New Jersey

UNIFORM APPLICATION
FY 2022 Mental Health Block Grant Report

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

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

A. State Information

State Information

State DUNS Number

Number	806418257
Expiration Date	

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

Agency Name	New Jersey Division of Mental Health and Addiction Services
Organizational Unit	Office of Planning, Research, Evaluation, Prevention and Olmstead
Mailing Address	5 Commerce Way PO Box 362
City	Hamilton Township
Zip Code	08691-0362

II. Contact Person for the Grantee of the Block Grant

First Name	Valerie
Last Name	Mielke
Agency Name	New Jersey Division of Mental Health and Addiction Services
Mailing Address	5 Commerce Way PO Box 362
City	Hamilton Township
Zip Code	08691-0362
Telephone	609-438-4350
Fax	609-341-2302
Email Address	Valerie.Mielke@dhs.nj.gov

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

From	7/1/2020
To	6/30/2021

IV. Date Submitted

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

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V. Contact Person Responsible for Report Submission

First Name	Donna
Last Name	Migliorino
Telephone	609-438-4295
Fax	609-431-2319
Email Address	Donna.Migliorino@dhs.nj.gov

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Footnotes:

B. Implementation Report

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

Priority #: 1

Priority Area: Pregnant Women/Women with Dependent Children

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

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

Objective:

Increase number of pregnant women or women with children entering substance abuse treatment.

Strategies to attain the goal:

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

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

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

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

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

Three workgroups convened: (1) Data Workgroup looked at statewide data systems (Medicaid ICD codes and DOH) that capture prenatal screening, linkage to treatment services, follow-up for parenting women, prevalence of NAS and associated costs. During the initiative, the team analyzed 2013 and 2014 Medicaid data to establish prevalence and costs of treatment NAS. (2) Prenatal Screening, Early Identification of Infants & Referral to Service Workgroup focused on how to increase connections to appropriate treatment and supportive services such as Central Intake and Perinatal Cooperatives, by mapping out current screening and referral practices across the state using Pregnancy Risk Assessment (PRA) data; New Jersey

implemented the 4Ps+ across the State and embedded the tool within the PRA. The workgroup found high utilization (over 80%) of 4Ps+ within doctors serving pregnant women on Medicaid. The mapping allowed the team to target low utilization areas to increase the prevalence of prenatal screening. (3) Labor, Delivery and Engagement (Infants) Workgroup developed a comprehensive survey with input from the medical community and perinatal cooperatives. The Hospital Birth Survey was disseminated statewide March 2017 to the labor and delivery hospitals. The survey sought to understand how pregnant women with SUD and substance-exposed infants are identified, treated, and triaged with partners at discharge, and if treatment for NAS was explored. The Hospital Birth Survey results was intended to guide Departments in establishing statewide guidelines for best practice; aid in the development of cross system models to ensure families get access to services; establish education needs on issues of SEI/NAS and identify high risk areas. The IDTA commenced in 2017, however DMHAS as the IDTA lead state agency, requested modified technical assistance from the NCSACW to support New Jersey to interpret the key findings from the Birthing Hospital Survey, and apply these findings to the Project ECHO program design.

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

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

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

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of pregnant women or women with children entering substance abuse treatment.

Baseline Measurement: SFY 2019: 32,276 admissions count

First-year target/outcome measurement: Increase number of pregnant women or women with children entering substance abuse treatment in SFY 2020 by 1%.

Second-year target/outcome measurement: Increase number of pregnant women or women with children entering substance abuse treatment by 2% by the end of SFY 2021. The change in SFY 2021 will be measured by calculating the percent difference from SFY 2019 to SFY 2021.

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

Data Source:

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

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

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

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

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

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

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

Priority #: 2

Priority Area: Persons Who Inject Drugs

Priority Type: SAT

Population(s): PWID

Goal of the priority area:

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

Objective:

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

Strategies to attain the goal:

• Referral to substance use disorder (SUD) treatment from statewide Harm Reduction Centers (HRCs) that are operational throughout New Jersey.
• Providing services in convenient locations, specifically utilizing mobile medication units, in order to reduce barriers and engage individuals in care as easily as possible.
• Promoting the use of medication assisted treatment (MAT) (e.g., methadone, buprenorphine, injectable naltrexone) for individuals with an opioid use disorder (OUD).
• Educating providers, individuals with an OUD, family members and the public about the benefits of MAT through a planned statewide public awareness campaign as well as public presentations on this topic.
• Contracts to three regional providers to provide community education and trainings for individuals at risk for an OUD, their families, friends and loved ones to recognize an opioid overdose and to subsequently provide naloxone kits to individuals in attendance.
• Increase the number of naloxone trainings specifically for underserved populations, such as schools, jails, licensed SUD treatment providers, Offices of Emergency Management, Emergency Medical Services teams, fire departments, homeless shelters and community health clinics.
• Contracts awarded to implement an opioid overdose recovery program with recovery specialists and patient navigators in all 21 counties for individuals who present in emergency departments following an opioid overdose reversal with naloxone in order to link them to treatment or other recovery support services in their communities.
• Contracts awarded to 11 providers for the Support Team for Addiction Recovery (STAR) program to provide case management and wraparound services for individuals with an OUD. Goals include linking clients to needed services, housing, primary care and treatment including MAT.
• Maternal Wraparound Program (M-WRAP) provides intensive case management and recovery support services for opioid dependent pregnant and postpartum women. Opioid dependent pregnant women are eligible for M-WRAP services during pregnancy and up to one year after birth event. Intensive case management focuses on developing a single, coordinated care plan for pregnant/postpartum women, their infants and families. Intensive Case Managers provide care coordination and warm hand-offs to appropriate service providers when necessary. Recovery Support Specialists provide non-clinical assistance and recovery supports while maintaining follow-up with the women and their infants. The M-WRAP program covers all

21 counties of NJ and alleviates barriers through comprehensive care coordination using a multi-system approach with the goal to improve outcomes for pregnant/postpartum opioid dependent women and their children.
• In September 2016, DMHAS was awarded a five-year grant to "Prevent Prescription Drug/Opioid Overdose-Related Deaths (PDO)" from SAMHSA to implement the Opioid Overdose Prevention Network (OOPN) initiative which entails the development and implementation of a comprehensive prescription drug/ opioid overdose prevention program which includes Naloxone training and distribution. Plans are to train 3,000 individuals and distribute 2,500 naloxone kits annually.
• In September 2016, DMHAS was awarded a "Strategic Prevention Framework for Prescription Drugs (SFP Rx)" five-year grant from SAMHSA to implement the NJAssessRx initiative. NJAssessRx expands interagency sharing of the state's Prescription Drug Monitoring Program data and gives DMHAS the capability to use data analytics to identify prescribers, prescriber groups and patients at high risk for inappropriate prescribing and nonmedical use of opioid drugs. Informed by the data, DMHAS and its prevention partners will strategically target communities and populations needing services, education or other interventions. The target population is youth (ages 12-17) and adults (18 years of age and older) who are being prescribed opioid pain medications, controlled drugs, or human growth hormone (HGH), and are at risk for their nonmedical use.
• In May 2017, SAMHSA awarded $12,9995,621 through the State Targeted Response (STR) to New Jersey annually for two years. The program aims to address the opioid crisis by increasing access to treatment, reduce unmet treatment need and reduce opioid overdose related deaths through the provision of prevention, treatment and recovery activities for OUD. A major activity of the grant is to implement and expand access to clinically appropriate evidence-based practices (EBPs) for OUD treatment, particularly, the use of MAT. To address these objectives, a new State Targeted Opioid Response Initiative (STORI) fee-for-service (FFS) treatment initiative was developed within the existing addiction fee for service treatment network, which provides access to treatment for under-insured and uninsured clients. It includes a wide range of services, specifically including MAT. DMHAS was awarded a no-cost extension for the STR grant to continue funding the STORI FFS treatment for part of SFY 2020.
• In September 2018, SAMHSA awarded $21.5 million through the State Opioid Response (SOR) to New Jersey annually for two years to continue to address the opioid crisis. The key objectives of the SOR grant are to increase access to MAT, reduce unmet treatment need and reduce opioid related deaths.
• In March 2019, DMHAS received notification from SAMHSA that its plan for an additional $11.2 million was approved through the SOR Grant for the period through FFY 2020. DMHAS submitted a plan proposing to use the SOR supplemental award to fund additional treatment, recovery support, prevention and education/training efforts to address the opioid epidemic.
• As part of SOR funding, the Low Threshold Buprenorphine Induction program (Low Threshold) is designed to make Buprenorphine treatment easily accessible to individuals who access syringes at Harm Reduction Centers (HRCs) located at South Jersey AIDS Alliance (SJAA) in Atlantic City and the Visiting Nurse Association (VNA) of Central Jersey in Asbury Park. Through the Low Threshold program, individuals will be offered same day, immediate enrollment in Buprenorphine treatment and care management services. The program will offer services to individuals who seek this type of service in a safe and nonjudgmental environment, despite continued drug use or lapses in care.
• As part of SOR and state funding, DMHAS is collaborating with NJ's 21 counties to establish MAT programs or enhance existing MAT services for inmates with OUD at county correctional facilities. In addition, DMHAS is working with county correctional facilities to establish justice involved re-entry services for detainees where case managers at county jails will conduct intake assessments and establish pre-release plans for needed services in the community.
• An attempt to increase access to MAT, specifically buprenorphine, has been the development of statewide buprenorphine training courses utilized as an educational component for physicians, Advanced Practical Nurses (APNs) and Physician Assistants (PAs) to attain their Buprenorphine Waiver. The State plans to hold a total of 16 trainings through both Rutgers University (northern region) and Rowan University (southern region) in CY 2019 in an effort to train over 1,000 prescribers in CY 2019.
• Interim Services have been a requirement of provider contracts, but a new initiative allows DMHAS to pay for these services through a fee-for-service (FFS) mechanism. The Interim Services initiative provides funding to agencies to support individuals awaiting admission to treatment following a SUD assessment. Interim Services are an engagement level of service intended to link individuals to services they may not be able to access due to lack of provider capacity. This service is designed to be provided by agencies contracted for any licensed ASAM level of care. Interim services will be made available to any individual eligible for treatment within the public system who cannot be admitted for the assessed level of care within 72 hours. Prior to this initiative agencies enrolled in the Block Grant initiatives were required to provide this service. Once launched in October 2019, funding for Interim Services will be open to all contracted FFS providers.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

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

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

Data Source:

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

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

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

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

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

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

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

Indicator #:	2
Indicator:	Increase the number of heroin and other opiate dependent individuals entering treatment.
Baseline Measurement:	SFY 2019: 47,007 admissions count
First-year target/outcome measurement:	Increase the number of heroin and other opiate dependent individuals entering treatment by 1%.
Second-year target/outcome measurement:	Increase number of opiate dependent individuals entering treatment by 2% by the end of SFY 2021. The change in SFY 2021 will be measured by calculating the percent difference from SFY 2019 to SFY 2021.

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

Data Source:

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

New Data Source*(if needed)*:

Description of Data:

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

discharge.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

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

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

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

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

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

Priority #: 3

Priority Area: Heroin/Opioid Users

Priority Type: SAT

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

Goal of the priority area:

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

Objective:

Increase the number of heroin/other opiate admissions for whom MAT is planned.

Strategies to attain the goal:

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

University. The goal of this project is to educate, support, and mentor graduate students to give free educational talks, through use of PowerPoint presentations, to the community.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

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

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

Data Source:

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

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

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

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

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

Priority #: 4

Priority Area: Tobacco

Priority Type: SAP

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

Goal of the priority area:

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

Objective:

Decreased past month use of tobacco products among persons aged 12 to 17.

Strategies to attain the goal:

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

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

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

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

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

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

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

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

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

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

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

Data Source:

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

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

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

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

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

Priority #: 5

Priority Area: Alcohol

Priority Type: SAP

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

Goal of the priority area:

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

Objective:

Decreased past month of binge drinking among persons aged 12 to 17

Strategies to attain the goal:

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

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

Individual Strategies
• Provide information – Educate parents and youth on the dangers of underage drinking by youth through awareness efforts, workshops, and

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

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

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

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

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

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

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

Data Source:

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

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

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

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

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

Priority #: 6

Priority Area: Marijuana

Priority Type: SAP

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

Goal of the priority area:

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

Objective:

Decreased use of marijuana in the past year among persons aged 12 to 17.

Strategies to attain the goal:

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

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

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

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

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

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

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

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

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

Data Source:

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

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

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

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

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

Priority #: 7

Priority Area: Prescription Drugs

Priority Type: SAP

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

Goal of the priority area:

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

Objective:

Decreased prescribing of analgesic opioids in the past year to all persons in New Jersey.

Strategies to attain the goal:

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

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Opioid Dispensations in New Jersey.

Baseline Measurement: According to data from NJ CARES – A Realtime Dashboard of Opioid-Related Data and Information (maintained by the Office of the New Jersey Attorney General), in 2018, 4,266,645 prescriptions for opioids were provided in New Jersey.

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

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

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

Data Source:

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

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

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

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

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

Priority #: 8

Priority Area: Heroin

Priority Type: SAP

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

Goal of the priority area:

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

Objective:

Increased perceptions of Great Risk from Trying Heroin Once or Twice among persons aged 12 to 17.

Strategies to attain the goal:

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

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

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

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

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

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

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

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

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

Data Source:

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

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

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

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

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

Priority #: 9

Priority Area: TB

Priority Type: SAT

Population(s): TB

Goal of the priority area:

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

Objective:

Increase the percentage of DMHAS' SAPT Block Grant contracted agencies offering every client a tuberculosis evaluation

Strategies to attain the goal:

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

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

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

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

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

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

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

Data Source:

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

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

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

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

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

Priority #: 10

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

Priority Type: MHS

Population(s): SED

Goal of the priority area:

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

Objective:

CSOC will develop a completed plan for screening, care coordination, and development of infant mental health service capacity for at risk children age 0-3.

Strategies to attain the goal:

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

1.Align state programs and investments between Medicaid and other early childhood systems to drive more strategic, evidence-based investments for infants and toddlers in low-income families; and
2.Demonstrate the value of early childhood cross-sector alignment for improving near- and long-term health and social outcomes.

