Inventory and Need Assessment for New Jersey Behavioral Health

Pursuant to P. L. 2009, c.243 (*N.J.S.A. 30:4-177.63)*, this is a report to the Governor, the Senate Health, Human Services and Senior Citizens Committee, and the Assembly Human Services Committee concerning activities of the Department of Human Services (DHS) with respect to available mental health services for adults in New Jersey. A separate report on available mental health services for children in New Jersey will be issued by the Department of Children and Families (DCF).

The following are some of the statute's key provisions applicable to the Commissioner of the Department of Human Services:

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 people who are voluntarily admitted or involuntarily committed to inpatient facilities for individuals with mental illness in the State, and for people 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 Behavioral Health Planning Council, the Division of Developmental Disabilities of the DHS, 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 DHS and DCF 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 purposes of this Act. The Commissioner also shall 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. The first report shall be provided no later than 18 months after the effective date of this Act.

A. Inventory of Behavioral Health Services

A mechanism has been developed to inventory all public and private behavioral health services in New Jersey. Several approaches are utilized, as described below.

Mental Health

An inventory of all New Jersey mental health treatment and service providers under contract with the Division of Mental Health and Addiction Services (DMHAS) has been prepared, which lists every agency, the agency's address and type of service provided (e.g., inpatient, outpatient, residential, etc.), by county. Information pertaining to the mental health treatment and service providers under contract with the DMHAS is available in the form of a Mental Health Services Treatment Directory. This is available at http://tinyurl.com/MHPrograms.

The Substance Abuse and Mental Health Services Administration (SAMHSA) hosts a Behavioral Health Treatment Services Locator on its website at http://findtreatment.samhsa.gov/ for all mental health programs nationally which can be searched by state. The locator has extensive search and sorting capabilities. By entering an address, a city, or zip code, the user can locate specific types of programs within a geographic area.

The DMHAS also participates in an annual survey, conducted by Mathematica, known as the National Survey of Mental Health Services Survey (N-MHSS) and a National Directory of Drug and Alcohol Abuse Treatment Programs is published annually using information from the survey.

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

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

A comprehensive listing of the locations and contact information for the Division's 23 Designated Screening Centers (DSCs) and 12 Affiliated Emergency Services (AES) can be found at http://tinyurl.com/MHScreening. In compliance with department regulations N.J.A.C. 10:31 et seq., Designated Screening Centers are public or private ambulatory care services designed and authorized by DMHAS, and authorized to evaluate individuals for involuntary commitment in conformance with the provision of the Mental Health Screening Law (P.L. 1987, ch. 116). Screening Centers are responsible for providing emergency psychiatric assessment, evaluation crisis intervention and referral services for residents of a specified geographic area.

Substance Abuse

An inventory of all New Jersey licensed substance abuse treatment providers is available on the DMHAS website. The inventory is in the form of a searchable, Substance Abuse Treatment Directory. The Directory includes information regarding the agency's address, type of care and treatment provided and the identification of any special populations served. The Directory is available on the DMHAS website at https://njsams.rutgers.edu/dastxdirectory/txdirmain.htm. SAMHSA hosts a Behavioral Health Treatment Services Locator on its website at http://findtreatment.samhsa.gov/ for all substance abuse treatment programs nationally which can be searched by state. The locator has extensive search and sorting capabilities. By entering an address, a city, or zip code, the user can locate specific types of programs within a geographic area.

The DMHAS also participates in an annual survey, conducted by Mathematica, known as the National Survey of Substance Abuse Treatment Services (N-SSATS), and a National Directory of Drug and Alcohol Abuse Treatment Programs is published annually using information from the survey.

An inventory of all funded substance abuse prevention programs also has been prepared by DMHAS and is available on the internet at http://tinyurl.com/MHPrevention.

B. Methodology to Estimate Behavioral Health Services Need

Substance Abuse

DMHAS employs a variety of scientifically-valid methods for estimating substance abuse treatment needs. Primary among these are 1) surveys, 2) social indicator analysis, and 3) "synthetic" statistical estimation techniques, called modeling. For 23 years, New Jersey has used a household survey to estimate: 1) the prevalence of both legal and illegal substance use, 2) alcohol treatment need and 3) unmet treatment demand.

In 1993, DMHAS established a periodic, five year, telephone household survey of drug use and health and a periodic survey of middle school students. Originally, the household survey supported statewide needs assessment with a sample of 3,336 completed interviews of residents 18 years of age or older. By 2003, DMHAS expanded the household survey sample size to its current standard sampling plan of 700 household interviews per county. The latest survey was conducted in 2009 which included a stratified random sample of 14,678 households. The Household Survey is underway for 2016. The proportions derived from the 2009 survey are

applied to annual state and county population estimates obtained from the American Communities Survey of the U.S. Census Bureau.

The need for alcohol treatment is derived from a series of questions based on Diagnostic Statistical Manual (DSM) criteria. Questions address use, quantity, effect on behavior, symptoms experienced, associated health problems, etc. As noted above, proportions obtained are applied to state and county population estimates. While the same questions are asked for drug use, the household survey underestimates illegal drug use due to under-reporting of illicit drug abuse or dependence and, therefore, drug treatment need. As a result, a statistical technique known as the two-sample capture-recapture model is applied to illicit drug treatment unique admissions data to estimate drug treatment need at both the state and county levels. The admissions data for the model are obtained from the web-based New Jersey Substance Abuse Monitoring System (NJSAMS), DMHAS' real-time, administrative, client information system for substance abuse treatment. Together with the derived alcohol treatment need obtained from the household survey technique described above, DMHAS produces an annual estimate of treatment need that is used in the distribution of alcohol and drug abuse treatment funds.

The household survey is used to assess the prevalence of both legal and illegal substance use and the need and demand for substance abuse treatment. A random sample of households is interviewed that yields sample proportions of both alcohol and illicit drug use, and alcohol treatment need and demand that can be applied beyond the sample itself to the adult populations of New Jersey and individual counties to obtain estimates of alcohol treatment need and illicit drug use at both the state and county levels. The proportions thus obtained in 2009 are to be found in the technical appendix to the survey final report, "Estimated Numbers and Percents of Adults Meeting DSM-IV Criteria for Lifetime and Past Year Alcohol Dependence or Abuse in the New Jersey Household Population by County." The proportions are applied repeatedly to successive annual state and county population estimates obtained from the American Communities Survey of the U.S. Census Bureau.

Obtaining reliable substance abuse treatment need estimates is critical to the state's ability to promote a rational planning and resource allocation process. Due to procurement issues, the survey was not able to be fielded as planned in 2015. A request for proposal (RFP) must be developed by DMHAS which will need to be issued through the Treasury Department. As an interim measure, a smaller survey, which cannot provide county level estimates, but can provide a statewide estimate, is being conducted during Spring 2016 through a Memorandum of Agreement (MOA) with the Robert Wood Johnson Medical School.

In addition, every three years since 1999, DMHAS conducts a statewide survey of middle school students that measures prevalence of student use of alcohol and illicit drugs, as well as student perceptions of risk and protective factors for substance abuse operative in their lives. The latest middle school survey began in the Fall 2015 and is currently in field through December 2016.

Table 1 below presents the 2015 estimates of substance abuse treatment need for the state and each county.

Table 1					
2015 Estimate of Treatment Need for Alcohol and Drug Addiction					
County	2015 Adult Population	Need for Alcohol Treatment	Need for Drug Treatment	Total Need for Alcohol and Drug	Total Need as Percent of the County Adult Population
	[1]	[2]	[3]	[4=2+3]	[5]
Atlantic	212,246	23,941	16,291	40,232	19.0
Bergen	731,096	65,799	20,280	86,079	11.8
Burlington	349,375	24,037	17,255	41,292	11.8
Camden	389,323	30,367	21,640	52,007	13.4
Cape May	77,392	6,718	10,262	16,980	21.9
Cumberland	118,761	10,582	11,877	22,459	18.9
Essex	602,063	46,841	36,526	83,367	13.8
Gloucester	222,690	20,643	15,110	35,753	16.1
Hudson	536,495	33,692	20,310	54,002	10.1
Hunterdon	97,755	9,492	17,300	26,792	27.4
Mercer	288,941	38,198	13,673	51,871	18.0
Middlesex	652,538	43,655	22,807	66,462	10.2
Monmouth	484,111	59,691	25,632	85,323	17.6
Morris	384,622	45,270	13,035	58,305	15.2
Ocean	450,372	39,408	22,864	62,272	13.8
Passaic	385,231	22,074	14,383	36,457	9.5
Salem	49,611	3,914	4,743	8,657	17.5
Somerset	253,577	21,427	7,894	29,321	11.6
Sussex	111,358	12,506	17,348	29,854	26.8
Union	421,842	31,638	17,451	49,089	11.6
Warren	83,037	6,859	5,462	12,321	14.8
Total	**6,902,434**	**596,750**	**352,145**	**948,893**	**13.7**

[1] Source: U.S. Census Bureau, Population Division. 2015 Annual Estimates of Resident Population: April 1 2010 to July 1 2015. American Community Survey, 5-year estimate.
[2] Alcohol treatment needs derived from the 2009 New Jersey Household Survey on Drug Use and Health (Technical Report pages 3-89 & 3-90, Alcohol Abuse and Dependence in past year).
[3] Drug treatment need is estimated by applying a two-sample Capture-Recapture statistical model using the 2013 and 2015 NJ-SAMS data.
[5] Percent of Drug treatment need was derived by dividing the population in need of treatment in each county (Columns 2+3) by the 2015 adult population in that county (Column 1) times 100.

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, 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 2014 to 2017, the RNAS model, updated to include data from the 2014 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.

In 2016, DMHAS deployed a questionnaire that yields a statewide need estimate. It was updated to include DSM-V diagnostic specifications and to test a new mental health section that uses validated questions from the federal behavioral risk factor surveys to estimate New Jersey's mental health treatment needs. The survey was recently completed and the data analysis is being finalized. A draft report is anticipated by the end of December 2016. The findings will be utilized in next year's needs assessment for substance abuse, as well as to estimate statewide mental health treatment need for depression and anxiety.

Mental Health

DMHAS has developed a mental health Relative Needs Assessment Scale using correlates of mental health disorders with known predictive power to estimate state and county mental health treatment needs.

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

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

DMHAS conducted its own review of recent epidemiological literature to determine the strongest social correlates of mental illness while retaining Cagle's original classifications. The social indicators and their definitions that were used to produce a mental health treatment needs assessment in New Jersey are presented in Table 2 and are partially based on Cagle's work. Table 3 presents the mental health treatment need by county. DMHAS seeks to refine the RNAS model for both substance abuse and mental health so that indices may be calculated by level of care, e.g., inpatient, outpatient and residential services. However, this would require validated social correlates of the full range of levels of care in each system and these have not been identified yet.

Table 2
Definition of Social Indicators Used in the RNAS Model to Calculate Mental Health Risk Index for New Jersey Counties, 2015

Indicator	Definition
Low socioeconomic status	
• Poverty [A]	Poor families below the poverty level, 2015
• No high school education [A]	Number of people age 25 years & over, with no high school diploma, 2015.
Marital status	
• Divorced families [A]	Adults 15 and over in 2015 who were separated or divorced.
• Female householder [A]	Female householder, no husband present with own children less than 18 years, 2015.
• Living alone [A]	Nonfamily householder living alone, 2015.
Environmental and Other Social Factors	
• Unemployment [A]	Population 16 and over unemployed in 2015
• Housing tenure [A]	Ratio of occupied housing which are renter occupied, 2015
• Population density [B]	County population per acre, 2015
• Suicide attempts [C]	2015 Non-fatal suicide attempts/self-inflicted injuries among the 10-24 age-group resulting in hospitalization (based on 2012-2014 data).

Source:
A U.S. Census Bureau, American Community Survey 5-year estimate (2010-2014). March 2016 release.
B U.S. Census Bureau: State and County QuickFacts. Last revised 8/5/2015
C New Jersey Department of Children and Families: New Jersey Youth Suicide Report, 2015

Also, 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. Cagle pointed out that the New York Office of Mental Health policy asserted that patients should be treated in the least restrictive setting and that focus on acute psychiatric beds could be shortsighted.

Table 3 2015 Mental Health Risk Index for New Jersey Counties Using The Relative Need Assessment Scale Model		
County	**Index**	**Percent**
Essex	0.185	18.5
Hudson	0.130	13.0
Bergen	0.129	12.9
Middlesex	0.100	10.0
Passaic	0.078	7.8
Camden	0.069	6.9
Ocean	0.065	6.5
Union	0.061	6.1
Monmouth	0.055	5.5
Mercer	0.024	2.4
Atlantic	0.022	2.2
Burlington	0.021	2.1
Morris	0.020	2.0
Gloucester	0.014	1.4
Somerset	0.011	1.1
Cumberland	0.007	0.7
Sussex	0.003	0.3
Cape May	0.002	0.2
Warren	0.002	0.2
Hunterdon	0.001	0.1
Salem	0.001	0.1
TOTAL OF INDEX	**1.0**	**100.0**

As noted earlier, DMHAS deployed a statewide level household survey, which included a new mental health section that uses validated questions from the federal behavioral risk factor surveys to estimate New Jersey's mental health treatment needs. The DMHAS will incorporate findings from this statewide household survey to refine its needs assessment for mental health next year.

C. Annual Assessment

With the establishment of a needs assessment methodology for mental health and the development of the inventory, it will be possible to annually assess the need for and availability of mental health services. Annual assessment of substance abuse treatment need using its existing methodologies also will continue.

D. Annual Funding for Existing Mental Health and Addictions Programs

The appropriations that the DMHAS received for fiscal year 2017 are reflected in Table 4 below.

Table 4
DMHAS FISCAL SUMMARY OF BEHAVIORAL HEALTH FOR FY 2016 - FY 2017
(State, Fed & Other $)
(Amounts in Thousands - $000's)

Category	FY 2017
Direct State Services:	
State Psychiatric Hospitals	**$ 302,513**
DMHAS Admin. (Includes Fed. Grants)	**$ 14,756**
Total Direct State Services	**$ 317,269**
Grants-In-Aid:	
BH Rate Increase	**$ 127,769**
Enhanced Federal Match and Third Party Recoveries	*($ 107,785)*
MH Community Care	**$ 255,943**
MH Olmstead	**$ 111,762**
MH Block and PATH Grant & Other	**$ 45,425**
SA Community Services	**$ 36,826**
SA Block Grant & Other Federal	**$ 58,299**
SA Dedicated Funds & Other	**$ 12,159**
MH Dedicated Fund	**$ 753**
	$ 541,151
Rutgers / UBHC Line-Items:	
Rutgers, UBHC- CMHC Newark	**$ 6,165**
Rutgers, UBHC-CMHC Piscataway	**$ 11,780**
Subtotal Rutgers, UBHC	**$ 17,945**
Total Grants-In-Aid	**$ 559,096**
State Aid - County Psychiatric Hospitals	**$ 105,214**
Federal DSH (Disproportionate Share Hospital) to Supplement Hospitals	**$ 53,000**
GRAND TOTAL DMHAS (State, Fed & Other)	**$ 1,034,579**

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

The Community Mental Health Citizens Advisory Board (Board) and the Behavioral Health Planning Council (Planning Council) are distinct groups that meet monthly as a joint advisory body with the DMHAS and Division of Children's System of Care (DCSOC). Members of the Board are appointed by the State Board of Human Services with the approval of the Governor of New Jersey and Planning Council members are appointed by the Assistant Commissioner of DMHAS. The Board and the Planning Council function together under the auspices of the New Jersey Behavioral Health Planning Council. The Planning Council fosters the interests of consumers and family members with serious mental illness, serious emotional disturbance (for parents of youth) or co-occurring disorders; and/or prevention, early intervention, treatment or recovery support services. Accordingly, membership includes consumers, family members of consumers, other advocates, providers and State government staff.

The Board consists of eight members chosen from among citizens of the State who, as consumers, have demonstrated an interest in the delivery of mental health services and are not providers of mental health services; one member shall be recommended by the Board of Chosen Freeholders; one member shall be recommended by the New Jersey League of Municipalities; two members shall be chosen from among providers of mental health services; one member shall be recommended by the Chairpersons of the Assembly and Senate committees on Human Services; and two members shall be designated by the State Board of Human Services from among persons currently serving as members of the Board of Trustees of the four State psychiatric hospitals to be appointed in July of each year. The Assistant Commissioner of the Division of Mental Health and Addiction Services or a designee shall be a non-voting ex-officio member.

Membership on the Planning Council includes citizens of the state who, as consumers, have demonstrated an interest in the delivery of behavioral health services; providers of children's and adult behavioral health services; advocacy organizations; and New Jersey State agencies. The purpose of the Behavioral Health Planning Council is: (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 DMHAS Assistant Commissioner; (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 DMHAS and DCSOC concerning the need for, and quality of, services and programs for persons with behavioral health disorders in the State; (5) to advise the DMHAS Assistant Commissioner concerning proposed and adopted plans affecting behavioral health services provided or coordinated by the DMHAS and DCSOC 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 can avail itself of whatever staff assistance is provided by the State Mental Health Authority, shall access information about

planning and provision of behavioral health services by the DMHAS and various state departments, can inform itself on national and international perspectives, and shall advise the DMHAS and DCSOC on coordination of services among various private and public providers.

Some highlights of Planning Council activities for FY 2016 included the following: There was a significant expansion of its membership to include people in recovery from, or providing treatment for, substance abuse (SA) services, which now represent 31% of its membership. These improvements were instituted at the Planning Council in response to the Substance Abuse and Mental Health Services Administration's (SAMHSA) combined application for the Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grants application guidance and instructions (OMB No. 0930–0168).

With this expansion of the Planning Council's purview, it subsequently hosted presentations on topics of interest to the substance abuse (SA) community, including the Division's Opioid Overdose Recovery Program (November 2015), and the Division's substance abuse prevention efforts (December 2015). The expansion of the Planning Council also has provided a reliable forum for individuals (and families) impacted by substance abuse issues to share their experiences, speak directly to DMHAS and DCSOC representatives, network with others, and learn about resources offered by the state, and its partners.

Although the Planning Council expanded its role and stakeholder community to include substance abuse in SFY 2016, it still remained faithful to its original mandate and purposes indicated above. In SFY 2016, the Council engaged in the following activities: it completed its overview of Block Grant Application for FY16-17; it reviewed the Block Grant Implementation Reports for SFY 2015; it presented an overview of Strengths and areas of improvement of system of care; it facilitated an overview of the Children's System of Care (CSOC) and the ≤ 18 population; it provided stakeholders with a review of the results of the 2015 Mental Health Consumer Perception of Care Survey, and; it hosted an overview of Consumer Operated Services. In SFY 2016, the Planning Council also presented information on: Violence Reduction Trainings conducted at New Jersey State psychiatric hospitals, Olmstead updates, how the Children's System of Care (CSOC) uses data to enhance service delivery, and the juvenile justice system. In March 2016, the members of the Planning Council also participated in SAMHSA's block grant monitoring visit which was held in Trenton. The minutes from the general meetings of the Planning Council are available in the following location http://tinyurl.com/bhpcminutes. In SFY16, the Planning Council also continued to convene its subcommittees, including but not limited to Advocacy, Data and Outcomes, and Block Grant.

Through its expanded membership, its proceedings, and its subcommittees, the New Jersey Behavioral Health Planning Council continued its important and good works in behavioral health in SFY 2016.

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

The Human Services Commissioner and the Assistant Commissioner of DMHAS, along with senior staff, conduct ongoing meetings with stakeholder leadership groups, trade organizations and consumer/family advocacy groups, inclusive of the New Jersey Hospital Association, to discuss services currently available, perceived service gaps, feedback on services working well and where services can improve to better meet the needs of individuals served. Ongoing stakeholder meetings are held with constituency and advocacy groups such as the Mental Health Association of New Jersey, New Jersey Association of Mental Health and Addiction Agencies, New Jersey Psychiatric Rehabilitation Association, Coalition of Mental Health Consumer Organizations, County Mental Health Administrators, County Alcohol and Drug Abuse Directors, National Alliance on Mental Illness New Jersey, Disability Rights New Jersey, New Jersey Hospital Association, and the Supportive Housing Association. Further, the DMHAS participates in regular, ongoing meetings with the New Jersey Department of Health, Administrative Office of the Courts, New Jersey Division of Medical Assistance and Health Services and the Division of Developmental Disabilities. The DMHAS is committed to consulting with these constituency and advocacy groups to discuss outcomes of needs assessment and plan development. This is in addition to the DMHAS' active, monthly participation in county-based system's review meetings, county advisory board meetings and county professional advisory committee meetings. In these meetings, local needs and plans are discussed.

G. Looking Ahead

The landscape of behavioral health services for adults in New Jersey continues to change and to improve. The publicly funded behavioral health system in New Jersey currently is undergoing a significant change, specifically due to the CMS' October 1, 2012 approval of the 1115 Comprehensive Medicaid Waiver application submitted by the state and will continue through the waiver renewal application which was submitted in September. DHS will also continue to assess the behavioral health needs of the residents on a regular basis in order to improve the behavioral health system in New Jersey.

DHS is in the process of reforming how adult behavioral health treatment services are financed in New Jersey. Specifically, the DMHAS is moving from a cost-based, deficit-funded contract model to one that is Fee-for-Service. DMHAS has implemented the Interim Managing Entity (IME) in partnership with NJFamilyCare. The IME was designed to manage NJFamilyCare, state and federal block grant funded Substance Use Disorder (SUD) services. Phase I of the IME was implemented on July 1, 2015 and included a statewide call center that provides screening, referral to an appropriate treatment provider, care coordination services, and some utilization management. The IME offers ease of access to services but individuals can continue to access services by going directly to the treatment agency.

To assist with placement and referral, the IME vendor, Rutgers University Behavioral Healthcare, developed an online, "bed management system" called the Service Capacity Management System (SCMS). The SCMS is updated by the provider regularly with the most recent information about available service capacity. The provider profiles in the SCMS also include provider contact information and any special services or enhancements that the provider can make available to consumers.

Phase II of the IME included full Utilization Management (UM) of SUD services and the conversion of existing cost-based contracts to managed Fee for Service. Implementation of Phase II began on May 24 of 2016 and continued through July 11, 2016. The phasing schedule was designed to allow providers a gradual process that minimized the possibility of denied claims due to systems or provider error.

To further DMHAS's transition from cost-based contracting to a Fee for Service contracting system, it is transitioning eight (8) mental health program elements to this payment method starting January 2017. These include: Outpatient, Partial Care, Partial Hospital, Residential Services, Supported Employment, Supported Education, Integrated Case Management Services (ICMS) and Programs in Assertive Community Treatment (PACT). Providers were given the option to transition in January or July of 2017; 17 providers have chosen to transition in January with the balance following in July. The conversion will not include management of the services.

Also, in July of 2017, Community Support Services (CSS) will transition to Fee for Service when the IME begins to prior authorize. Providers will bill Medicaid for Medicaid enrollees and for Medicaid reimbursed services. The DMHAS developed a web-based IT application, the NJ Mental Health Payment Processing Application (NJMHAPP), to pay provider for non-Medicaid eligible individuals and non-Medicaid reimbursed services for which the state developed rates.

In accordance with the "Inventory and Need Assessment for New Jersey Behavioral Health" report issued November 2013, behavioral health services for adults were expanded for individuals who were impacted by Superstorm Sandy and who resided in one of the following 10 counties (Atlantic, Bergen, Cape May, Cumberland, Essex, Hudson, Middlesex, Ocean, Monmouth and Union). These services are made available through funding from the US Department of Health and Human Services' Administration for Children and Families. The specific funding mechanism is the Social Services Block Grant (SSBG). This time limited funding was from September 2013 through September 30, 2015, to support the disaster recovery efforts related to Superstorm Sandy. While most services ended in September of 2015, detox and short term residential services were extended through February 2016. Additionally, rental subsidies with wraparound services and legal services were extended through June 30, 2017.

The DMHAS administered the following programs/services: detoxification and short term residential treatment services for individuals with a substance use disorder; outpatient services (for individuals with a substance use disorder and/or mental illness); supportive housing with support services (for individuals with a substance use disorder and/or mental illness); Early Intervention Support Services (for individuals with a mental illness and/or co-occurring mental illness and substance use disorder), a media campaign, which informed the public of the services available, and legal services.

In its continuing efforts to expand the availability of comprehensive behavioral health services and expand access to those services, DMHAS in partnership with the Division of Medical Assistance and Health Services (DMAHS) and the Children's System of Care was awarded a one-year Planning Grant for Certified Community Behavioral Health Clinics (CCBHC) in October 2015 for $982,372 from Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services for the development of CCBHCs. The New Jersey CCBHC

Project seeks to expand service delivery to a model of integrated care that combines care coordination with actual service delivery of behavioral health and primary care to adults with serious mental illness, children with serious emotional disturbance, and those with long term and serious substance use disorders, as well as others with mental illness and substance use disorders. The project began with a one-year planning phase consisting of activities to prepare New Jersey's participation in the two-year demonstration program, if selected. Major planning activities included: outreach to the state's extensive network of stakeholder groups for input and feedback on project design; certification of seven CCBHCs; development of a NJ CCBHC Prospective Payment System for payment of CCBHC services; and preparation of the demonstration grant application which was submitted in October 2016.

New Jersey currently is in the midst of an opioid overdose crisis epidemic. To help address the issue and need DMHAS has taken action by applying for and being awarded several federal grants from SAMHSA to implement the following initiatives: Medication Assisted Treatment Outreach Program, Opioid Overdose Prevention Network, and NJAssessRx. DMHAS has also initiated other efforts to address the need through the issuance of Request for Proposals to implement the Opioid Overdose Recovery Program and Opioid Overdose Prevention Program. New Jersey seeks to further its commitment to addressing opioid addiction by utilizing the information it has gained and the expertise and relationships it has developed through its involvement in numerous national and state initiatives.

Medication Assisted Treatment Outreach Program

In August 2015, DMHAS was awarded a Targeted Capacity Expansion: Medication Assisted Treatment – Prescription Drug and Opioid Addiction (MAT-PDOA) grant from SAMHSA, Center for Substance Abuse Treatment (CSAT) for $950,000 annually for three years to develop the Medication Assisted Treatment Outreach Program (MATOP). The goal of MATOP is to expand the use of evidence-based practices to more effectively treat opioid addiction and to provide patients with the knowledge, skills, and tools to better enable them to achieve and maintain recovery.

MATOP will provide medication assisted treatment, smoking cessation and other recovery support services for individuals with an opioid use disorder in Essex, Monmouth, and Ocean Counties. Three (3) New Jersey licensed Opioid Treatment Programs are partners 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. MATOP began on December 1, 2015 and will serve 135 unduplicated individuals annually and 405 unduplicated individuals over the entire project period.

Opioid Overdose Prevention Network

In September 2016, DMHAS was awarded a grant to "Prevent Prescription Drug/Opioid Overdose-Related Deaths (PDO)" from SAMHSA, Center for Substance Abuse Prevention (CSAP) for $1 million annually for five years to implement the Opioid Overdose Prevention Network (OOPN) initiative. DMHAS will partner with Rutgers University, Robert Wood Johnson Medical School, for the development and implementation of a comprehensive prescription drug/opioid overdose prevention program for this project which will include Naloxone training and

distribution. Plans are to train 3,000 individuals and distribute 2,500 naloxone kits annually. The New Jersey State Police, Regional Operations & Intelligence Center (ROIC), another DMHAS partner in this initiative will use real-time, statewide information about drug overdoses to allow DMHAS to almost immediately alert front-line practitioners and to make data-driven decisions about where to deploy prevention interventions, which includes community education and distribution of naloxone. This project will fund a Senior Analyst/GIS Mapping Specialist that will make extensive use of the ROIC's Journey to Crime surveillance system for drug arrest data. Points of origination will be 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. New Jersey's project team will use these mappings to help prioritize where project resources should be allocated.

NJAssessRx

In September 2016, DMHAS was awarded a "Strategic Prevention Framework for Prescription Drugs (SFP Rx)" grant from SAMHSA, CSAP for $371,616 annually for five years to implement the NJAssessRx initiative. NJAssessRX expands interagency sharing of the state's Prescription Drug Monitoring Program data and gives DMHAS the capability to use data analytics to identify prescribers, prescriber groups and patients at high risk for inappropriate prescribing and nonmedical use of opioid drugs. Informed by the data, DMHAS and its prevention partners will strategically target communities and populations needing services, education or other interventions. The target population is youth (ages 12-17) and adults (18 years of age and older) who are being prescribed opioid pain medications, controlled drugs, or Human Growth Hormone (HGH), and are at risk for their nonmedical use. Part of New Jersey's efforts will focus on young athletes, since this population may be more likely than non-athletes to receive prescription pain medication for sports related injuries. DMHAS will conduct epidemiological analysis on the NJ PDMP data and employ geographic information systems (GIS) to identify communities and issues that require targeted interventions and public health initiatives. Reports will identify those populations, practice settings and geographic areas, with the highest rates of nonmedical use of opioid prescriptions. The reports developed from the DMHAS data analysis will be shared with other state agencies and with DMHAS' Regional Prevention Coalitions to inform planning in local communities, which might, for example, target locales for naloxone distribution to prevent drug overdoses. These reports also will be the basis for a public awareness campaign and for training of providers and the health care community on addictions and the risks of opioid prescribing.

Opioid Overdose Recovery Program

In October 2015, DMHAS awarded funds to five (5) organizations to develop an Opioid Overdose Recovery Program (OORP) to respond to individuals who are reversed from opioid overdoses and who are subsequently being treated at hospital emergency departments. The organizations provide OORP services in Camden, Essex, Ocean, Monmouth, and Passaic Counties, all of which have demonstrated the highest need for these services. The Opioid Overdose Recovery Program utilizes recovery specialists to engage individuals who were reversed from an opioid overdose and provide non-clinical assistance and recovery supports and patient navigators to make appropriate referrals for assessment and substance use disorder treatment while also maintaining follow-up with these individuals. Peer recovery services provided for these individuals will be fundamentally strengths-based. Additionally,

they will deliver or assertively link individuals to appropriate and culturally-specific services, and provide support and resources throughout the process. At a minimum, recovery specialists are accessible and on-call from Thursday evenings through Monday mornings. Data for these initial programs has been very positive, indicating that there were 624 individuals that were Narcan reversed in the ED and 45.4% entered detox or treatment. The program recently has expanded to six (6) additional counties. In October 2016, awards were made to five (5) new counties, Atlantic, Bergen, Gloucester, Middlesex and Hudson. An RFP was issued in November 2016 to start the sixth (6th) OORP in Burlington or Mercer County.

Opioid Overdose Prevention Program

In October 2015, DMHAS awarded funding to three (3) organizations to establish regional (North, Central and South) Opioid Overdose Prevention Programs (OOPP) for the purpose of providing education to recognize an opioid overdose and to subsequently be equipped to provide life-saving rescue measures to reverse the effects of an opioid overdose. Funded organizations provide naloxone kits to those who are either at-risk or have family, friends or loved ones at-risk for an opioid overdose. Intranasal administration of naloxone is the protocol recommended by DMHAS. However, it is understood that for some individuals in the community, it may be preferable to administer naloxone in its injectable form.