNA)
The SNA is the Child Family Team (CFT) planning tool to support decision making about the individual treatment planning for children and families within the CSOC. It supports the rapid and consistent communication of the strengths as well as the needs of children and their families being served through the CSOC. It is intended to be completed by the individuals who are

directly involved with the child/family as part of CFT. The SNA tool serves to document the identified strength and needs of the child/family throughout the time they are in the CSOC. The SNA tool serves as the documentation of the progress as well as to ensure the child and family receive the appropriate services for the appropriate length of time.

Individual Service Plan (ISP)
The ISP is the treatment plan developed by the Child Family Team. The ISP incorporates formal and informal services and supports into an integrated plan that, using the identified strengths of the youth and family, addresses the needs of the youth and family across life domains in order to support the youth and family in remaining in, or returning to, the community where they live, work and/or attend school.

Child Family Team (CFT) Process
A CFT consists of family members, professionals, and community residents organized by a CMO to design and oversee implementation of the ISP. To complete ISP, the CMO develops a CFT in coordination with the family member or caregiver. At a minimum, the following members comprise the CFT: a CMO care manager; the youth and the parent or other caregiver; any interested person the family wishes to include as a member of the team, including, but not limited to, clergy members, family friends, and any other informal support resource; a representative from the FSO, if desired by the family; a clinical staff member who is directly involved in the treatment of the youth that the comprehensive 30 day plan is being developed for, if desired by the family; representation from outside agencies the youth is involved with, including, but not limited to, current providers of services, parole/probation officers, and/or educators that the youth and his or her family/caregiver agree to include on the team; and, the DCP&P caseworker assigned to the child, if the child is receiving child protection or permanency services from DCP&P.

The CMO Care Manager assigned to the youth and their family/caregiver is responsible to: refer the youth or the family/caregiver for multi-system or any additional specialized assessments as indicated; serve as the facilitator of the CFT; actively engage the child and family as full partners in the CFT, assuring their participation in the assessment, planning and service delivery process; ensure that all services and care management processes respect the youth and family/caregiver's rights to define specific goals and choice of providers and resources; ensure that all services and resources are family friendly and culturally competent; ensure that all CFT meetings are conveniently scheduled and located for the family/caregiver; ensure that the ISP is developed as a collaborative effort of all team members; ensure that the ISP is approved by each team member, including the family/caregiver and the child, at the team meeting.

Wrap Around
Wraparound is an evidence-based structured approach to service planning and care coordination for individuals with complex needs (most often children, youth and their families). Wrap Around is built on key system of care values: family and youth driven, team based, collaborative, individualized, and outcomes-based. Wrap around adheres to specified procedures: engagement, individualized care planning, identifying strengths, leveraging natural supports, and monitoring progress.

The Wraparound Process User's Guide A Handbook for Families is available at the following link: http://www.nwi.pdx.edu/pdf/Wraparound_Family_Guide09-2010.pdf
The Youth Guide to Wrap Around Services is available at the following link:
http://www.nj.gov/dcf/families/csc/documents/YouthGuideWraparound.pdf

Family Support Organizations (FSO)
Family Support Organizations (FSO's) are family-run, county-based organizations that provide direct family-to-family peer support, education, advocacy and other services to family members of children with emotional and behavioral problems. To access services, families may call these organizations directly or call 1-877- 652-7624.

A list of the FSO's with their contact information is available at:
http://www.nj.gov/dcf/families/support/support/

Mobile Response Stabilization Services (MRSS)

MRSS-Initial 72 hours
Mobile Response and Stabilization Services are available 24 hours a day, seven days a week, to help children and youth who are experiencing emotional or behavioral crises. The services are designed to defuse an immediate crisis, keep children and their families safe, and maintain the children in their own homes or current living situation (such as a foster home, treatment home or group home) in the community.

The goals of Mobile Response Initial Services are to rapidly respond to any non-immediate life threatening mental health crisis reaction and/or youth with escalating emotional and/or behavioral health needs; provide immediate intervention to assist children/youth and their parents/caregivers/guardians in de-escalating behaviors, emotions and/or dynamics impacting youth life functioning ability' prevent/reduce the need for care in more restrictive settings e.g. inpatient psychiatric hospitalization, detention, etc. by providing timely community based intervention and wrap around service delivery/resource development; effectively engage, assess and plan for appropriate interventions to minimize risk, aid in behavior stabilization, and improve life functioning, allowing the child/youth to remain in, or return to, his/her present living arrangement, functioning in school and community settings, and maintain least restrictive treatment setting; facilitate the child/youth's and the parent/caregiver/guardian's transition into identified supports, resources and services post Mobile Response Initial Services including but not limited to Mobile Response Stabilization Management Services, Care Management Services, outpatient services, evidence based services, community based supports and natural resources.

More detailed information is available at the following link:
http://www.performcarenj.org/pdf/provider/clinicalcriteria/mobile-response-serv-72-hrs.pdf

MRSS-Up to 8 Weeks
Mobile Response Stabilization interventions provide parents/caregivers/guardians with short-term, flexible services that assist in stabilizing children/youth in their home/community setting. Interventions are designed to maintain the child/youth in his/her current living arrangement, to prevent repeated hospitalizations, to stabilize behavioral health needs and to improve functioning

in life domains, as identified. Interventions at this level of care include the delivery of a flexible variety of services through the development of a comprehensive and coordinated Individual Crisis Plan (ICP). Children/youth, based upon need, enter Mobile Response Stabilization Services following the completion of the Mobile Response Assessment and the development of the ICP by the Mobile Response Team during the first 72 hours.

Interventions may include, but are not limited to, crisis intervention, counseling, stabilization bed services, behavioral assistance, in-home therapy, intensive in-community services, skill building, mentoring, medication management and/or parent/caregiver/guardian stabilization interventions. Mobile Response Stabilization Services are managed and monitored by the Children's Mobile Response Stabilization Services Agency and pre-authorized and reviewed by the CSA. Mobile Response Stabilization interventions can be delivered for up to eight weeks. Use of these interventions will vary by setting, intensity, duration and identified needs. The objective of Mobile Response Stabilization Services would be to ultimately defuse the current crisis and help link the youth and family with longer-standing therapeutic resources which are consistent with their treatment needs. This may involve linking the family with services outside of the CSOC system, such as Division of Developmental Disabilities, Autism specialized services, or community based therapeutic nursery programs, where available.

More detailed information is available at the following link:
http://www.performcarenj.org/pdf/provider/clinicalcriteria/mobile-response-serv-8-wks.pdf

CMO Treatment Planning
The Individual Service Plan (ISP) is comprehensive in nature, strength based, and developed in partnership with the child, youth, young adult and the family or other caregivers. The ISP is based on the comprehensive assessments completed as indicated by the presenting challenges, needs and strengths of the child, youth or young adult and his or her family/caregiver; identifies the services to be provided and shall ensure that the services are provided to the child, youth, or young adult in the least restrictive manner possible; and, consists of outcome based, short term, interim, and long term goals to address each area of unmet need with measurable goals and time frames, specific individual roles and responsibilities, a crisis/emergency response plan and a schedule for ongoing review and assessment. The ISP is developed within 30 days of the referral to the CSA and is submitted to the CSA for registration within 30 calendar days of the referral.

At a minimum, the ISP addresses areas of unmet need in all areas of the following life domains, as indicated by the multi-system assessment process, including, but not limited to: child safety; child risk; clinical needs; non-clinical needs, if deemed therapeutic and approved by the Child/Family Team; permanency planning; and community safety issues. Additionally the ISP includes child safety, child risk, permanency planning and community safety issues coordinated with the DCP&P worker, who has the primary responsibility for child safety under the Federal child protection mandates contained in Title IV-E of the Social Security Act.

The ISP must contain the following information: documentation of the participation of providers and local community partners and the integration of available and appropriate services and resources; documentation of the responsibilities, objectives, and requirements of child welfare, mental health, juvenile justice, the courts, and other service systems, as applicable;

documentation of the coordination of system partner mandates and responsibilities with the assessment plan; documentation of the involvement of FSOs, if desired by the family; a plan for permanency, clinical care, and child and community safety (DCP&P maintains the primary responsibility for permanency and child safety for the DCP&P child.); a community based crisis management plan, which includes emergency response capability to respond in person to deliver in-home or off-site crisis support as warranted, and coordination of crisis response services, if intervention is needed beyond care manager response; a plan to develop and purchase those items and/or services necessary to support the individual's needs as determined by the team; documentation of the coordination of applicable services with the physical health insurer; measurable goals and the criteria to be met to obtain those goals; a plan for transitioning the youth and the family/caregiver from CMO services to a community based, natural support network of services; a plan to maintain enrollment for the youth receiving the CMO services on a "no eject/no reject" basis until the defined outcomes and discharge criteria specified in the ISP are met; and, the signatures of the CMO care manager, the parent/caregiver and the child, youth or young adult receiving the services.

Behavioral Health Homes (BHH)

CSOC, in coordination with the DHS Division of Mental Health and Addiction Services developed and implemented Behavior Health Homes (BHH) in Bergen and Mercer counties. BHH serve as a "bridge" that connects prevention, primary care, and specialty care, and is designed to avoid fragmented care that leads to unnecessary use of high end services (i.e. emergency rooms and inpatient hospital stays.) The current child family teams are to include medical expertise and health/wellness education for purpose of providing fully integrated and coordinated care for children who have chronic medical conditions. Behavioral Health Home provides services to children with serious emotional disturbance with the goal of improving health outcomes; promoting better functional outcomes (such as increased school attendance); decreasing overall cost, and the cost associated with the use of acute medical and psychiatric services; improving child/family's satisfaction with care; and, improving the family's ability to manage chronic illness.

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 constitutes 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.

Intensive In-Home Services (IIH)

IIH are an array of rehabilitation and/or habilitation services delivered face-to-face as a defined set of interventions by clinically licensed or certified practitioners. IIH are geared to augment those services already being provided in the school and other settings; they do not supplant existing services. All other benefits for which the youth may be eligible (such as SSI and private insurance) must be accessed before accessing IIH resources. Services are not a guarantee and are based on the youth's and family's need and availability of resources.

IIH are provided in the youth's home and/or in community-based settings, and not in provider offices or office settings. Providers must be able to safely address complex needs and challenging behaviors including but not limited to: noncompliance to verbal/written directions,

tantrums, elopement, property destruction, physical/verbal aggression, self-injurious behaviors, and inappropriate sexual behavior.

These services are provided as part of an approved intensive individualized in-home service plan and encompass a variety of clinical and behavioral intervention supports and services including, but not limited to, Clinical (Rehabilitation) and Behavioral (Habilitation) services.

Clinical (Rehabilitation) supports and services are provided as part of an integrated plan of care which includes but is not limited to: CSOC Information Management Decision Support (IMDS) Strengths and Needs Assessment or other CSOC approved/required IMDS tools and other assessment tools as indicated. Clinicians must be familiar with the array of considerations that would indicate preferred assessment methods. IIH services may include individual, family and group counseling; Positive Behavioral Supports; instruction in learning adaptive frustration tolerance and expression, which may include anger management; instruction in stress reduction techniques; problem solving skill development; psycho-educational services to improve decision making skills to manage behavior and reduce risk behaviors; social skills development; trauma informed counseling; and the implementation of an individualized Behavior Support Plan, if present. The Clinician shall provide coordinated support with agency staff and participate as part of the clinical team; collaborate effectively with professionals from other disciplines that are also supporting the youth, including but not limited to: education staff, clinicians, physicians, etc.; and recommendation referrals for medical, dental, neurological or other identified evaluations.

Behavioral (Habilitation) supports and services are provided as part of an integrated plan of care which includes but is not limited to: Applied Behavior Analysis (ABA) Functional Behavior Assessment (FBA) and related assessments, e.g., preference assessments, reinforcer assessments; Level of Functioning in the six major life areas, also known as Activities of Daily Living (ADL) as measured by the Vineland or other similar accepted tool; augmentative and alternative communication supports and functional communication training, e.g. visual schedules, contingency maps, Picture Exchange Communication System (PECS), wait signal training; instruction in Activities of Daily Living; implementation of an individualized Behavior Support Plan; individual behavioral supports such as Positive Behavioral Supports; training/coaching to address the youth/young adult's behavioral needs; support and training of parent/legal guardian to successfully implement Behavior Support Plan, use of Assistive Technology, and other support services as needed, gradually diminishing the need for outside intervention; modifying behavior support plans based on frequent, systematic evaluation of direct observational data; providing training and supervision to support staff providing in home ABA services; recommendations for referrals for medical, dental, neurological or other identified evaluations; providing coordinated support with agency staff and participating as part of the clinical team; collaborating effectively with professionals from other disciplines that are also supporting the youth, including but not limited to: education, clinicians, physicians, etc. The Functional Behavior Assessment and development of a Behavior Support Plan shall be an integral part of the treatment planning process for those identified youth.

Intensive In-Community Services (IIC)

IIC services are flexible, multi-purpose, in-home/community clinical support for parents/caregivers/guardians and children/youth with behavioral and emotional disturbances who

are receiving care management or MRSS services. The purpose of these interventions is to strengthen the family, to provide family stability and to preserve the family constellation in the community setting. These services are flexible both as to where and when they are provided based on the family's needs. They may be provided as a component of the MRSS. This family-driven treatment is based on targeted needs as identified in the plan of care and includes specific intervention(s) with target dates for accomplishment of goals that focus on the restorative functioning of the child/youth.

The services provided will also facilitate a youth's transition from an intensive treatment setting back to his/her community. They are designed to be time limited in nature with the objective of helping the youth and family transition to longer term community based mental health services which are congruent with their treatment needs when needed. Interventions will be delivered with the goal of diminishing the intensity of treatment over time.

Each youth receiving intensive in-community services shall have an approved, documented comprehensive plan of care addressing the services. The plan shall be individually tailored to address identified behavior(s) that impact on the youth's ability to function at home, school or in the community, and shall incorporate generally accepted professional interventions. The plan of care shall be authorized by the DCF, the CSA or other authorized DCF designated agent(s). For those youth receiving CMO services, this plan shall be included as part of the youth's CMO ISP prepared by the CFT. For all other CSOC enrolled youth receiving intensive in-community services, this plan of care shall be included in the plan of care as coordinated and/or authorized by the CSA or other designated agent, prior to implementation.

New DCF Initiatives under the NJ Comprehensive Waiver

The three new DCF initiatives under the NJ Comprehensive Waiver are now operational. The services provide additional community support and coordination of services for an expanded population of youth that meet the clinical criteria for services. This includes services for certain NJ FamilyCare eligible individuals that have been diagnosed with a Serious Emotional Disturbance (SED), Autism Spectrum Disorder (ASD) and Individuals with Intellectual/ Developmental Disabilities and a co-occurring Mental Illness (ID/DD-MI). These waivered services are not yet included as part of NJ State Plan: The ASD pilot provides NJ FamilyCare children with needed therapies that they are unable to access through the NJ FamilyCare State Plan and are not yet available to other children with private health insurance. By providing intensive home and community based services, the ID-DD/MI pilot is built to provide a safe, stable and therapeutically supportive environment for children with developmental disabilities and co-occurring mental health diagnoses, age five up to 21, with significantly challenging behaviors. The SED demonstration provides health services for enrollees who have been diagnosed as seriously emotionally disturbed—an at-risk population for hospitalization and out-of-home placement. Over the past two and ½ years, the Children's System of Care has worked with the Division of Medical and Health Services (DMHAS) and its fiscal agency, Molina to build and implement the new service codes so that the Molina system would support the new program, and allow for CSOC Medicaid providers to successfully bill for services provided. These codes were operationalized on March 1. 2015.

Out-of-Home Treatment

Out-of-home (OOH) treatment is a time-limited intervention aimed at stabilizing a child/youth/young adult's identified behaviors/needs and addressing the underlying etiology of these behaviors/needs so that he/she may safety return home or to a non-clinical setting with as little disruption to his/her life as possible. The long-term goal of OOH treatment is to facilitate the youth's reintegration with his/her family/caregiver and community or in an alternative permanency plan preparing for independent living. OOH treatment is the CSOC's highest level of intervention and thus should only be accessed when all other therapeutic interventions have been exhausted. Prior to submission of an OOH Referral Request, CMO must facilitate a Child Family Team (CFT) meeting to discuss the current needs of the child, obtain consent from the youth/family for OOH care, and obtain supervisor approval. The CSA determination for an OOH Intensity of Service (IOS) is based on the clinical information provided in the OOH Referral Request as well as in required supporting documentation.

Out-of-Home Intensities of Service (IOS)
CSOC serves children, youth, and young adults with a wide range of challenges associated with emotional and behavioral health, intellectual/developmental disabilities, and substance use. CSOC is committed to providing these services based on the individualized need of each child and family within a family-centered, strength-based, culturally competent, and community-based environment. CSOC offers a full continuum of out-of-home services which are based on intensity, frequency, and duration of treatment.

The full continuum of out-of-home services (from highest to lowest intensity) includes the following:

Behavioral Health
(IRTS) Intensive Residential Treatment Services
(PCH) Psychiatric Community Home
(SPEC) Specialty
(RTC) Residential Treatment Services
(GH) Group Home
(TH) Treatment Home

Intellectual/Developmental Disabilities (IDD)
(IPCH-IDD) Intensive Psychiatric Community Home-IDD
(PCH-IDD) Psychiatric Community Home-IDD
SPEC-IDD (Specialty-IDD)
GH 2-IDD (Group Home Level 2-IDD)
GH-1 IDD (Group Home Level 1-IDD)
SSH IDD (Special Skills Home-IDD)

Substance Use
Short Term Detox
Short Term Residential
Long Term Residential

Children's Interagency Coordinating Council (CIACC)
Located within each county, CIACCs were created by statute to serve as the mechanism in each county to develop and maintain a responsive, accessible, and integrated system of care for children with emotional and behavioral challenges and their families, through the involvement of parents, consumers, youth and child serving agencies as partners. The CIACCs provide a forum where the system of services for children with emotional and behavioral challenges is developed, reviewed, revised and/or redirected, through collaborative decision-making process with DCF to promote optimal services provided in the least-restrictive, but most appropriate setting possible.

Each CIACC completes an annual county needs assessment to determine how DCSOC community development funds should be allocated within that county.

CIACC Education Partnership
The mission of the *CIACC Education Partnership* is to promote, develop, and enhance collaborative efforts between school, behavioral health and child protective service systems and other interested parties to improve the well-being of children in Ocean County.

The Partnership was conceived in 2006 by members of the CIACC who recognized a need for ongoing, standardized exchange of procedural information between local schools, the child protective service agency and children's behavioral health programs. The services and supports available for children are continually growing and evolving. Through this Partnership, professionals from each of the three systems are provided up-to-date, ongoing training and education on the services that are available and how to access and effectively coordinate with those services, which will help ensure that children receive the help that they need. Through enhancing the knowledge of and communication between professionals, Ocean County children may see the full benefit of these systems working together to meet their multifaceted needs.

Educational Services
The McKinney-Vento Act defines homeless children as "individuals who lack a fixed, regular, and adequate nighttime residence." This includes youth in OOH/state facilities. The Department of Corrections, the DCF, the DHS, and the JJC are required to provide educational programs to students in State facilities ages five through 20 and for students with disabilities ages three through 21 who do not hold a high school diploma. Students must be able to receive high school credit.

In general State agencies are required to:
provide a program comparable to the special education student's current individualized education program (IEP), and implement the current IEP or develop a new IEP; develop an individualized program plan (IPP), within 30 calendar days, for each general education student, in consultation with the student's parent, school district of residence, and a team of professionals with knowledge of the student's educational, behavioral, emotional, social, and health needs to identify appropriate instructional and support services; discuss the IPP with the student and make a reasonable effort to obtain parental consent for an initial IPP, including written notice; and, review and revise the IPP at any time during the student's enrollment, as needed, or on an annual basis if the student remains enrolled in the State facility educational program, in consultation with the school district of residence.

Attendance in educational programs is compulsory for all students, except for a student age 16 or above who may explicitly waive this right. For a student between the ages 16 and 18, a waiver is not effective unless accompanied by consent from a student's parent or guardian. A waiver may be revoked at any time by the former student.

The actual number of days a student with a disability must attend the educational program shall be determined by the student's IEP.

Students with a Disability

Each State agency shall ensure all students with a disability in the agency's State facilities are provided a free and appropriate public education as set forth under the Individuals with Disabilities Education Act, 20 U.S.C. §§1400 et seq., and shall provide special education and related services as stipulated in the individualized education program (IEP) in accordance with the rules governing special education.

The State of New Jersey Department of Education Homeless Education link at http://www.state.nj.us/education/students/homeless/ provides additional links for information/resources.

Educational Stability for Youth in Out-of-Home Placement

In October 7, 2008, the federal government signed into law the Fostering Connections to Success and Increasing Adoptions Act (P.L. 110-351). This act required all states to arrange for children and youth in foster care to remain in their "school of origin" to ensure educational stability unless it is determined to be in a child's best interest to go to the new district where the Resource Family Home is located. New Jersey responded to this charge by passing the Education Stability Law on September 9, 2010, which established a system that supports the act. The DCF, Department of Education (DOE) and Office of the Child Advocate (OCA) worked together to implement this law. For children, changing schools can affect their ability to thrive academically, socially, behaviorally and psychologically. This is especially true for children in resource family homes. For these children – who often suffer the lingering effects of abuse or neglect and the trauma of being removed from their homes and families – school can often be the most stable part of their lives.

Work continues to fully implement the requirements of coordination between the DCF and the local school districts. To support the continued progress "*Improving the Educational Outcomes of Children in Out-of-Home Placements: An Interagency Guidance Manual*" is available on the DCF website at http://www.nj.gov/dcf/families/educational/stability/GuidanceManual.pdf and on the NJDOE website at http://www.state.nj.us/education/students/safety/edservices/stability .

The guidance manual includes a model memorandum of agreement (MOA) and provides specific actions to reach the indicators and goals in the MOA.

A one page flyer with information for School Registration of Youth in Out-of-Home Care is available at http://www.nj.gov/dcf/documents/divisions/dyfs/OOHflyer.pdf

A two page directory of local DCF Education Stability Liaison Staff is available at http://www.nj.gov/dcf/families/educational/stability/Directory.pdf

Training and Technical Assistance

The mission of Training and Technical Assistance Services for the Children's System of Care is to support learning the requisite knowledge and skills to provide services and support the unique needs and strengths of families and children with complex needs. The training and technical assistance effort draws on a commitment to competency based curriculum design, training based on adult principles of learning and skill development, and development of local expertise and training capacity.

Rutgers University Behavioral HealthCare (RUBHC), Behavioral Research and Training Institute, is responsible for all CSOC curriculum development, training and technical assistance activities statewide. This includes all IMDS training and certification, as well as the provision of training contact hours for social workers and counselors.

Additional information regarding the Training and Technical Assistance programs can be accessed at:
http://nj.gov/dcf/providers/csc/training/

Additional information regarding the New Jersey Children's System of Care is available in the Planning Steps Section of the Grant.

Environmental Factors and Plan

19. Pregnant Women and Women with Dependent Children

Narrative Question:

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant (Title XIX, Part B, Subpart II, Sec.1922 (c)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at http://www.samhsa.gov/women-children-families: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges.*

Please consider the following items as a guide when preparing the description of the state's system:

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.
5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

19. Pregnant Women and Women with Dependent Children

Please consider the following items as a guide when preparing the description of the state's system:

1. The implementing regulation **requires** the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.

   The Annex A of each Department of Human Services (DHS) contract includes a statement to the effect that pregnant women will receive priority for admission to treatment. In the event that admission of a pregnant woman is not possible due to insufficient treatment capacity, referral to another agency and/or provision of identified interim services must be documented by the facility. Monitoring site visits conducted by the DMHAS staff includes a review of this documentation to ensure that appropriate and timely treatment was provided.

   The Treatment Directory on the DMHAS website is updated on a regular basis to maximize its currency and utility. A separate clickable link specified services offered by each provider, including specialized treatment services for PW/WDC.

2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.

   The Annex A of each Department of Human Services (DHS) contract includes a statement to the effect that pregnant women will receive priority for admission to treatment. If any substance abuse treatment facility has insufficient capacity to accept a pregnant woman for treatment, the facility must refer the woman to another facility or make interim services available within 48 hours. In the event that a referral to another program is not possible, the facility reporting insufficient capacity is required to provide interim services for the woman until either an appropriate referral to a specialized women's service agency is made, or until that agency is able to accept the woman into treatment. Provision of interim services include: referral and follow up for prenatal care; the provision of literature addressing pregnancy and addiction; and the availability of health care and social services within the community, including WIC services, Healthy Mothers/Healthy Babies programs, nutrition, and parenting. Providers are also advised to contact the DMHAS Women's Treatment Coordinator who can actively intervene to ensure the prompt placement of pregnant women in an appropriate treatment program. In instances where the caller indicates a problem in accessing services within the treatment system (most frequently for residential care), the Women's Treatment Coordinator identifies available capacity within funded agencies and follows up with providers.

3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.

   As per the Annex A contract, if any substance abuse treatment facility has insufficient capacity to accept a pregnant woman for treatment, the facility must refer the woman to

another facility or make interim services available within 48 hours. In the event that a referral to another program is not possible, the facility reporting insufficient capacity is required to provide interim services for the woman until either an appropriate referral to a specialized women's service agency is made, or until that agency is able to accept the woman into treatment. Provision of interim services include: referral and follow up for prenatal care; the provision of literature addressing pregnancy and addiction; and the availability of health care and social services within the community, including WIC services, Healthy Mothers/Healthy Babies programs, nutrition, and parenting. Providers are also advised to contact the DMHAS Women's Treatment Coordinator who can actively intervene to ensure the prompt placement of pregnant women in an appropriate treatment program. In instances where the caller indicates a problem in accessing services within the treatment system (most frequently for residential care), the Women's Treatment Coordinator identifies available capacity within funded agencies and follows up with providers. The women's treatment providers attend monthly Child Welfare Substance Abuse Consortia meetings and Women's Steering Committee meetings and are informed by the Women's Treatment Coordinator about the process followed when programs are at full capacity.

4. Discuss who within your state is responsible for monitoring the requirements in 1-3.

   To ensure compliance all programs are carefully monitored by DMHAS monitors in the Office of Olmstead, Prevention, Compliance, Planning and Evaluation. Trained staff performs a minimum of annual site visits of PW/WDC programs, which includes reviewing charts, interviewing clients, and inspecting buildings and ground. The number of pregnant women and children in residence are documented. Staffing is monitored to ensure that expected credentials are in order and that the client staff ratio is appropriate. Technical assistance is available at all times. DMHAS staff will assist in making appropriate referrals when necessary.

   Data gained from site visits and documentation in charts assist in determining the number of PW/WDC receiving services. If problems utilizing treatment capacity occurs, additional site visits take place to provide technical assistance and for planning outreach strategies to ensure that treatment capacity is available.

   To ensure that pregnant women receive the special medical care required, affiliation agreements are in place to ensure prenatal care at area hospitals. Most recipients of TANF funds are also Medicaid eligible. High-risk pregnancies are carefully monitored. Children residing with their mothers receive medical care at well-baby clinics. Case management includes determining eligibility for Women, Infants and Children (WIC) and the Healthy Mothers, Healthy Babies programs.

   Children may present with numerous problems when entering programs with their mothers. Childcare workers are trained to observe behavior and use appropriate interventions, or to refer children for evaluations when necessary. Psychosocial evaluations of the children are conducted when appropriate. Separate chars are maintained for the children, and all services are documented.

5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)

   Long Term Residential – three (3); Short Term Residential – four (4); Halfway House – three (3); Intensive Outpatient – six (6); Outpatient – four (4); Methadone Outpatient Care – fifteen (15).

   a. How many of the programs offer medication assisted treatment for the pregnant women in their care?

      Fifteen (15)

   b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?

      There are currently thirty (30) licensed Opioid Treatment Programs (OTPs) that operate throughout the State of NJ; fifteen (15) OTPs currently receive Women's set-aside funding. All 30 OTPs make treatment admission a priority for a pregnant woman who has an active opioid use disorder. 17 of 21 NJ counties have a licensed OTP. If a woman lives in a county that does not have a licensed OTP, she will be admitted to an OTP that is in an adjacent county or the closest proximity to where she resides.

6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)

   Long Term Residential – three (3); Short Term Residential – four (4); Halfway House – three (3); Intensive Outpatient – six (6); Outpatient – four (4); Methadone Outpatient Care – fifteen (15).

   a. How many of the programs offer medication assisted treatment for the pregnant women in their care?

      Fifteen (15)

   b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

      There are currently thirty (30) licensed Opioid Treatment Programs (OTPs) that operate throughout the State of NJ; fifteen (15) OTPs receive Women's set-aside funding. All 30 OTPs make treatment admission a priority for a pregnant woman who has an active opioid use disorder. 17 of 21 NJ counties have a licensed OTP. If a woman lives in a county that does not have a licensed OTP, she will be admitted to an OTP that is in an adjacent county or the closest proximity to where she resides.

Environmental Factors and Plan

20. Suicide Prevention

Narrative Question:

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised National Strategy for Suicide Prevention (2012).
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans.[96]

Please indicate areas of technical assistance needed related to this section.

[96] http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

20. Suicide Prevention

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised National Strategy for Suicide Prevention (2012).

   Attached is a copy of the NJ Adult Suicide Prevention Plan (2014-2017). This plan was based on the National Strategy for Suicide Prevention that was issued in 2001. At the time of development our goal was to be consistent with the New Jersey Youth Suicide Prevention Plan 2011-2014. Between September and December 2014 the DMHAS Suicide Prevention Committee started the process of updating the New Jersey Adult Suicide Prevention Plan (2014-2017) to make it consistent with the 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action. Special consideration was given to four goals that were prioritized by Stakeholders and Executive Leadership. These prioritized goals correspond to goals # 5, 7, 8, and 9 of the 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action. In addition to the four prioritized goals (# 5, 7, 8, and 9) that are already updated consistent with the 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action, the remaining nine goals will be updated accordingly in the fall of 2015 with the NJ Adult Suicide Prevention Advisory Council's input.

2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.

   The NJ Adult Suicide Prevention Plan (2014-2017) is a statewide plan that covers all populations of New Jersey. The Advisory Council has been discussing issues regarding suicide prevention interventions for certain at risk population, such as LGBTQI, Veterans, Older Adults, individuals with serious mental illness and/or addiction, and/or forensic issues. It is expected that the Goal Workgroups will propose specific recommendations for a number of these populations.

3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans:

   Attached are the four prioritized goals # 5, 7, 8, and 9 with rationales and objectives that were updated to be consistent with the 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action. In addition to the four prioritized, updated goals (# 5, 7, 8, and 9) the remaining nine goals will be updated accordingly in the fall of 2015 with the NJ Adult Suicide Prevention Advisory Council's input.

Goal # 5:

Strengthen, develop, implement, and monitor effective suicide prevention programs that promote wellness and prevent suicide and related behaviors.

Rationale

Clinical and community-based services should promote wellness, reduce risk factors, and increase resilience and protective factors for individuals at risk for suicide. In addition, linking individuals in crisis with appropriate services and supports, and addressing the environmental and social conditions that can contribute to suicide behaviors is necessary. In developing, implementing, and monitoring programs, it is critical to use suicide prevention strategies that have shown to be effective.

Objectives:

5.1 Encourage behavioral health providers and local communities to develop, implement and evaluate effective suicide prevention programs tailored to meet the unique needs of identified at risk groups.

5.2 Expand and improve education of suicide prevention to increase knowledge regarding evidence-based practices and best practices for suicide prevention, intervention and postvention for schools, colleges and universities, work sites, psychiatric hospitals, correctional institutions, aging programs, and family and community-based organizations.

5.3 In coordination with the DMHAS' Disaster and Terrorism Branch, mobilize available resources to communities and/or individuals negatively affected by natural and/or man-made disasters and terroristic attacks (e.g., 9/11, hurricanes, flooding, fire).

5.4 Increase access to care by effective coordination of and linkages between programs that provide services addressing mental health, substance use, and physical health.

5.5 Continue to promote and enhance the NJ Suicide Prevention HOPELINE (855-NJ-HOPELINE or 855-654-6735.

Goal # 7:

Provide training to community and clinical service providers on the prevention of suicide and related behaviors.

Rationale

Suicide risk often can go undetected. Thus, clinicians who treat individuals at risk for suicide require ongoing professional development and training in the growing body of suicide evaluation and treatment. Education on the proper screening and recognition of protective and risk factors could facilitate a decrease in the number of suicides by quickly intervening and expediting referrals for treatment. In addition, many health professionals lack training in the recognition of risk factors often found in grieving family members of loved ones who have died by suicide.

Objectives:

7.1 Provide training to mental health and substance use providers on the recognition, assessment, and management of at-risk behavior, identification of persons at risk and delivery of effective clinical care for people with suicide risk; including referral to community-based services.

7.2 Provide education for physicians, primary care physicians, physician assistants, nurse practitioners, nurses, social workers, psychologists, counselors and other primary care providers on the identification of depression and substance use and their relationship to suicide risk.

7.3 Provide education for clergy, teachers and other educational staff, correctional workers, and attorneys on how to identify and respond to persons at risk for suicide.

7.4 Provide educational programs for family members of persons evaluated to be at risk.

7.5 Develop and implement protocols and programs that will guide a collaborative approach for clinicians and clinical supervisors, first responders, crisis staff and others to manage care of at risk individuals until the risk is reduced.

Goal # 8:

Promote suicide prevention as a core component of health care services.

Rationale
Integrating suicide prevention into the delivery of health and social services and making it a core component shows promising outcomes of reducing suicides. Furthermore, suicide prevention activities have to coordinate the care across multiple settings to ensure continuity of care and promote safety. Even in cases when full integration is not feasible, increasing coordination and collaboration among services and continuity of care can greatly reduce the risk of suicide.

Objectives:
8.1 Promote the adoption of "zero suicides" as an aspirational goal by health care and community support systems for at risk populations.

8.2 Increase the number of state and local agencies, professional (including primary care), volunteer, faith-based communities and other groups that integrate suicide prevention activities into their ongoing activities.

8.3 Work with all appropriate state departments and health and social services programs for at-risk populations to develop and implement protocols for effective, efficient, and culturally competent mental health and substance use services.

8.4 Define and implement screening and linkage guidelines with mental health and substance use service providers including schools, colleges, hospital inpatient settings, correctional institutions and programs, and primary care sites.

8.5 Promote timely access to assessment, intervention, and effective care for individuals at risk for suicide using resources such as crisis hotlines, online crisis chats, mobile screening teams, etc.

8.6 Promote continuity of care and the safety of all patients treated for suicide risk in emergency departments and hospital inpatient units.

8.7 Encourage health care delivery systems to assess and evaluate all suicide attempts and suicides to identify systemic issues where improvements can be made.

8.8 Develop collaborations between emergency departments and other health care providers to provide alternative to emergency department care and hospitalization when appropriate and promote rapid follow-up after discharge.

Goal # 9:

Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicide and suicidal behaviors.

Rationale
Clinical judgment and practice methods have to be grounded in evidence-based care or in best practices. Such clinical and professional approaches will improve clinical decision making, thereby leading to a reduction of suicide attempts and completions. Gathering, disseminating and promoting the latest research-based knowledge to all health professionals will ensure that they are equipped to properly treat individuals who present at risk to self.

Objectives:
9.1 Adopt, promote, disseminate and implement evidence-based best practice guidelines and uniformed procedures and/or policies on suicide risk assessment and treatment of suicidality across all settings that provide health care services.

9.2 Establish, disseminate and implement clinical practice guidelines for treatment providers to ensure that all services are patient-centered, recovery-oriented, and provide continuity of care.

9.3 Decrease barriers to the safe disclosure of suicidal thoughts and behaviors for all at-risk individuals and treatment providers.

9.4 Foster education for family members and significant others of individuals at risk for suicide to ensure the continuity of their care.

9.5 Adopt, promote, disseminate and implement policies and procedures for suicide risk assessments and interventions to promote safety and prevent suicide among individuals receiving mental health and substance use treatment.

9.6 Develop standardized suicide risk assessment and treatment protocols that emphasize person-centered and stepped approaches for use in emergency departments based upon risk profiles.

9.7 Develop documentation guidelines for psychiatric assessment and treatment interventions for at-risk individuals and provide technical assistance for their implementation.

20. Suicide Prevention

Division of Mental Health and Addiction Services (DMHAS)

New Jersey currently has two Suicide Prevention Plans, one that addresses youth through age 24 (New Jersey Youth Suicide Prevention Plan) and one for adults that covers the remainder of the life span. This is referred to as the New Jersey Adult Suicide Prevention Plan.

In May 2014 DMHAS introduced the newly developed NJ Adult Suicide Prevention Plan to a large group of stakeholders. Steps towards practical implementation, including prioritization of suicide prevention goals and time lines were discussed. It was recommended to organize a State Interagency Committee (consistent with goal #2; objective # 2.1 in the original plan) that will expand the DMHAS Suicide Prevention Committee to function as an Adult Suicide Prevention Advisory Council.

In July 2014 DMHAS submitted an application for a SAMHSA National Strategy Grants, (PPHF 2014-Cooperative Agreements to Implement the National Strategy for Adult Suicide Prevention) to secure additional resources for the implementation of the Adult Suicide Prevention Plan. Unfortunately, New Jersey was not one of the four states awarded for the grant.

Between September and December 2014 the DMHAS Suicide Prevention Committee started the process of updating the New Jersey Adult Suicide Prevention Plan (2014-2017) to make it consistent with the 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action. Special consideration was given to the four goals that were prioritized by Stakeholders and Executive Leadership. These goals correspond to goals # 5, 7, 8, and 9 of the 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action.

In October 2014 invitation letters were sent out to specific State Agencies; Professional Organizations; Agencies; Universities; Support and Advocacy Groups; Consumer Organizations; as well as Family Survivors of Suicide Loss and Attempt Survivors requesting that they identify a representative to become a member of an Advisory Council to work cooperatively towards the development of action steps and outcome measures for the New Jersey Adult Suicide Prevention Plan. This Council would be called the New Jersey Adult Suicide Prevention Advisory Council.

In December 2014 the first meeting of the Adult Suicide Prevention Advisory Council took place and was well attended. The main topic of this first meeting was a review of the four goals that had been revised to be consistent with the 2012 National Strategy. At the second meeting of the Advisory Council in January 2015 four Advisory Council Workgroups were formed to develop action steps and outcome measures for each of the four prioritized goals (# 5, 7, 8, & 9). These Workgroups will be meeting independently for the next few months to review their respective objectives and develop deliverables, action steps, and outcome measures. In March 2015 the workgroups shared their first progress reports and received input from other members for incorporation.

In April 2015, three representatives from New Jersey were invited by the ICRC-S Injury Control Research Center for Suicide Prevention to participate in a meeting, "Partnering for Suicide Prevention Research and Practice in the Northeast," with other Region 1&2 State suicide prevention directors, state injury prevention directors, and researchers involved in suicide prevention. The two-day meeting in Boston, MA, was intended to support suicide prevention research and practice in the Regions by providing opportunities for the States to network with each other and with experts in the field, providing presentation from content experts on subjects selected by attendees, advancing the collection, dissemination, and use of suicide data, and identifying current and future needs for suicide prevention practitioners and researchers.

In May 2015, the NJ Suicide Prevention Advisory Council accepted the invitation of the New Jersey State Police (NJSP) to meet at their Regional Operation Intelligence Center (NJSP ROIC) where they introduced Council members to the New Jersey Drug Monitoring Initiative (NJDMI) which includes "geo-mapping" of the location of drug overdoses and use of the overdose antidote Naloxone. A discussion ensued of the possibility of developing a similar surveillance system through geo mapping for suicides and suicide attempts. Also at this meeting, the Council received updates on New Jersey Violent Death Reporting System: Data collection, Dissemination, and Use and a Wellness Project initiated by the Governor's Council on Alcohol and Drug Abuse that could provide assistance to individuals seeking mental health, addiction and suicide prevention services.

In June 2015, the updated progress reports of the four Goal Workgroups were presented to the full Council. In September 2015, final recommendations of the Workgroups are expected to the

Advisory Council and to DMHAS Executive Staff for final review and a determination of next steps.

During the last six months, PowerPoint presentations of the NJ Adult Suicide Prevention Plan and Suicide Prevention initiatives were provided to different entities: the NJ Study Commission on Violence; a quarterly provider meeting for mental health and addiction service providers; a DMHAS All Staff Meeting; NJ Partners: Aging, Mental Health, and Substance Abuse; The Monmouth County Suicide Prevention Task Force; the Mental Health Planning Council; and at the ICRC-S initiated Partnering for Suicide Prevention and Practice in the Northeast (poster-board presentation in Boston, MA).

In May 2015, Representatives from the Adult Suicide Prevention Advisory Council actively participated at "The Campus Mental Health and Suicide Prevention: Creating a Competent Community Conference" at Monmouth University. Thirty-two colleges and universities attended an all-day presentation which provided assistance and discussion regarding how best to develop coordination between college campuses and emergency services for mental health and/or addiction, including inpatient care to assist students who might require such service.

DMHAS continues to coordinate and collaborate with the New Jersey Department of Children and Families (DCF) to reduce suicide in New Jersey. DFC together with Rutgers, The State University, responded to a SAMHSA Request for Applications (RFA), entitled, 2015 Garrett Lee Smith (GLS) Cooperative Agreements for State-Sponsored Youth Suicide Prevention and Early Intervention. Individuals between the ages of 10 to 24 are targeted. DMHAS agreed to expand their partnership and collaboration with Rutgers UBHC and DCF to assist in the successful implementation of this new grant application. Specifically, DMHAS will provide membership to the Rutgers University New Jersey Youth Suicide Prevention Project (NJYSPP) on the DMHAS Adult Suicide Prevention Advisory Council. In return, DMHAS will participate as a member on the NJYSPP Advisory Board. DMHAS will encourage mental health and addiction service providers to participate in NJYSPP training opportunities, including the possibility for trainer certifications. Furthermore, DMHAS will encourage the participation of County Mental Health Administrators and County Drug and Alcohol Directors at NJYSPP regional consortia meetings and assist NJYSPP with disseminating and promoting program campaign efforts. In addition, DMHAS will assist with establishing new partnerships for the purpose of suicide prevention.

In addition to the four prioritized goals (# 5, 7, 8, and 9) that were already updated consistent with the 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action, the remaining nine goals will be updated accordingly in the fall of 2015 with the NJ Adult Suicide Prevention Advisory Council's input.

With the formation of a broad-based Adult Suicide Prevention Advisory Council DMHAS has promoted that effective suicide prevention efforts have to be comprehensive and coordinated across organizations and systems at the national and local level. Working consistently and cooperatively together guided by a written strategic plan that is consistent with the 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action has the best chance of preventing suicides in New Jersey.

Children's System of Care Youth Suicide Prevention

- **Traumatic Loss Coalition for Youth**

Suicide is the fourth leading cause of death for New Jersey's youth. DCF/DCSOC is dedicated to the prevention of youth suicide. New Jersey's primary youth suicide prevention program is the Traumatic Loss Coalition for Youth funded by DCF/CSOC. The Traumatic Loss Coalitions for Youth Program at Rutgers - University Behavioral HealthCare is an interactive, statewide network that offers collaboration and support to professionals working with school-age youth. In 1999 the Traumatic Loss Coalitions for Youth Program (TLC) was created to establish TLCs in each of New Jersey's 21 counties and to provide ongoing technical assistance to communities in crisis. The dual mission of the TLC is excellence in suicide prevention and trauma response assistance to schools following unfortunate losses due to suicide, homicide, accident and illness. This is accomplished through county, regional and statewide conferences, training, consultation, onsite traumatic loss response, and technical assistance. The purpose is to ensure that those working with youth from a variety of disciplines and programs have up-to-date knowledge about mental health issues, suicide prevention, traumatic grief, and resiliency enhancement. Since its inception, the TLC has trained thousands of individuals throughout the state with the purpose of saving lives and promoting post trauma healing and resiliency for the youth of New Jersey. The TLC website can be accessed at http://ubhc.rutgers.edu/tlc/

- **The New Jersey Youth Suicide Prevention Advisory Council**

The New Jersey Youth Suicide Prevention Advisory Council was formed under legislation signed into law in January 2004. The Council meets monthly to examine existing needs and services and make recommendations to the Department of Children and Families (DCF) for youth suicide reporting, prevention and intervention. The Council also advises DCF on the content of informational materials to be made available to persons who report attempted or completed suicides. Along with the Council, DCF works to develop and publicize public awareness campaigns on youth suicide prevention and intervention, and to compile data about reported attempted and completed suicides by youths in the State, without identifying any individuals involved. A report by DCF is also issued annually to the council, the Governor and the Legislature containing a summary of the data compiled by the Division that includes aggregate demographic information about youth who attempt or complete suicide. In 2012 two reports were issued. The enabling legislation charges the NJ Youth Suicide Prevention Advisory Council with making formal recommendations to DCF for the development of the New Jersey Youth Suicide Prevention Plan, which outlines the goals, rationale, objectives and strategies for increasing the prevention effort throughout the state.

In March 2011, the NJ DCF/DCSOC released its Youth Suicide Prevention Plan 2011-2014:

http://www.state.nj.us/dcf/adolescent/prevention/documents/preventionplan.pdf
DCF is in the process of updating the Department-wide Suicide Prevention Plan.

In January 2015, DCF released the SFY 2014 Youth Suicide report:

http://www.state.nj.us/dcf/news/reportsnewsletters/dcfreportsnewsletters/FY14_YouthSuicideReport.pdf

- **2nd Floor – New Jersey's Youth Helpline/Suicide Hotline**

The New Jersey Statewide youth helpline/hotline, 2NDFLOOR, is available 24-hours a day, seven days a week to youth and young adults ages 10-24 to help find solutions to the problems they face at home, school, or play.

Youth can either call the helpline/hotline, 1-888-222-2228, or access the interactive Web site www.2NDFLOOR.org The helpline/hotline is supervised at all times by a mental health professional. Youth are provided with relevant and appropriate linkages to information and services to address their social, emotional, and physical needs. Calls to the 2NDFLOOR youth helpline/hotline are anonymous and confidential except in life-threatening situations.

2nd Floor is certified by the American Association of Suicidology as a statewide suicide hotline.

- **Jersey Voice**

This peer-to-peer Web site, Jersey Voice - www.jerseyvoice.net - helps to promote suicide prevention and encourages youth and young adults to communicate creatively about the difficult times they are experiencing so their messages can help peers encountering similar problems.

- **Society for the Prevention of Teen Suicide**

The The Society for the Prevention of Teen Suicide (SPTS) was started in 2006 by two fathers who had lost teenaged children to suicide. This Web site includes information for teens, parents and educators, including a video, ***Not My Kid: What Every Parent Should Know***. This short video asks and answers questions about whether or not your child may be at risk for suicide. More importantly, it demonstrates how to ask those questions - and keep asking - until you get answers that help you understand whether or not your child is at risk....and what to do about it.

New Jersey Department of Human Services

Division of Mental Health and Addiction Services

Adult Suicide Prevention Plan

2014 - 2017

Suicide is the 10th leading cause of death for all Americans, the 2nd leading cause of death for adults ages 25-34, and the 3rd leading cause of death for youth ages 15-24.[1] In New Jersey 60% of all violent deaths are suicides. Furthermore, suicides outnumber homicides in New Jersey by nearly two to one. [2]

New Jersey is committed to developing and implementing an Adult Suicide Prevention Plans/Initiatives/Strategies to address these statistics. In order to adequately and effectively respond to this national health problem, the Division of Mental Health and Addiction Services' (DMHAS) Suicide Prevention Committee began developing an Adult Suicide Prevention Plan for New Jersey in 2012 in accordance with, and guided by, the National Strategy for Suicide Prevention: Goals and Objectives for Action, published by the U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (2008). In addition, the committee used as guidance and reference, the New Jersey Youth Suicide Prevention Plan.

This plan contains strategies and actions in addition to crisis responses for the specific concerns related to adult suicides; addressing current New Jersey needs and activities and linking up-to-date science for prevention with practical application in the field. The plan and subsequent action steps go beyond organizations and agencies to include broad based community activism in preventing suicides. Although New Jersey's rate of suicide is the second lowest in the nation, every suicide can potentially be prevented. This plan provides a guide to the process.

We are aware that preventing suicide can only be accomplished through collaborative efforts in partnership with our communities and agencies throughout the State as well as everyone's commitment to contribute to it.

Jennifer Velez
Commissioner
Department of Human Services

Lynn A. Kovich
Assistant Commissioner
Division of Mental Health and Addiction Services

[1] http://actionallianceforsuicideprevention.org/

[2] New Jersey Violent Death Reporting System v.05/09/2013, Center for Health Statistics, New Jersey Department of Health

New Jersey Division of Mental Health and Addiction Services

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In addition, the Suicide Prevention Committee would like to acknowledge contributions of:

Deborah Klaszky, MSN, APN, previous Co-Chair. We are extremely grateful and indebted to Debi for her rich contributions and tireless efforts with regards to the formation and evolution of this committee in leading the cause to prevent suicides in New Jersey's adult population.

Table of Contents

Introduction

Following the release of the final New Jersey Youth Suicide Prevention Plan 2011 – 2014 by the Department of Children and Families (DCF), the Department of Human Services' Division of Mental Health and Addiction Services (DMHAS) began to review its own mental health and addiction assessment and treatment systems in relation to the recommendations included in the 'Youth Plan'.

Beginning in December 2011, a DMHAS internal workgroup (later formalized into the Suicide Prevention Committee of DMHAS), composed of staff with mental health and addictions training and experience, began an analysis of the current system and identified opportunities relevant to suicide prevention. The initial foci were as follows:

- Review DMHAS' goals and initiatives in relationship to the NJ Youth Suicide Prevention Plan 2011 – 2014;
- Enhance statewide strategies to prevent suicide;
- Promote greater public awareness about suicide prevention and resources statewide;
- Identify barriers to accessing mental health and substance use services, as well as opportunities to enhance this access;
- Promote evidenced-based and best practice programs, as listed on the Suicide Prevention Resource Center's Best Practices Registry, for the prevention and treatment of suicide and self-injury;
- Provide training to contracted agency staff on suicide prevention; and
- Explore expansion of the National Suicide Prevention Lifeline available in New Jersey.

Regular meetings were held, literature was reviewed and best practices across the nation were sought. Stigma related to mental illness and suicide, training, education and the development of a standardized suicide risk assessment tool were ideas explored that will be detailed in the section: New Jersey Adult Suicide Prevention Activities.

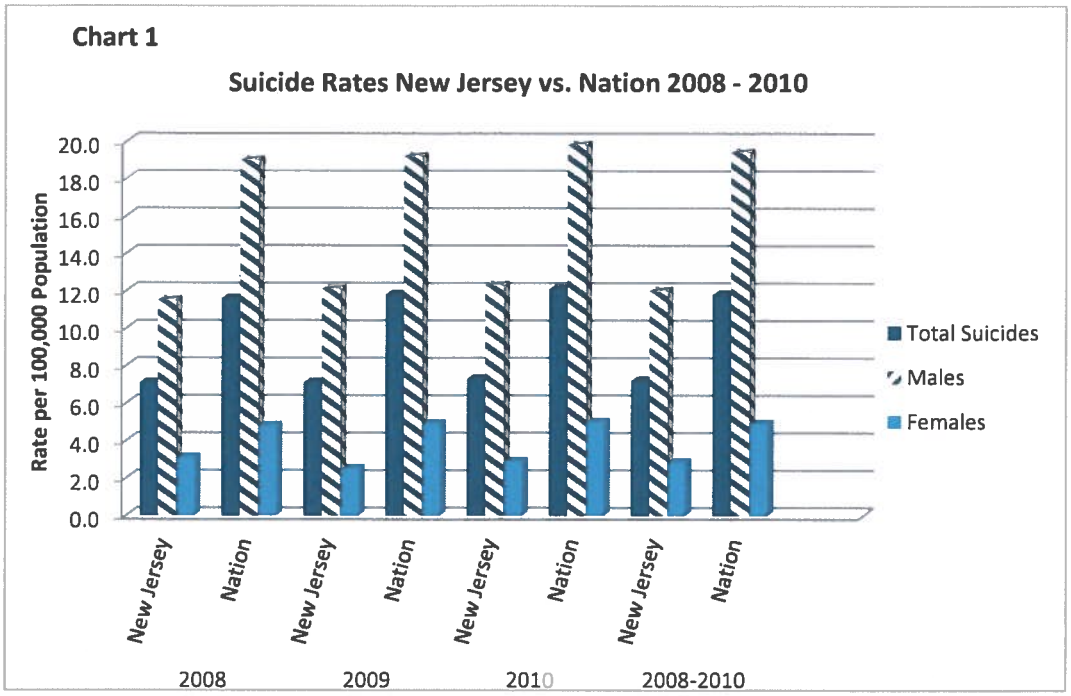
The Suicide Prevention Committee has overall responsibility for implementing, monitoring and evaluating this Plan.

Next Steps

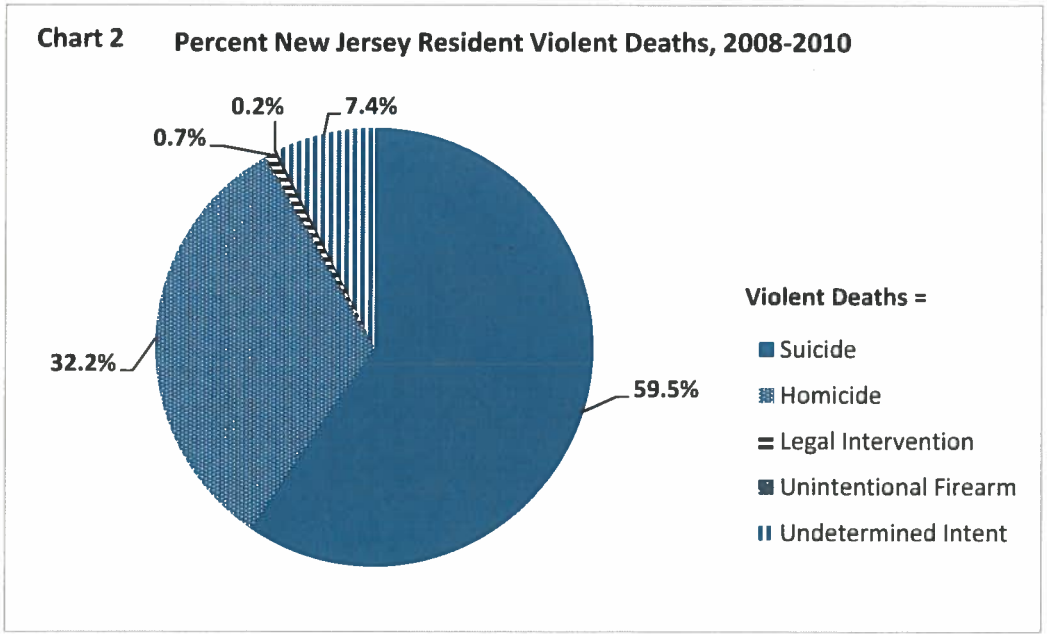
Action steps, monitoring and evaluation criteria will be developed with full involvement of representatives from our regional coalitions, Mental Health Planning Council and other key stakeholders. Each will be data-driven in order to allocate resources to prioritized regions, counties, and subgroups of the population, etc. The monitoring and evaluation components of this plan will include sections for accountability, regular reporting (at least annually) and revisions as necessary.

New Jersey Suicide Statistics

While the adult suicide rate (per 100,000 population) in New Jersey is lower than most other states, suicide remains a public health issue in NJ (Chart 1). From 2008-2010, 3,325 New Jersey residents died a violent death. Of those, 60% (the majority) were related to suicide (Chart 2).



Rates are age-adjusted using the 2000 US Standard Population Data
Source: New Jersey Violent Death Reporting System, v.5/9/2013



Source: New Jersey Violent Death Reporting System v.05/09/2013, Center for Health Statistics, Office of Policy and Strategic Planning, Office of the Commissioner, New Jersey Department of Health, May 10, 2013

According to the New Jersey Department of Health (DOH), male suicide victims outnumber females by nearly four to one in our State (Table 1). In addition, as seen nationally, there has been a marked increase in suicides among 45 – 64 year olds.

Table 1
Suicide by Gender and Age, New Jersey, 2008-2010

		2008		2009		2010		2008-2010	
		N	*Rate*	*N*	*Rate*	*N*	*Rate*	*N*	*Rate*
Males									
	Under 19	18	**	27	2.3	25	2.1	70	2.0
	20-24	34	12.6	45	16.4	40	14.3	119	14.4
	25-44	162	13.7	173	14.8	142	12.2	477	13.6
	45-64	202	17.9	227	19.7	237	20.2	666	19.3
	65+	83	17.3	60	12.3	99	20.0	242	16.6
Male Total		499	11.5	532	12.1	543	12.3	1,574	12.0
Females									
	Under 19	8	**	3	**	8	**	19	**
	20-24	4	**	6	**	8	**	18	**
	25-44	49	4.1	38	3.2	45	3.8	132	3.7
	45-64	57	4.7	55	4.5	66	5.3	178	4.8
	65+	28	4.1	16	**	13	**	57	2.8
Female Total		146	3.1	118	2.5	140	2.9	404	2.9
All Suicides									
	Under 19	26	1.1	30	1.3	33	1.4	89	1.3
	20-24	38	7.3	51	9.6	48	8.9	137	8.6
	25-44	211	8.8	211	8.9	187	8.0	609	8.6
	45-64	259	11.1	282	11.8	303	12.5	844	11.8
	65+	111	9.6	76	6.5	112	9.4	299	8.5
All Total		645	7.1	650	7.1	683	7.3	1,979	7.2

** Rates not calculated for <20 observations.
Rates are per 100,000 population and are age-specific or age-adjusted using the 2000 US Standard Population.

New Jersey's Center for Health Statistics, Office of Policy and Strategic Planning within DOH has provided the suicide data by county, as well, in Table 2. There are four counties with large increases in suicide rates (close to 50% or more) when comparing 2008-2010 data to data from 2003-2005: Cape May; Hunterdon; Sussex; and Warren. This data will assist the State in prioritizing resource allocation for suicide prevention activity efforts.

Table 2
Suicide Rates by County of Residence, 2003-2005 and 2008-2010

	2003 - 2005		2008 - 2010		% Rate Change
	N	*Rate*	*N*	*Rate*	
Atlantic	72	8.9	90	10.2	15%
Bergen	160	5.7	185	6.4	12%
Burlington	98	7.3	92	6.4	-12%
Camden	176	11.4	142	9.1	-20%
Cape May	31	10.2	47	14.9	47%
Cumberland	45	9.8	41	8.8	-11%
Essex	124	5.3	122	5.1	-3%
Gloucester	64	7.7	72	8.1	5%
Hudson	89	4.8	115	5.8	21%
Hunterdon	28	7.1	46	11.5	62%
Mercer	70	6.3	87	7.4	18%
Middlesex	136	5.6	181	7.1	26%
Monmouth	138	7.3	151	7.9	9%
Morris	80	5.5	91	5.7	3%
Ocean	144	8.6	167	9.4	10%
Passaic	90	6.1	104	6.8	10%
Salem	16	8.4	12	**	
Somerset	54	5.9	56	5.5	-6%
Sussex	33	7.4	48	11.2	52%
Union	86	5.2	86	5.3	1%
Warren	21	6.5	37	10.7	66%
Total*	1,759	6.6	1,978	7.2	9%

* Total 2003-2005 includes 4 suicides with unknown residence county. Total 2008- 2010 includes 6 suicides with unknown residence county.

** Rates not calculated for <20 observations.

Rates are per 100,000 population and are age-adjusted using the 2000 US Standard Population

Source: New Jersey Violent Death Reporting System v.05/09/2013, Center for Health Statistics, Office of Policy and Strategic Planning, Office of the Commissioner, New Jersey Department of Health, May 10, 2013

Risk Factor and Protective Factors for Suicidal Behavior

Identifying risk and protective factors is critical in suicide prevention. Many lists are available in the literature that summarize what makes it more likely (risk factors), or less likely (protective factors), that individuals will consider, attempt, or die by suicide. These factors can be fixed (historical/static factors) or modifiable (clinical/dynamic). Risk depends on the interaction and dynamics between historical, clinical and risk management factors not just the number of factors present.

The following are examples of each category and **are not exhaustive**:

RISK FACTORS

Historical/Static factors

- History, including family history of suicide attempt, suicidal gestures or ideation
- Mental illness (diagnosed or undiagnosed), especially mood and substance use disorders
- Gender, age
- LGBTQI (Lesbian, Gay, Bisexual, Transgender, Queer, Questioning and Intersex)
- History of trauma (PTSD) and traumatic events, including bullying
- Lack of Social Support, living alone, without a significant other
- Unemployment and/or decrease in social or economic status
- Significant disappointment by lover or spouse, family members
- Loss of a loved one, anniversary of important losses
- Struggle with cultural adjustment

Current Clinical/Dynamic risk factors

- Current suicidal ideation and/or intention to commit suicide with or without plan
- Availability of highly lethal methods
- Impulsivity
- Feelings of worthlessness, hopelessness or helplessness
- Serious medical problems/disabilities
- Severe psychic pain, anxious ruminations
- Insomnia
- Command hallucinations to hurt self or other delusions

PROTECTIVE FACTORS

- Reasons for living (meaning and future plans)
- Children/family/social supports and supportive community environment
- Moral/religious belief system
- Availability of physical and mental health care and substance use treatment
- Restrictions on lethal means of suicide
- Coping/Problem solving skills

New Jersey Adult Suicide Prevention Activities

Throughout 2011 and 2012, the NJ Youth Suicide Prevention Advisory Council advised the DHS-DMHAS and the Department of Children and Families (DCF) that the majority of calls originating in New Jersey to the National Suicide Prevention Lifeline were not being answered in NJ, but instead by Lifeline Crisis Centers located out-of-state.

In reaction to these concerns and P.L. 2011, C. 166, which required DCF and DHS to complete a study of the status of NJ-based suicide prevention hotlines, the DMHAS and DCF collaborated on a report to the NJ Legislature titled: "The Effectiveness and Sufficiency of Services Provided by NJ-based Suicide Prevention Hotlines". One of the chief findings in this report was that none of the five agencies (CONTACT of Burlington County, CONTACT of Mercer County, CONTACT We Care, Mental Health Association of New Jersey, University of Medicine & Dentistry of New Jersey---now Rutgers University, and University Behavioral Healthcare), which were certified by the National Suicide Prevention Lifeline program as Lifeline Crisis Centers, had the resources to provide 24/7 Lifeline services. Therefore, no Lifeline calls could be answered in State after 11p.m.

In December 2012, DMHAS issued a Request for Proposals (RFP) to "Implement a Statewide Suicide Prevention Hotline and Coordinate Call Response with the National Suicide Prevention Lifeline to Increase Suicide Prevention Efforts for Youth and Adults in NJ." The RFP made available $674,000 on an annual basis to one provider agency to develop a 24/7 hotline available for callers of any age (youth and adults). Following an intensive comparative review of all applicant proposals, a contract for this service was awarded to Rutgers University Behavioral Health Care. This service, now known as the NJ Hopeline, began operations on May 1, 2013 with promising outcomes. The calls are answered by a combination of trained volunteers, paid and volunteer peer positions with a minimum of one clinician supervisor per work shift. The Hopeline staff provide follow up calls and are able to "warm transfer" emergency calls to emergency service providers. The service also includes the capability to handle text messaging and live chat.

Education on the recognition of at-risk behavior and the delivery of effective clinical treatment to reduce suicide attempts and suicide was assessed as a critical need. Actions already taken involved training for mental health and addiction treatment staff in the use of the Columbia-Suicide Severity Rating Scale (C-SSRS) by Dr. Kelly Posner, PhD. Dr. Posner provided four, half-day training sessions in May 2012 with a total of 319 people from all areas of the State. The audience included psychiatric emergency service screeners, mental health (both adult and child) clinicians, school-based personnel and state officials.

In addition, in September and October 2012, in coordination with the US Substance Abuse and Mental Health Services Administration's (SAMHSA) administrative staff, DMHAS was able to schedule and provide 48 individuals with Mental Health First Aid Training utilizing our State hospitals as training locations.

Two New Jersey schools were awarded Garrett Lee Smith Grants to reduce youth suicide. DMHAS has begun coordinating suicide prevention efforts with UMDNJ-TLC (Traumatic Loss Coalitions) and Monmouth University. The TLC will be concentrating their activities in six counties (2 each year): Camden and Monmouth the first year; Bergen and Passaic the second year; and Hudson and Middlesex the last year; targeting youths from age 10-24 years of age. Monmouth University's focus is on promoting wellness and resiliency on their campus. DMHAS will assist in coordinating with service providers in our systems of care and linking them to specific training opportunities provided through Garrett Lee Smith Grant Awards. We plan to continue such efforts with any new Garrett Lee Smith award recipients in New Jersey.

On May 3, 2013, DMHAS staff met with DOH staff and the Assistant State Medical Examiner (in charge) to review and discuss ways to improve our collaboration regarding suicide data and suicide prevention efforts. By state law, the DOH is responsible for collecting data on suicide attempts and completions throughout the state. The DOH is also a member of the National Violent Death Reporting System coordinated by the CDC. All participants agreed this was a positive step and will continue to meet on a quarterly basis to ensure ongoing collaborative efforts among the Departments.

A recent CDC-funded initiative: the Injury Control Research Center for Suicide Prevention (ICRC-S) focuses on a public health approach to suicide research and suicide prevention. The University of Rochester was awarded a five-year grant to establish an ICRC-S. Rochester's center is one of only 11 in the country funded by the CDC. It also is the only one focused primarily on suicide prevention. The University of Rochester has partnered with the Education Development Center, Inc. (EDC) for this ICRC-S. The ICRC-S is designed to serve as a catalytic role in the northeastern regions, and nationally, promoting public health approaches that will reduce the mortality and morbidity associated with suicide and attempted suicide. In May of 2013 DMHAS appointed an "injury control officer" to represent New Jersey in this collaborative community and to participate in their first initiative of a Research Training Institute (RTI). The purpose of this was to learn about the shared body of knowledge and skills in suicidology, public health and prevention, as well as relevant research methodologies. This collaboration is a work in progress with promising outcomes.

DMHAS has recently funded and contracted for the development of three Peer Respite Centers, one in each of the 3 regions of the state. Half of the staff members at these Peer Operated Respite Centers must be peer providers. There are five respite beds at each site and the individual respites will function as a treatment alternative for consumers who may be experiencing a psychiatric crisis and not wanting/needing inpatient hospitalization or other traditional mental health services. The average length of stay will be 7-14 days, with the expectation that the consumers will be able maintain safety during their brief stay at the Peer Respite Center. The sites will link consumers to community Self-help Centers and other supportive care resources in their community.

On June 27, 2013, the Commissioners of the DHS and the Department of Transportation and the Executive Director of NJ Transit met at the Trenton Rail Transportation Center to publicly announce a collaborative effort to prevent suicides by train throughout the state. NJ

Transit also unveiled a new poster that listed the call number 855-NJ HOPEL (654-6735) for the NJ Hopeline 24/7 statewide suicide prevention hotline. NJ Transit has placed a NJ Hopeline poster at every NJ Transit station in New Jersey.

The Mental Health Association of New Jersey's (MHA-NJ) Peer Recovery WarmLine is a statewide, toll-free line operated 365 days per year to assist individuals during times of need or concern, as well as at any point to further their mental health wellness and recovery. All calls are answered by trained, supportive mental health consumers with the goal of getting to know the caller – how they view themselves, understand their situation, and see the world around them. The WarmLine received national recognition in 2012 as a recipient of the Innovative Program of the Year from Mental Health America. The Peer Recovery WarmLine answered 12,265 calls in 2012.

DMHAS is moving towards a 'trauma informed system of care', in which all mental health and addiction services (assessing, treating or support services) will consider whether individuals have experienced trauma and will intervene to ameliorate its effects.

At present, task force and work groups are forming to develop policies and action steps for this goal. As part of these initiatives, DMHAS is providing Mental Health First Aid training throughout the State which will raise awareness that trauma is one of the risk factors for suicidal behaviors and provide response interventions.

NJ Adult Suicide Prevention Plan Goals

1. Promote **awareness** that suicide is a public health problem that is preventable.

2. Develop **broad-based support** for suicide prevention.

3. Improve and expand **surveillance systems.**

4. Develop and implement strategies to **reduce the stigma** associated with being a consumer of mental health, substance use and suicide prevention services.

5. Strengthen and expand **community-based suicide prevention** and postvention programs.

6. Implement **education** for **recognition** of at-risk behavior and delivery of effective treatment.

7. Develop and promote effective **clinical practices** to reduce suicide attempts and suicide.

8. Improve **access to community services** for persons with mental health and substance use disorders.

9. **Improve media reporting and the depiction** of suicide, suicidal behavior, mental illness and substance use in the electronic and print formats.

10. Promote and support **research** on adult suicide and suicide prevention and its dissemination and incorporation into clinical practice and public health efforts.

Goal #1:

Promote awareness that suicide is a public health problem that is preventable.

Rationale

There are many ways to address the common social, emotional, environmental and health factors related to suicide and suicide risk. By educating the community at large about suicide, the risk and protective factors, we would be more effective in preventing suicide.

Objectives:

1.1 Advocate for significantly reduced rates of adult suicidality among health care and community support systems that provide services and support to individuals at risk for suicide in the State.

1.2 Continue to develop and implement a public information strategy that explains that suicide is preventable and is related to mental health, substance use and other at-risk factors.

1.3 Implement a public information campaign designed to reduce accessibility of lethal means used to commit suicide.

1.4 Establish effective and sustainable programs for suicide prevention by fostering collaboration among providers of the Division of Mental Health and Addiction Services (DMHAS) and other state departments and divisions, social and other media, community-based organizations, stakeholders and the general public.

1.5 Increase the number and quality of public and private agencies that are involved in collaborative and complementary dissemination of current suicide prevention information.

Goal #2:

Develop broad-based support for suicide prevention.

Rationale

Since the cause of suicide is complex, prevention must address psychological, biological, and social factors if it is to be effective. Collaboration across a broad spectrum of agencies, institutions, and groups –from schools to faith-based organizations to health care associations –is necessary to ensure that prevention efforts are comprehensive and effective.

Objectives:

2.1 Organize a State interagency committee involved with the coordination and implementation of the New Jersey Adult Suicide Prevention Plan.

2.2 Establish public and private partnerships dedicated to implementing the New Jersey Adult Suicide Prevention Plan.

2.3 Increase the number of state and local agencies, professional (including primary care), volunteer, faith-based communities and other groups that integrate suicide prevention activities into their ongoing activities.

2.4 Promote access to materials such as monographs, periodicals, videos, outreach posters, information pamphlets, electronic communication and related materials on suicide prevention for New Jersey residents.

2.5 Educate and seek out the support of policymakers with dedicated communication efforts.

Goal #3:

Improve and expand surveillance systems.

Rationale

Surveillance has been defined as the systematic and ongoing collection of data. Surveillance systems are key to health planning. These systems are used to track trends, identify new problems, provide evidence to support activities and initiatives, and identify risk and protective factors. Data provides information about the factors associated with of suicide and who —by gender, age, race, and location - is statistically most at risk. Such data enables us to target high risk populations for program interventions more precisely and increase the likelihood of their effectiveness.

Objectives:

3.1. Work collaboratively with the Department of Health (DOH)—Center for Health Statistics, Office of Policy and Strategic Planning and the Office of the State Medical Examiner regarding suicide and suicide attempt data.

3.2 Improve coordination of data collection regarding suicide investigations with state, local agencies, and their partners.

3.3 Establish a mechanism for systematic collection and analysis of suicide attempt data.

3.4 Publish an annual report on suicides in New Jersey integrating data from multiple state data management systems.

Goal #4:

Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance use and suicide prevention services.

Rationale

Destigmatizing mental illness and substance use disorders can improve access to treatment by reducing barriers, integrating care and increasing the willingness of individuals to seek treatment. "Normalizing" mental health and substance use can change public perception, convey the benefits of prevention among both stakeholders and the general public. Identifying and engaging all target audiences in the effort to reduce stigma also helps to establish a level of community connectedness where every person in the community can become an "anti-stigma ambassador".

Objective:

4.1 Increase coordination among state agencies and entities such as DHS, DCF, DOH, Department of Education, DMHAS, the Division of Aging Services, the Governor's Council on Mental Health Stigma, the Governor's Council on Alcoholism and Drug Abuse, professional groups, associations and individuals to address the issue of stigma associated with using mental health and substance use services.

4.2 Change public attitudes to understand mental health and substance use disorders as real illnesses equal to physical illness, that respond to specific treatments and to view persons who obtain treatment, as pursuing basic health care.

Goal # 5:

Strengthen and expand community-based suicide prevention and postvention programs.

Rationale

Effective suicide prevention, intervention and postvention strategies are based on a public health approach and require a broad-based community commitment. Although there is not one "suicide type," there are adults who are at a higher risk based on particular risk factors. To help adults in need, community professionals and organizations must mobilize resources, identify risk and protective factors, and bring focused attention to the issue of suicide.

Rigorous evaluations for measuring effectiveness are needed as evidence-based programs are developed and implemented. The science of suicide prevention is still developing. Therefore, emerging strategies, promising practices, and other approaches, with a foundation based in best practices may be used in addition to existing evidence-based strategies.

Objectives:

5.1 Increase the number of behavioral health providers and local communities with comprehensive suicide prevention plans.

5.2 Expand and improve training in suicide prevention to increase knowledge regarding evidence based practices and best practices for suicide prevention, intervention and postvention for schools, colleges and universities, work sites, correctional institutions, aging programs, family and community-based organizations.

5.3 Improve coordination with cultural and faith-based entities to share resources and information on suicide prevention and postvention.

5.4 Gear specific suicide prevention and postvention efforts towards higher risk populations such as individuals with mental illness, severe medical conditions, individuals involved in non-suicidal self-injuries, college students, Lesbian, Gay, Bisexual, Transgender, Queer, Questioning and Intersex populations, men in mid-life, older adults, immigrants, non-English speaking adults, individuals who are deaf and hard of hearing, persons addicted to and/or abusing substances, individuals with gambling addictions, adults affected by trauma (including veterans), and adults in the correctional system and other out-of-home settings.

5.5 In coordination with the DMHAS' Disaster and Terrorism Branch, mobilize available resources to communities and/or individuals negatively affected by natural and/or man-made disasters and terroristic attacks (e.g., 9/11, hurricanes, flooding, fire).

Goal # 6:

Implement education for recognition of at-risk behavior and delivery of effective treatment.

Rationale

Suicide risk often can go undetected. Thus, clinicians who treat individuals at risk for suicide require ongoing professional development and training in the growing body of suicide evaluation and treatment. Health professionals could benefit from additional training on the proper assessment, treatment and management of suicidal patients. Education on the proper screening and recognition of risk factors, such as depression and substance use, could facilitate a decrease in the number of suicides by expediting individuals' referrals for treatment. In addition, many health professionals lack training in the recognition of risk factors often found in grieving family members of loved ones who have died by suicide (suicide survivors).

Objectives:

6.1 Provide training to mental health and substance use providers on the recognition, assessment, and management of at-risk behavior, identification of persons at risk and delivery of effective clinical care for people with suicide risk; including referral to community-based services.

6.2 Improve and provide education for physicians, primary care physicians, physician assistants, nurse practitioners, nurses, social workers, psychologists, counselors and other primary care providers on the identification of depression and substance use and their relationship to suicide risk.

6.3 Provide education for clergy, teachers and other educational staff, correctional workers, and attorneys on how to identify and respond to persons at risk for suicide.

6.4 Provide educational programs for family members of persons at evaluated to be at risk.

Goal # 7:

Develop and promote effective clinical practices in the least restrictive setting to reduce suicide attempts and suicide.

Rationale

Clinical judgment and practice methods improve when structured and anchored by research findings. Gathering, disseminating and promoting the latest research-based knowledge to professionals will ensure that they are equipped to properly treat individuals who present as a risk to self. Research that identifies risk factors for suicide and related treatment approaches should be promptly implemented and utilized. Such research must address group and individual characteristics, as well as environmental and situational factors. Clinical and professional practices, informed by evidenced-based practices, will improve clinical decision making, thereby lead to a reduction of suicide attempts and completions.

Objectives:

7.1 Implement and promote evidence-based, best practice guidelines and uniform procedures and/or policies across all settings that provide services to consumers with mental health and substance use disorders on suicide prevention, assessment and treatment of suicidality.

7.2 Encourage all New Jersey suicide prevention programs to review and implement evidence-based or best-practices; including an evaluation component that demonstrates outcome effectiveness.

7.3 Incorporate depression and suicide-risk screening in primary care with appropriate mental health and substance use referrals as needed.

7.4 Promote the use of evidence-based tools for screening, assessment, diagnosis and treatment of persons with mental health and substance use disorders; including the assessment of lethal means in the home.

7.5 Ensure that people who are treated in emergency departments for suicide attempts, trauma, sexual assault, or physical abuse also receive mental health services.

7.6 Foster suicide-risk education for family members and significant others of people receiving care for the treatment of mental health and substance use disorders.

7.7 Ensure that individuals (e.g., emergency medical technicians, firefighters, police and funeral directors) who typically interface with suicide survivors (significant others, family, friends, etc.) are educated to understand and respond appropriately to their unique needs.

7.8 Educate health care providers and health and safety officials on the assessment of lethal means in the home and the appropriate actions to reduce suicide risk.

Goal # 8:

Improve access to community services for persons with mental health and substance use disorders.

Rationale

Barriers to equal access and affordability of health care may be influenced by financial, structural, and personal factors. Financial barriers include not having adequate health insurance or not having the financial capacity to pay for services outside of a health plan or insurance plan. Structural barriers refer to a lack of primary care providers, medical specialists or other health care professionals to meet special needs or the lack of health care facilities. Personal barriers may be caused by cultural or spiritual differences, language difficulties, not knowing when or how to seek care, as well as concerns about confidentiality or discrimination. The transition of Medicaid expansion and new Marketplace opportunities may reduce such barriers. The easier and more acceptable it is to seek and receive treatment for mental health and substance use, the more likely it is that people will do so. With timely and appropriate treatment and social services, most people can recover and rebuild healthy productive lives.

Objectives:

8.1 Identify, address and overcome barriers to access mental health and substance use services.

8.2 Work with all appropriate state departments and health and social services outreach programs for at-risk populations to increase access to an integrated network of effective, efficient, culturally competent and linguistically accessible mental health and substance use services; including suicide prevention and treatment services.

8.3 Increase community awareness of culturally competent and linguistically relevant mental health and substance use services.

8.4 Define and implement screening guidelines, along with guidelines on linkages with service providers, for schools, colleges, correctional institutions, and primary care sites.

8.5 Implement support programs for persons who have survived the suicide of someone close.

8.6 Continue to promote and enhance the NJ Suicide Prevention HOPELINE.

8.7 Encourage all DMHAS contracted agencies to promote NJ Mental Health Cares and 211 as resources for families seeking mental health and addiction services.

8.8 Improve access to mental health and substance use treatment via linkage and referral.

Goal # 9:

Improve media reporting and the depiction of suicide, suicidal behavior, mental illness and substance use in the electronic and print formats.

Rationale

Changing media representation of suicide, suicidal behavior, mental illness and substance use is one of several strategies needed to reduce the suicide rate. The way that suicide is depicted in the media is particularly important. The media can play a positive role in suicide prevention by creating the kind of long-lasting culture change that makes suicide prevention universally relevant, relatable and attainable.

Objectives:

9.1 Disseminate information on nationally recognized guidelines for media reporting about suicide with an effort to reduce the stigma and prevent future suicides.

9.2 Utilize the nationally recognized guidelines outlined in the "Reporting on Suicide: Recommendations for the Media" (Annenberg Public Policy Center, 2001) and Suicide Prevention Resource Centers' "At a Glance: Safe Reporting on Suicide" for reporting on suicide.

9.3 Utilize local experts on suicide and suicide prevention for consultation and training with the media and academic programs in journalism.

9.4 Work with New Jersey academic journalism and film programs to include guidance on the appropriate depiction and reporting of mental illness, suicide and self-injury in their curricula.

Goal # 10:

Promote and support research on adult suicide and suicide prevention and its dissemination and incorporation into clinical practice and public health efforts.

Rationale

Suicide is a widely recognized public health problem. As a result, it has been researched extensively. In recent decades, this research has yielded findings that have informed public education efforts, affected clinical practice and, ultimately, permitted individuals to access pertinent services in times of urgent need. Continued research into the complexities of suicide is needed to promote effective clinical practice, public health efforts and prevention strategies.

Objectives:

10.1 Encourage mental health and substance use providers to apply for grant funding and actively participate in research on suicide prevention.

10.2 Encourage all mental health and substance use agencies to stay abreast of the newest research findings related to assessment and treatment of suicidality and implementation of suicide prevention strategies.

10.3 Promote ongoing statewide dissemination of evidence-based suicide prevention models and strategies for suicide prevention.

This section to be developed at a later date after input from key stakeholders and will be included as an addendum to this plan

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Environmental Factors and Plan

21. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please consider the following items as a guide when preparing the description of the state's system:

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

21. Support of State Partners

Joint Single State Authority on Substance Abuse (SSA) and State Mental Health Authority (SMHA)Partnerships with Other State Partners

Division of Medical Assistance & Health Services

The state remains well positioned to take advantage of the Patient Protection and Affordable Care Act (PPACA) and move forward with a number of related initiatives that will promote medical homes, reform its Medicaid program, and further promote illness self-management for individuals with SMI and other behavioral health issues. New Jersey has approval from Centers for Medicare and Medicaid Services (CMS) for one State Plan Amendment (SPA) to provide health home services to the SMI population in Bergen County, one SPA pending approval in Mercer County for health home services, and anticipates submitting a SPA for health homes for three additional counties in FY'16.

New Jersey's Medicaid Comprehensive Waiver includes under Section 2703 of the ACA, Health Homes as part of its Medicaid state plan, thereby becoming eligible to receive additional federal funds (90/10 match) for health home services in the first two years after implementation. This component of the waiver includes provisions for Behavioral Health Homes (BHHs) for people with SMI. The SPA approved for health homes services in Bergen County has an effective date of 7/1/14 and the SPA for health home services in Mercer County has an expected effective date of 10/1/14.

As each SPA is approved by Centers for Medicare and Medicaid Services (CMS), care coordination services in the health home model, consistent with federal CMS guidelines under Section 2703 of the ACA, will be reimbursed as a new service at an enhanced rate for up to two years. The provider will be permitted to retain the funds for service expansion and/or investment into health information technology, such as a certified electronic health record, if certain outcomes are achieved. DMHAS received technical assistance from SAMHSA on financing models and developed a three phase service delivery model that is reimbursed at a per member-per month rate (PMPM) relative to the consumer's current phase of service. Additionally, DMHAS has supported system readiness activities and capacity building through state only funds for BHH certified providers.

In addition to the waiver regarding BHHs, DMAHS and DMHAS are partnering bidirectional behavioral health and primary care screening, identification, referral to, and linkage for consumers. The partnership between the two divisions is critical to the full integration of services and both divisions are committed to work together toward that goal.

DMHAS and DMAHS have explored several models of integration, and continues to evaluate the needs of all populations. While the health home is designed as a high intensity service targeting those with the most need, there also is a call for integrated care for others. DMHAS is currently working with several technical advisors, exploring how best to test and then implement integrated care in less intensive settings. This includes a CMS State Innovation Model grant that includes integration as one of its priorities, and technical assistance from the National Academy for State Health Policy (NASHP) to assist with developing a more integrated systems.

Partnerships Involving Veteran and Military Service Member Services

While the VA serves many eligible soldiers and veterans, at least half come instead to DMHAS. Last year DMHAS served over 7,500 military men and women with mental health outpatient counseling, psychiatric rehabilitation and other evidence based programs, emergency and justice involved services and case management. It is believed that number is actually double to 15,000 due to nondisclosure by the individual as well as providers not asking the right questions. There were 1,557 veterans admitted to substance use disorder treatment in CY 2014.

Judiciary Veterans Assistance Initiative (VAI). The Veterans Assistance Initiative is a combined effort of the Judiciary, the NJ Department of Military and Veterans Affairs (DMVA) and the Department of Human Services, Division of Mental Health and Addictions Services (DMHAS). It uses existing resources of the participating state agencies to provide the needed services.

The project was initially piloted in the municipal courts and in the criminal division of Superior Court and Municipal divisions in Atlantic; it is now statewide. It formally provides a referral for behavioral health and generic services through DMVA to those present and former military service men and women who become entangled with the criminal justice system. These individuals may come to the attention of the courts by police arrest documents, identification in jail or during the court process.

This program aims to connect service members with services that can address physical, mental and personal issues through the local Veterans Service Offices of DMVA. Local DMHAS funded mental health and justice involved services may compliment behavioral health available through the Veterans Health Administration. The program is geared toward providing services to veterans through referral, not diverting veterans from the courts, although this can happen when appropriate. Veterans who are charged with indictable and non-indictable offenses other than minor traffic matters, as well as veterans who are on probation, are eligible to participate in the program. The nature of the offense will not matter in the decision as to whether or not a veteran should be referred for services.

As of March 1, 2012 the 1,386 referrals have been made to DMAVA Veteran Service Officers through the local courts. Atlantic, Union and Burlington Counties have the largest volume, about 200 each. The program is voluntary and although referrals are made, present and former service members may not take advantage of the opportunity.

Atlantic Veterans Diversion Pilot. The Atlantic Veterans Diversion Pilot is a partnership between the Office of the Attorney General (OAG) and DMHAS in conjunction with DMVA and the VA. The OAG sought to create this program and partnered DMHAS and Department of Military and Veterans Affairs (DMAVA) to make it happen. While New Jersey has Drug Courts, it does not mental health courts or veteran court diversion programs, so the pilot, a prosecutor diversion strategy was developed to have a different response. This pilot program will help those present and former military services members selected to gain access to often confusing Federal, State and County veteran services that they may be entitled to through case management provided Jewish Family Services of Atlantic/Cape May (JFS) with resources from the OAG, DMHAS, the VA and DMVA. The Atlantic Pilot Team made up of the Office of the Prosecutor,

public defender or private bar, JFS and VA and state Veteran service officers and DMHAS will identify appropriate candidates who have committed non-violent offenses. This pilot program will afford eligible veterans and/or active duty personnel, after receiving a treatment screening from a qualified professional and with the review and input of the Atlantic County Prosecutors Office, the opportunity to receive needed treatment in the community in lieu of a prison sentence. Diverted defendants will be expected to comply with an agreed upon treatment regimen that will include penalties for failure to comply, up to and including incarceration. OAG has given DMHAS $100,000 over two years to provide the case management through JFS. Services may include substance abuse and or mental health treatment, medical services, access to housing, employment, social services and other critical services

Expanding Community Mental Health and Addictions Providers to Join TRICARE. DMHAS recognizes that access to services is one of the greatest barriers to active and former service members and their families not receiving adequate help. With the encouragement of SAMHSA, DMHAS sent out a statewide letter from Assistant Commissioner Kovich encouraging community providers to help meet the mental health needs of military service members and their families in New Jersey through joining the Health Net Federal Services, LLC and MHN. Health Net Federal Services, LLC and MHN are seeking clinicians interested in participating in their behavioral health network within the TRICARE North Region, who qualify for participation in the MHN network.

DMHAS also encouraged its over 120 community providers through the statewide letter to ensure that question regarding military service or veteran's status is included in the agency's intake process.

NJ Department of Military and Veterans Affairs (DMVA). DMVA has partnered with DMHAS in its Medication Assisted Treatment Outreach Program (MATOP) under the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) Targeted Capacity Expansion: Medication Assisted Treatment-Prescription Drug and Opioid Addiction grant opportunity (MAT-PDOA). DMHAS was awarded this grant with a start date of August. MATOP will provide accessible, comprehensive and integrated care, using evidence-based programs such as medication assisted treatment (MAT), mindfulness based recovery maintenance, smoking cessation and other recovery support services for individuals with an opioid use disorder. Three New Jersey licensed Opioid Treatment Programs (OTPs) will participate in this initiative and provide outreach and other engagement strategies to diverse populations at risk such as veterans. DMVA offices will allow training and education from the project OTP partners in regards to MAT services for veterans and families who experience an opioid use disorder and refer veterans and families directly to the project treatment providers for MAT services. Letter of commitment is attached.

Partnership with other State Agencies, Professional Organizations, Support and Advocacy Groups, and Consumer Organizations to Prevent Suicide in NJ

In the fall of 2014, DMHAS formed an Adult Suicide Prevention Advisory Council to broadly represent Mental Health and Addiction Service Stakeholders and other groups and organizations to work cooperatively towards implementing the 2014-2017 New Jersey Adult Suicide Prevention Plan. State partners who are members of the Advisory Council include: Department

of Children and Family; Department of Health; Department of Military and Veterans Affairs; Department of Correction; Division of Aging Services; Division of Medical Assistance and Health Services; New Jersey Courts; Governor's Council of Alcohol and Drug Abuse; New Jersey State Police; New Jersey Transit, and Rutgers University. The current work of the Council is centered upon the development of action steps and outcome measures of four prioritized Goals of the Adult Suicide Prevention Plan (Goals 5, 7, 8 and 9), which have been updated to be consistent with the 2012 National Strategy for Suicide Prevention: Goals and Objectives for Actions.

In April 2015, State representatives from New Jersey were invited by the Injury Control Research Center for Suicide Prevention (ICRC-S) to participate in a meeting with other Region 1 and State Suicide Prevention Directors, State Injury Prevention Directors, and Researchers involved in suicide prevention. This meeting was intended to support suicide prevention research and practice in the Regions by providing opportunities for the States to network with each other and with experts in the field. This initiative has developed into an ongoing collaboration between these Northeastern States.

The Single State Authority on Substance Abuse (SSA)

New Jersey State Parole Board and New Jersey Department of Corrections
The SSA oversees the Mutual Agreement Program (MAP), an Inmate/Parolee Substance Use Treatment Project implemented through Memoranda of Agreements between the SSA, the New Jersey State Parole Board (NJSPB) and the New Jersey Department of Corrections (NJDOC). This funding is a combination of direct appropriations from DMHAS and funds transferred from the NJDOC and NJSPB. Funding for long term residential is available for DOC inmates pending parole through a network of FFS providers. For the NJSPB, these funds support a similar FFS network which offers the full continuum of care including long term and short term residential care, halfway house, partial care, detoxification, outpatient and intensive outpatient treatment, co-occurring services, psychotropic medication reimbursement, and medication assisted treatment by way of Naltrexone injections for NJSPB parolees.

New Jersey Motor Vehicles Commission (MVC) and Administrative Offices of the Courts Municipal Division
The DMHAS works closely with the NJ MVC and AOC in the management of the Driving Under the Influence court mandates. For more than three decades these three entities have worked jointly to ensure the safety of New Jersey's roads. Upon conviction, in any of New Jersey's Municipal Courts, the Intoxicated Driving Program (a Unit within DMHAS) is notified of the conviction and the court mandates. The New Jersey law (N.J.S.A 39:4-50) requires that convicted offenders have both driver's license suspension, managed by the MVC, and a addictions intervention including addictions screening, evaluation and education, managed and monitored by the DMHAS. This monitoring of the conviction requirements ensures that an individual has dealt with their alcohol and drug use. When the Courts mandates have not been successfully fulfilled the IDP works closely with the MVC to ensure that an individual's driving license is not restored, therefore ensuring the safety of NJ's residents.

Administrative Office of the Courts
A Memorandum of Agreement (MOA) with the Administrative Office of the Courts (AOC) will be maintained to fund a full continuum of treatment services for Drug Court applicants who are deemed legally and clinically eligible for Drug Court. State funding appropriated to the AOC for this purpose will be transferred to the SSA to implement and manage the statewide network of treatment services in coordination with the AOC and participating Superior Court vicinages. Enhanced services will be maintained as funding permits, including: medication, psychiatric/psychological evaluations, medication monitoring, physical exams, transportation, counselor appearances, partial care, co-occurring integrated services, methadone, and methadone intensive outpatient services.

Department of Children and Families' Division of Child Protection & Permanency
Effective July 1, 2015, the treatment contracts for parents with substance use disorders that is currently addressed via a Memorandum of Understanding between the SSA and DCF Division of Child Protection & Permanency (DCP&P) will transition over to DCF.

Department of Education
The SSA will continue to coordinate with the Department of Education (DOE) to develop school health goals and priorities. The primary focus of this interdepartmental group will be to reduce risky behaviors and promote adoption of health enhancing behaviors. Additionally, the SSA will continue to collaborate with the DOE in identifying and creating survey instruments that can be jointly used to collect data required by both entities, and to coordinate schedules for administering student surveys so as to minimize duplication of data collection efforts.

The SSA is also participating in a new initiative from DOE involving the development of a Social and Emotional Learning (SEL) curriculum. The mission of the group is to support the NJ DOE in ensuring that all children, regardless of life circumstances, graduate from high school ready for college and career by improving school climate and increasing overall academic achievement. The group will determine practices reflect current research to produce desired social and emotional learning outcomes including, knowledge, responsibility, care and social awareness, and propose sustainable social emotional learning standards that can be implemented with fidelity.

DMHAS and the Department of Education entered into a MOA for a Student Health Survey on health behaviors in New Jersey high school students. Included in the survey items are be substance use questions and questions regarding factors protecting and posing risk to adolescent substance use. Findings will assist in prevention and treatment planning, community organization and coalition building and school planning via the New Jersey Student Health (High School) Survey.

Department of Health's Office of Tobacco Control
Since 2004, the SSA has worked collaboratively via MOU with the Department of Health Office of Tobacco Control (OTC), Tobacco Age of Sale Enforcement (TASE), to implement the Synar portion of the SAPT Block Grant. Staff from the OTC TASE work annually with youth inspectors to conduct random unannounced inspections of licensed tobacco retailers by attempting to purchase tobacco products while the adult inspectors follow up with retailer staff

with merchant education materials and with violations if necessary. DMHAS staff generates the random list of retailers to inspect and provide the template for data collection forms as well as the analytical support for the Synar Report by analyzing the data obtained on the forms utilizing SSES. In addition to the annual Synar joint efforts, DMHAS and OTC work collaboratively every three years to conduct a coverage study to ascertain the accuracy of the licensed tobacco retailer list that is used to generate the Synar inspection sites annually. DMHAS staff generates the walking routes for the coverage study using census tracts, provide the data collection template, and analyze the data obtained to ascertain the coverage study rate. OTC adult inspectors canvass the identified areas and visit retailers to ascertain license status and provide merchant education.

Rutgers, The State University of New Jersey

Center for Alcohol Studies (CAS). The SSA continued to build capacity among current licensed clinical professionals through its Memorandum of Agreement with Rutgers Center for Alcohol Studies (CAS) Education and Training Division. CAS offered highly specialized, one-day professional development seminars throughout the year as well as offering an intensive weeklong summer training program. Topic areas include clinical supervision, cultural competency, trauma informed care, SBIRT, motivational interviewing, and co-occurring disorders. Both the seminars and weeklong program offered training education hours that can be applied towards recertification or renewal for alcohol and drug counselors and behavioral healthcare professionals working within the addiction and co-occurring treatment fields. Rutgers, CAS serves as the NJ SBIRT training contractor.

School of Social Work (SSW). Rutgers School of Social Work (SSW) has a long-standing partnership with the SSA and has overseen the community level and statewide evaluation of the SSA's previous Strategic Prevention Framework State Infrastructure Grant (SPF-SIG) and State Prevention Enhancement (SPE) federal awards. At the present time, Rutgers SSW is overseeing the evaluation of DMHAS' Screening, Brief Intervention and Referral to Treatment (SBIRT), Partnership for Success (PFS) federal awards, and recently awarded Medication Assisted Treatment-Prescription Drug and Opioid Addiction (MAT-PDOA) federal grant. Letter of commitment is attached. As lead project evaluator, Rutgers SSW conducts process and outcome evaluations, in addition to overall project data management for the federal projects.

University Behavioral Health Care. In 2013, the New Jersey legislature passed a bill approving the licensure of internet gaming. The legislation requires that each licensee provide $250,000 annually to be used for two purposes: $140,000 to be awarded to the Council on Compulsive Gambling to be used for the development and delivery of gambling prevention programming and $110,000 to be used for the development and maintenance of a network of clinicians who are licensed to treat gambling disorders. The legislation also specified that each $250,000 allocation should be administered by the Department of Human Services, Division of Mental Health and Addiction Services. DMHAS has developed a Memorandum of Agreement with Rutgers University Behavioral Health Care (UBHC) to expand the existing network of clinicians who treat gambling disorders and to administer all activities related to the administration of the network and the services it provides.

Robert Wood Johnson Medical School. The SSA obligated a portion of its HIV Block Grant funds to implement a Memorandum of Agreement (MOA) with Rutgers, Robert Wood Johnson (RWJ) Medical School, Department of Pathology and Laboratory Medicine, that provides administrative services including lab directorship, consultation, lab oversight, authorization, HIV test kits and technical support to ensure rapid HIV testing for clients in several licensed substance abuse treatment facilities statewide.

MATOP Smoking Cessation – Scientific literature has frequently reported that tobacco cessation treatment outcomes can be enhanced when integrated into usual substance abuse care. A combination approach of counseling and pharmacotherapy provides the best quit outcomes. New Jersey's MATOP project trainer, Dr. Jill Williams is a nationally recognized leader in treating tobacco dependence in individuals with mental illness and addiction. Dr. Williams and her colleagues have been working for decades in NJ to enhance tobacco treatment efforts in the behavioral health treatment setting through various policy, education and treatment efforts. New Jersey's MATOP project will build on these efforts and provide enhanced opportunities for training and consultation to assist opiate treatment providers in providing evidence-based tobacco dependence treatment. Letter of commitment is attached.

Partnership for Success (PFS) - The goals of New Jersey's Partnership for Success initiative are threefold: 1) to strengthen and enhance the work of 17 DMHAS-funded regional prevention coalitions; 2) to further develop the prevention data infrastructure and information systems capacity at the state level; and 3) in collaboration with state partners and community stakeholders, to continue work in developing a unified statewide prevention planning and service delivery system. Specifically, New Jersey's SPF-PFS seeks to 1) reduce underage drinking among persons aged 12 to 20; and 2) reduce prescription drug misuse and abuse among persons aged 12 to 25. New Jersey will also focus on unhealthy drinking patterns and prescription drug abuse among adults age sixty and older; and will serve military families with prevention education, addressing military community risk levels, striving to mitigate the risk factors, and enhancing the protective factors to support military members and their families in making responsible parenting and individual choices in regards to drug and alcohol use. Rutgers, Robert Wood Johnson Medical School is the PFS trainer and technical assistance provider.

Committees and Collaborative Projects

New Jersey began their participation in the SAMHSA supported National Center on Substance Abuse and Child Welfare (NCSACW), program of In-Depth Technical Assistance (IDTA) January 2009 through 2013 with the goal to improve outcomes for children and families involved with child welfare, substance abuse and the courts. The IDTA was led by the SSA, DCP&P and the Administrative Office of the Courts (AOC). Through the IDTA, the New Jersey team: (1) accomplished the first cross system drop off analysis; held a first ever statewide Values Conference from which a significant statewide cross-system training initiative emerged; developed policy changes reflecting improved practice for child welfare parents needing Medication Assisted Treatment (MAT); and completed initial planning for a Recovery Support Specialist model to work with highest risk priority parents.

In early 2014 the SSA reached out to the NCSACW to request continuation of IDTA to address emergent issues of concern where New Jersey like many other states, has been experiencing an

increase in illicit opioid use among women. New Jersey's 2012 treatment data reflected the most commonly used substances among New Jersey's pregnant women include heroin and other opiates. The NCSACW granted an IDTA continuation for a limited scope of work with DMHAS as the lead agency to address NJ's increase in substance using pregnant women, and the associated Substance Exposed Infants (SEI), including those with Neonatal Abstinence Syndrome (NAS).

The IDTA continuation involved a Monmouth county walkthrough that included an MAT provider, local hospital, Maternal Health Consortia, the local DCP&P office, and other stakeholders who provide services to substance using pregnant women who reside in Monmouth County revealed both effective practices and unexpected yet significant SEI gaps. As this limited TA came to a close, NJ as a recent SAMHSA Prescription Drug Abuse Policy Academy State was eligible to apply for a unique IDTA offered through SAMHSA's NCSACW to address the multi-faceted problems of NAS and SEI. Since NJ identified significant SEI gaps with the Monmouth county walkthrough, NJ as the lead State agency partnered with DCF and DOH and submitted a successful application for IDTA on SEI and NAS. Multiple State Departments and their Divisions, as well as the provider community, will participate on the IDTA with the goal to strengthen collaboration and linkages across addiction treatment, medical communities, child welfare, providers and other organizations to improve services for pregnant women with opioid and other substance use disorders and outcomes for their babies.

The Alcohol and Drug Abuse Program for the Deaf, Hard of Hearing and Disabled and a Program Advisory Committee was established pursuant to PL 1995, c.318 (NJSA 26:2B-36 to 39), and continues to meets on a quarterly basis to ensure quality substance abuse treatment services are provided to individuals who identify as being Deaf, hard of hearing or disabled in the community. The Committee is comprised of individuals from statewide disability, substance abuse and social service providers, including five State representative from the Division of Disability Services, Division of Deaf and Hard of Hearing, Division of Vocational Rehabilitation Services, the Council on Developmental Disabilities and the GCADA, in addition to five members who are identified as Deaf, Hard of hearing or disabled and two public members with an interest in substance abuse and co-existing disabilities. Staff from the SSA convene and coordinate this meeting.

Since 2006, the New Jersey State Epidemiological Outcomes Workgroup (SEOW) has met to collect and organize multiple sources of data to guide relevant and effective substance abuse prevention strategies. The purpose is to develop and support a statewide, cross-system, data-driven alcohol, tobacco, and other drug prevention prioritization, implementation and evaluation infrastructure, which will guide and support communities across New Jersey. The SEOW is comprised of government and community agency-based experts in the field of substance abuse. The members come from diverse entities, including universities, research institutions, government agencies, and private organizations. All have extensive experience working with substance-related data. Organizations/institutions that are represented on the SEOW include: DMHAS Regional Coalitions, County Alcohol and Drug Directors Association, Department of Education, Department of Health, Division of Highway Traffic Safety, NJ Intoxicated Driving Program, New York/New Jersey High Intensity Drug Trafficking Area, GCADA, Juvenile Justice Commission, NJ Prescription Drug Monitoring Program, New Jersey State Police, New

Jersey Prevention Network, Barnabas Health, Robert Wood Johnson Medical School, and Rutgers University.

In August of 2012, DMHAS completed its five-year Addiction Prevention Strategic Plan. The purpose of the DMHAS Addiction Prevention Strategic Plan is to focus statewide prevention efforts on specific data-driven priorities for which measurable change can be achieved at the state and community levels. The Strategic Planning committee included community stakeholders and State government partners, including the Alcoholic Beverage Control, CSOC, DCP&P, and the Division of Developmental Disabilities. In conducting its work, the planning committee formed needs assessment, capacity, and planning sub-committees to analyze existing data on addictions in the state population and current prevention resources. These data provided the foundation for identifying and selecting statewide prevention priorities. The group continues to meet on an as needed basis.

New Jersey, like many states, has developed a comprehensive prevention infrastructure at both state and community levels. Until very recently, however, there was little coordination of planning and service delivery among the various state and community-level entities that are implementing prevention programs and environmental strategies. In early 2012, GCADA, DMHAS, the New Jersey Prevention Network (NJPN) and representatives from county government came together to collaborate in the development of a unified, transparent, data-driven process to plan for and deliver services and strategies at the state, county, and municipal levels. This process continues to date.

The State Mental Health Authority (SMHA)

State agency representation on the Community Mental Health Planning Council includes the following: DMHAS, DMAHS (Medicaid), DOC, JJC, State Housing Authority (New Jersey Housing and Mortgage Finance Agency-NJHMFA), Division of Vocational Rehabilitation, Division of Family Development (Social Services), and the DOE. Some of the consumer and family members are representatives of consumer advocacy groups, including National Alliance on Mental Illness in New Jersey (NAMI-NJ), County Family Support Organizations, Self Help Centers, Youth Development Council, Statewide Consumer Advisory Committees (SCAC), and various other New Jersey Partners.

The SMHA has a number of formal and informal partnerships with the criminal justice system:

DMHAS representatives were appointed to Governor Christie's Task Force on Reducing Recidivism and participated during the last calendar year. The Task Force had representatives of the Departments of Corrections, Labor and Workforce Development, Community Affairs, the Office of the Attorney General and the State Parole Board and Governor’s Office.

Office of the Attorney General
DMHAS has two MOU's with the Office of the Attorney General (OAG); one moves $50,000 from the OAG to DMHAS to support our joint CIT Center for Excellence. The second MOU creates a pilot Prosecutor Diversion program in Atlantic County for military members and

veterans who become entangled in the criminal justice system and who have behavioral health issues.

Administrative Office of the Courts (AOC) /Judiciary
The DMHAS was a an active participant over the past two year in the Chief Justice's Interbranch Advisory Committee on Mental Health Initiatives. The committee recommendations will be implemented and DMHAS will be an integral part of the effort. Several recommendations of the report involve cross training of Judges. DMHAS has presented at the last two Judicial Colleges for Superior Court Judges and also at the Annual Municipal Court Judges Conference.

The DMHAS was instrumental in assisting the AOC to establish a Veteran's Assistance Initiative which is a formal referral system for military service members and veterans who come before the court or are in jail. The referral goes from the court to the New Jersey Department of Military and Veterans Affairs so that the service member can get services if desired. DMHAS can also supplement and/or assist.

The Division of Probation created an advisory committee for its demonstration project of special mental health probation officers (MHPO's). A DMHAS representative was appointed to this group and assisted with the training of the 30 MHPO's and has been troubleshooting the collaboration between the local mental health system and probation office.

State Parole Board (SPB)
While there are no written MOU's or advisory committee memberships, DMHAS has collaborated with the SPB in jointly submitting three Bureau of Justice Assistance Grants, which were unfortunately not funded. There is also regular dialogue and collaboration to gains access for parolees to mental health services.

DMHAS is an official partner in the SPB's new Veterans Assistance Project.

Department of Corrections
While no formal agreement exists, DOC and DMHAS work together to get access to mental health services for ex-offenders.

New Jersey Housing and Mortgage Finance Agency (NJHMFA)
In January 2015, the Department of Human Services/the Division of Mental Health and Addiction Services launched a partnership with the New Jersey Housing and Mortgage Finance Agency (NJHMFA, http://www.nj.gov/dca/hmfa/), to administer housing subsidies to consumers receiving services from the Division. NJHMFA is undertaking the following tasks on behalf of the Division: Housing Search Assistance, Landlord Recruitment, Housing Inspections, Subsidy Processing, Rental Subsidy Administration, and Tenant/Landlord Inquiry Resolutions. The ultimate goal of this partnership is to increase community-based living, and enhance community tenure for consumers recently recovering from and/or at-risk for homelessness and/or placement in inpatient psychiatric settings.

Children's System of Care (CSOC)

Collaboration with the Department of Human Services (DHS) Division of Medical Assistance and Health Services (DMAHS)

The DHS DMAHS administers the state-and federally- funded Medicaid and NJ Family Care (S-CHIP) programs for certain groups of low- to moderate- income adults and children. DCF CSOC provides behavioral healthcare to youth and families in a broad continuum of behavioral health services with total budget authority of state and federal resources consisting of GIA, Medicaid (Title XIX) and S-CHIP (Title XXI). Services are primarily funded through Medicaid (Title XIX and Title XXI) Mental Health Rehabilitation Services Option, Targeted Case Management and Psychiatric Residential Treatment Facility (PRTF) Services for Individuals Under age 21. These benefits are approved by the CMS. Services are provided on a medical necessity basis. CSOC and DMAHS meet regularly regarding the New Jersey State Plan.

Three new DCF initiatives under the NJ Comprehensive Waiver are now operational. The services provide additional community support and coordination of services for an expanded population of youth that meet the clinical criteria for services. This includes services for certain NJ FamilyCare eligible individuals that have been diagnosed with a Serious Emotional Disturbance (SED), Autism Spectrum Disorder (ASD) and Individuals with Intellectual/ Developmental Disabilities and a co-occurring Mental Illness (ID/DD-MI). These waivered services are not yet included as part of NJ State Plan: The ASD pilot provides NJ FamilyCare children with needed therapies that they are unable to access through the NJ FamilyCare State Plan and are not yet available to other children with private health insurance. By providing intensive home and community based services, the ID-DD/MI pilot is built to provide a safe, stable and therapeutically supportive environment for children with developmental disabilities and co-occurring mental health diagnoses, age five up to 21, with significantly challenging behaviors. The SED demonstration provides health services for enrollees who have been diagnosed as seriously emotionally disturbed—an at-risk population for hospitalization and out-of-home placement. Over the past two and ½ years, the Children's System of Care has worked with the Division of Medical and Health Services (DMHAS) and its fiscal agency, Molina to build and implement the new service codes so that the Molina system would support the new program, and allow for CCOS Medicaid providers to successfully bill for services provided. These codes were operationalized on March 1. 2015.

In collaboration with the New Jersey Department of Human Services' Divisions of Medical Assistance and Health Services and Mental Health and Addiction Services, the Department of Children and Families' Children's System of Care received approval from Centers for Medicare and Medicaid Services (CMS) for one State Plan Amendment (SPA) to provide behavioral health home services to the SED population in Bergen County, one SPA pending approval in Mercer County for health home services, and anticipates submitting a SPA for health homes for three additional counties in FY'16.

Development and implementation of Behavior Health Homes (BHH) in Bergen and Mercer counties serve as a "bridge" that connects prevention, primary care, and specialty care, and is designed to avoid fragmented care that leads to unnecessary use of high end services (i.e. emergency rooms and inpatient hospital stays.) The current child family teams are to include

medical expertise and health/wellness education for purpose of providing fully integrated and coordinated care for children who have chronic medical conditions. Behavioral Health Home provides services to children with serious emotional disturbance with the goal of improving health outcomes; promoting better functional outcomes (such as increased school attendance); decreasing overall cost, and the cost associated with the use of acute medical and psychiatric services; improving child/family's satisfaction with care; and, improving the family's ability to manage chronic illness. 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 constitutes 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 2016 three additional BHH will open in one each in Cape May, Atlantic and Monmouth counties.

Collaboration with the Department of Children and Families' (DCF) Division of Child Protection and Permanency (DCP&P) Child Welfare Service Recipients

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

DCF Office of Adolescent Services (OAS) Transitions for Youth

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

All TFY programs are rooted in best practices and integrate Positive Youth Development, a model for improving outcomes for youth by addressing the following domains: housing stability; improved academic functioning; job-readiness skills; financial literacy; emotional regulation and physical wellness; and peer, adult and community partnerships. TFY services for Special Populations include: Gay, Lesbian, Bisexual, Transgender, Questioning and Intersex youth (GLBTQI); parenting youth; youth living with HIV/AIDS and youth with juvenile justice involvement and/or mental health concerns.

A complete description of the programs and supports available through TFY can be accessed at: TFY can be accessed at: http://www.nj.gov/dcf/about/divisions/oas/

DCF Division of Family and Community Partnerships (DFCP)

DFCP serves as DCF's grant-making and best practices team committed to strengthening New Jersey's families. DFCP is committed to provide the resources and technical assistance needed to grow a robust network of public/private partnerships and programs. Schools and community-based organizations are two prime locations for prevention and intervention services. DFCP's goal is to build a continuum of child abuse prevention and intervention programs that are culturally competent, strength based and family-centered, with a strong emphasis on primary child abuse prevention. DFCP's programs include but are not limited to:

Family Success Centers

New Jersey now has one of the country's only statewide systems of publicly supported Family Success Centers. These centers are neighborhood-based gathering places where any community resident can find family support, information and services. The purpose of the Family Success Center is to enrich the lives of children by making families and neighborhoods stronger. There is no cost to access services provided by Family Success Centers. Some of the services include: employment, information and referral, parent education, health care, parent-child activities, home visiting, life skills training, advocacy and housing.

PALS Programs (PEACE: A Learned Solution)

DFCP oversees PALS programs in counties for children who have witnessed domestic violence. PALS is an intensive program that provides counseling and creative arts therapy for children who have witnessed domestic violence. The program serves children primarily aged four to twelve.

Outreach to At-Risk Youth

Outreach to At-Risk Youth is an initiative designed to prevent crime and deter gang involvement by providing enhanced recreational, vocational, educational, outreach or supportive services to youth, ages 13 to 18, with the option to serve youth until age 21. Programs are located in communities with demonstrated high crime and gang violence.

Home Visitation Program

The Home Visitation Program provides services to families challenged by complex health related and/or social problems. This program focuses on young families who are at risk for abuse and neglect with primary prevention and early intervention services for pregnant women and children up to age five.

Strengthening Families through Early Care and Education

The Strengthening Families Initiative (SFI) is an approach to preventing child abuse and neglect by strengthening families through early care and education. The Center for the Study of Social Policy developed the Strengthening Families through Early Care and Education Framework. The fundamental principle is that certain protective factors contribute towards family resiliency and strength. Early Care and Education Centers play a prominent role in building these protective

factors among the families they serve. Through seven key strategies, centers become well positioned to help families build these protective factors that have proven to be effective in preventing child abuse and neglect.

Children's Trust Fund

Children's trust and prevention funds are state level organizations dedicated to the prevention of child abuse and neglect. There are now 52 trust and prevention funds, established by legislative action, in every state of the union, Puerto Rico and the District of Columbia. Trust and prevention funds create a vital public-private partnership, since, in most states, boards of directors have representatives of government, the corporate sector, and private citizens are appointed by the Governor. The funds are situated within state government and may be located administratively within various state agencies, governors' offices, or independently.

Funding for trust and prevention funds comes from a variety of sources, such as voluntary state income tax check-off contributions; surcharges on birth, divorce, or death certificates; line item state appropriations; interest from the trust fund; corporations and private foundations; and individual contributions. Every state that has an established children's trust or prevention fund is eligible for a federal community-based grant.

The common purpose of trust or prevention funds is the prevention of child abuse and neglect. Each state undertakes a variety of creative and innovative activities to accomplish this purpose, just as each state has established funding guidelines and policies that identify the types of prevention programs eligible for financial support, funding priorities, and funding limitations. The funding process encourages the development of creative strategies for preventing child abuse and neglect. Examples of such strategies are parenting education and role modeling for incarcerated women, curriculum development for religious communities, culturally specific sexual abuse prevention education for children, and programs for families recovering from substance abuse.

Additional information regarding the NJ Children's Trust fund can be accessed at: http://www.nj.gov/dcf/about/child_trust_fund.html

School Based Youth Services Program (SBYSP)

The School Based Youth Services Program (SBYSP) sites are located in each of the 21 counties in or near schools in urban, rural and suburban communities. The programs are open to all youth ages 10 -19 enrolled in the school that is home to the SBYSP, and provide services before, during and after school and throughout the summer. Major services include: mental health and family services; health services; substance abuse counseling; employment services; pregnancy prevention programs; learning support services; referrals to community based services; and recreation.

Prevention of Juvenile Delinquency Programs (PJD)

Prevention of Juvenile Delinquency Programs (PJD) provide healthy alternatives for youth who have had trouble with the law, in conjunction with the Stationhouse Adjustment regulations of the NJ Department of Law and Public Safety and has increased the state's capacity to address the complex needs of school-aged children.

Adolescent Pregnancy Prevention Initiative

The Adolescent Pregnancy Prevention Initiative uses education, counseling and health services to reduce the birth rate among teens in high school. Any youth, at-risk or not, enrolled in the school that is home to the APPI program is eligible for services. Risk factors include sexual abuse or neglect at home, low school achievement, poverty, substance abuse or living in a home where siblings or relatives gave birth during their teen years. Referrals can come from peers, family members, guidance counselors, or foster families. Students also may enroll themselves.

Family Empowerment Program
The Family Empowerment Program (FEP) is a unique intervention program that targets students and families with intergenerational distress related to substance abuse. It provides a comprehensive intervention that integrates direct family system and adolescent development services with school and community resources. Related issues include substance abuse, mental health, academic performance and attendance, violence, gangs and juvenile justice involvement. The goal of the program is to maintain the student in school, while facilitating positive change that reduces risk factors in both student and family.

Collaboration with the New Jersey Juvenile Justice Commission and Juvenile Detention Centers
Currently, youth in juvenile detention facilities are eligible for Medicaid or New Jersey FamilyCare (S-CHIP) only after adjudication and referral to a non-secure setting. Coverage expansion for the juvenile justice system under the Affordable Care Act has not yet been determined.

Protocol for Court-Ordered Assessment of Children with Emotional and Behavioral Health Needs (14 Day Plan Protocol)

In the course of proceedings involving juvenile delinquency matters or family crisis petitions, the court may learn that the child involved exhibits behavior suggesting a need for emotional, behavioral, or mental health services. When this becomes apparent at any point in court proceedings, the court may order DCF to submit a service plan to the court within 14 days (14 Day Plan) that assesses the needs of the child and the family and details how those needs may be met.

Attached is the Protocol for Court-Ordered Assessment of Children with Emotional and Behavioral Health Needs (14 Day Plan Protocol) between the DCF Children's System of Care (formerly the Division of Child Behavioral Health Services) and the New Jersey Judiciary, Family Division.

Biopsychosocial Assessments

The NJ regulations for juvenile detention facilities require that all youth entering Detention must receive the MAYSI (Massachusetts Youth Screening Instrument) within 24 hours of admission. CSOC and JJC developed a process that permits juvenile detention centers to request a Biopsychosocial clinical evaluation on any youth that may score on the MAYSI regarding possible mental health concerns.

When a court-involved youth held in a county juvenile detention facility is ordered by a Family Court judge into an out-of-home treatment facility, the youth must be transitioned from the juvenile detention center as quickly as possible. To effectively accomplish this, it is critical that youth for which a congregate care placement is contemplated be identified as early in the court involvement as possible. The New Jersey Department of Children and Families' (DCF) Children's System of Care (CSOC) has implemented an easily accessed clinical assessment process for any youth in a county juvenile detention center that may have behavioral and/or mental health issues. Clinical assessments, which a have a turn-around time of five business days, can be requested by the Social Services staff at the detention center. To accomplish this, CSOC developed a tracking system for children in county detention centers for whom a congregate care placement is being considered. The contracted system administrator's (CSA) management information system was modified to incorporate information about detention status for system-involved children. The information in the CSA management information system identifies children for whom proactive placement is initiated.

The DCF CSOC is represented on the New Jersey Council for Juvenile Justice Improvement. Diversion and the Reentry processes are being addressed by the Access to Treatment and Racial Disparities sub-committees of the Council. Formal recommendations will be presented to the full Council by the individual sub-committees.

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

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

Special Case Review Committee

The Special Case Review Committee (SCRC) reviews those juveniles, both male and female, who present multi-system needs/issues and the need for special attention or advocacy. Included are: those who appear to have developmental disabilities; those who need placement by DCF/DCP&P due to court orders for diversion or aftercare, special presenting problems, and/or homelessness; and those who are being referred or are accepted by DCF/CSOC.

The Office of Special Needs oversees the SCRC, in terms of intra- and inter-agency planning. It is chaired by the Special Needs Assistant. Members include representatives from the DCP&P Central, Middlesex, Union and Camden offices, the JJC Juvenile Parole and Transitional Services (JP & TS) Pre-Release Teams, Regional Court Liaisons/designees, the JJC Child Study Teams, JJC community residential homes, and the New Jersey Training School at Jamesburg (NJTS), Juvenile Medium Security Facility (JMSF), and the Juvenile Female Secure Care and Intake Facility (Hayes Unit) Social Services Departments.

Meetings are held twice a month, for northern and southern regional cases respectively. Referrals are primarily made from the Reception and Program Review committees, from the Reception and Assessment Center (RAC) the New Jersey Training School (NJTS), and Juvenile Female Secure Care and Intake Facility. However, youth may be referred by any source identifying a special need for advocacy and planning, including the Institutional Classification Committees, JP & TS staff, court liaisons and supervisors and program staff.

In addition to this population of JJC/DCP&P involved juveniles, DCP&P maintains an existing Memoranda of Understanding (MOU) with JJC. This MOU stipulates that DCP&P has the responsibility to plan for ***any homeless*** juvenile pending discharge from JJC. The Special Needs Review Committee will identify those juveniles and make referrals to DCP&P via State Centralized Screening (SCR) when appropriate for homeless juveniles not known to DCP&P or those juveniles whose DCP&P cases are closed. In cases where a juvenile with an open DCP&P case is pending discharge and known to be homeless, it is expected that the DCP&P worker is already engaged in permanency plans.

When JJC juveniles have permanency **and** treatment needs that require the intervention of CSOC, the JJC Special Needs Review Committee will work with CSOC and DCP&P to make appropriate referrals prior to time of discharge. In circumstances where CSOC is unable to facilitate a timely permanency plan in accordance with mandatory release dates, DCP&P will be expected to effectuate the most appropriate contingency plan until such time that a more feasible plan is developed. Care Management Organization (CMO) involvement is inclusive in this agreement when appropriate.

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

Attached is the DCF CSOC "Protocol for Supervision of Juvenile Probationers Court-ordered to Attend and Complete a CSOC Specialty Services Program." This protocol was approved in 2012 by the following: NJ Juvenile Probation Managers; NJ Conference of Chief Probation Officers; CSOC Representative for Specialty Programs; NJ Juvenile Committee of Family Presiding Judges; and, the NJ Conference of Family Presiding Judges.

DCF/CSOC funds the Technical Assistance Center through University Behavioral Health Care Rutgers, the State University to provide training statewide. CSOC, through the UMDNJ Training

contract, offers training to all children's system of care providers free of charge. The following courses are available on a regularly scheduled basis throughout the year:

- Risk Assessment and Mental Health
- Crisis Intervention for At-Risk Youth
- Crisis Assessment for Parents and Caregivers
- Crisis Cycle
- Developing and Managing the Family Crisis Plan
- Safety Issues Working in the Community
- Youth Behavior, Diagnosis and Intervention Strategies
- Risk Assessment and Mental Health
- Domestic Violence: An Introduction to Domestic Violence
- Working with Challenging and Aggressive Adolescent Behaviors
- Working with Traumatized and Aggressive Youth
- MRSS Orientation – Crisis Response Protocol (Day One)
- MRSS Orientation – Crisis Assessment Tool (CAT) and Developing the
- Individualized Crisis Plan (ICP)
- MRSS Orientation – Crisis Response Protocol (Day 2)
- Understanding Child Abuse and Mandatory Reporting Laws
- Youth Gang Involvement in NJ
- Substance Use and Abuse: Youth with Co-Occurring Developmental and Mental Health Challenges
- Substance Abuse 2: A Closer Look – Family and Addiction

In addition, CSOC staff provides training on working with individuals with behavioral health challenges to staff of the Juvenile Justice Commission.

Collaboration with the Department of Human Services (DHS) Division of Developmental Disabilities (DDD) and Division of Mental Health and Addiction Services (DMHAS)

On June 29, 2012 Governor Chris Christie signed a bill that reorganized DCF into a single point of entry for all families with children, youth and young adults with developmental disabilities and/or substance abuse disorders. This realignment of services removed barriers to accessibility, provides more complete care through all service offerings, and improves efficiency for those families served by DCF throughout the state. The transition of these services to DCF from the DHS began January 1, 2013. The Children's System of Care collaborates with the DHS DDD and DMHAS to coordinate transition into the adult services systems.

Transition of Aging Out Youth to the Adult Mental Health System

DCF CSOC and the DHS DMHAS continue their effort in long-term joint planning for easing the transition of aging-out youth who need to move from the child system to the adult mental health system. Guidelines for successful transition were developed as well as "The Tool" to document information and inform participants. Additional information regarding these services is available at: http://www.state.nj.us/dcf/providers/csc/

Collaboration with the New Jersey Department of Education (DOE)

County Children's Inter-Agency Coordinating Council (CIACC) Education Partnership
The mission of the *CIACC Education Partnership* is to promote, develop, and enhance collaborative efforts between school, behavioral health and child protective service systems and other interested parties to improve the well-being of children in Ocean County.

The Partnership was conceived in 2006 by members of the CIACC who recognized a need for ongoing, standardized exchange of procedural information between local schools, the child protective service agency and children's behavioral health programs. The services and supports available for children are continually growing and evolving. Through this Partnership, professionals from each of the three systems are provided up-to-date, ongoing training and education on the services that are available and how to access and effectively coordinate with those services, which will help ensure that children receive the help that they need. Through enhancing the knowledge of and communication between professionals, Ocean County children may see the full benefit of these systems working together to meet their multifaceted needs.

Educational Services
The McKinney-Vento Act defines homeless children as "individuals who lack a fixed, regular, and adequate nighttime residence." This includes youth in OOH/state facilities. The Department of Corrections, the DCF, the DHS, and the JJC are required to provide educational programs to students in State facilities ages five through 20 and for students with disabilities ages three through 21 who do not hold a high school diploma. Students must be able to receive high school credit.

In general State agencies are required to:
provide a program comparable to the special education student's current individualized education program (IEP), and implement the current IEP or develop a new IEP; develop an individualized program plan (IPP), within 30 calendar days, for each general education student, in consultation with the student's parent, school district of residence, and a team of professionals with knowledge of the student's educational, behavioral, emotional, social, and health needs to identify appropriate instructional and support services; discuss the IPP with the student and make a reasonable effort to obtain parental consent for an initial IPP, including written notice; and, review and revise the IPP at any time during the student's enrollment, as needed, or on an annual basis if the student remains enrolled in the State facility educational program, in consultation with the school district of residence.

Attendance in educational programs is compulsory for all students, except for a student age 16 or above who may explicitly waive this right. For a student between the ages 16 and 18, a waiver is not effective unless accompanied by consent from a student's parent or guardian. A waiver may be revoked at any time by the former student.

The actual number of days a student with a disability must attend the educational program shall be determined by the student's IEP.

Educational Stability for Youth in Out-of-Home Placement
In October 7, 2008, the federal government signed into law the Fostering Connections to Success and Increasing Adoptions Act (P.L. 110-351). This act required all states to arrange for children

and youth in foster care to remain in their "school of origin" to ensure educational stability unless it is determined to be in a child's best interest to go to the new district where the Resource Family Home is located. New Jersey responded to this charge by passing the Education Stability Law on September 9, 2010, which established a system that supports the act. The DCF, Department of Education (DOE) and Office of the Child Advocate (OCA) worked together to implement this law. For children, changing schools can affect their ability to thrive academically, socially, behaviorally and psychologically. This is especially true for children in resource family homes. For these children – who often suffer the lingering effects of abuse or neglect and the trauma of being removed from their homes and families – school can often be the most stable part of their lives.

Work continues to fully implement the requirements of coordination between the DCF and the local school districts. To support the continued progress "*Improving the Educational Outcomes of Children in Out-of-Home Placements: An Interagency Guidance Manual*" is available on the DCF website at http://www.nj.gov/dcf/families/educational/stability/GuidanceManual.pdf and on the NJDOE website at http://www.state.nj.us/education/students/safety/edservices/stability .
The guidance manual includes a model memorandum of agreement (MOA) and provides specific actions to reach the indicators and goals in the MOA.
A one page flyer with information for School Registration of Youth in Out-of-Home Care is available at http://www.nj.gov/dcf/documents/divisions/dyfs/OOHflyer.pdf
A two page directory of local DCF Education Stability Liaison Staff is available at http://www.nj.gov/dcf/families/educational/stability/Directory.pdf

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

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

The main programs offered by the DCF Office of Education include:

- Regional School and Institutional programs for children, youth and young adults receiving DCF services. Each of the Office of Education's 18 Regional Schools offers individualized, comprehensive year-round programs designed to meet the educational and psychological needs of students with moderate and severe cognitive impairments. Multiple disabilities, autism, behavioral or emotional disturbances and other disabilities that cannot be served in the public school system. In addition to their educational program, children receive child study, clinical and rehabilitative services.

- Project TEACH (Teen Education and Child Health) is an alternative, year-round education program for pregnant or parenting teens. Project TEACH services students at risk of school failure.

- Transition Education Center is an alternative year-round program designed to meet the needs of an array of "at-risk" students who are referred because of their involvement with the juvenile justice system. The TEC program provides a comprehensive educational program which provides the at risk adolescent with the skills needed to create a positive live for themselves in order to promote their successful reintegration to future school, work and/or community endeavors.

- Technology for Life and Learning Center (TLLC) assists students with disorders that affect their ability to communicate. The TLLC provides two distinct programs: Augmentative and Alternative Communication (AAC) and Assistive Technology Educational Achievement Models (ATEAM). Both provide diagnostic and intervention services to enable student so become proficient users of assistive technology tools/strategies, thereby increasing their function in identified areas.

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CHRIS CHRISTIE
Governor
Commander-in-Chief

MICHAEL L. CUNNIFF
Brigadier General
The Adjutant General

30 April 2015

Diane Abbate, Director of Grant Review
Office of Financial Resources
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 3-1044
Rockville, MD 20850

Re: MAT-PDOA TI-15-007 FEDERAL Grant Opportunity

Dear Ms. Abbate:

The New Jersey Department of Military and Veterans Affairs (DMVA) is pleased to partner with the Department of Human Services (DHS), Division of Mental Health and Addiction Services (DMHAS) in its project funded by the Medication Assisted Treatment – Prescription Drug and Opioid Addiction (MAT-PDOA) federal grant. Additional funding to New Jersey will 1) increase the number of individuals receiving MAT services for the treatment of opioid use disorders; 2) increase the number of individuals receiving integrated care; and 3) decrease illicit drug use at 6-months follow-up.

Should DMHAS be awarded the grant, DMVA will be pleased to offer the following support to ensure the success of the project.

- The DMVA service offices will allow training and education from the project treatment providers in regards to MAT services for veterans and families who experience an opioid use disorder
- Refer veterans and families from the DMVA service offices directly to the project treatment providers for MAT services

DMVA is excited about the new partnership opportunity with DMHAS proposed in this grant application. Please look favorably on DMHAS' application for funding as it will enable the State to enhance/expand their treatment service systems to increase capacity and provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based MAT and other recovery support services to individuals with opioid use disorders seeking or receiving MAT.

Sincerely,

ALBERT J. BUCCHI
Director
Division of Veterans Services

C: Lynn Kovich, DMAHS

"SERVING THOSE WHO SERVED"

RUTGERS
Robert Wood Johnson
Medical School

Psychiatry Department
Addiction Psychiatry Division
Rutgers, The State University of New Jersey
317 George Street, Suite 105
New Brunswick, NJ 08901

rwjms.rutgers.edu/addiction

p. 732-235-4341
f. 732-235-4277

April 29, 2015

Diane Abbate, Director of Grant Review
Office of Financial Resources
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 3-1044
Rockville, MD 20850

Re: MAT-PDOA TI-15-007 Federal Grant Opportunity

Dear Ms. Abbate:

Rutgers, The State University of New Jersey, Robert Wood Johnson Medical School (RWJMS) is pleased to partner with the Department of Human Services (DHS), Division of Mental Health and Addiction Services (DMHAS) in its project funded by the Medication Assisted Treatment – Prescription Drug and Opioid Addiction (MAT-PDOA) federal grant. RWJMS will oversee the training component of this project.

RWJMS Professor Jill Williams, MD will develop and deliver a series of in-person presentations and webinars on the latest research and developments specific to the use of MAT for the treatment of opioid addiction. The presentations will be delivered to both treatment providers as well as people suffering from opioid addiction and their families. In addition to these presentations, Dr. Williams will also oversee the provision of both smoking cessation services to patients as well as Mindfulness Based Recovery Management programs, which is one of the evidence-based practices DMHAS proposes to utilize in its project.

RWJMS has a current partnership with DMHAS as its provider of training and technical assistance to DMHAS' 17 regionally-based prevention coalitions, their stakeholders, partners, and staff for the Partnership for Success (PFS) federal award. RWJMS is excited about the new partnership opportunity with DMHAS proposed in this grant application. Additional funding to New Jersey will 1) increase the number of individuals receiving MAT services for the treatment of opioid use disorders; 2) increase the number of individuals receiving integrated care; and 3) decrease illicit drug use at 6-months follow-up.

Sincerely,

Jill M Williams, M.D.
Professor of Psychiatry and Director of the Division of Addiction Psychiatry
Rutgers University-Robert Wood Johnson Medical School

cc. Lynn A. Kovich, DMHAS

RUTGERS

School of Social Work
Rutgers, The State University of New Jersey
536 George Street
New Brunswick, NJ 08901-1167

April 29, 2015

Diane Abbate, Director of Grant Review
Office of Financial Resources
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 3-1044
Rockville, MD 20850

Re: MAT-PDOA TI-15-007 Federal Grant Opportunity

Dear Ms. Abbate:

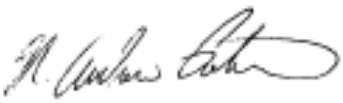
Rutgers University, The State University of New Jersey, School of Social Work, Institute for Families (IFF) is pleased to partner with the Department of Human Services (DHS), Division of Mental Health and Addiction Services (DMHAS) in its project funded by the Medication Assisted Treatment – Prescription Drug and Opioid Addiction (MAT-PDOA) federal grant. IFF will oversee the overall evaluation of this project. In its role as Project Evaluator, IFF will conduct a performance assessment to document the progress, implementation, accomplishment, and challenges of this project. I am personally committed to participate as lead evaluator and data manager in this project.

IFF has a long-standing partnership with DMHAS and has overseen the community level and statewide evaluation of DMHAS's previous Strategic Prevention Framework State Infrastructure Grant (SPF-SIG) and State Prevention Enhancement (SPE) federal awards. At the present time, IFF is overseeing the evaluation of DMHAS' Screening, Brief Intervention and Referral to Treatment (SBIRT) and Partnership for Success (PFS) federal awards.

Rutgers University, School of Social Work, IFF is excited about the partnership opportunity with DMHAS proposed in this grant application. Additional funding to New Jersey will 1) increase the number of individuals receiving MAT services for the treatment of opioid use disorders; 2) increase the number of individuals receiving integrated care; and 3) decrease illicit drug use at 6-months follow-up.

We look forward to collaborating with you in this important work.

Sincerely,



N. Andrew Peterson, Ph.D.
Associate Professor

c. Lynn A. Kovich, DMHAS

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Narrative Question:

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.[97]

Additionally, Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) applicable to the SABG and the MHBG, requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

For MHBG and integrated BHPC; States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.

SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[98]

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[97] http://beta.samhsa.gov/grants/block-grants/resources

[98] There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).

   The Block Grant Committee of the Planning Council reviewed and assisted with the FY 2016-2017 combined Mental Health and Substance Abuse Block Grant Application and Plan, as well as monitored the Behavioral Health Implementation Reports submitted December 2014. The Block Grant Committee met on October 10, 2014 and November 12, 2014 to review the Implementation Reports, and provided updates at the general Planning Council meeting on the progress of the reports. The Block Grant Committee also met June 10, 2015, July 8, 2015 and August 12, 2015 to review and assist with crafting the combined Mental Health and Substance Abuse Block Grant Application and Plan, providing updates to the general council each month on its status.

   The citizen login for WebBGAS was provided to the Planning Council members and published in the meeting minutes which are posted on the DMHAS website. In addition, a Notice of Solicitation of Comment on the FY 2016-2017 combined Mental Health and Substance Abuse Block Grant application with the citizen login information was posted on the Department of Human Services and DMHAS websites. A request for advertisement of the Notice was sent to five newspapers: Asbury Park Press, Camden Courier Post, Bergen Record/Herald News, Atlantic City Press, and Trenton Times.

   Notes from the Block Grant Committee meetings are available upon request, and the minutes from the general Planning Council meeting are available online at: http://www.state.nj.us/humanservices/dmhas/home/councils/bhpc_2015.html. The Planning Council also documented their recommendations in its letter, which is attached to the combined Mental Health and Substance Abuse Block Grant Application and Plan

2. What mechanism does the state use to plan and implement substance abuse services?

   Substance abuse services are planned based on a needs assessment process completed by the State. State funding is allocated to counties based on a funding formula. Substance Abuse Prevention and Treatment Block Grant funding is allocated to third party contracts and fee-for-service contracts for prevention, early intervention, treatment and recovery services based on the needs assessment. As needs emerge, new Requests for Proposals are drafted for contracts, which may be renewed annually, as needed.

3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?

   In 2014, the New Jersey Mental Health Planning Council voted to change its name to better reflect its purpose, and is now the New Jersey Behavioral Health Planning Council. This

State Fiscal Year membership was also reconstituted to greatly increase the representation of individuals impacted or associated with addiction services, fully integrating membership between mental health and addictions consumers and providers. Meeting topics routinely consist of addiction issues/topics, as is evident through the agendas and minutes that are posted on the Planning Council website at: http://www.state.nj.us/humanservices/dmhas/home/councils/bhpc_2015.html. The co-chair of the council represents the substance abuse prevention and treatment issues/concerns.

4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

   Members of the Community Mental Health Citizen's Advisory Board are appointed by the Governor of New Jersey. Planning Council members are appointed by Assistant Commissioner of the DMHAS. The Community Mental Health Citizen's Advisory Board and the Planning Council function together as a cohesive group as the Planning Council. The Planning Council's membership is geographically representative of the State, and reflects the diversity of the State. No more than 50% of the membership of the Planning Council consists of state or provider members. A minimum of 50% of the members of the Planning Council are individuals in recovery, family members of individuals in recovery (including adults with serious mental illnesses (SMI), family members adults with SMI or children with severe emotional disturbances (SED) or other non-state or non-provider members.

   The membership includes individuals in recovery from co-occurring disorders, recovery from addiction, providers that offer either or both mental health and addiction services, state agencies, tobacco and addiction prevention expertise, the County Drug and Alcohol Director's Association, County Mental Health Administrators Association, community wellness centers, Citizen's Advisory Council (CAC), etc. This State Fiscal Year membership was reconstituted to greatly increase the representation of individuals impacted or associated with addiction services. A number of provider agency Planning Council representatives are consumer/survivors, giving consumers an even greater participation than reflected in the Planning Council Membership Composition Chart. Many of the Planning Council representatives are actively involved in other Councils, Committees or Advocacy activities throughout the State. These unique qualities of the Planning Council foster interagency collaboration, coordination of services, and alliances with other Councils and Committees.

5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

   The purposes of the combined Council include: (1) to review New Jersey's Federal Community Mental Health Services Block Grant and Substance Abuse Prevention and Treatment Block Grant plans each year before submission and to make recommendations for improving the plans to the Assistant Commissioner of the New Jersey Division of Mental Health and Addiction Services (the Division), (2) to serve as an advocate for consumers concerning State policy, legislation, and regulations affecting behavioral health, (3) to monitor, review, and evaluate the allocation and adequacy of behavioral health

services in New Jersey,(4) to advise the Department of Human Services (Department) and the Division concerning the need for, and quality of, services and programs for persons with behavioral health disorders in the state, (5) to advise the Assistant Commissioner concerning proposed and adopted plans affecting behavioral health services provided or coordinated by the Division and the implementation thereof, (6) as appropriate, to assist in the development of strategic plans for behavioral health services in the State and advocate for the adoption of such plans to other state departments or branches of government, and (7) to exchange information and develop, evaluate, and communicate ideas about mental health, substance abuse and co-occurring planning and services. In accomplishing these purposes the Council makes use of a State Planning Council Liaison, accesses information about planning and provision of behavioral health services by the Division and various state departments, stays informed on national and international perspectives, and advises the Division on coordination of services among various private and public providers.

The Planning Council gathers input from people in recovery, families and other important stakeholders through means of the meetings being open to the public. Guests routinely join the meetings to ask questions or become more informed about behavioral health services in the State. In addition, the Planning Council also makes use of a telephone call-in feature to make the meetings as accessible as possible. The Planning Council advocates for individuals with SMI and SED in various ways, from presenting personal insights to presenters during the general meeting, to writing letters for/against programs, and having the Advocacy Committee focus on topics of interest such as stricter enforcement of regulations regarding boarding homes.

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES
222 SOUTH WARREN STREET
PO BOX 700
TRENTON, NJ 08625-0700

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

ELIZABETH CONNOLLY
Acting Commissioner

VALERIE L. MIELKE, MSW
Assistant Commissioner

August 28, 2015

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, MD 20850

RE: New Jersey's Combined Community Mental Health and Substance Abuse Prevention and Treatment Block Grant for FY 2016-2017

Dear Ms. Simmons:

On behalf of the New Jersey Behavioral Health Planning Council (herein referred to as the Planning Council), I am pleased to submit this letter of endorsement for the combined Community Mental Health and Substance Abuse Prevention and Treatment Block Grant application for 2016-2017 submitted by the New Jersey Division of Mental Health and Addiction Services (DMHAS). The Planning Council meets monthly, and in addition to regular presentations of interest to members about services and programs throughout the State, the Planning Council has focused much time on the review of the application components.

The Planning Council has had the opportunity to review and provide input regarding the Combined Block Grant Application. Specifically, the Planning Council provided feedback regarding the unmet needs and gaps of the service system which has been incorporated into the Combined Block Grant Application. The Planning Council received presentations at our Block Grant Subcommittee meetings, as well as at the general membership meetings on the content being developed and the tables being completed. In addition, by using the WebBGAS Citizen's log in, the Planning Council members have had the opportunity to review the Combined Block Grant Application prior to the State's submission.

The Planning Council will continue to evaluate and monitor the implementation of the Block Grant funding and make recommendations as needed. The Planning Council meetings are “Open Public Meetings” and as a result the public at large has also had the opportunity to comment on this submission either in person or on BGAS.

Sincerely,

Phillip Lubitz, Chair
New Jersey Behavioral Health Planning Council

C: Valerie Mielke, DMHAS
Elizabeth Manley, Children’s System of Care
Roger Borichewski, DMHAS
Donna Migliorino, DMHAS
Suzanne Borys, DMHAS
Geri Dietrich, Children’s System of Care

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2016

End Year: 2017

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Jacob Bucher	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Collaborative Support Programs of NJ, Inc.		
Winifred Chain	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Joseph Delany	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Lisa Negron	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Karen Vogel-Romance	Providers	Jersey Shore University Medical Center		
Annette Wright	Providers	COMHCO		
Donna Hallworth	State Employees	New Jersey Department of Education		
Bruce Blumenthal	State Employees	NJ Housing Mortgage and Finance Agency		
Robert Paige	State Employees	NJ Department of Labor, Vocational Rehabilitation, DVRS		
Irina Stuchinsky	State Employees	NJ Division of Medical Assistance and Health Services (Medicaid)		
Mary Ditri	Providers	NJ Hospital Association		
Maryanne Evanko	Parents of children with SED			
Angel Gambone	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Independent Survivors		
Bianca Ramos	State Employees	NJ Juvenile Justice Commission		
Marilyn Goldstein	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Joseph Gutstein	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Renee Ingram	State Employees	NJ Division of Family Development (Social Services)		

Michael Ippoliti	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	
Barbara Johnston	Providers	Mental Health Association in New Jersey
Gail Levinson	Providers	Supportive Housing Association
Philip Lubitz	Others (Not State employees or providers)	National Alliance on Mental Illness of NJ (NAMI)
Christopher Lucca	State Employees	New Jersey Department of Corrections
Patricia Matthews	State Employees	Division of Aging
Michelle Madiou	Others (Not State employees or providers)	NJ Association of County Mental Health Admin.
Linda Meyer	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	
Joanne Oppelt	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	
Thomas Pyle	Parents of children with SED	
Regina Sessoms	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Self Help Center, Brighter Day
Robin Weiss	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Consumer Provider Association of NJ
Debra Wentz	Providers	New Jersey Association of Mental Health and Addictions Agencies, Inc.
Marie Verna	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	
Helen Williams	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Collaborative Support Programs of NJ
John Calabria	State Employees	NJ Department of Health
Ellen Taner	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Citizen's Advisory Council
John Pellicane	Others (Not State employees or providers)	County Drug and Alcohol Directors Association
Connie Greene	Providers	Barnabas Health- Institute for Prevention
Harry Coe	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	
Ernst DeHaas	Others (Not State employees or providers)	
Tonia Ahern	Family Members of Individuals in Recovery (to include family members of adults with SMI)	
Christina Fagan	Parents of children with SED	

James Fowler	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Joseph Gutstein	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Sharon Harrigan	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Scott Kelsey	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Michael Litterer	Providers	Prevention Links		
Dan Meara	Others (Not State employees or providers)	National Council on Alcoholism and Drug Dependence - NJ		
Pam Nickisher	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Linda Sacco	Providers	Barnabas Health		
Brenda Sorrentino	Parents of children with SED			
Pamela Taylor	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Joy Tozzi	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
LeeAnn Wagner	Providers	Community YMCA		
Rocky Schwartz	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Valerie Mielke	State Employees		222 South Warren Street Trenton , NJ 08625 PH: 609-777-0702	Valerie.Larosiliere@dhs.state.nj.us

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2016

End Year: 2017

Type of Membership	Number	Percentage
Total Membership	54	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	19	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	6	
Parents of children with SED*	4	
Vacancies (Individuals and Family Members)	0	
Others (Not State employees or providers)	5	
Total Individuals in Recovery, Family Members & Others	34	62.96%
State Employees	10	
Providers	10	
Federally Recognized Tribe Representatives	0	
Vacancies	0	
Total State Employees & Providers	20	37.04%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	5	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	5	
Persons in recovery from or providing treatment for or advocating for substance abuse services	18	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

The Block Grant Committee of the Planning Council reviewed and assisted with the FFY 2016-2018 combined Mental Health and Substance Abuse Block Grant Application and Plan, as well as monitored the Behavioral Health Implementation Reports submitted December 2014. The Block Grant Committee met on October 10, 2014 and November 12, 2014 to review the Implementation Reports, and provided updates at the general Planning Council meeting on the progress of the reports. The Block Grant Committee also met June 10, 2015, July 8, 2015 and August 12, 2015 to review and assist with crafting the combined Mental Health and Substance Abuse Block Grant Application and Plan, providing updates to the general council each month on its status. Notes from the Block Grant Committee meetings are available upon request, and the agenda and minutes from the general Planning Council meeting are available online at:

http://www.state.nj.us/humanservices/dmhas/home/councils/bhpc_2015.html. The Planning Council also documented their recommendations in its letter, which is attached to the combined Mental Health and Substance Abuse Block Grant Application and Plan

Footnotes:

Substance Abuse and Mental Health Services Administration
SAMHSA
1 Choke Cherry Road • Rockville, MD 20857
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

JUL 7 2015

Mr. Lynn Kovich
New Jersey Division of
Health and Addiction Services
222 South Warren Street, 3rd Floor
Trenton, NJ 08625

Dear Mr. Kovich:

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) invites you to apply for the Mental Health Block Grant (MHBG) for federal fiscal year (FY) 2016. The FY 2016-2017 Uniform Application (0930-0168), which will serve as the application to the Secretary for the MHBG for FY 2016, must include funding agreements, assurances, certifications and planning tables for FY 2016.

The FY 2016-2017 Uniform Application is available electronically via the Block Grant Application System (Web-BGAS). An Adobe Acrobat version of the FY 2016-2017 Uniform Application may be downloaded from SAMHSA's block grant website. A copy of the authorizing legislation (42 USC § 300x-21 et seq) available on Web-BGAS under the Frequently Asked Questions section as well as SAMHSA's block grant website.

The FY 2016 Justification of Estimates for Appropriations Committees, includes a table of the estimated State/Territory allotments for the FY 2016 MHBG. However, a final FY 2016 Departments of Labor, Health and Human Services, Education (Labor-HHS-ED) and Related Agencies appropriations bill is pending. Upon enactment of the FY 2016 appropriations for Labor-HHS-ED and related agencies, a final allotment table for FY 2016 MHBG will be sent to you and uploaded on BGAS. In the interim, please refer to the enclosed FY 2016 MHBG allocation as authorized by the Consolidated Appropriations Act, 2016 (P.L. 112-74) for purposes of completing the FY 2016 Intended Use Plan (Table 7) and related planned expenditure checklists (Table 6 & Table 8).

All states and jurisdictions are required to prepare and submit their respective FY 2016-2017 Uniform Applications on or before September 1, 2015. All states and jurisdictions are required to execute the "Application Complete" function not later than Tuesday, September 1, 2015 at 11:59 p.m. EST. When a state or jurisdiction executes the "Application Complete" function, the Web-BGAS records "Application Completed by State User." This is SAMHSA's only evidence that a state or jurisdiction has complied with the statutory requirement regarding the September 1 receipt date.

Any state or jurisdiction planning to submit a combined FY2016-2017 Uniform Application must execute the "Application Complete" function not later than Tuesday, September 1, 2015 at 11:59 p.m. SAMHSA's block grant programs are subject to an annual audit pursuant to the Office of Management and Budget Circular A-123, "Management's Responsibility for Internal Controls," and one of the controls involves a review of how SAMHSA ensures states' and jurisdictions' compliance with the statutory receipt dates as described in sections 1917(a)(1) and 1932(a)(1) of Title XIX, Part B, Subpart I and Subpart II of the PHS Act, respectively.

The contact person for questions related to MHBG business management issues is:

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, Maryland 20857
TEL. (240) 276-1422

Please submit a single copy of the Funding Agreements, Assurances Non-Construction Programs, Certification and Lobbying Disclosure Form, signed by the state's chief executive officer or designee, to SAMHSA and upload an electronic copy to Web-BGAS using the Attachments Tab. If one or more of the documents described above is signed by a designee, please include a current delegation of authority letter(s) from the state's chief executive officer. Forwarding any paperwork related to the FY 2016-2017 Uniform Application to any other addressee results in processing delays. To ensure express/overnight mail delivery, please use the following address:

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, 7-1109
Rockville, Maryland 20850
Telephone: (240) 276-1422

Questions of a fiscal or programmatic nature should be directed to your respective State Project Officer within CMHS's Division of State and Community Systems Development. Enclosed is a State project officer directory.

Sincerely,

Paolo del Vecchio, M.S.W.
Director
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration

cc: Donna Migliorino
Geraldine Dietrich
Phil Lubitz

Enclosures:
2016 MHBG Prospective Allotments
MHBG Project Officer Directory