NJ DCF/CSOC has identified the following goals:

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

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

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

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Completed plan for screening, care coordination, and development of infant mental health srvice capacity for at risk children age 0-3

Baseline Measurement: To be determined after the first year of implementation of screening services to children age 0-3

First-year target/outcome measurement: An increase in the percentage of children age 0-3 receiving screening srvices in SFY 2021. The percentage will be determined when the baseline measure is set.

Second-year target/outcome measurement: An increase in the percentage of children age 0-3 receiving screening srvices in SFY 2022. The percentage will be determined when the baseline measure is set.

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

Data Source:

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

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

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

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

How first year target was achieved *(optional)*:
CSOC has made great progress by collaborating with the Department of Human Services / Medicaid, with support from the Center for Health Care Strategies / Aligning Early Childhood and Medicaid (AECM), and by participating with a broad group of stakeholders to develop the report, "Unlocking Potential: A Roadmap to Making New Jersey the Safest, Healthiest, and Most Supportive Place to Give Birth and Raise a Family," which outlines steps to expand infant mental health services in New Jersey (the Executive Summary of this report can be found online. https://acnj.org/downloads/2020_06_24_Unlocking_Potential_Executive_Summary.pdf). While a component of this report establishes clear steps to expand infant mental health (IMH) services to 7,247 more low-income infants and toddlers annually, beginning in 2023, the public health emergency caused conflicts that precluded further development of a plan for screening, care coordination, and increased service capacity. CSOC is continuing to engage in the AECM and Pritzker initiatives and is exploring additional opportunities to build IMH capacity within CSOC. Efforts include the In-Home recovery Program (priority area 12).

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

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

How second year target was achieved *(optional)*:
Although New Jersey's Aligning Early Childhood with Medicaid (AECM) technical assistance project concluded in 2020, the objectives of the AECM have been shared with other entities, including the Pritzker Initiative, who has identified the expansion of infant mental health services for at-risk families as one of its goals. Aligning its work with Pritzker, CSOC launched a new initiative in 2021, "Zero to Five: Helping Families Thrive," which provides staff development opportunities for Mobile Response Stabilization Services (MRSS) and Intensive In-Community (IIC) providers. Specifically, CSOC is funding Montclair State University (MSU) to provide training for over 400 MRSS direct service providers and their supervisors. MSU will also train 72 IIC clinicians and their supervisors in an evidence-based model, Child and Parent Psychotherapy, over a 3-year period.

Priority #: 11

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

Priority Type: MHS

Population(s): SED

Goal of the priority area:

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

Objective:

1. Implement at least one expansion or enhancement of integrated health and behavioral health services.

2. Increase the number of children youth and young adults receiving integrated physical and behavioral health care services.

Strategies to attain the goal:

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

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

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

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

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

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

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

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increased number of children, youth or young adults provided with integrated physical and behavioral health services.
Baseline Measurement:	In SFY 2019 CSOC proved Behavioral Health Home services to 503 youth.
First-year target/outcome measurement:	CSOC will increase the number of youth served by Behavioral Health Homes/other Integrated Care models by 5%. Target outcome measurement is 528 youth.
Second-year target/outcome measurement:	CSOC will increase the number of youth served by Behavioral Health Homes/other Integrated Care models by 5%. Target outcome measurement is 554 youth.

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

Data Source:

Performcare NJ - the NJ DCF/CSOC Administrative Services Organization

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

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

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

As expected, given the challenges around the public health emergency, we did not expand BHH services by 5%. FY21 did show an increase, having provided BHH services to 536 youth.
We will continue to strive to expand this service by working closely with the programs to ensure they are able to take up a more assertive, standardized approach to identifying and engaging BHH eligible youth. This quality improvement effort will include enhanced tracking of eligible youth, youth engaged in the screening process, and youth engaged in the program. By counting youth at different decision points within the process, we will be able to identify any procedural barriers to expansion. We will also adjust our method of determining progress, by utilizing future targets based on projected increases in the overall percentage of eligible youth who have engaged in the program.

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

Priority #: 12

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

Priority Type: MHS

Population(s): SED

Goal of the priority area:

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

Objective:

Plan, implement, and evaluate at least 1 evidence-based program, the In-Home Recovery Program, to support youth and families with substance use disorders who are involved with the Department of Children and Families Division of Child Protection and Permanency. The In-Home Recovery Program is an innovative pilot program seeking to improve outcomes for parents who have a substance use disorder and are actively parenting a child under 36 months.

Strategies to attain the goal:

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

The Nicholson Foundation, in partnership with New Jersey Department of Children and Families (NJDCF), issued a Request for Proposals (RFP) to solicit

proposals for a family-based recovery program from New Jersey–based mental health and substance use disorder treatment providers serving adults, families, and/or young children.

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

An important objective of the Program is to demonstrate the effectiveness of a trauma informed in-home treatment for families involved with the NJDCF Division of Child Protection and Permanency (DCP&P) who have an index parent (client) with a substance use disorder and an index child (child) under the age of 36 months. Outcome measures will include parental substance use, child placement at discharge, and a client's repeat involvement with child protective services.

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

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

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

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

Functional Family Therapy for Foster Care (FFT-FC)

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

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

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

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

Functional Family Therapy for Foster Care (FFT-FC)

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

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

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

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

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

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

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

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

Functional Family Therapy for Foster Care (FFT-FC)

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

Therapy (FFT) in a comprehensive and systemic approach adapted to helping youth and families involved with DCP&P to overcome individual and relational trauma to promote placement stability, increase youths' lifelong connections and improve youths' permanency outcomes.

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

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

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

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

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

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

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

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

Second-year target/outcome measurement: Each Project team will treat a caseload of twelve (12) families concurrentlyand serve a minimum of eighteen (18) families over the 18-month grant period, beginning on September 1, 2019

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

Data Source:

Grant awardee

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

None.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

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

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

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

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

We have exceeded our target of serving 36 families in an 18 month period ending on June 30, 2021. As of the identified end date, a total of 46 families were provided with In-Home Recovery Program services.

Priority #: 13

Priority Area: Housing Services in Community Support Services

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

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

Objective:

SMHA continues to increase opportunities for community living among mental health consumers by developing additional housing units and maintaining levels of occupancy to satisfy the needs of consumers served in Community Support Services.

Strategies to attain the goal:

Community Support Services (CSS) is a mental health rehabilitation service that assists the consumer in achieving mental health rehabilitative and recovery goals as identified in an individualized rehabilitation plan (IRP). CSS promotes community inclusion, housing stability, wellness, recovery, and

resiliency. Consumers are expected to be full partners in identifying and directing the types of support activities that would be most helpful to maximize successful community living. This includes use of community mental health treatment, medical care, self-help, employment and rehabilitation services, and other community resources, as needed and appropriate. The adoption of CSS enhances Supportive Housing.

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

SMHA staff will monitor the continued development of new Supportive Housing opportunities. The BEDS data system will foster more timely and accurate tracking of residential resources, as well as facilitate their more efficient utilization (e.g., to reduce vacancy rates and increase community placements), and enable monitoring of compliance with Administrative Bulletin 5:11 (Residential Placement from Psychiatric Hospital).

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Consumers who remain in Community Support Services (CSS) during the fiscal year as a proportion of total consumers served in Community Support Services.
Baseline Measurement:	The total number of clients served in CSS in SFY 2018 were 4,762. 80.72% of the total consumers served in CSS remained in CSS during SFY 2018. The total number of clients served in CSS in SFY 2019 will be available by September 2019. At that time, the percentage for SFY 2019 will be calculated.
First-year target/outcome measurement:	The percentage of consumers who remain in Community Support Services during SFY 2020 will be no less than 85% of total consumers served in Community Support Services.
Second-year target/outcome measurement:	The percentage of consumers who remain in Community Support Services during SFY 2021 will be no less than 87% of total consumers served in Community Support Services.

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

Data Source:

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

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

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

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

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

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

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

The total number of clients served in CSS in SFY 2021 was 4,968 with 598 individuals terminated. The percentage of consumers who remained in CSS for SYF 2021 was 87.96%.

Priority #: 14

Priority Area: Olmstead Access to Service/Occupancy Rate

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

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

Objective:

SMHA continues to increase opportunities for community living among mental health consumers by developing additional housing units and maintaining levels of occupancy to satisfy the needs of consumers served in Community Support Services.

Strategies to attain the goal:

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

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator:	Improved Utilization of Housing Service Slots measured by occupancy rates of Community Support Services (CSS) housing units.
Baseline Measurement:	In SFY2019, the occupancy rate (of CSS housing units that are occupied and/or have a consumer assigned to them) was 95.9%. Conversely, the vacancy rate (state-funded CSS housing units that are vacant and/or have no consumers assigned to them) was 4.1%.
First-year target/outcome measurement:	In SFY 2020, the occupancy rate (i.e., occupied CSS housing units and those units with an assignment) is expected to be 97%.
Second-year target/outcome measurement:	In SFY 2021, the occupancy rate (i.e., occupied CSS housing units and those units with an assignment) is expected to be 97%.

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

Data Source:

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

New Data Source*(if needed)*:

Description of Data:

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

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

New Description of Data:*(if needed)*

With the successful state rollout of these Provider Weekly Reports, this information has been used to give the SMHA improved time-sensitive (weekly) updates on the capacity census, vacancy status of its full range of community-based housing resources.

The 2019 values were calculated by dividing the sum of the reported number of requested assignments, by the sum of the reported capacities at each program. The SMHA collected this data from 33 CSS providers at the end of SFY19. In SFY 2021, PWR data was provided by 70 different community housing entities. This has grown; in SFY 2021 Provider Weekly report data was collected from 72 different reporting entities, representing 43 different SMHAS-funded agencies.

Data issues/caveats that affect outcome measures:

The reporting of occupancy strictly among CSS provider agencies necessitated the use of the Provider Weekly Reports (PWRs). The rollout of the standardized PWRs came late in SFY19, so there is a small number of providers who have yet to submit their data in the proscribed fashion. This performance indicator is expressed as a proportion, and the SMHA does not feel that the SFY19 occupancy rate of 95.9% would be materially different if/when all of the data was reported.

New Data issues/caveats that affect outcome measures:

Provider Weekly Reports data is self-reported by agencies contracted by the SMHA. However this information is reviewed by NJ State Psychiatric Hospital personnel from the NJ Department of Health, as well as Olmstead/Housing specialists from DMHAS. Although the 95% occupancy rate was not met in SFY21, the reported occupancy rate of 94% is materially quite close to the intended target. Extraneous factors—namely the COVID19 pandemic may have adversely impacted both full reporting of the data by providers and may

have caused slight disruptions in the CSS housing placement process.

Report of Progress Toward Goal Attainment

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

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

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

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

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

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

When the first year data were reported and the target not met, we adjusted the target occupancy rate for SFY 2021 to be 95%. The Covid -19 pandemic situation did unfortunately likely persisting in for the majority of SFY 2021. The situation of community placement was not improved. Although the 95% occupancy rate was not met in SFY 2021, the reported occupancy rate of 94% is materially quite close to the intended target.

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

Priority #: 15

Priority Area: First Episode Psychosis (FEP)

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

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

Objective:

Among consumers who received coordinated specialty care services for individuals with first episode psychosis, a majority will show improved symptoms and adhere to psychotic medication after receiving treatment for six months.

Strategies to attain the goal:

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

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

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

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

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Medication adherence among clients who need psychotropic medication prescribed for FEP treatment.

Baseline Measurement: In SFY 2018, among clients who were taking or in need of antipsychotic medication for the treatment of their psychosis at intake, 78.4% adhere to their medication regimen. In SFY 2019, out of 215 clients being served, 190 were taking or in need of antipsychotic medication. Among them, 86.8% (165) adhered to their psychotropic medication regimens.

First-year target/outcome measurement: In SFY 2020, it is anticipated that at least 88% of the client who are taking or in need of antipsychotic medication adhere to the medication regimen.

Second-year target/outcome measurement: In SFY 2021, it is anticipated that at least 90% of the client who are taking or in need of antipsychotic medication adhere to the medication regimen.

New Second-year target/outcome measurement*(if needed)*: The target for SFY 2021 was revised to 88% after the first year.

Data Source:

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

New Data Source*(if needed)*:

Description of Data:

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

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

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

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

Reason why target was not achieved, and changes proposed to meet target:
The original first-year (SFY 2020) target was set at 88%. The results showed that 87% of the clients who were taking or in need of antipsychotic medication adhered to the medication regimens in SFY 2020, which is consistent with the rate in SFY 2019 (86.8%). It seems the targets for SFY 2020 (88%) and SFY 2021 (90%) were set too high. We, therefore, propose the new second-year (SFY 2021) target to be 88%.

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

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

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

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

The overall medication adherence rate for SFY2021 was 85.9%. This total is slightly lower than the proposed second-year target of 88%. Frequent staffing changes have contributed to a lower medication adherence rate. A few of our agencies did not have a full time prescriber or clinicians on staff for some period of time during the fiscal year. Staff turnover may have affected client medication maintenance, where clients would not maintain service from the same prescriber or therapist. Secondly, increased stress associated with the pandemic also caused some clients to stop-and-start psychotropic medication regimens. Lastly, the majority of therapy sessions was conducted though the virtual platform due to COVID-19. As a result, medication adherence could not be reinforced as strongly as in face-to-face sessions.

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

Priority #: 16

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

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

System wide assessment for delivering services to diverse populations.

Objective:

All agencies are required to have a Cultural Competence Plan in place. The multicultural plans are required of both mental health and substance use agencies.

Strategies to attain the goal:

Since 1985, the Division of Mental Health and Addiction Services (DMHAS) has had the commitment to improve services to individuals from diverse backgrounds, including LGBTQ. The mechanism for addressing these system needs began with the 2015 reformation of DMHAS' multicultural activities into a Multicultural Services Advisory Committee (MSAC). The MSAC has developed a process for systems assessment that will begin by surveying all contracted agencies about their existing planning and service delivery to diverse populations. As the SMHA reviewed the results of these surveys, gaps in service and needs for technical assistance (TA) were identified. Beginning in early 2016, TA groups were held in the north and south to assist agencies in formulating multicultural plans. Those plans became a part of the SMHA's contracting process in FY 2017 and have been followed by the DMHAS Multicultural Training and Technical Assistance Center each year to ensure that the plans continue to grow. In addition, in FY 2018, DMHAS contracted with a diversity consultant to provide administrative and research-based assistance with this initiative. The diversity consultant was charged with securing scholarly presenters for trainings and workshops to further educate and engage providers with completing their Cultural Competence Plan. The diversity consultant's role expanded in FY 2019 to include qualitative and quantitative analysis of data in order to present a more robust picture of DMHAS' agency gaps and trends leading to greater concentration of creating and sustaining a culture of inclusion.

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

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

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Proportion of agencies that have three areas identified from their self-assessment included in their Cultural Competence Plans.

Baseline Measurement: The baseline variable is the number of provider agencies that complete their self-assessments and have a written Cultural Competence Plan containing at least three of the areas needed to enhance cultural competency. The establishment of a baseline is still in process and is expected to be completed in SFY 2020. The MSAC will complete the "Center for Cultural Competency Excellence" designation for agencies.

First-year target/outcome measurement: Thirty (30) percent of all providers will have written Cultural Competence Plans which include at least three areas identified in their self-assessment. Agencies will apply for "Center for Cultural Competency Excellence" designation.

Second-year target/outcome measurement: Fifty percent (50%) of all providers will have written Cultural Competence Plans which include at least three areas identified in their self-assessment. Agency "Center for Cultural Competency Excellence" designations will be reviewed and awarded.

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

Data Source:

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

New Data Source*(if needed)*:

Description of Data:

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

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

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

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

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

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

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

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

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

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

For FY 2021, the target was set at 50%. There is a gap due to lack of consultants to agencies to work on Cultural Competency Plans. The Assistant Commissioner of the Division of Mental Health and Addiction Services (DMHAS) will reinforce with all DMHAS contracted

providers that a Cultural Competence Plan is mandatory. Current number of agencies that have a cultural competency plan is around 40%. Once the consultant begins to work with the providers, the number will likely to increase.

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

Footnotes:

for the Community Services Mental Health Block Grant (MHBG)
for Federal Fiscal Year Ending September 30, 2021
Due Date: December 31, 2021

For the Federal Fiscal Year ending September 30, 2021, please upload a Word or PDF document in Table 1 of the FY22 MHBG Report on the COVID Testing and Mitigation activities and expenditures by providing the following information, due by December 31, 2021:

List the items and activities of expenditures completed by September 30, 2021. (if no activities were completed, note here with Not Applicable)

COVID Testing and Mitigation Program Report for **New Jersey**	
Item/Activity	Amount of Expenditure
Not Applicable	**Not Applicable**

C. State Agency Expenditure Reports

MHBG Table 2A (URS Table 7) - State Agency Expenditures Report

This table describes expenditures for public mental health services provided or funded by the state mental health agency by source of funding. Include ONLY funds expended by the executive branch agency administering the Mental Health Block Grant.

Expenditure Period Start Date: 7/1/2020 Expenditure Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	Source of Funds								
	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG) [1]	I. ARP Funds (MHBG) [2]
1. Substance Abuse Prevention and Treatment									
a. Pregnant Women and Women with Dependent Children									
b. All Other									
2. Primary Prevention[3]		$0	$0	$0	$0	$0	$0	$0	$0
3. Evidence-Based Practices for Early Serious Mental Illness[4]		$2,133,979	$0	$0	$0	$0	$0	$0	$0
4. Tuberculosis Services									
5. HIV Early Intervention Services									
6. State Hospital			$66,582,901	$0	$324,265,587	$0	$0	$0	$0
7. Other Psychiatric Inpatient Care			$0	$0	$0	$0	$0	$0	$0
8. Other 24-Hour (residential Care)		$10,407,909	$371,220,784	$0	$173,953,609	$0	$0	$0	$0
9. Ambulatory/Community Non-24 Hour Care		$7,566,990	$515,823,802	$17,472,386	$292,608,186	$0	$400,000	$0	$0
10. Administration (Excluding Program and Provider Level)		$1,706,497	$1,772,637	$1,311,093	$12,984,192	$0	$0	$0	$0
11. Crisis Services (5 percent set -aside)[5]		$0	$0	$0	$0	$0	$0	$0	$0
12. Total	**$0**	**$21,815,375**	**$955,400,124**	**$18,783,479**	**$803,811,574**	**$0**	**$400,000**	**$0**	**$0**
Comments on Data:									

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the 'standard' MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A-G are for the state planned expenditure period of July 1, 2020 – June 30, 2021, for most states.

[2]The expenditure period for the American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from expenditure period for the 'standard' MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A-G are for the state planned expenditure period of July 1, 2021 - June 30, 2022, for most states.

[3]States may only use MHBG funds to provide primary prevention services to the priority populations of adults with serious mental illness and children with severe emotional disturbance.

[4]Column 3B is for expenditures related to ESMI including First Episode Psychosis programs funded through MHBG setaside. These funds are not to be also counted in #9 Ambulatory/Community Non-24-Hour Care.

[5]Row 11 should include Crisis Services programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

Please indicate the expenditures are actual or estimated.

Actual Estimated

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Footnotes:

C. State Agency Expenditure Reports

MHBG Table 2B (URS Table 7A) - MHBG State Agency Early Serious Mental Illness and First Episode Psychosis Expenditures Report

Expenditure Period Start Date: 7/1/2020 Expenditure Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	Source of Funds					
	A. Mental Health Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. CSC-Evidences-Based Practices for First Episode Psychosis[1]	$2,050,541	$0	$0	$0	$0	$0
Training for CSC Practices	$0	$0	$0	$0	$0	$0
Planning for CSC Practices	$83,438	$0	$0	$0	$0	$0
2. Other Early Serious Mental Illnesses programs (other than FEP or partial CSC programs)	$0	$0	$0	$0	$0	$0
3. Training for ESMI	$0	$0	$0	$0	$0	$0
4. Planning for ESMI	$0	$0	$0	$0	$0	$0
5. Total	**$2,133,979**	**$0**	**$0**	**$0**	**$0**	**$0**
Comments on Data:						

[1]When reporting CSC- Evidence Based Practices for First Episode Psychosis, report only those programs that are providing all the components of a CSC model. If the state uses only certain components of a CSC model specifically for FEP, please report them in row 2.

Note, The Totals for this table should equal the amounts reported on Row 3 (Evidence-Based Practices for Early Serious Mental Illness) on MHBG Table 2a (URS Table 7a)

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Footnotes:

C. State Agency Expenditure Reports

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

Reporting Period Start Date: 7/1/2020 Reporting Period End Date: 6/30/2021

Statewide Expenditures for Children's Mental Health Services			
Actual SFY 1994	**Actual SFY 2020**	**Estimated/Actual SFY 2021**	**Expense Type**
$20,612,000	$162,003,254	$196,956,638	(●) Actual ( ) Estimated

If estimated expenditures are provided, please indicate when actual expenditure data will be submitted to SAMHSA: _____

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

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Footnotes:

The increase in FY 2021 as compared to FY 2020 is driven by a significantly higher figure for State share of Medicaid spending for children. A possible explanation could be care was delayed in FY 2020 due to COVID.

C. State Agency Expenditure Reports

MHBG Table 4 (URS Table 8) - Profile of Community Mental Health Block Grant Expenditures for Non-Direct Service Activities

This table is used to describe the use of MHBG funds for non-direct service activities that are sponsored, or conducted, by the State Mental Health Authority

Expenditure Period Start Date: 7/1/2020 Expenditure Period End Date: 6/30/2021

Activity	A. Total of Block Grant	B. COVID Funds[a]	C. ARP[b]
Total Non-Direct Services	$	$	$
Comments on Data:			

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023,** which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured for the state planned expenditure period of
July 1, 2020 – June 30, 2021, for most states.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 1, 2025,** which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured for the state planned expenditure period of July 1, 2020 – June 30, 2021, for most states.

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Footnotes:

C. State Agency Expenditure Reports

MHBG Table 5 (URS Table 10) - Profiles of Agencies Receiving Block Grant Funds Directly from the State MHA

Expenditure Period Start Date: 7/1/2020 Expenditure Period End Date: 6/30/2021

								Source of Funds			
Entity Number	Area Served (Statewide or Sub-State Planning Area)	Provider/Program Name	Street Address	City	State	Zip	Total Block Grant Funds	Adults with Serious Mental Illness	Children with Serious Emotional Disturbance	Set-aside for FEP Programs	Set-aside for ESMI Programs
28	Statewide	ACENDA					$1,306,630.00	$0.00	$0.00	$0.00	$0.00
24	Atlantic	AtlantiCare Behavioral Health	6550 Delilah Rd., Suite 301	Egg Harbor Twp	NJ	08234	$478,851.00	$0.00	$0.00	$0.00	$0.00
16	Statewide	Bridgeway Rehabilitation, Inc.	615 North Broad Street	Elizabeth	NJ	07208	$3,939,933.00	$0.00	$0.00	$0.00	$0.00
17	Cape May	Cape Counseling Services	1129 Route 9 South, Suite #1	Cape May Court House	NJ	08210	$0.00	$0.00	$0.00	$0.00	$0.00
3	Statewide	Care Plus NJ, Inc.	610 Valley Health Plaza	Paramus	NJ	07652	$878,604.00	$0.00	$0.00	$878,604.00	$0.00
26	Atlantic	Career Opportunity Development, Inc.	901 Atlantic Avenue	Egg Harbor	NJ	08215	$496,951.00	$0.00	$0.00	$0.00	$0.00
7	Statewide	Catholic Charities of the Archdiocese of Newark/ Mt. Carmel Guild Behavioral Healthcare Division	590 North 7th Street	Newark	NJ	07107	$45,944.00	$0.00	$0.00	$0.00	$0.00
15	Statewide	Catholic Charities, Diocese of Trenton	383 W. State St., Box 1423	Trenton	NJ	08607	$2,163,709.00	$0.00	$0.00	$0.00	$0.00
1	Bergen	Comprehensive Behavioral Healthcare, Inc. (CompCare)	516 Valley Brook Avenue	Lyndhurst	NJ	07071	$340,337.00	$0.00	$0.00	$0.00	$0.00
14	Monmouth	CPC Behavioral Healthcare, Inc.	10 Industrial Way East	Eatontown	NJ	07724	$1,072,004.00	$0.00	$0.00	$0.00	$0.00
19	Cumberland, Salem	Cumberland County Guidance Center	2038 Carmel Road - Box 808	Millville	NJ	08332	$817,282.00	$0.00	$0.00	$0.00	$0.00
20	Salem	Healthcare Commons, Inc. - Family Health Services	500 South Pennsville-Auburn Road	Carneys Point	NJ	08069	$103,571.00	$0.00	$0.00	$0.00	$0.00
4	Hudson	Jersey City Medical Center	395 Grand Street, 3rd Floor	Jersey City	NJ	07302	$182,589.00	$0.00	$0.00	$0.00	$0.00
25	Atlantic, Cape May	Jewish Family Service of Atlantic County	607 N. Jerome Avenue	Margate	NJ	08402	$154,368.00	$0.00	$0.00	$0.00	$0.00
23	Burlington, Ocean, Mercer	Legacy Treatment Services (formerly The Lester A. Drenk Behavioral Health Center)	1289 Route 38 West, Suite 203	Hainesport	NJ	08036	$3,972.00	$0.00	$0.00	$0.00	$0.00
8	Essex	Mental Health Association of Essex County	33 South Fullerton Avenue	Montclair	NJ	07042	$867,252.00	$0.00	$0.00	$0.00	$0.00
27	Statewide	Mental Health Clinic of Passaic	1451 VanHouten Ave	Clifton	NJ	07013	$56,998.00	$0.00	$0.00	$0.00	$0.00
6	Essex	Newark Beth Israel Medical Center/St. Barnabas	201 Lyons Avenue at Osborne Terrace	Newark	NJ	07112	$0.00	$0.00	$0.00	$0.00	$0.00
18	Gloucester, Salem, Cumberland	NewPoint Behavioral Health Center	404 Tatum Street	Woodbury	NJ	08096	$0.00	$0.00	$0.00	$0.00	$0.00
22	Burlington, Camden, Mercer	Oaks Integrated Care (formerly Twin Oaks Community Services)	770 Woodlane Road	Mt. Holly	NJ	08060	$518,141.00	$0.00	$0.00	$518,141.00	$0.00
12	Ocean	Ocean Mental Health Services, Inc.	160 Route 9	Bayville	NJ	08721	$999,816.00	$0.00	$0.00	$0.00	$0.00
13	Ocean	Preferred Behavioral Health of NJ	700 Airport Road, P.O. Box 2036	Lakewood	NJ	08701	$908,001.00	$0.00	$0.00	$0.00	$0.00
9	Essex	Project Live	465-475 Broadway	Newark	NJ	07104	$452,625.00	$0.00	$0.00	$0.00	$0.00
		Rutgers - University									

5	Statewide	Behavioral Healthcare - NEWARK	Box 1392 - 671 Hoes Lane	Piscataway	NJ	08855	$0.00	$0.00	$0.00	$0.00	$0.00
21	Camden	South Jersey Behavioral Health Resources (CAMcare)	2500 McClellan Avenue, Suite 300	Pennsauken	NJ	08109	$751,692.00	$0.00	$0.00	$0.00	$0.00
2	Passaic	St. Joseph's Hospital & Medical Center	703 Main Street	Paterson	NJ	07503	$482,105.00	$0.00	$0.00	$0.00	$0.00
11	Statewide	Trinitas Hospital (Elizabeth General)	655 East Jersey Street	Elizabeth	NJ	07206	$10,695.00	$0.00	$0.00	$0.00	$0.00
10	Statewide	UMDNJ - University Behavioral Healthcare - PISCATAWAY	Box 1392 - 671 Hoes Lane	Piscataway	NJ	08855	$653,795.00	$0.00	$0.00	$653,795.00	$0.00
Total							$17,685,865.00	$0.00	$0.00	$2,050,540.00	$0.00

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Footnotes:

C. State Agency Expenditure Reports

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

Period (A)	Expenditures (B)	B1 (2019) + B2 (2020) 2 (C)
SFY 2019 (1)	$467,306,902	
SFY 2020 (2)	$490,412,748	$478,859,825
SFY 2021 (3)	$470,319,447	

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

SFY 2019	Yes	X	No	
SFY 2020	Yes	X	No	
SFY 2021	Yes	X	No	

If estimated expenditures are provided, please indicate when actual expenditure data will be submitted to SAMHSA: _____

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Footnotes:

The FY 2020 figure is to be adjusted to $490,412,748 through a revision request as of December 1, 2021.

D. Population and Services Report

MHBG Table 7 (URS Table 1) - Profile of the State Population by Diagnosis

This table summarizes the estimates of adults residing within the state with serious mental illness (SMI) and children residing within the state with serious emotional disturbances (SED). The table calls for estimates for two-time periods, one for the report year and one for three years into the future. CMHS will provide this data to states based on the standardized methodology developed and published in the Federal Register and the state level estimates for both adults with SMI and children with SED.

Expenditure Period Start Date: Expenditure Period End Date:

	Current Report Year	Three Years Forward
Adults with Serious Illness (SMI)		
Children with Serious Emotional Disturbances (SED)		

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Footnotes:

D. Population and Services Report

MHBG Table 8A and MHBG Table 8B (URS Tables 2A and 2B) - Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity

This table provides an aggregate profile of persons in the reporting year. The reporting year should be the latest state fiscal year for which data are available. This profile is based on a client receiving services in programs provided or funded by the state mental health agency. The client profile takes into account all institutional and community services for all such programs. Please provide unduplicated counts if possible.

Table 13A

Expenditure Period Start Date: 7/1/2020 Expenditure Period End Date: 6/30/2021

	Total			American Indian or Alaska Native			Asian			Black or African American			Native Hawaiian or Other Pacific Islander			White			More Than One Race Reported			Race Not Available		
	Female	Male	Not Available	Total	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available
0-12 years	1,263	1,806	0	3,069	2	5	0	15	14	0	170	297	0	0	0	0	410	550	0	0	0	0	666	940	0
13-17 years	3,350	4,114	3	7,467	11	21	0	56	65	0	461	639	0	0	0	0	1,162	1,279	2	0	0	0	1,660	2,110	1
18-20 years	3,143	4,074	26	7,243	21	32	0	47	74	0	438	705	2	0	0	0	1,254	1,314	5	0	0	0	1,383	1,949	19
21-24 years	6,294	7,303	12	13,609	29	46	0	134	140	0	1,005	1,421	2	0	0	0	2,466	2,642	4	0	0	0	2,660	3,054	6
25-44 years	52,145	52,989	181	105,315	395	473	3	978	1,017	3	10,430	12,096	23	0	0	0	24,549	23,891	64	0	0	0	15,793	15,512	88
45-64 years	74,082	59,233	323	133,638	781	602	2	1,041	799	5	14,321	11,959	46	0	0	0	40,979	33,856	168	0	0	0	16,960	12,017	102
65-74 years	27,191	20,568	136	47,895	285	246	2	330	212	2	4,443	3,470	17	0	0	0	16,421	13,362	82	0	0	0	5,712	3,278	33
75 and older	24,289	13,512	109	37,910	244	136	2	230	163	1	3,335	1,771	6	0	0	0	15,927	9,318	72	0	0	0	4,553	2,124	28
Age not Available	1,864	943	29	2,836	18	14	2	13	6	0	151	86	0	0	0	0	1,514	742	5	0	0	0	168	95	22
Total	193,621	164,542	819	358,982	1,786	1,575	11	2,844	2,490	11	34,754	32,444	96	0	0	0	104,682	86,954	402	0	0	0	49,555	41,079	299
Pregnant Women	0	0	0	0	0			0			0			0			0			0			0		

Are these numbers unduplicated?

- [x] Unduplicated
- [ ] Duplicated : between Hospitals and Community
- [ ] Duplicated : Among Community Programs
- [ ] Duplicated between children and adults
- [ ] Other : describe

Comments on Data (for Age):	
Comments on Data (for Gender):	Pregnancy is not collected in USTF
Comments on Data (for Race/Ethnicity):	Pacific Islanders are coded in USTF data as a single category Asian/Pacific Islander. All results are listed under Asian in URS table. USTF system does not have a code for multiple races.
Comments on Data (Overall):	Since the 2020 removal of Hispanic Origin from URS Table 2A, consumers coded in USTF with Race/Ethnicity coded as "Hispanic" have been included in "Race Not Available."

Table 13B

Of the total persons served, please indicate the age, gender and the number of persons who are Hispanic/Latino or not Hispanic/Latino. Total persons served would be the total as indicated in Table 13A.

Expenditure Period Start Date: 7/1/2020 Expenditure Period End Date: 6/30/2021

	Not Hispanic or Latino			Hispanic or Latino			Hispanic or Latino Origin Not Available			Total			
	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Total
0-12 years	688	994	0	396	577	0	179	235	0	1,263	1,806	0	3,069
13-17 years	2,063	2,568	2	944	1,160	1	343	386	0	3,350	4,114	3	7,467
18-20 years	2,134	2,862	19	699	973	1	310	239	6	3,143	4,074	26	7,243
21-24 years	4,619	5,401	7	1,315	1,575	1	360	327	4	6,294	7,303	12	13,609
25-44 years	40,661	41,379	98	8,988	9,445	15	2,496	2,165	68	52,145	52,989	181	105,315
45-64 years	60,306	49,790	234	11,163	7,408	39	2,613	2,035	50	74,082	59,233	323	133,638
65-74 years	22,323	17,946	107	4,151	2,155	9	717	467	20	27,191	20,568	136	47,895
75 and older	20,391	11,766	83	3,392	1,466	10	506	280	16	24,289	13,512	109	37,910
Age not Available	1,723	863	8	91	49	1	50	31	20	1,864	943	29	2,836
Total	154,908	133,569	558	31,139	24,808	77	7,574	6,165	184	193,621	164,542	819	358,982
Pregnant Women	0			0			0			0	0	0	0

Comments on Data (for Age):	
Comments on Data (for Gender):	
Comments on Data (for Ethnicity):	
Comments on Data (Overall):	The NJ State Mental Health Authority does not collect data on pregnant women

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Footnotes:

D. Population and Services Report

MHBG Table 9 (URS Table 3) - Profile of Persons served in the Community Mental Health Settings, State Psychiatric Hospitals and Other Settings

Expenditure Period Start Date: 7/1/2020 Expenditure Period End Date: 6/30/2021

This table provides a profile for the clients that received public funded mental health services in community mental health settings, in state psychiatric hospitals, in other psychiatric inpatient programs, and in residential treatment centers for children. Note: Clients can be duplicated between Rows: e.g., The same client may be served in both state psychiatric hospitals and community mental health centers during the same year and thus would be reported in counts for both rows.

Service Setting	Age 0-17			Age 18-20			Age 21-64			Age 65+			Age Not Available			Total			
	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Total
Community Mental Health Programs	4,609	5,961	3	3,161	4,104	26	133,096	118,315	458	51,363	33,558	234	1,732	865	28	193,961	162,803	749	357,513
State Psychiatric Hospitals	0	0	0	5	13	0	445	1,350	0	70	107	0	0	0	0	520	1,470	0	1,990
Other Psychiatric Inpatient	31	33	0	24	56	0	5,225	6,721	60	1,870	1,754	11	132	74	1	7,282	8,638	72	15,992
Residential Treatment Centers	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Institutions in the Justice System	1	0	0	0	3	0	158	529	2	36	112	1	1	5	0	196	649	3	848

Comments on Data (for Age):

Comments on Data (for Gender):

Comments on Data (Overall):

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Footnotes:

D. Population and Services Report

MHBG Table 10A and MHBG Table 10B (URS Tables 5A and 5B) - Profile of Clients by Type of Funding Support

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Table 10A

This table provides a summary of clients by Medicaid coverage. Since the focus of the reporting is on clients of the public mental health service delivery system, this table focuses on the clientele serviced by public programs that are funded or operated by the State Mental Health Authority. Persons are to be counted in the Medicaid row if they received a service reimbursable through Medicaid.

Please note that the same person may be served in both Medicaid and Non-Medicaid programs during the same reporting period.

Expenditure Period Start Date: 7/1/2020 Expenditure Period End Date: 6/30/2021

	Total				American Indian or Alaska Native			Asian			Black or African American			Native Hawaiian or Other Pacific Islander			White			More Than One Race Reported			Race Not Available		
	Female	Male	Not Avail	Total	Female	Male	Not Avail	Female	Male	Not Avail	Female	Male	Not Avail	Female	Male	Not Avail	Female	Male	Not Avail	Female	Male	Not Avail	Female	Male	Not Avail
Medicaid (only Medicaid)	54,641	41,749	162	96,552	566	407	0	648	537	2	13,994	11,613	30	0	0	0	22,121	16,019	87	0	0	0	17,312	13,173	43
Non-Medicaid Sources (only)	94,085	83,186	376	177,647	923	898	9	1,392	1,158	5	12,633	13,124	35	0	0	0	60,234	51,320	224	0	0	0	18,903	16,686	103
People Served by Both Medicaid and Non-Medicaid Sources	12,244	10,302	59	22,605	111	89	0	138	146	0	2,650	2,263	6	0	0	0	6,416	5,400	40	0	0	0	2,929	2,404	13
Medicaid Status Not Available	32,651	29,305	222	62,178	186	181	2	666	649	4	5,477	5,444	25	0	0	0	15,911	14,215	51	0	0	0	10,411	8,816	140
Total Served	193,621	164,542	819	358,982	1,786	1,575	11	2,844	2,490	11	34,754	32,444	96	0	0	0	104,682	86,954	402	0	0	0	49,555	41,079	299

☐ Data Based on Medicaid Services ☑ Data Based on Medical Eligibility, not Medicaid Paid Services ☐ 'People Served By Both' includes people with any Medicaid

Comments on Data (for Race):

The New Jersey State Mental Health Authority does not collect race data for "Native Hawaiian or Other Pacific Islander" or "More than One Race Reported."

Comments on Data (for Gender):

Comments on Data (Overall):

Each row should have a unique (unduplicated) count of clients: (1) Medicaid Only, (2) Non-Medicaid Only, (3) Both Medicaid and Other Sources funded

their treatment, and (4) Medicaid Status Not Available.

If a state is unable to unduplicate between people whose care is paid for by Medicaid only or Medicaid and other funds, then all data should be reported into the 'People Served by Both Medicaid and Non-Medicaid Sources' and the 'People Served by Both includes people with any Medicaid' check box should be checked.

Table 10B

Of the total persons covered by Medicaid, please indicate the gender and number of persons who are Hispanic/Latino or not Hispanic/Latino. Total persons covered by Medicaid would be the total indicated in Table 10A.
Please note that the same person may be served in both Medicaid and Non-Medicaid programs during the same reporting period.

Expenditure Period Start Date: 7/1/2020 Expenditure Period End Date: 6/30/2021

	Hispanic or Latino			Not Hispanic or Latino			Hispanic or Latino Origin Not Available			Total			
	Female	Male	Not Avail	Female	Male	Not Avail	Female	Male	Not Avail	Female	Male	Not Avail	Total
Medicaid Only	13,859	10,298	34	40,015	30,856	122	767	595	6	54,641	41,749	162	96,552
Non-Medicaid Only	12,310	10,438	30	80,536	71,745	285	1,239	1,003	61	94,085	83,186	376	177,647
People Served by Both Medicaid and Non-Medicaid Sources	1,964	1,409	2	10,029	8,674	46	251	219	11	12,244	10,302	59	22,605
Medicaid Status Unknown	3,006	2,663	11	24,328	22,294	105	5,317	4,348	106	32,651	29,305	222	62,178
Total Served	154,908	133,569	558	31,139	24,808	77	7,574	6,165	184	193,621	164,542	819	358,982

Comments on Data (for Ethnicity):

Comments on Data (for Gender):

Comments on Data (Overall):

Each row should have a unique (unduplicated) count of clients: (1) Medicaid Only, (2) Non-Medicaid Only, (3) Both Medicaid and Other Sources funded their treatment, and (4) Medicaid Status Unknown.

Footnotes:

D. Population and Services Report

MHBG Table 11 (URS Table 6) - Profile of Client Turnover

Expenditure Period Start Date: 7/1/2020 Expenditure Period End Date: 6/30/2021

Profile of Service Utilization	Total Served at Beginning of Year (unduplicated)	Admissions During the year (duplicated)	Discharges During the year (duplicated)	Length of Stay (in Days): Discharged Patients		For Clients in Facility for Less Than 1 Year: Length of Stay (in Days): Residents at end of year		For Clients in Facility More Than 1 Year: Length of Stay (in Days): Residents at end of year	
				Average (Mean)	Median	Average (Mean)	Median	Average (Mean)	Median
State Hospitals	**1,236**	**754**	**849**	**0**	**0**	**0**	**0**	**0**	**0**
Children (0 to 17 years)	0	0	0	0	0	0	0	0	0
Adults (18 yrs and over)	1,236	754	849	570	260	148	134	1,704	924
Age Not Available	0	0	0	0	0	0	0	0	0
Other Psychiactric Inpatient	**15,992**	**156**	**38**	**0**	**0**	**0**	**0**	**0**	**0**
Children (0 to 17 years)	64	30	21	8	7	8	7	0	0
Adults (18 yrs and over)	15,721	125	17	14	9	14	9	0	0
Age Not Available	207	1	0	0	0	0	0	0	0
Residential Tx Centers	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Children (0 to 17 years)	0	0	0	0	0	0	0	0	0
Adults (18 yrs and over)	0	0	0	0	0	0	0	0	0
Age Not Available	0	0	0	0	0	0	0	0	0
Community Programs	**357,513**	**12,336**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Children (0 to 17 years)	10,573	1,491							
Adults (18 yrs and over)	344,315	10,835							
Age Not Available	2,625	10							

Comments on Data (State Hospital):

Comments on Data (Other Inpatient):

Comments on Data (Residential Treatment):

Comments on Data (Community Programs):

Comments on Data (Overall):

Footnotes:

D. Population and Services Report

MHBG Table 12 (URS Table 12) - State Mental Health Agency Profile

The purpose of this profile is to obtain information that provides a context for the data provided in the tables. This profile covers the populations served, services for which the state mental health agency is responsible, data reporting capacities, especially related to duplication of numbers served as well as certain summary administrative information.

Expenditure Period Start Date: 7/1/2020 Expenditure Period End Date: 6/30/2021

Populations Served

1. Which of the following populations receive services operated or funded by the state mental health agency? Please indicate if they are included in the data provided in the tables. (Check all that apply.)

	Populations Covered:		Included in Data	
	State Hospitals	Community Programs	State Hospitals	Community Programs
1. Aged 0 to 3	☐ Yes	☐ Yes	☐ Yes	☐ Yes
2. Aged 4 to 17	☐ Yes	☑ Yes	☐ Yes	☑ Yes
3. Adults Aged 18 and over	☑ Yes	☑ Yes	☑ Yes	☑ Yes
4. Forensics	☑ Yes	☑ Yes	☑ Yes	☑ Yes
Comments on Data:	For state hospitals, data is included only when inpatient data is requested.			

2. Do all of the adults and children served through the state mental health agency meet the Federal definitions of serious mental illness and serious emotional disturbances?

☑ Serious Mental Illness
☑ Serious Emotional Disturbances

2.a. If no, please indicate the percentage of persons served for the reporting period who met the federal definitions of serious mental illness and serious emotional disturbance?

2.a.1. Percent of adults meeting Federal definition of SMI: 37.9 %

2.a.2. Percentage of children/adolescents meeting Federal definition of SED: 32.0 %

3. Co-Occurring Mental Health and Substance Abuse:

3.a. What percentage of persons served by the SMHA for the reporting period have a dual diagnosis of mental illness and substance abuse?

3.a.1. Percentage of adults served by the SMHA who also have a diagnosis of substance abuse problem: 18.9 %

3.a.2. Percentage of children/adolescents served by the SMHA who also have a diagnosis of substance abuse problem: 1.5 %

3.b. What percentage of persons served for the reporting period who met the Federal definitions of adults with SMI and children with SED have a dual diagnosis of mental illness and substance abuse?

3.b.1. Percentage of adults meeting Federal definition of SMI who also have a diagnosis of substance abuse problem: 24.2 %

3.b.2. Percentage of children/adolescents meeting the Federal definition of SED who also have a diagnosis of substance abuse problem: 2.0 %

3.b.3. Please describe how you calculate and count the number of persons with co-occurring disorders.

4. State Mental Health Agency Responsibilities

a. Medicaid: Does the State Mental Health Agency have any of the following responsibilities for mental health services provided through Medicaid? (Check All that Apply)

	1. State Medicaid Operating Agency	☑
	2. Setting Standards	☑
	3. Quality Improvement/Program Compliance	☐
	4. Resolving Consumer Complaints	☐
	5. Licensing	☑
	6. Sanctions	☑
	7. Other	

	b. Managed Care (Mental Health Managed Care)		**Are Data for these programs reported on URS Tables?**
4.b.1	Does the State have a Medicaid Managed Care initiative?	☑ Yes	☐ Yes
4.b.2	Does the State Mental Health Agency have any responsibilities for mental health services provided through Medicaid Managed Care?	☐ Yes	☐ Yes

If yes, please check the responsibilities the SMHA has:

4.b.3	Direct contractual responsibility and oversight of the MCOs or BHOs	☐ Yes
4.b.4	Setting Standards for mental health services	☐ Yes
4.b.5	Coordination with state health and Medicaid agencies	☐ Yes
4.b.6	Resolving mental health consumer complaints	☐ Yes
4.b.7	Input in contract development	☐ Yes
4.b.8	Performance monitoring	☐ Yes
4.b.9	Other	

5. Data Reporting: Please describe the extent to which your information systems allows the generation of unduplicated client counts between different parts of your mental health system. Please respond in particular for Table MHBG 13a and MHBG 13b, which require unduplicated counts of clients served across your entire mental health system.

Are the data reporting in the tables?

5.a.	**Unduplicated:** counted once even if they were served in both State hospitals and community programs and if they were served in community mental health agencies responsible for different geographic or programmatic areas.	☑
5.b.	**Duplicated:** across state hospital and community programs	☐
5.c.	**Duplicated:** within community programs	☐
5.d.	**Duplicated:** Between Child and Adult Agencies	☐
5.e.	**Plans for Unduplication:** If you are not currently able to provide unduplicated client counts across all parts of your mental health system, please describe your plans to get unduplicated client counts by the end of your Data Infrastructure Grant.	

6. Summary Administrative Data

6.a.	Report Year:	FY 2021
6.b.	State Identifier:	NJ

Summary Information on Data Submitted by SMHA:

6.c.	Year being reported:	7/1/2020 12:00:00 AM to 6/30/2021 12:00:00 AM
6.d.	Person Responsible for Submission:	Donna Migliorino
6.e.	Contact Phone Number:	609-438-4295
6.f.	Contact Address:	5 Commerce Way, Suite 100, Hamilton, NJ 08691
6.g.	E-mail:	Donna.Migliorino@dhs.nj.gov

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Footnotes:

D. Population and Services Report

MHBG Tables 13A and 13B (URS Tables 14A and 14B) - Profile of Persons with SMI/SED Served By Age, Gender and Race/Ethnicity

Table 13A

This table requests counts for persons with SMI or SED using the definitions provided by SAMHSA. MHBG Table 8A and 8B (URS Table 2A and 2B) included all clients served by publicly operated or funded programs. This table counts only clients who meet the federal definition of SMI or SED. For many states, this table may be the same as MHBG Tables 8A and 8B (URS Table 2A and 2B). States should report using the Federal Definitions of SMI and SED if they can report them, if not, please report using your state's definitions of SMI and SED and provide information below describing your state's definition.

Expenditure Period Start Date: 7/1/2020 Expenditure Period End Date: 6/30/2021

	Total			American Indian or Alaska Native			Asian			Black or African American			Native Hawaiian or Other Pacific Islander			White			More Than One Race Reported			Race Not Available		
	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available
0-12 years	337	556	0	2	1	0	4	4	0	65	125	0	0	0	0	81	143	0	0	0	0	185	283	0
13-17 years	1,003	1,476	1	4	10	0	12	25	0	161	285	0	0	0	0	347	407	1	0	0	0	479	749	0
18-20 years	1,095	1,537	3	6	9	0	13	28	0	175	363	1	0	0	0	434	476	1	0	0	0	467	661	1
21-24 years	2,113	2,841	2	6	13	0	42	50	0	439	704	0	0	0	0	741	941	0	0	0	0	885	1,133	2
25-44 years	17,703	20,406	49	92	141	0	359	410	0	4,201	5,436	9	0	0	0	7,530	8,265	24	0	0	0	5,521	6,154	16
45-64 years	25,585	24,263	113	235	209	1	382	309	1	6,196	5,955	25	0	0	0	12,335	12,524	64	0	0	0	6,437	5,266	22
65-74 years	9,840	8,546	53	99	101	1	125	74	1	2,070	1,718	8	0	0	0	5,237	5,204	35	0	0	0	2,309	1,449	8
75 and older	10,447	6,074	49	107	59	1	99	66	1	1,693	930	3	0	0	0	6,459	3,970	38	0	0	0	2,089	1,049	6
Age not Available	879	387	5	6	8	1	4	3	0	70	43	0	0	0	0	724	305	1	0	0	0	75	28	3
Pregnant Women	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	69,002	66,086	275	557	551	4	1,040	969	3	15,070	15,559	46	0	0	0	33,888	32,235	164	0	0	0	18,447	16,772	58

Comments on Data (for Age):	
Comments on Data (for Gender):	
Comments on Data (for Race/Ethnicity):	

Comments on Data (Overall):	The New Jersey State Mental Health Authority does not collect race data for "Native Hawaiian or Other Pacific Islander" or for "More than One Race Reported."

1. State Definitions Match the Federal Definitions

(●) Yes ( ) No Adults with SMI, if No describe or attach state definition:

( ) Yes (●) No Diagnoses included in the state SMI definition:

(●) Yes ( ) No Children with SED, if No describe or attach state definition:

( ) Yes (●) No Diagnoses included in the state SED definition:

Table 13B

Of the total persons served, please indicate the age, gender and the number of persons who meet the Federal definition of SMI and SED and who are Hispanic/Latino or not Hispanic/Latino. The total persons served who meet the Federal definition of SMI or SED should be the total as indicated in MHBG Table 13b.

Expenditure Period Start Date: 7/1/2020 Expenditure Period End Date: 6/30/2021

	Not Hispanic or Latino			Hispanic or Latino			Hispanic or Latino Origin Not Available			Total			
	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Total
0-12 years	169	307	0	97	149	0	71	100	0	337	556	0	893
13-17 years	607	884	1	280	427	0	116	165	0	1,003	1,476	1	2,480
18-20 years	730	1,051	2	245	395	1	120	91	0	1,095	1,537	3	2,635
21-24 years	1,447	1,977	0	507	707	1	159	157	1	2,113	2,841	2	4,956
25-44 years	13,252	15,344	35	3,412	4,120	7	1,039	942	7	17,703	20,406	49	38,158
45-64 years	20,097	19,877	92	4,475	3,529	15	1,013	857	6	25,585	24,263	113	49,961
65-74 years	7,785	7,340	46	1,855	1,071	5	200	135	2	9,840	8,546	53	18,439
75 and older	8,689	5,207	43	1,646	791	4	112	76	2	10,447	6,074	49	16,570
Age not Available	817	365	2	49	18	0	13	4	3	879	387	5	1,271
Pregnant Women	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	53,593	52,352	221	12,566	11,207	33	2,843	2,527	21	69,002	66,086	275	135,363

Comments on Data (for Age):	
Comments on Data (for Gender):	

Comments on Data (for Race/Ethnicity):	The New Jersey State Mental Health Authority does not collect race data for "Native Hawaiian or Other Pacific Islander" or for "More than One Race Reported."
Comments on Data (Overall):	

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Footnotes:

D. Population and Services Report

MHBG Table 14 (URS Table 15A) - Profile of Persons served in the community mental health setting, State Psychiatric Hospitals and Other Settings for Adults with SMI and Children with SED

This table provides a profile for adults with Serious Mental Illness (SMI) and children with serious emotional disturbance (SED) that received public funded mental health services in community mental health settings, in state psychiatric hospitals, in other psychiatric inpatient programs, residential treatment centers and Institutions under Justice System.

Expenditure Period Start Date: 7/1/2020 Expenditure Period End Date: 6/30/2021

Service Setting	Age 0-17			Age 18-20			Age 21-64			Age 65+			Age Not Available			Total			
	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Total
Community Mental Health Programs	1,325	2,016	1	1,081	1,510	3	42,548	43,557	145	19,227	13,533	95	771	324	5	64,952	60,940	249	126,141
State Psychiatric Hospitals	0	0	0	5	13	0	445	1,350	0	70	107	0	0	0	0	520	1,470	0	1,990
Other Psychiatric Inpatient	14	16	0	14	25	0	2,780	3,662	18	1,045	1,026	7	108	62	0	3,961	4,791	25	8,777
Residential Treatment Centers	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Institutions in the Justice System	1	0	0	0	13	0	73	291	1	15	61	0	0	1	0	89	366	1	456

Comments on Data (for Age):

Comments on Data (for Gender):

Comments on Data (Overall):

Note: *Clients can be duplicated between Rows (e.g. The same client may be served in both state psychiatric hospitals and community mental health centers during the same year and thus would be reported in counts for both rows).*

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Footnotes:

E. Performance Indicators and Accomplishments

MHBG Table 15A (URS Table 4) - Profile of Adult Clients by Employment Status

This table describes the status of adult clients served in the reporting year by the public mental health system, in terms of employment status. The focus is on employment for the working age population, recognizing, however, there are clients who are disabled, retired, or who are homemakers, care-givers, etc., and not a part of the workforce. These persons should be reported in the "Not in Labor Force" category. Unemployed refers to persons who are looking for work but have not found employment. Data should be reported for clients in non-institutional settings at time of discharge or last evaluation.

Expenditure Period Start Date: 7/1/2020 Expenditure Period End Date: 6/30/2021

Adults Served	18-20			21-64			65+			Age Not Available			Total			
	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Avail	Total
Employed: Competitively Employed Full or Part Time (includes Supported Employment)	266	190	0	33,353	25,139	92	11,602	9,042	40	0	0	0	**45,221**	**34,371**	**132**	**79,724**
Unemployed	402	435	0	40,316	33,318	88	16,702	11,558	63	0	0	0	**57,420**	**45,311**	**151**	**102,882**
Not In Labor Force: Retired, Sheltered Employment, Sheltered Workshops, Other (homemaker, student, volunteer, disabled, etc.)	1,979	2,950	1	41,818	43,712	110	17,562	9,169	60	0	0	0	**61,359**	**55,831**	**171**	**117,361**
Not Available	474	436	25	13,081	11,533	169	4,327	2,936	73	0	0	0	**17,882**	**14,905**	**267**	**33,054**
Total	**3,121**	**4,011**	**26**	**128,568**	**113,702**	**459**	**50,193**	**32,705**	**236**	**0**	**0**	**0**	**181,882**	**150,418**	**721**	**333,021**

How Often Does your State Measure Employment Status? ☑ At Admission ☑ At Discharge ☐ Monthly ☐ Quarterly ☐ Other, describe:

What populations are included: ○ All clients ○ Only selected groups, describe:

Comments on Data (for Age):
Age "Not Available" was not computed since it could include children from the database.

Comments on Data (for Gender):

Comments on Data (Overall):

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Footnotes:

E. Performance Indicators and Accomplishments

MHBG Table 15B (URS Table 4A) - Optional Table: Profile of Adult Clients by Employment Status: by Primary Diagnosis Reported

The workgroup exploring employment found that, the primary diagnosis of consumer results in major differences in employment status. The workgroup has recommended that we explore the ability of states to report employment by primary diagnosis and the impact of diagnosis on employment. The workgroup recommended 5 diagnostic clusters for reporting.

Expenditure Period Start Date: 7/1/2020 Expenditure Period End Date: 6/30/2021

Clients Primary Diagnosis	Employed: Competitively Employed Full or Part Time (includes Supported Employment)	Unemployed	Not In Labor Force: Retired, Sheltered Employment, Sheltered Workshops, Other (homemaker, student, volunteer, disabled, etc.)	Employment Status Not Available	Total
Schizophrenia & Related Disorders (F20, F25)	1,831	13,500	11,103	1,950	**28,384**
Bipolar and Mood Disorders (F30,F31,F32,F33,F34.1,F60.89,F34.0,F32.9)	17,115	30,281	22,617	5,409	**75,422**
Other Psychoses (F22,F23,F24,F28,F29)	592	1,836	1,395	237	**4,060**
All Other Diagnoses	30,551	25,958	43,554	6,717	**106,780**
No DX and Deferred DX (R69,R99,Z03.89)	29,635	31,307	38,692	18,741	**118,375**
Diagnosis Total	**79,724**	**102,882**	**117,361**	**33,054**	**333,021**

Comments on Data (for Diagnosis):

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Footnotes:

E. Performance Indicators and Accomplishments

MHBG Table 16 (URS Table 9) - Social Connectedness and Improved Functioning

Expenditure Period Start Date: Expenditure Period End Date:

Adult Consumer Survey Results	Number of Positive Responses	Responses	Percent Positive (calculated)
1. Social Connectedness	588	687	86%
2. Functioning	619	702	88%
Child/Adolescent Consumer Survey Results	**Number of Positive Responses**	**Responses**	**Percent Positive (calculated)**
3. Social Connectedness	570	704	81%
4. Functioning	439	730	60%
Comments on Data:			

Adult Social Connectedness and Functioning Measures

1. Did you use the recommended new Social Connectedness Questions? (●) Yes ( ) No

2. Did you use the recommended new Functioning Domain Questions? Measure used (●) Yes ( ) No

3. Did you collect these as part of your MHSIP Adult Consumer Survey? Measure used (●) Yes ( ) No
   If No, what source did you use?

Child/Family Social Connectedness and Functioning Measures

4. Did you use the recommended new Social Connectedness Questions? (●) Yes ( ) No

5. Did you use the recommended new Functioning Domain Questions? Measure used (●) Yes ( ) No

6. Did you collect these as part of your YSS-F Survey? Measure used (●) Yes ( ) No
   If No, what source did you use?

Recommended Scoring Rules

Please use the same rules for reporting Social connectedness and Functioning Domain scores as for calculating other Consumer Survey Domain scores for Table MHBG Table 18a: E.g.:

1. Recode ratings of "not applicable" as missing values.
2. Exclude respondents with more than 1/3 of the items in that domain missing
3. Calculate the mean of the items for each respondent.
4. FOR ADULTS: calculate the percent of scores less than 2.5 (percent agree and strongly agree).
5. FOR YSS-F: calculate the percent of scores greater than 3.5 (percent agree and strongly agree).

Footnotes:

E. Performance Indicators and Accomplishments

MHBG Table 17A (URS Table 11) - Summary Profile of Client Evaluation of Care

Expenditure Period Start Date: 7/1/2020 Expenditure Period End Date: 6/30/2021

Adult Consumer Survey Results:	Number of Positive Responses	Responses	Confidence Interval*
1. Reporting Positively about Access.	609	729	5.3
2. Reporting Positively about Quality and Appropriateness for Adults.	604	706	5.2
3. Reporting Positively about Outcomes.	536	691	6
4. Adults Reporting on Participation In Treatment Planning.	591	622	6.7
5. Adults Positively about General Satisfaction with Services.	673	728	5.4

Child/Adolescent Consumer Survey Results:	Number of Positive Responses	Responses	Confidence Interval*
1. Reporting Positively about Access.	631	752	
2. Reporting Positively about General Satisfaction for Children.	584	763	
3. Reporting Positively about Outcomes for Children.	426	730	
4. Family Members Reporting on Participation In Treatment Planning for their Children.	652	762	
5. Family Members Reporting High Cultural Sensitivity of Staff.	687	759	

Please enter the number of persons responding positively to the questions and the number of total responses within each group. Percent positive will be calculated from these data.

**** Please report Confidence Intervals at the 95% level. See directions below regarding the calculation of confidence intervals.***

Comments on Data:

Adult Consumer Surveys

1. Was the Official 28 Item MHSIP Adult Outpatient Consumer Survey Used? ○ Yes ◉ No

1.a. If no, which version:

1. Original 40 Item Version ◉ Yes
2. 21-Item Version ○ Yes
3. State Variation of MHSIP ○ Yes

4. Other Consumer Survey ○ Yes

1.b. If other, please attach instrument used.

1.c. Did you use any translations of the MHSIP into another language?
☐ 1. Spanish
☐ 2. Other Language:

Adult Survey Approach

2. Populations covered in survey? (Note all surveys should cover all regions of state)
○ 1. All Consumers In State
◉ 2. Sample of MH Consumers

2.a. If a sample was used, what sample methodology was used?
○ 1. Random Sample
◉ 2. Stratified / Random Stratified Sample
○ 3. Convenience Sample
○ 4. Other Sample:

2.b. Do you survey only people currently in services, or do you also survey persons no longer in service?
☑ 1. Persons Currently Receiving Services
☐ 2. Persons No Longer Receiving Services

3. Please describe the populations included in your sample: (e.g., all adults, only adults with SMI, etc.)
☑ 1. All Adult Consumers In State
☐ 2. Adults With Serious Mental Illness
☐ 3. Adults Who Were Medicaid Eligible Or In Medicaid Managed Care
☐ 4. Other (for example, if you survey anyone served in the last 3 months, describe that here):

4. Methodology of collecting data? (Check all that apply)

	Self-Administered	Interview
Phone	☐ Yes	☐ Yes
Mail	☐ Yes	
Face-to-face	☐ Yes	☐ Yes
Web-Based	☐ Yes	☐ Yes

4.b. Who administered the survey? (Check all that apply)
☐ 1. MH Consumers

- [ ] 2. Family Members
- [ ] 3. Professional Interviewers
- [ ] 4. MH Clinicians
- [ ] 5. Non Direct Treatment Staff
- [x] 6. Other, describe:

Web-based survey, shared by treatment staff/clinicians

5. Are Responses Anonymous, Confidential and/or Linked to other Patient Databases?
   - [x] 1. Responses are Anonymous
   - [x] 2. Responses are Confidential
   - [ ] 3. Responses are Matched to Client Databases

6. Sample Size and Response Rate

6.a. How Many surveys were Attempted (sent out or calls initiated)?	5,240
6.b. How many survey Contacts were made? (surveys to valid phone numbers or addresses)?	5,240
6.c. How many surveys were completed? (survey forms returned or calls completed)	739
6.d. What was your response rate? (number of Completed surveys divided by number of Contacts)	14.0 %

6.e. If you receive "blank" surveys back from consumers (surveys with no responses on them), did you count these surveys as "completed" for the calculation of response rates? ○ Yes ◉ No

7. Who Conducted the survey

7.a. SMHA Conducted or contracted for the survey (survey done at state level) ◉ Yes ○ No

7.b. Local Mental Health Providers/County mental health providers conducted or contracted for the survey (survey was done at the local or regional level) ○ Yes ○ No

7.c. Other, describe:

* Report Confidence Intervals at the 95% confidence level

Note: The confidence interval is the plus-or-minus figure usually reported in newspaper or television opinion poll results. For example, if you use a confidence interval of 4 and 47% percent of your sample picks an answer you can be "sure" that if you had asked the question of the entire relevant population between 43% (47-4) and 51% (47+4) would have picked that answer.
The confidence level tells you how sure you can be. It is expressed as a percentage and represents how often the true percentage of the population who would pick an answer lies within the confidence interval. The 95% confidence level means you can be 95% certain; the 99% confidence level means you can be 99% certain. Most researchers use the 95% confidence level.
When you put the confidence level and the confidence interval together, you can say that you are 95% sure that the true percentage of the population is between 43% and 51%. (From www.surveysystem.com)

Child / Family Consumer Surveys

1. Was the MHSIP Children / Family Survey (YSS-F) Used? [x] Yes

If no, what survey did you use?

If no, please attach instrument used.

1.c. Did you use any translations of the Child MHSIP into another language? [ ] 1. Spanish

☐ 2. Other Language:

Child Survey Approach

2. Populations covered in survey? (Note all surveys should cover all regions of state)
   - ◉ 1. All Consumers In State
   - ○ 2. Sample of MH Consumers

2.a. If a sample was used, what sample methodology was used?
   - ○ 1. Random Sample
   - ○ 2. Stratified / Random Stratified Sample
   - ○ 3. Convenience Sample
   - ○ 4. Other Sample:

2.b. Do you survey only people currently in services, or do you also survey persons no longer in service?
   - ☐ 1. Persons Currently Receiving Services
   - ☑ 2. Persons No Longer Receiving Services

2a. If yes to 2, please describe how your survey persons no longer receiving services.

3. Please describe the populations included in your sample: (e.g., all children, only children with SED, etc.)
   - ☑ 1. All Child Consumers In State
   - ☐ 2. Children with Serious Emotional Disturbances
   - ☐ 3. Children who were Medicaid Eligible or in Medicaid Managed Care
   - ☐ 4. Other (for example, if you survey anyone served in the last 3 months, describe that here):

4. Methodology of collecting data? (Check all that apply)

	Self-Administered	Interview
Phone	☐ Yes	☐ Yes
Mail	☐ Yes	
Face-to-face	☐ Yes	☐ Yes
Web-Based	☑ Yes	☐ Yes

4.b. Who administered the survey? (Check all that apply)
   - ☐ 1. MH Consumers
   - ☐ 2. Family Members
   - ☐ Professional Interviewers

3. ☐ MH Clinicians
4. ☐ Non Direct Treatment Staff
5. ☑ Other, describe:
6. State of NJ/DCF/Contracted Systems Administrator

5. Are Responses Anonymous, Confidential and/or Linked to other Patient Databases?
   1. ☐ Responses are Anonymous
   2. ☐ Responses are Confidential
   3. ☐ Responses are Matched to Client Databases

6. Sample Size and Response Rate

6.a. How Many surveys were Attempted (sent out or calls initiated)?	13,127
6.b. How many survey Contacts were made? (surveys to valid phone numbers or addresses)?	13,127
6.c. How many surveys were completed? (survey forms returned or calls completed)	764
6.d. What was your response rate? (number of Completed surveys divided by number of Contacts)	6.0 %

6.e. If you receive "blank" surveys back from consumers (surveys with no responses on them), did you count these surveys as "completed" for the calculation of response rates? ○ Yes ◉ No

7. Who Conducted the survey

7.a.	SMHA Conducted or contracted for the survey (survey done at state level)	◉ Yes ○ No
7.b.	Local Mental Health Providers/County mental health providers conducted or contracted for the survey (survey was done at the local or regional level)	○ Yes ◉ No
7.c.	Other, describe:	

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Footnotes:

E. Performance Indicators and Accomplishments

MHBG Table 17B (URS Table 11A) - Consumer Evaluation of Care by Consumer Characteristics: (Optional Table by Race/Ethnicity)

Expenditure Period Start Date: Expenditure Period End Date:

Adult Consumer Survey Results:

Indicators	Total		American Indian or Alaska Native		Asian		Black or African American		Native Hawaiian or Other Pacific Islander		White		More Than One Race Reported		Other / Not Available		Hispanic Origin	
	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses
1. Reporting Positively About Access.	609	729	0	0	14	15	100	118	1	1	272	330	25	29	197	236	79	91
2. Reporting Positively About Quality and Appropriateness.	604	706	0	0	13	15	105	117	1	1	271	318	25	29	189	226	79	91
3. Reporting Positively About Outcomes.	536	691	0	0	13	15	90	116	1	1	244	312	21	28	167	219	65	88
4. Reporting Positively about Participation in Treatment Planning	591	622	0	0	13	14	104	110	1	1	266	281	25	27	182	189	81	84
5. Reporting Positively about General Satisfaction	673	728	0	0	12	15	112	117	1	1	301	330	27	29	220	236	82	91
6. Social Connectedness	588	687	0	0	14	15	94	114	1	1	264	311	24	28	191	218	77	88
7. Functioning	619	702	0	0	13	15	103	118	1	1	286	317	24	28	192	223	79	88

Child/Adolescent Family Survey Results:

Indicators	Total		American Indian or Alaska Native		Asian		Black or African American		Native Hawaiian or Other Pacific Islander		White		More Than One Race Reported		Other / Not Available		Hispanic Origin	
	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses	# Positive	Responses
1. Reporting Positively About Access.	631	752	3	3	21	23	78	93	3	3	335	391	38	49	153	190	546	637
2. Reporting Positively About General Satisfaction	584	763	3	3	20	24	74	95	3	3	309	394	32	50	143	194	504	644

3. Reporting Positively About Outcomes.	426	730	3	3	14	23	46	94	3	3	238	393	27	50	95	164	393	642
4. Reporting Positively Participation in Treatment Planning for their Children.	652	762	3	3	19	23	82	95	3	3	339	394	42	50	164	194	560	644
5. Reporting Positively About Cultural Sensitivity of Staff.	687	759	3	3	22	23	88	94	3	3	358	392	46	50	167	194	589	641
6. Social Connectedness	570	704	3	3	19	23	81	94	3	3	304	384	52	60	108	137	524	643
7. Functioning	439	730	3	3	14	23	48	94	3	3	245	393	27	50	99	164	394	641

Comments on Data:

Please enter the number of persons responding positively to the questions and the number of total responses within each group. Percent positive will be calculated from these data.

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E. Performance Indicators and Accomplishments

MHBG Table 18 (URS Table 15) - Living Situation Profile

Number of Clients in Each Living Situation as Collected by the Most Recent Assessment in the Reporting Period
All Mental Health Programs by Age, Gender, and Race/Ethnicity

Please provide unduplicated counts, if possible. This table provides an aggregate profile of persons served in the reporting year. The reporting year should be the latest state fiscal year for which data are available. This profile is based on a client's last known Living Situation.
Please report the data under the Living Situation categories listed - "Total" are calculated automatically.
Expenditure Period Start Date: 7/1/2020 Expenditure Period End Date: 6/30/2021

	Private Residence	Foster Home	Residential Care	Crisis Residence	Children's Residential Treatment	Institutional Setting	Jail / Correctional Facility	Homeless / Shelter	Other	NA	Total
0-17	8,996	107	44	0	8	7	1	34	129	1,210	10,536
18-64	199,261	1,921	8,457	0	457	2,304	1,031	6,219	6,790	33,365	259,805
65+	53,983	202	6,163	0	5	2,156	191	1,636	3,647	17,822	85,805
Not Available	1,287	8	237	0	0	208	7	9	136	944	2,836
TOTAL	**263,527**	**2,238**	**14,901**	**0**	**470**	**4,675**	**1,230**	**7,898**	**10,702**	**53,341**	**358,982**
Female	146,137	1,054	6,539	0	239	2,031	268	3,135	5,634	28,584	193,621
Male	116,931	1,176	8,297	0	230	2,605	959	4,746	5,044	24,554	164,542
Not Available	459	8	65	0	1	39	3	17	24	203	819
TOTAL	**263,527**	**2,238**	**14,901**	**0**	**470**	**4,675**	**1,230**	**7,898**	**10,702**	**53,341**	**358,982**
American Indian/Alaska Native	2,099	12	164	0	8	33	9	104	267	676	3,372
Asian	3,848	43	207	0	5	49	6	70	115	1,002	5,345
Black/African American	48,116	973	3,840	0	157	1,046	461	2,890	2,400	7,411	67,294
Hawaiian/Pacific Islander	0	0	0	0	0	0	0	0	0	0	0
White/Caucasian	140,483	808	8,939	0	179	2,916	561	3,511	5,447	29,194	192,038
More than One Race Reported	0	0	0	0	0	0	0	0	0	0	0

Race/Ethnicity Not Available	68,981	402	1,751	0	121	631	193	1,323	2,473	15,058	90,933
TOTAL	**263,527**	**2,238**	**14,901**	**0**	**470**	**4,675**	**1,230**	**7,898**	**10,702**	**53,341**	**358,982**

	Private Residence	Foster Home	Residential Care	Crisis Residence	Children's Residential Treatment	Institutional Setting	Jail / Correctional Facility	Homeless / Shelter	Other	NA	Total
Hispanic or Latino Origin	212,522	1,994	13,632	0	386	4,201	1,085	6,959	8,502	39,754	289,035
Non Hispanic or Latino Origin	47,288	227	1,083	0	79	406	128	839	2,104	3,870	56,024
Hispanic or Latino Origin Not Available	3,717	17	186	0	5	68	17	100	96	9,717	13,923
TOTAL	**263,527**	**2,238**	**14,901**	**0**	**470**	**4,675**	**1,230**	**7,898**	**10,702**	**53,341**	**358,982**

Comments on Data:	
How Often Does your State Measure Living Situation?	☑ At Admission ☑ At Discharge ☐ Monthly ☐ Quarterly ☐ Other: Describe

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E. Performance Indicators and Accomplishments

MHBG Table 19 (URS Table 16) - Profile of Adults With Serious Mental Illnesses And Children With Serious Emotional Disturbances Receiving Specific Services

Expenditure Period Start Date: 7/1/2020 Expenditure Period End Date: 6/30/2021

Age	Adults with Serious Mental Illnesses (SMI)				Children with Serious Emotional Disturbances (SED)			
	N Receiving Supported Housing	N Receiving Supported Employment	N Receiving Assertive Community Treatment	Total unduplicated N - Adults with SMI Served	N Receiving Therapeutic Foster Care	N Receiving Multi-Systemic Therapy	N Receiving Family Functional Therapy	Total unduplicated N - Children with SED
0-12 years					0	11	79	24,178
13-17 years					0	82	187	19,916
18-20 years	0	0	0	0	0	0	1	2,448
21-64 years	0	0	0	0				
65-74 years	0	0	0	0				
75+ years	0	0	0	0				
Not Available	4,789	1,315	2,087	131,990	0	0	0	66
Total	4,789	1,315	2,087	131,990	0	93	267	46,608

Gender	Adults with Serious Mental Illnesses (SMI)				Children with Serious Emotional Disturbances (SED)			
	N Receiving Supported Housing	N Receiving Supported Employment	N Receiving Assertive Community Treatment	Total unduplicated N - Adults with SMI Served	N Receiving Therapeutic Foster Care	N Receiving Multi-Systemic Therapy	N Receiving Family Functional Therapy	Total unduplicated N - Children with SED
Female	0	0	0	0	0	34	127	21,712
Male	0	0	0	0	0	59	140	24,895
Not Available	4,789	1,315	2,087	131,990	0	0	0	1

Race/Ethnicity	Adults with Serious Mental Illnesses (SMI)	Children with Serious Emotional Disturbances (SED)

	N Receiving Supported Housing	N Receiving Supported Employment	N Receiving Assertive Community Treatment	Total unduplicated N - Adults with SMI Served	N Receiving Therapeutic Foster Care	N Receiving Multi-Systemic Therapy	N Receiving Family Functional Therapy	Total unduplicated N - Children with SED
American Indian / Alaska Native	0	0	0	1,095	0	1	0	43
Asian	0	0	0	1,967	0	0	4	1,231
Black / African American	0	0	0	30,039	0	31	59	9,441
Hawaiian / Pacific Islander	0	0	0	0	0	0	0	18
White	0	0	0	65,308	0	8	146	18,354
More than one race	0	0	0	0	0	2	14	2,278
Not Available	4,789	1,315	2,087	33,581	0	51	44	15,243

Hispanic/Latino Origin	Adults with Serious Mental Illnesses (SMI)				Children with Serious Emotional Disturbances (SED)			
	N Receiving Supported Housing	N Receiving Supported Employment	N Receiving Assertive Community Treatment	Total unduplicated N - Adults with SMI Served	N Receiving Therapeutic Foster Care	N Receiving Multi-Systemic Therapy	N Receiving Family Functional Therapy	Total unduplicated N - Children with SED
Hispanic / Latino origin	0	0	0	22,853	0	26	51	16,313
Non Hispanic / Latino	0	0	0	104,198	0	26	164	18,959
Not Available	4,789	1,315	2,087	4,939	0	41	52	11,336

	Adults with Serious Mental Illnesses (SMI)				Children with Serious Emotional Disturbances (SED)			
	N Receiving Supported Housing	N Receiving Supported Employment	N Receiving Assertive Community Treatment	Total unduplicated N - Adults with SMI Served	N Receiving Therapeutic Foster Care	N Receiving Multi-Systemic Therapy	N Receiving Family Functional Therapy	Total unduplicated N - Children with SED
Do you monitor fidelity for this service?	○ Yes ◉ No	○ Yes ◉ No	○ Yes ◉ No		○ Yes ◉ No	○ Yes ◉ No	○ Yes ◉ No	
IF YES,								
What fidelity measure do you use?								
Who measures fidelity?								

How often is fidelity measured?								
Is the SAMHSA EBP Toolkit used to guide EBP Implementation?	Yes ○ No ●	Yes ○ No ●	Yes ○ No ●		Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	
Have staff been specifically trained to implement the EBP?	Yes ○ No ●	Yes ○ No ●	Yes ○ No ●		Yes ○ No ○	Yes ○ No ○	Yes ○ No ●	

Comments on Data (overall):
Total unduplicated N - Children with SED was provided by Children's System of Care (CSOC). It does not include N of Children with SED served by SMHA.

Comments on Data (Supported Housing):

Comments on Data (Supported Employment):

Comments on Data (Assertive Community Treatment):

Comments on Data (Theraputic Foster Care):

Comments on Data (Multi-Systemic Therapy):

Comments on Data (Family Functional Therapy):

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E. Performance Indicators and Accomplishments

MHBG Table 19A (URS Table 16A) - Adults with Serious Mental Illness and Children with Serious Emotional Disturbances Receiving Evidence-Based Services for First Episode Psychosis

Expenditure Period Start Date: 7/1/2020 Expenditure Period End Date: 6/30/2021

Program Name	Number of Adult Admissions into CSC Services During FY	Current Number of Adults with FEP Receiving CSC FEP Services	Number of Child/ Adolescents Admissions with FEP Receiving CSC FEP Services	Current number of Children/Adolecents with FEP Receiving CSC FEP Services	Did you monitor fidelity for this service?	What fidelity measure did you use?	Who measures fidelity?	How often is fidelity measured?	Has staff been specifically trained to implement the CSC EBP?
Oaks Integrated Care	33	49	9	7	Yes ◉ No ○	a 25-domain fidelity tool based on Ontrack NY Fidelity measures	SMHA staff overseeing the CSC programs	Goal is to conduct the visit annually. But the visit was delayed to FY 2022 due to COVID. Virtual site-visit to be set up in 2022	Yes ◉ No ○
Rutgers UBHC	66	82	10	7	Yes ◉ No ○	a 25-domain fidelity tool based on Ontrack NY Fidelity measures	SMHA staff overseeing the CSC programs	Goal is to conduct the visit annually. But the visit was delayed to FY 2022 due to COVID. Virtual site-visit to be set up in 2022	Yes ◉ No ○
CarePlus NJ	20	61	5	6	Yes ◉ No ○	a 25-domain fidelity tool based on Ontrack NY Fidelity measures	SMHA staff overseeing the CSC programs	Goal is to conduct the visit annually. But the visit was delayed to FY 2022 due to COVID. Virtual site-visit to be set up in 2022	Yes ◉ No ○

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E. Performance Indicators and Accomplishments

MHBG Table 20 (URS Table 17) - Profile of Adults with Serious Mental Illnesses Receiving Specific Services during the Year

This table provides a profile of adults with serious mental illness receiving specific evidence-based practices in the reporting year. The reporting year should be the latest state fiscal year for which data are available.

Expenditure Period Start Date: 7/1/2020 Expenditure Period End Date: 6/30/2021

	ADULTS WITH SERIOUS MENTAL ILLNESS			
	Receiving Family Psychoeducation	**Receiving Integrated Treatment for Co-occurring Disorders (MH/SA)**	**Receiving Illness Self Management**	**Receiving Medication Management**
Age				
18-20	0	0	0	0
21-64	0	0	0	0
65-74	0	0	0	0
75+	0	0	0	0
Not Available	0	0	3,298	0
TOTAL	**0**	**0**	**3,298**	**0**

Gender				
Female	0	0	0	0
Male	0	0	0	0
Gender NA	0	0	3,298	0

Race				
American Indian or Alaska Native	0	0	0	0
Asian	0	0	0	0
Black or African American	0	0	0	0
Native Hawaiian or Pacific Islander	0	0	0	0
White	0	0	0	0
More Than One Race	0	0	0	0
Unknown	0	0	3,298	0

Ethnicity				
Hispanic / Latino origin	0	0	0	0

Non Hispanic / Latino	0	0	0	0
Hispanic origin not available	0	0	3,298	0

Do you monitor fidelity for this service?	○ Yes ○ No	○ Yes ○ No	○ Yes ◉ No	○ Yes ○ No
IF YES,				
What fidelity measure do you use?				
Who measures fidelity?				
How often is fidelity measured?				
Is the SAMHSA EBP Toolkit used to guide EBP Implementation?	○ Yes ○ No	○ Yes ○ No	○ Yes ◉ No	○ Yes ○ No
Have staff been specifically trained to implement the EBP?	○ Yes ○ No	○ Yes ○ No	○ Yes ◉ No	○ Yes ○ No

Comments on Data (overall):

Comments on Data (Family Psycho-education):

NJ's data system does not capture number of adults with SMI receiving family psychoeducation services. It only captures number of family members of individuals with SMI receiving this service.

Comments on Data (Integrated Treatment for Co-occurring Disorders):

Comments on Data (Illness Self-Management):

Comments on Data (Medication Management):

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E. Performance Indicators and Accomplishments

MHBG Table 21 (URS Table 19A) - Profile of Criminal Justice or Juvenile Justice Involvement

1. The SAMHSA National Outcome Measure for Criminal Justice measures the change in Arrests over time.
2. If your SMHA has data on Arrest records from alternatives sources, you may also report that here. If you only have data for arrests for consumers in this year, please report that in the T2 columns. If you can calculate the change in Arrests from T1 to T2, please use all those columns.
3. Please complete the check boxes at the bottom of the table to help explain the data sources that you used to complete this table.
4. Please tell us anything else that would help us to understand your indicator (e.g., list survey or MIS questions; describe linking methodology and data sources; specify time period for criminal justice involvement; explain whether treatment data are collected).

}

class="ExpenditureDates"> Expenditure Period Start Date: 7/1/2020 Expenditure Period End Date: 6/30/2021

For Consumers in Service for at least 12 months

	T1			T2			T1 to T2 Change						Assessment of the Impact of Services					
	"T1" Prior 12 months (more than 1 year ago)			"T2" Most Recent 12 months (this year)			If Arrested at T1 (Prior 12 Months)			If Not Arrested at T1 (Prior 12 Months)			Over the last 12 months, my encounters with the police have...					
	Arrested	Not Arrested	No Response	Arrested	Not Arrested	No Response	# with an Arrest in T2	# with No Arrest at T2	No Response	# with an Arrest in T2	# with No Arrest at T2	No Response	# Reduced (fewer encounters)	# Stayed the Same	# Increased	# Not Applicable	No Response	Total Responses
Total	**28**	**382**	**0**	**25**	**386**	**0**	**19**	**9**	**0**	**31**	**351**	**0**	**50**	**17**	**6**	**344**	**1**	**418**
Total Children/Youth (under age 18)	**2**	**57**	**0**	**2**	**57**	**0**	**0**	**2**	**0**	**2**	**55**	**0**	**7**	**3**	**4**	**44**	**1**	**59**
Female	0	28	0	0	28	0	0	0	0	0	28	0	3	2	1	21	1	28
Male	2	29	0	2	29	0	0	2	0	2	27	0	4	1	3	23	0	31
Gender NA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Adults (age 18 and over)	**26**	**325**	**0**	**23**	**329**	**0**	**19**	**7**	**0**	**29**	**296**	**0**	**43**	**14**	**2**	**300**	**0**	**359**
Female	7	184	0	10	178	0	2	5	0	11	173	0	14	4	1	172	0	191
Male	16	141	0	12	144	0	14	2	0	18	123	0	29	10	0	120	0	159
Gender NA	3	0	0	1	7	0	3	0	0	0	0	0	0	0	1	8	0	9

For Consumers Who Began Mental Health Services during the past 12 months

	T1	T2	T1 to T2 Change	Assessment of the Impact of Services

	"T1" 12 months prior to beginning services			"T2" Since Beginning Services (this year)			If Arrested at T1 (Prior 12 Months)			If Not Arrested at T1 (Prior 12 Months)			Since starting to receive MH Services, my encounters with the police have...					
	Arrested	Not Arrested	No Response	Arrested	Not Arrested	No Response	# with an Arrest in T2	# with No Arrest at T2	No Response	# with an Arrest in T2	# with No Arrest at T2	No Response	# Reduced (fewer encounters)	# Stayed the Same	# Increased	# Not Applicable	No Response	Total Responses
Total	**16**	**715**	**2**	**11**	**718**	**2**	**4**	**12**	**0**	**10**	**704**	**1**	**56**	**29**	**12**	**637**	**3**	**737**
Total Children/Youth (under age 18)	**6**	**533**	**2**	**4**	**535**	**2**	**1**	**5**	**0**	**3**	**529**	**1**	**33**	**18**	**10**	**474**	**3**	**538**
Female	4	248	1	2	250	1	1	3	0	1	246	1	13	10	3	225	2	253
Male	2	282	1	2	282	1	0	2	0	2	280	0	20	8	7	249	1	285
Gender NA	0	3	0	0	3	0	0	0	0	0	3	0	0	0	0	0	0	0
Total Adults (age 18 and over)	**10**	**182**	**0**	**7**	**183**	**0**	**3**	**7**	**0**	**7**	**175**	**0**	**23**	**11**	**2**	**163**	**0**	**199**
Female	2	100	0	4	97	0	1	1	0	4	96	0	12	4	0	92	0	108
Male	8	77	0	3	81	0	2	6	0	3	74	0	11	7	2	66	0	86
Gender NA	0	5	0	0	5	0	0	0	0	0	5	0	0	0	0	5	0	5

Please Describe the Sources of your Criminal Justice Data

Source of adult criminal justice information:

- ☐ 1. Consumer survey (recommended questions)
- ☐ 2. Other Consumer Survey: Please send copy of questions
- ☐ 3. Mental health MIS
- ☐ 4. State criminal justice agency
- ☐ 5. Local criminal justice agency
- ☐ 6. Other (specify)

Sources of children/youth criminal justice information:

- ☐ 1. Consumer survey (recommended questions)
- ☐ 2. Other Consumer Survey: Please send copy of questions
- ☐ 3. Mental health MIS
- ☐ 4. State criminal/juvenile justice agency
- ☐ 5. Local criminal/juvenile justice agency
- ☐ 6. Other (specify)

Measure of adult criminal justice involvement:

- ○ 1. Arrests
- ○ 2. Other (specify)

Measure of children/youth criminal justice involvement:

- ◉ 1. Arrests
- ○ 2. Other (specify)

Mental health programs included:

- ☐ 1. Adults with SMI only
- ☐ 2. Other adults (specify)
- ☐ 3. Both (all adults)
- ☐ 1. Children with SED only
- ☐ 2. Other Children (specify)
- ☐ 3. Both (all Children)

Region for which adult data are reported:

- ○ 1. The whole state
- ○ 2. Less than the whole state (please describe)

Region for which children/youth data are reported:

- ◉ 1. The whole state
- ○ 2. Less than the whole state (please describe)

What is the Total Number of Persons Surveyed or for whom Criminal Justice Data Are Reported

	Child/Adolescents	Adults
1. If data is from a survey, What is the total Number of people from which the sample was drawn?		
2. What was your sample size? (How many individuals were selected for the sample)?		
3. How many survey Contacts were made? (surveys to valid phone numbers or addresses)	13,127	
4. How many surveys were completed? (survey forms returned or calls completed) If data source was not a Survey, How many persons were CJ data available for?	764	
5. What was your response rate? (number of Completed surveys divided by number of Contacts)	6.0 %	

State Comments/Notes:

Instructions: If you have responses to a survey by person not in the expected age group, you should include those responses with other responses from the survey (e.g., if a 16 or 17 year old responds to the Adult MHSIP survey, please include their responses in the Adult categories, since that was the survey they used)." to be included in BGAS form at the bottom of the page.

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Footnotes:

E. Performance Indicators and Accomplishments

MHBG Table 22 (URS Table 19B) - Profile of Change in School Attendance

1. The SAMHSA National Outcome Measure for School Attendance measures the change in days attended over time. The DIG Outcomes Workgroup pilot tested 3 consumer self-report items that can be used to provide this information. If your state has used the 3 Consumer Self-Report items on School Attendance, you may report them here.
2. If your SMHA has data on School Attendance from alternative sources, you may also report that here. If you only have data for School attendance for consumers in this year, please report that in the T2 columns. If you can calculate the change in the Attendance from T1 to T2, please use all these columns.
3. Please complete the check boxes at the bottom of the table to help explain the data sources that you used to complete this table.
4. Please tell us anything else that would help us to understand your indicator (e. g., list survey or MIS questions; describe linking methodology and data sources; specifiy time period for criminal justice involvement; explain whether treatment data are collected).

Reporting Period Start Date: 7/1/2020 Reporting Period End Date: 6/30/2021

For Consumers in Service for at least 12 months

	T1			T2			T1 to T2 Change						Impact of Services					
	# Suspended or Expelled	# Not Suspended or Expelled	No Response	# Suspended or Expelled	# Not Suspended or Expelled	No Response	# with an Expelled or Suspended in T2	# with No Suspension or Expulsion at T2	No Response	# with an Expelled or Suspended in T2	# with No Suspension or Expulsion at T2	No Response	# Greater (Improved)	# Stayed the Same	# Fewer days (gotten worse)	# Not Applicable	No Response	Total Responses
Total	**5**	**54**	**0**	**6**	**52**	**1**	**2**	**3**	**0**	**4**	**49**	**1**	**21**	**19**	**9**	**10**	**0**	**59**
Gender																		
Female	1	27	0	3	24	1	1	0	0	2	24	1	7	13	4	4	0	28
Male	4	27	0	3	28	0	1	3	0	2	25	0	14	6	5	6	0	31
Gender NA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Age																		
Under 18	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

For Consumers Who Began Mental Health Services during the past 12 months

	T1			T2			T1 to T2 Change						Impact of Services					
	"T1" 12 months prior to beginning services			"T2" Since Beginning Services (this year)			If Suspended at T1 (Prior 12 Months)			If Not Suspended at T1 (Prior 12 Months)			Since starting to receive MH Services, the number of days my child was in school have					
	# Suspended or Expelled	# Not Suspended or Expelled	No Response	# Suspended or Expelled	# Not Suspended or Expelled	No Response	# with an Expelled or Suspended in T2	# with No Suspension or Expulsion at T2	No Response	# with an Expelled or Suspended in T2	# with No Suspension or Expulsion at T2	No Response	# Greater (Improved)	# Stayed the Same	# Fewer days (gotten worse)	# Not Applicable	No Response	Total Responses
Total	**34**	**527**	**2**	**14**	**546**	**3**	**5**	**29**	**0**	**9**	**515**	**3**	**110**	**200**	**32**	**221**	**0**	**563**
Gender																		
Female	9	257	1	4	262	1	2	7	0	2	254	1	51	97	16	103	0	267
Male	24	268	1	10	281	2	3	21	0	7	259	2	59	101	16	117	0	293
Gender NA	1	2	0	0	3	0	0	1	0	0	2	0	0	2	0	1	0	3
Age																		
Under 18	34	505	2	14	524	3	5	29	0	9	493	3	104	193	32	212	0	541

Source of School Attendance Information:
- [x] 1. Consumer survey (recommended items)
- [ ] 2. Other Survey: Please send us items
- [ ] 3. Mental health MIS
- [ ] 4. State Education Department
- [ ] 5. Local Schools/Education Agencies
- [ ] 6. Other (specify)

Measure of School Attendance:
- (•) 1. School Attendance
- ( ) 2. Other (specify):

Mental health programs include:
- [x] 1. Children with SED only
- [ ] 2. Other Children (specify)
- [ ] 3. Both

Region for which data are reported:
- (•) 1. The whole state
- ( ) 2. Less than the whole state (please describe):

What is the Total Number of Persons Surveyed or for whom School Attendance Data Are Reported?

Child/Adolescents:

1. If data is from a survey, what is the total number of people from which the sample was drawn?

2. What was your sample size? (How many individuals were selected for the sample)?	
3. How many survey contacts were made? (surveys to valid phone numbers or addresses)	13,127
4. How many surveys were completed? (survey forms returned or calls completed) If data source was not a Survey, how many persons were data available for?	764
5. What was your response rate? (number of Completed surveys divided by number of Contacts)	

State Comments/Notes:

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Footnotes:

E. Performance Indicators and Accomplishments

MHBG Table 23A (URS Table 20A) - Profile of Non-Forensic (Voluntary and Civil-Involuntary) Patients Readmission to Any State Psychiatric Inpatient Hospital within 30/180 Days of Discharge

Expenditure Period Start Date: 7/1/2020 Expenditure Period End Date: 6/30/2021

	Total number of Discharges in Year	Number of Readmissions to ANY STATE Hospital within		Percent Readmitted	
		30 days	180 days	30 days	180 days
TOTAL	**701**	**13**	**56**	**1.85 %**	**7.99 %**
Age					
0-12 years	0	0	0	**0.00 %**	**0.00 %**
13-17 years	0	0	0	**0.00 %**	**0.00 %**
18-20 years	9	0	2	**0.00 %**	**22.22 %**
21-64 years	644	11	50	**1.71 %**	**7.76 %**
65-74 years	38	2	4	**5.26 %**	**10.53 %**
75+ years	10	0	0	**0.00 %**	**0.00 %**
Not Available	0	0	0	**0.00 %**	**0.00 %**
Gender					
Female	209	6	21	**2.87 %**	**10.05 %**
Male	492	7	35	**1.42 %**	**7.11 %**
Gender Not Available	0	0	0	**0.00 %**	**0.00 %**
Race					
American Indian/Alaska Native	1	0	0	**0.00 %**	**0.00 %**
Asian	18	0	2	**0.00 %**	**11.11 %**
Black/African American	257	3	16	**1.17 %**	**6.23 %**
Hawaiian/Pacific Islander	0	0	0	**0.00 %**	**0.00 %**
White	420	10	38	**2.38 %**	**9.05 %**

More than one race	0	0	0	**0.00 %**	**0.00 %**
Race Not Available	5	0	0	**0.00 %**	**0.00 %**
Hispanic/Latino Origin					
Hispanic/Latino Origin	92	3	10	**3.26 %**	**10.87 %**
Non Hispanic/Latino	605	10	46	**1.65 %**	**7.60 %**
Hispanic/Latino Origin Not Available	4	0	0	**0.00 %**	**0.00 %**

Are Forensic Patients Included? ○ Yes ◉ No

Comments on Data:

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Footnotes:

E. Performance Indicators and Accomplishments

MHBG Table 23B (URS Table 20B) - Profile of Forensic Patients Readmission to Any State Psychiatric Inpatient Hospital within 30/180 Days of Discharge

Expenditure Period Start Date: 7/1/2020 Expenditure Period End Date: 6/30/2021

	Total number of Discharges in Year	Number of Readmissions to ANY STATE Hospital within		Percent Readmitted	
		30 days	180 days	30 days	180 days
TOTAL	**149**	**3**	**10**	**2.01 %**	**6.71 %**
Age					
0-12 years	0	0	0	**0.00 %**	**0.00 %**
13-17 years	0	0	0	**0.00 %**	**0.00 %**
18-20 years	4	0	0	**0.00 %**	**0.00 %**
21-64 years	142	3	10	**2.11 %**	**7.04 %**
65-74 years	1	0	0	**0.00 %**	**0.00 %**
75+ years	2	0	0	**0.00 %**	**0.00 %**
Not Available	0	0	0	**0.00 %**	**0.00 %**
Gender					
Female	12	1	2	**8.33 %**	**16.67 %**
Male	137	2	8	**1.46 %**	**5.84 %**
Gender Not Available	0	0	0	**0.00 %**	**0.00 %**
Race					
American Indian/Alaska Native	0	0	0	**0.00 %**	**0.00 %**
Asian	4	0	1	**0.00 %**	**25.00 %**
Black/African American	70	0	3	**0.00 %**	**4.29 %**
Hawaiian/Pacific Islander	2	0	0	**0.00 %**	**0.00 %**
White	71	3	6	**4.23 %**	**8.45 %**

More than one race	0	0	0	**0.00 %**	**0.00 %**
Race Not Available	2	0	0	**0.00 %**	**0.00 %**
Hispanic/Latino Origin					
Hispanic/Latino Origin	22	0	1	**0.00 %**	**4.55 %**
Non Hispanic/Latino	126	3	9	**2.38 %**	**7.14 %**
Hispanic/Latino Origin Not Available	1	0	0	**0.00 %**	**0.00 %**

Comments on Data:

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Footnotes:

E. Performance Indicators and Accomplishments

MHBG Table 24 (URS Table 21) - Profile of Non-Forensic (Voluntary and Civil-Involuntary Patients) Readmission to Any Psychiatric Inpatient Care Unit (State Operated or Other Psychiatric Inpatient Unit) within 30/180 Days of Discharge

Expenditure Period Start Date: Expenditure Period End Date:

	Total number of Discharges in Year	Number of Readmissions to ANY Psychiatric Inpatient Care Unit Hospital within the state		Percent Readmitted	
		30 days	180 days	30 days	180 days
TOTAL	**0**	**0**	**0**	**0.00 %**	**0.00 %**
Age					
0-12 years	0	0	0	**0.00 %**	**0.00 %**
13-17 years	0	0	0	**0.00 %**	**0.00 %**
18-20 years	0	0	0	**0.00 %**	**0.00 %**
21-64 years	0	0	0	**0.00 %**	**0.00 %**
65-74 years	0	0	0	**0.00 %**	**0.00 %**
75+ years	0	0	0	**0.00 %**	**0.00 %**

Not Available	0	0	0	**0.00 %**	**0.00 %**
Gender					
Female	0	0	0	**0.00 %**	**0.00 %**
Male	0	0	0	**0.00 %**	**0.00 %**
Gender Not Available	0	0	0	**0.00 %**	**0.00 %**
Race					
American Indian/Alaska Native	0	0	0	**0.00 %**	**0.00 %**
Asian	0	0	0	**0.00 %**	**0.00 %**
Black/African American	0	0	0	**0.00 %**	**0.00 %**
Hawaiian/Pacific Islander	0	0	0	**0.00 %**	**0.00 %**
White	0	0	0	**0.00 %**	**0.00 %**
More than one race	0	0	0	**0.00 %**	**0.00 %**
Race Not Available	0	0	0	**0.00 %**	**0.00 %**
Hispanic/Latino Origin					

Hispanic/Latino Origin	0	0	0	**0.00 %**	**0.00 %**
Non Hispanic/Latino	0	0	0	**0.00 %**	**0.00 %**
Hispanic/Latino Origin Not Available	0	0	0	**0.00 %**	**0.00 %**

1. Does this table include readmission from state psychiatric hospitals? ○ Yes ○ No

2. Are Forensic Patients Included? ○ Yes ○ No

Comments on Data:

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Footnotes: