I: State Information

State Information

State DUNS Number

Number	80-641-825
Expiration Date	

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

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

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

From	7/1/2013
To	6/30/2014

IV. Date Submitted

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

Submission Date	11/25/2014 12:17:46 PM
Revision Date	

V. Contact Person Responsible for Report Submission

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II: Annual Report

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

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.

Strategies to attain the goal:

• 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.
• Continuing contract with the community-based provider in Mercer County for the outstation of substance abuse counselors in four Health Care Centers that provide substance abuse screenings using the 4 P's Plus, assessment, case management and referrals to treatment for pregnant women.
• 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."
• During 2014, DMHAS will be integrating the CHOICES program, an evidence based intervention designed for women about choosing healthy behaviors to avoid alcohol –exposed pregnancies for use in by licensed substance abuse treatment providers serving pregnant and parenting women.
• 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.

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: 9816 estimated for FY 2013

First-year target/outcome measurement: Increase number of pregnant women or women with children receiving substance abuse treatment in 2014 by 2%.

Second-year target/outcome measurement: Increase number of pregnant women or women with children receiving substance abuse treatment by 5% by the end of 2015. The change in FY 2015 will be measured by calculating the percent difference from 2013 to 2015.

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

Data Source:

The number pregnant women and women with children in SFY 2014– 2015 (and beyond) will be tracked by the SSA's New Jersey Substance Abuse Monitoring System (NJSAMS).

New Data Source*(if needed)*:

Description of Data:

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

discharge.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

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

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Priority #: 2

Priority Area: 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.

Strategies to attain the goal:

• 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 medication assisted treatment (e.g., methadone, buprenorphine, Vivitrol) for opiate dependent individuals.
• Educating providers and clients about the benefits of MAT.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of IVDUs who obtain MAT in combination with other treatment modalities

Baseline Measurement: 10,081 estimate for FY 2013

First-year target/outcome measurement: Increase the number of IVDUs who obtain MAT in combination with other treatment modalities by 2%.

Second-year target/outcome measurement: Increase the number of IVDUs who obtain MAT in combination with other treatment modalities by 5% by the end of 2015. The change in FY 2015 will be measured by calculating the percent difference from 2013 to 2015.

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

Data Source:

The number of IVDUs in SFY 2014 and 2015 will be tracked by the SSA's NJSAMS.

New Data Source*(if needed)*:

Description of Data:

All agencies licensed to provide substance abuse treatment in New Jersey must report on NJSAMS, the SSA's real-time web-based client

administrative data system. The system collects basic client demographic, financial, level of care and clinical information for every client. All NOMS are incorporated into the system. Outcome measures are linked to the client at admission and discharge.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

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

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Indicator #:	2
Indicator:	Increase the number of opiate dependent individuals who obtain MAT in combination with other treatment modalities
Baseline Measurement:	17,798 estimate for FY 2013
First-year target/outcome measurement:	Increase the number of opiate dependent individuals who obtain MAT in combination with other treatment modalities by 2%.
Second-year target/outcome measurement:	Increase number of opiate dependent individuals who obtain MAT in combination with other treatment modalities by 5% by the end of 2015. The change in FY 2015 will be measured by calculating the percent difference from 2013 to 2015.

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

Data Source:

The number opiate dependent individuals in SFY 2014 and 2015 will be tracked by the SSA's NJSAMS.

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

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

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Priority #: 3

Priority Area: 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.

Strategies to attain the goal:

• Expend 5% of the SAPTBG award for HIV Early Intervention Services.
• Continue MOA with the University of Medicine and Dentistry of New Jersey (UMDNJ) for Rapid HIV Testing.
• Provide funding to the DOH Public Health and Environmental laboratory (PHEL) for laboratory services.
• Conduct web-based survey of agencies to assess where HIV testing services are most needed and their interest in providing such services.
• Coordinate and provide trainings/conferences in regards to the provision of best practices in HIV testing and counseling services for DMHAS licensed agencies (e.g., motivational interviewing).
• Develop data sharing agreement with the Department of Health (DOH).
• Provide de-identified data to DOH to match against their HIV/AIDS database to determine the number of infected or at risk clients in substance abuse treatment.

Annual Performance Indicators to measure goal success

Indicator #: 3

Indicator: Increase the number of agencies engaged in the Rapid HIV Testing Initiative in 2015

Baseline Measurement: 24 sites

First-year target/outcome measurement: 30 sites

Second-year target/outcome measurement: 34 sites

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

Data Source:

DOH HIV database, NJSAMS and UMDNJ agency listing

New Data Source *(if needed)*:

Description of Data:

Data on the number of SSA licensed agencies engaged in the Rapid HIV Testing initiative is provided by UMDNJ. The change in FY 2015 will be measured by calculating the percent difference from FY 2013 to FY 2015.

New Description of Data: *(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Priority #: 4

Priority Area: Underage Drinking

Priority Type: SAP

Population(s): Other (Persons aged 12 - 20)

Goal of the priority area:

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

Strategies to attain the goal:

Beginning in January, 2012, DMHAS funded 17 Regional Prevention Coalitions, all of whom utilize the SPF model to guide their work. These coalitions are all required to address underage drinking. 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: 29.94% of the target population reported drinking any alcohol during the month prior to participating in the survey (NSDUH, 2010-2011)

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.

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

Data Source:

National Survey on Drug Use and Health (NSDUH), 2010-2011 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

New Data Source *(if needed)*:

Description of Data:

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

New Description of Data: *(if needed)*

Data issues/caveats that affect outcome measures:

None.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Priority #: 5

Priority Area: Suicide Prevention Hotline

Priority Type: MHP

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.

Strategies to attain the goal:

DMHAS issued an RFP for a Suicide Prevention Hotline on 12/13/12. In early 2013, this RFP was awarded to the University Behavioral Healthcare (UBHC) for the development of a NJ-based suicide hotline to be answered by a trained staff member or volunteer and to accept calls that are routed by the National Suicide Prevention Lifeline Network (NSPLN). The phone number was launched on o May 1, 2013 and is 855—NJHOPELINE (855-654-6735).

This "Hopeline" serves as suicide prevention hotline, similar to the NSPLN, but located in New Jersey, with 27/7 coverage, and it will have clinical supervisors whom are familiar with the constellation of New Jersey behavioral health resources. In addition, the Hope Line will be a backup to the current active Lifeline Crisis Centers hotline and it will receive and answer calls that are transferred by Lifeline that cannot be answered by these entities during times of excess call volume or after the Lifeline Crisis Centers' operating hours. To better describe this in sequential terms, the NSPLN is the 'first line of defense'--the default for handling 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.

One of the reasons that the NJ Hopeline was created was to avoid the need for a third entity, (and one located outside of New Jersey) to handle excess suicide prevention calls.

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:	Due to the start of the newly-operational NJ Hopeline, no baseline/SFY 2013 data will be available.
First-year target/outcome measurement:	The target/outcome measurement for SFY 2014 is for the newly-created, DMHAS-funded, "NJ Hopeline" suicide prevention hotline to answer 85% 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 (see footnote 2)). NJ Hopeline is contracted to provide 25,194 calls for the year.
Second-year target/outcome measurement:	In year two of the grant award (SFY 2015) this benchmark will be increased to 90%.

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

In SFY 2015, SMHA's goal is consistent with what was achieved in SFY14. That is 98.4%. NJ Hopeline is contracted to provide 25,200 calls in SFY2015.

Data Source:

In October 2013, the SMHA will receive 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.

New Data Source *(if needed)*:

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 is looking forward to receiving both raw and summary call data from both NSPLN and NJ Hopeline on a quarterly basis. It is anticipated that both datasets will include: dates of calls, lengths of calls, call source data, dispositions, and frequencies of all diversion.

New Description of Data: *(if needed)*

Data issues/caveats that affect outcome measures:

In the summer of 2013, DMHAS will begin reviewing NSPLN call record data to learn about the format and quality of the data. The New Jersey Hopeline began operations on May 1, 2013 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.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

The New Jersey Hopeline began operations on May 1, 2013. From 5/1/2013 to 8/31/2014, NJ Hopeline handled over 25,000 calls. The call volume it handled has been increasing by month during the same period of time.

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).

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.

Strategies to attain the goal:

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. Improvements in the SMHA's data infrastructure—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).

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increased number of individuals served by Supportive Housing

Baseline Measurement: The number of consumers served by Supportive Housing in SFY 2013 is estimated to be approximately 4,792 (see footnote 1).

First-year target/outcome measurement: The number of consumers served by Supportive Housing in SFY 2014 is estimated to be 4,900.

Second-year target/outcome measurement: In SFY 2015 this number will be increased 2% to a total of 5,000 individuals served by Supportive Housing.

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

In SFY 2013, 5,353 clients were served. In SFY 2014: 5,531 clients were served. In SFY 2015 this number will increase 2% to a total of 5,650 individuals served.

Data Source:

The number of consumers served by Supportive Housing in SFY 2014 – 2015 (and beyond) will be tracked by the SMHA's QCMR database.

New Data Source *(if needed)*:

Description of Data:

The QCMR Database collects quarterly, cumulative, program-specific data from each of the service providers contracted by 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 46 agencies contracted by the SMHA provide QCMR data for Supportive Housing.

New Description of Data: *(if needed)*

In SFY 2014, 44 agencies were contracted by the SMHA to 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 nor unreasonably. Failure to reach performance indicators may also result in contract contingencies or termination

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Indicator #: 2

Indicator: Creation of additional community-based supportive housing beds

Baseline Measurement: At the time of writing, 292 supportive housing beds were created in SFY 2013.

First-year target/outcome measurement: In SFY 2014, the SMHA will develop no fewer than 250 community-based supportive housing beds.

Second-year target/outcome measurement: Due to the exigencies of the court-mandated Olmstead Settlement that expires at the end of SFY 2014, the SMHA is not currently able to indicate the number of community-based supportive housing beds that will be created in SFY 2015.

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

The SMHA is committed to enhance access to supportive housing and will continue to develop additional supportive housing placements in the community.

Data Source:

The SMHA, in collaboration with the DHS Office of Licensing will continue to provide updates on the development of community-based supportive housing beds. Specifically, internal SMHA contracting data will be used for the baseline measurement and for the first-year target outcomes. In the second year, this data will be buttressed by the SMHA's forthcoming Bed Enrollment Data System (BEDS) which is expected to be operational by early SFY 2014.

New Data Source *(if needed)*:

There was a delay in the launch of the SMHA's Bed Enrollment Data System (BEDS). The new BEDS system will become operational by the end of calendar year 2014.

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").

New Description of Data: *(if needed)*

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). The total number of beds to be developed from SFY 2010 through SFY 2014 is targeted to be 1065 in accordance with the Olmstead Settlement Agreement.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

The total number of community-based supportive housing beds created in SFY2014 was 352. Among these beds, a total of 148 were for CEPP population. A total of 101 beds were for at-risk population. There were an additional 103 beds created in SFY2014 for non-specific hospital population. While these placements were not specifically developed for CEPP consumers, they were available to be utilized by CEPP consumers.

Indicator #: 3

Indicator:	Increased technical assistance activities to be delivered to providers of Supportive Housing (SH). Overview- the SMHA is currently in negotiation with the University Behavioral Health Care (UBHC) School of Health-Related Professions (SHRP) to provide technical assistance for SH providers to facilitate better community integration of consumers of SH services. In SFY 2014, the SMHA will contract with SHRP to provide two separate tracks of Technical Assistance 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 will be geared toward direct care providers and is to provide training in core competencies. Both tracks of TA will be conducted in a series of trainings to be conducted over the course of a year. In addition, the TA will attempt to facilitate training communities (peer networks of SH supervisors and direct care staff) in order to refine, deepen and expand the understanding of the concepts taught in the TA sessions themselves.
Baseline Measurement:	Not relevant. The Technical Assistance to Supportive Housing Programs will be a new initiative with no antecedents.
First-year target/outcome measurement:	To be determined. The SMHA plans to contract SHRP to provide TA to a specific number of either agencies, or personnel. (The exact number has yet to be determined through vendor contract negotiations).
Second-year target/outcome measurement:	To be determined (See above).

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

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).

New Data Source *(if needed)*:

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.

New Description of Data: *(if needed)*

Data issues/caveats that affect outcome measures:

The manner at which the outcome measures are to be established, quantified and reported on have yet to be determined (contingent on direct negotiations between the SMHA and UBHC-SHRP to occur in mid-May 2013).

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Significant progress towards the implementation of Community Support Services (CSS) here in NJ has been made. The Rutgers, School of Health Related Professions (SHRP) has completed an in depth four month CSS training to 100 supervisors of Supportive Housing throughout the state. In the week of September 8, 2014, SHRP had kicked off an in depth CSS training series for 120 Supportive Housing direct care workers. In addition, SHRP along with a DMHAS staff person have begun to conduct 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.

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 self-help centers (SHCs) throughout New Jersey.

Strategies to attain the goal:

Provide a wide range of peer delivered wellness and recovery activities at DMHAS sponsored self-help centers statewide. Encourage participation by publicizing planned activities in monthly activity calendars, discussing at center community meetings, networking with DMHAS self-help 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: Not available. The SMHA has not recently performed comparable studies of these performance indicators.

First-year target/outcome measurement: In SFY 2014, 80% of individuals participating in Consumer Operated Services will participate 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.).

Second-year target/outcome measurement: In SFY 2015, 83% of individuals participating in Consumer Operated Services will participate in wellness/recovery activities

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

Data Source:

This performance indicator will be measured through use of the Self-Help Outcome Utilization Tracking (SHOUT) data application. SHOUT is used by 30 DMHAS-funded and community-based, self-help centers to track member participation at SHCs through a unified, individual record system specifically designed for self-help centers.

New Data Source *(if needed)*:

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 self-help centers to track member participation at self-help centers through a unified, individual record system specifically designed for self-help centers. Among the 33 DMHAS-funded self-help centers, three are hospital-based and thirty 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, self-help center staff will input and monitor self-help center member participation in wellness and recovery activities statewide through the use of SHOUT™. Electronic surveys will be administered annually with self-help center members and in combination with SHOUT utilization data which will be used to assess performance against the stated indicator.

New Description of Data: *(if needed)*

Data issues/caveats that affect outcome measures:

Differential submission of SHOUT data by the SHCs may impact the timing of quarterly reports. Due to the independent nature of the Self-Help Centers themselves, the completeness and comprehensiveness of SHOUT data is expected to vary considerably from center to center.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

The target that was set for SFY 2014 of 80% of individuals engaged in consumer-operated services participating in wellness/recovery activities has been achieved. In SFY 2014, there were a total of 7,026 unduplicated individuals participating in DMHAS sponsored and funded self-help/wellness centers across the state. The number of attendees in most of the mutual aid self-help support groups offered at the centers was tracked; while in other groups, in order to protect the anonymity of the members, the number of participants was not included in the total count. A count of 4,306 unduplicated individuals—which amounts to 61.27%--participated in wellness/recovery activities through support groups which were being tracked. Because of the anonymity factor, the number of attendees in the anonymous support groups was unknown and unrepresented. However, almost all of the 33 centers offer at least one anonymous support group to its membership. These support groups are very popular and remain highly attended. Thus, if the number of attendees of these groups had been represented in the count of participants in wellness/recovery activities, the percentage of individuals participating in wellness/recovery activities would have exceeded the 80% target.

Priority #: 8

Priority Area: Access to community-based services for children, youth and young adults with a dual diagnosis of DD/ID and behavioral health

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Increase access to community-based services for children, youth and young adults with a dual diagnosis of DD/ID and behavioral health challenges.

Strategies to attain the goal:

DCSOC will continue to expand its community-based services throughout the State of New Jersey in SFY 2014 and 2015 in order to increase the total number of children, youth and young adults and the number of children, youth, and young adults with SED provided services through DCSOC. Community based services include both in-home and out of home services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: In SFY 2014, DCSOC will develop a baseline of the number of children, youth and young adults with DD/ID and behavioral health challenges served.

Baseline Measurement: The total number of children, youth and young adults enrolled by DCSOC during SFY 2012 was 35,859. The number of children, youth and young adults with SED receiving DCSOC services during SFY 2012 was 27,028. The transition of services for children, youth and young adults with developmental disabilities and/or intellectual disabilities and behavioral health challenges to the DCF began on January 1, 2013.

First-year target/outcome measurement: 5% increase in 2013 baseline of children, youth and young adults with DD/ID and behavioral challenges.

Second-year target/outcome measurement: 5% increase in 2014 number of children, youth and young adults served by DCSOC.

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

Data Source:

DCSOC will utilize the CYBER database to collect enrollment data.

New Data Source *(if needed)*:

Description of Data:

The total number of children, youth and young adults enrolled by DCSOC as well as the number of children, youth and young adults with SED served during SFY 2013 will be reported in the SFY 2013 Implementation Report. Additionally DCSOC will provide a 6-month baseline measurement of children, youth and young adults with DD/ID and behavioral health challenges.

New Description of Data: *(if needed)*

Data issues/caveats that affect outcome measures:

Access to community-based services for children, youth and young adults with a dual diagnosis of substance abuse and behavioral health will be transitioned to DCSOC beginning July 1, 2013. At the close of SFY 2014 DCSOC will provide a baseline of the number of

children, youth and young adults with substance abuse and behavioral health challenges served. The addition of this population to DCSOC services will impact the total number of children, youth and young adults served.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

Baseline indicates 2143 youth with ID/DD and Behavioral Health challenges were served by CSOC during SFY 2014. This indicates a 41% increase over January 1 - June 30, 2013.

Priority #: 9

Priority Area: Provision of in-state, community-based specialty treatment services to children, youth and young adults with specialized treatment needs.

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Provide in-state services to children, youth and young adults with specialized treatment needs.

Strategies to attain the goal:

Continue to identify gaps in service for children, youth and young adults with specialized treatment needs. Develop in-state services and supports to address the needs of children, youth and young adults with specialized treatment needs including, but not limited to: deaf/hard of hearing, mental illness/developmental disabilities and/or medical challenges.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: In SFY 2014, DCSOC will continue to decrease the number of children, youth, and young adults receiving treatment for specialized needs out of state.

Baseline Measurement: At the close of SFY 2012, four youth requiring services for deaf/heard of hearing continued to receive services in an out of state treatment setting.

First-year target/outcome measurement: SFY 2014 will use the same database to measure a specified percentage of change.

Second-year target/outcome measurement: SFY 2015 will use the same database to measure a specified percentage of change.

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

Data Source:

DCSOC will utilize reports generated by the CYBER database and the DCSOC Special Residential Treatment Unit (SRTU), which facilitates all referrals to out of state treatment settings.

New Data Source *(if needed)*:

Description of Data:

CYBER and SRTU reports will identify gaps in services and the array of services needed to develop in-state capacity.

New Description of Data: *(if needed)*

Data issues/caveats that affect outcome measures:

DCSOC anticipates the transition of new populations (DD/ID and youth with substance abuse challenges) to increase the number of children, youth and young adults requiring specialized treatment services.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

Two (2) youth with hearing impairment and behavioral health challenges remain in treatment out of state. DCSOC is working in coordination with the NJ Department of Human Services, Division of the Deaf on the developmental of a residential program on the grounds of the Marie Katzenbach School for the Deaf in Ewing, New Jersey. A contract has been awarded however opening of the program is delayed due to antiquated plumbing, which is in the process of being replaced.

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

Priority #: 10

Priority Area: Youth Suicide

Priority Type: MHP

Population(s): SED

Goal of the priority area:

Decrease youth suicide attempts and completions.

Strategies to attain the goal:

The Traumatic Loss Coalition (TLC) for Youth Program at UBHC provides 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: DCSOC/TLC will continue to increase the number of school personnel trained in Suicide Awareness Training for Educators.

Baseline Measurement: The number of school personnel trained during SFY 2013 will serve as baseline.

First-year target/outcome measurement: SFY 2014 will use the same database to measure a specified percentage of change.

Second-year target/outcome measurement: SFY 2015 will use the same database to measure a specified percentage of change.

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

Data Source:

DCSOC will utilize reports generated by the Traumatic Loss Coalition (UMDNJ).

New Data Source*(if needed)*:

Description of Data:

The number of school personnel trained during given SFY.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

During SFY 2014, 3503 Educators were trained in Suicide Awareness Training for Educators. During SFY 2013, 3342 Educators were trained in Suicide Awareness Training for Educators. This represents an increase of 5%.

footnote:

Priority areas (#1 to #4) of the Single State Authority (Substance Abuse) are not applicable to this report.

III: Expenditure Reports

MHBG Table 3 - MHBG Expenditures By Service.

Expenditure Period Start Date: 7/1/2013   Expenditure Period End Date: 6/30/2014

Service	Unduplicated Individuals	Units	Expenditures
Healthcare Home/Physical Health			$0
Specialized Outpatient Medical Services			$0
Acute Primary Care			$0
General Health Screens, Tests and Immunizations			$0
Comprehensive Care Management			$0
Care coordination and Health Promotion			$0
Comprehensive Transitional Care			$0
Individual and Family Support			$0
Referral to Community Services Dissemination			$0
Prevention (Including Promotion)			$0
Screening, Brief Intervention and Referral to Treatment			$0
Brief Motivational Interviews			$0
Screening and Brief Intervention for Tobacco Cessation			$0
Parent Training			$0
Facilitated Referrals			$0
Relapse Prevention/Wellness Recovery Support			$0
Warm Line			$0
Substance Abuse (Primary Prevention)			$0
Classroom and/or small group sessions (Education)			$0
Media campaigns (Information Dissemination)			$0
Systematic Planning/Coalition and Community Team Building(Community Based Process)			$0
Parenting and family management (Education)			$0

Education programs for youth groups (Education)			$0
Community Service Activities (Alternatives)			$0
Student Assistance Programs (Problem Identification and Referral)			$0
Employee Assistance programs (Problem Identification and Referral)			$0
Community Team Building (Community Based Process)			$0
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental)			$0
Engagement Services			$0
Assessment			$0
Specialized Evaluations (Psychological and Neurological)			$0
Service Planning (including crisis planning)			$0
Consumer/Family Education			$0
Outreach			$0
Outpatient Services			$0
Evidenced-based Therapies			$0
Group Therapy			$0
Family Therapy			$0
Multi-family Therapy			$0
Consultation to Caregivers			$0
Medication Services			$0
Medication Management			$0
Pharmacotherapy (including MAT)			$0
Laboratory services			$0
Community Support (Rehabilitative)			$0
Parent/Caregiver Support			$0
Skill Building (social, daily living, cognitive)			$0
Case Management			$0

Behavior Management			$0
Supported Employment			$0
Permanent Supported Housing			$0
Recovery Housing			$0
Therapeutic Mentoring			$0
Traditional Healing Services			$0
Recovery Supports			$0
Peer Support			$0
Recovery Support Coaching			$0
Recovery Support Center Services			$0
Supports for Self-directed Care			$0
Other Supports (Habilitative)			$0
Personal Care			$0
Homemaker			$0
Respite			$0
Supported Education			$0
Transportation			$0
Assisted Living Services			$0
Recreational Services			$0
Trained Behavioral Health Interpreters			$0
Interactive Communication Technology Devices			$0
Intensive Support Services			$0
Substance Abuse Intensive Outpatient (IOP)			$0
Partial Hospital			$0
Assertive Community Treatment			$0
Intensive Home-based Services			$0
Multi-systemic Therapy			$0

Intensive Case Management			$0
Out-of-Home Residential Services			$0
Children's Mental Health Residential Services			$0
Crisis Residential/Stabilization			$0
Clinically Managed 24 Hour Care (SA)			$0
Clinically Managed Medium Intensity Care (SA)			$0
Adult Mental Health Residential			$0
Youth Substance Abuse Residential Services			$0
Therapeutic Foster Care			$0
Acute Intensive Services			$0
Mobile Crisis			$0
Peer-based Crisis Services			$0
Urgent Care			$0
23-hour Observation Bed			$0
Medically Monitored Intensive Inpatient (SA)			$0
24/7 Crisis Hotline Services			$0
Other (please list)			$0

footnote:

III: Expenditure Reports

MHBG Table 4 - Set-aside for Children's Mental Health Services

State Expenditures for Mental Health Services		
Actual SFY 2008	Actual SFY 2013	Estimated/Actual SFY 2014
$162,677,110	$188,128,142	$178,610,941

States are required to not spend less than the amount expended in Actual SFY 2008. This is a change from the previous year, when the baseline for the state expenditures was 1994.

footnote:
$188,128,142 for SFY 2013 is an estimated number. The actual number will be provided on 12/1/15.
$178,610,941 for SFY 2014 is an estimated number. The actual number will be provided on 12/1/15.

III: Expenditure Reports

MHBG Table 7 - Maintenance of Effort for State Expenditures on Mental Health Services

Total Expenditures for SMHA		
Period (A)	Expenditures (B)	B1(2012) + B2(2013) 2 (C)
SFY 2012 (1)	$421,598,063	
SFY 2013 (2)	$449,718,759	$435,658,411
SFY 2014 (3)	$462,681,392	

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

	Yes		No	
SFY 2012	Yes	X	No	
SFY 2013	Yes		No	X
SFY 2014	Yes		No	X

If estimated expenditures are provided, please indicate when actual expenditure data will be submitted to SAMHSA: 12/1/2015

footnote: