State of New Jersey
DEPARTMENT OF HUMAN SERVICES
PO Box 700
TRENTON NJ 08625-0700

Jon S. Corzine
Governor

Jennifer Velez
Acting Commissioner

April 18, 2007

Honorable Richard J. Codey
Senate President
State House
Trenton, New Jersey 08625

Honorable Joseph Roberts, Jr.
Speaker of the General Assembly
State House
Trenton, New Jersey 08625

Dear Senate President and Assembly Speaker:

Enclosed is the Department's Division of Addiction Services plan for the establishment and funding of regional substance abuse treatment facilities, in accordance with P.L. 2006, c. 99.

The substantial funding appropriated to the Department affords us the opportunity to promote innovative approaches to substance abuse treatment and expand access to treatment services for an underserved population. It is an excellent beginning to address a portion of the unmet demand for treatment statewide. I believe this plan will enhance treatment opportunities statewide, and I look forward to working with you, your respective committees and the Senate and Assembly leadership.

I am available to discuss the details of our plan at your convenience. If you have any questions, comments or concerns, please do not hesitate to call on me or Raquel Mazon Jeffers, Director of the Division of Addiction Services.

Sincerely,

Jennifer Velez
Acting Commissioner

JV:17:jc
Enclosure
c: Raquel Mazon Jeffers
Kathleen Crotty, Senate Democratic Office
John Samerjan, Senate Republican Office
William J. Castner, Jr., Assembly Democratic Office
Richard Wright, Assembly Republican Office
Lori O'Mara-Van Driesen

Plan for the Establishment and Funding of Regional Substance Abuse Treatment Facilities

Presented to the Governor and Legislature April 18, 2007

I. BACKGROUND

The Bloodborne Disease Harm Reduction Act (P.L. 2006 c. 99) was signed into law by Governor Jon Corzine on December 19, 2006. This plan for the establishment and funding of regional substance abuse treatment facilities is being submitted in accordance with P.L. 2006 c. 99. This law initiated New Jersey as the 50th state in the Nation to enact what is commonly called "Needle Exchange" policy. The law provides that the Department of Health and Senior Services (DHSS) shall establish a demonstration program to permit up to six municipalities to operate a sterile syringe access program in accordance with the provisions of this act. In addition, the law appropriates $10,000,000 from the General Fund annually to the Division of Addiction Services (DAS) for inpatient and outpatient drug abuse treatment program slots and outreach.

The law further required that:

> The Commissioner of Human Services develop a plan for establishing and funding regional substance abuse treatment facilities, and to solicit proposals from nonprofit agencies and organizations in the State, including State-licensed health care facilities, with experience in the provision of long-term care or outpatient substance abuse treatment services to meet the post-acute health, social, and educational needs of persons living with HIV/AIDS.
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> The Commissioner shall submit the plan to the Governor and to the Legislature no later than the 120th day after the effective date of this act, and shall report biannually thereafter to the Governor and the Legislature on the implementation of the plan.

The substantial amount of funding in this legislation will greatly expand access to treatment services, particularly for a population that is currently underserved in New Jersey, as well as promote some new innovative approaches to treatment in the State. However, it is important to note that this funding is not anticipated to fully meet the unmet demand for treatment statewide.

II. PLANNING

After the passage of this law, the Director of DAS immediately established a workgroup with the task of developing a best practice model that will provide optimal substance abuse treatment for Syringe Exchange Program (SEP) participants. The workgroup

researched the evolution and efficacy of SEP and substance abuse treatment. In addition, input was solicited from members of the Division's Professional Advisory Committee (see Appendix for List of Members).

A brief summary of the Division's literature review focused on the efficacy of SEP and substance abuse treatment is as follows: SEP began in Amsterdam, Netherlands, in 1983. The first official SEP in the United States was not established until 1988 in Tacoma, Washington. As of 2006, there were 177 SEPs operating throughout the country. In 2000, David Satcher, MD, Assistant Secretary for Health and Surgeon General of the United States, reviewed twenty needle exchange program evaluations published after 1998, and found that SEPs reduced the incidence of HIV, increased the numbers of Injection Drug Users (IDUs) referred to and retained in substance abuse treatment, and served as opportunities for multiple prevention services and referral and entry into medical care, did not increase the use of illegal drugs among participants in syringe exchange programs and reduced injection frequency. Further, with regard to the effectiveness of referrals for substance abuse treatment among needle exchange participants, Satcher cited other authorities which concluded that half of syringe exchange program clients referred for substance abuse treatment actually entered treatment, with 76% completing the first 13 weeks of treatment despite the fact that the clients in this study had more severe drug use, more HIV risk behaviors, less employment and greater engagement in illegal activities than clients referred to substance abuse treatment from traditional sources. Likewise, other research reported reduced injection frequency and increased entry and retention in drug treatment associated with needle exchange participation in Seattle's SEP, and that participation in an SEP was positively associated with individuals entering detoxification services independent of other variables, again demonstrating that SEPs are an important bridge facilitating entry into substance abuse treatment.

In addition to researching the effectiveness of SEP, DAS also gathered information from other states, including Pennsylvania, Maryland and Connecticut, to identify best practices. DAS also worked with the Drug Policy Alliance to gather best practice data nationwide.

Because best practice requires treatment on demand for SEP participants, DAS is soliciting proposals to implement a pilot program to provide multiple modalities of treatment for individuals with substance use disorders in order to meet the post acute health, social and educational needs of persons living with HIV/AIDS. DAS will issue multiple Requests for Proposals (RFPs) and Requests for Interest (RFIs) to implement a full continuum of services, which includes mobile medication, office based stabilization, outpatient services, community based outreach, case management services, intensive supportive housing/alternatives to residential treatment, intermediate medical detoxification and a voucher program for referral to traditional inpatient and outpatient substance abuse treatment.

Under this draft plan, successful applicants must demonstrate an ability to cooperate and coordinate with local health departments and sterile syringe access programs. In

addition, all providers of drug treatment services under these contracts must have in place established, facility-wide policies which prohibit discrimination against clients of substance abuse prevention, treatment and recovery support services who are assisted in their prevention, treatment and/or recovery from substance addiction with legitimately prescribed medication/s, without limits to frequency and duration.

III. COLLABORATION WITH DEPARTMENT OF HEALTH AND SENIOR SERVICES, DIVISION OF HIV/AIDS SERVICES

DAS staff and the DHSS/Division of HIV/AIDS Services collaborated in meetings, joint visitation of a needle exchange program in another State and joint seminars on best practices in SEP at Rutgers University. These collaborative meetings resulted in our agreement to share our individual RFPs and RFIs and to attend our respective Mandatory Bidder's Conference. DAS attended the DHSS Bidder's Conference on March 29, 2007 and responded to questions from the five potential cities for the SEP regarding the substance abuse treatment. DHSS staff will attend the DAS Bidder's Conference on May 1, 2007 which corresponds with the application due date for DHSS. In addition, we coordinated our timelines for funding and are considering collaborating on a joint data system that would track clients participating in both SEP and substance abuse treatment.

IV. COLLABORATION WITH LOCAL GOVERNMENTS

Our collaboration with local governments and municipal health departments will encompass, at a minimum, the following: referral to existing local services, local law enforcement, outreach venues, getting local ordinances for the parking of our mobile medication units, getting local resources for ancillary needs and sharing data. This is to achieve the goal of moving a client seamlessly from exchanging needles to attaining treatment.

In addition, successful applicants for the mobile medication units RFP must demonstrate an ability to cooperate and coordinate with local health departments and sterile syringe access programs.

V. DESCRIPTION OF SERVICES

A. Mobile Medication, Office Based Services and Outreach

The FDA approved the use of buprenorphine, in the form of Suboxone and Subutex, for the treatment of opiate dependence on October 8, 2002 for medical maintenance and medically supervised withdrawal. Buprenorphine is a partial agonist that is available for use solely by certified physicians in Addiction Medicine and those who have satisfied qualifications set-forth by under the provisions of the Drug Addiction Treatment Act of 2000 (DATA 2000).

The efficacy of Suboxone has been established (Walsh SL, Eissenberg, T., *Drug Alcohol Dependency,* 2003:70 (suppl2) S12-S27). The unique pharmacological properties of Suboxone make it a safe medication for either acute or chronic dosing. Suboxone is the formulation of choice for use in outpatient detoxification settings. It is similar to but different from methadone with greater safety, less abuse and less diversion potential. (As with methadone, there is no evidence of significant disruption in cognitive or psychomotor performance with Buprenorphine/Suboxone maintenance. New York City's Lower East Side needle exchange has six month outcomes on their buprenorphine program, showing 59% abstinence from all drugs.

The Division's plan pilot the use of mobile medication units is influenced by an extensive literature search as to what constitutes SEP best practices. It was further influenced by various visits to other States SEPs, particularly the Yale University Mobile Suboxone program. The use of a mobile medication unit will make treatment accessible to SEP participants who otherwise may not seek treatment in traditional substance abuse programs. Mobile medication provides the advantages of easy access without the often arduous process of attaining permits for construction and siting of a free standing facility.

The Division's initial RFP, slated to be released in the New Jersey Register in Spring 2007, focuses on the provision of mobile medication units that will provide methadone maintenance, Suboxone detoxification and induction six days per week, as well as corresponding office based services including case management to intravenous drug users.

The siting of the mobile medication units will be in close proximity to the sterile syringe access programs developed by the DHSS and designated municipalities, as well as in any identified existing gaps in service capacity. This collaboration enables treatment to be provided on demand where unmet need is identified; however, not all need will be met by the units.

The initial RFP will award multiple contracts. Each unit is comprised of a van and office based site with community based outreach and accompanying referral capacity to substance abuse treatment.

The operating costs include: annualized staffing costs, medication costs, operation of the units including maintenance and insurance, case management, outreach, and screening. DAS will be purchasing the units through the Department of Treasury, Division of Purchase and Property, directly for use by the contracted programs at a cost of approximately $300,000 for each unit. The units, which will be specially outfitted to meet federal requirements for operation, will include: safes for storage of medications, doctor's offices, lab station, computers, confidential counseling office, lavatory and patient waiting area. Bidders will be required to lease the mobile medication units from the State at a nominal cost. Cost sharing is not required, however, any program income/revenue/fees from the mobile medication unit shall be returned to DAS. Eligibility for these contracts is limited to licensed substance abuse treatment agencies.

B. Intensive Supportive Housing Program

Supportive housing is a successful, cost-effective, combination of affordable housing with services that help people live more stable, productive lives. It offers permanent housing with services that work for individuals and families who face complex challenges such as homelessness and/or have serious and persistent issues that may include substance use, mental illness, and HIV/AIDS.

A limited but growing body of research suggests that stabilizing individuals in supportive housing can reduce their use of expensive public crisis services such as emergency rooms, psychiatric hospitals, jails and substance use treatment programs. Studies cited by the Corporation for Supportive Housing indicate that supportive housing has positive impacts on reducing or ending substance use. Once people with histories of substance use achieve sobriety, their living situation is often a factor in their ability to stay clean and sober. According to the Kentucky Interagency Council on Homelessness, a one-year follow-up study of 201 graduates of the Eden Programs chemical dependency treatment programs in Minneapolis found that 56.6% of those living independently remained sober, 56.5% of those living in a halfway house remained sober, while 90% of those living in supportive housing remained sober.

There are also documented positive impacts on health with decreases of more than 50% in tenants' emergency room visits and hospital inpatient days; decreases in tenants' use of emergency detoxification services by more than 80%; and increases in the use of preventive health care services. Positive impacts on employment have also been found, with increases of 50% in earned income and 40% in the rate of participant employment when employment services are provided in supportive housing.

In 1998, a longitudinal, four-year, multi-site study of homelessness prevention by SAMHSA compared the Housing First model with New York City's Continuum of Care Programs that required participation in treatment as a condition for access to housing. In this study, 225 homeless persons with severe mental illness and often co-occurring substance use disorders were randomly assigned to one or the other of these programs. Participants were interviewed periodically after assignment to evaluate changes across a range of outcomes. At 6 months, 79% of Housing First participants were living in stable housing compared to 27% of the control group. At one year, the proportions were 85% and 25%, respectively. At two years, they were 80% and 30%, respectively.

Rates of homelessness also varied significantly between the two groups. At baseline, clients had spent approximately 55% of the period before placement into the Housing First program literally homeless, but this rate dropped to 12% after one year and 5% after year two. By contrast, the COC clients had spent 50% of the time homeless at baseline, but still 27% after the first year and 25% after two years. Further, Housing First participants utilized significantly fewer psychiatric and substance abuse treatment

services than the controls, but were just as able to control symptoms and substance use (Tsemberis, Gulcur, & Nakae, 2004).

Research confirms that permanent housing is crucial to recovery. It represents safety and permanency, allowing individuals to focus on wellness and recovery and, where clinically necessary, treatment. The DAS Intensive Supportive Housing Program will provide permanent housing to homeless or near homeless individuals with substance abuse disorders; intravenous drug users (IVDU); or individuals who are on medication assisted therapies for substance abuse disorders and are homeless or at risk of homelessness and may have had difficulty attaining placement in traditional inpatient residential treatment. DAS is developing this new program model as an alternative to traditional residential treatment.

The Intensive Supportive Housing Program pilot represents an attempt to address a small portion of the critical need by eliminating housing as an obstacle to recovery and wellness for a few eligible families. This concept is innovative because there is a lack of permanent affordable housing in New Jersey in which securing and maintaining permanent housing and focusing on wellness and recovery for individuals with substance use disorders is emphasized equally.

There are two separate programs that will utilize the Intensive Supportive Housing Program pilot. Level A is a specially designed program of residential treatment to address the needs of this population, which are not otherwise available in New Jersey. DAS will develop a residential treatment program that will combine the benefits of treatment with the researched based benefits of Supportive Housing. This innovative model will provide substance abuse treatment at a minimum of five hours per week, to include at least one individual therapy session, and group and family therapy, along with the benefits of supportive housing. The added benefit of this program is to provide the wrap around services that are often lacking in more traditional substance abuse treatment. Through the treatment component the program will address the development of skills to obtain and maintain long term abstinence and provide relapse prevention. Level B is a Housing First model with a supportive service component.

This concept is uniquely suited for the IVDU population because most of the existing traditional residential treatment models serving individuals in recovery will not admit individuals who are on medication assisted therapies for substance abuse disorders and/or mental health disorders, despite the overwhelming research that medication assisted treatment is evidenced based practice for the treatment of opiate addiction and for those with co-occurring disorders. In this model, individuals who are on medication assisted therapies, as well as those who are not, may access both Level A and Level B housing.

DAS has collaborated with the New Jersey Housing and Mortgage Financing Agency (HMFA) and the Department of Community Affairs (DCA) to implement the construction/renovation, and expects that successful applicants will do the same.

RFPs, slated to be issued in the New Jersey Register in early summer, will award contracts for the development of this pilot program, which includes two Intensive Supportive Housing teams, with funding for rental subsidies (both tenant-based and project-based) and service dollars for providing intensive support services. Funding for clinical/treatment services will be available through treatment vouchers.

The project-based subsidies will be attached to the building to ensure the landlord has ongoing operating support for the housing units. These project-based vouchers can be used for leveraging construction financing available through HFMA. If a client leaves the program, the project-based rental subsidy remains with the building. The tenant-based subsidies are tied to the client and will be used to secure permanent housing for the client from the open rental market. Management of the subsidies, (i.e., paying landlords, are handled by the agencies awarded the supportive services contract. Oversight of the rental subsidies will be provided by DAS. A format has been developed by the Division of Mental Health Services for handling this process, which will be shared with DAS.

Successful applicants must demonstrate knowledge of what is required for clients to: secure and maintain housing, develop and maintain individualized financial budgets, adjust to normalized patterns of living, obtain gainful employment and/ or vocational activities, improve and maintain healthy community, family and social functioning while maintaining recovery. All clinical and support services must be client centered and recovery oriented.

The RFPs will call for the development of an intensive support team component that consists of a Licensed Clinical Alcohol and Drug Counselor (LCADC), housing specialist, motivational counselor, employment counselor and Recovery Mentor. This team will provide intensive in home services to clients participating in both Level A and B housing.

Funding will also be utilized for the intensive supportive housing program, which includes two teams, project based and tenant based subsidies. Priority will be given to the Intensive Supportive Housing program located in a county with a municipality operating a pilot sterile syringe exchange program.

C. Intermediate Medical Detoxification

DAS has identified a gap in the current treatment capacity that is specific to IVDU clients. Currently the substance abuse treatment system can provide only sub acute detoxification. This level of care does not accommodate clients with very specific complications like the maintenance of clients on their opiate replacement medications during detoxification, or the ability to detoxify clients from benzodiazepines, a frequently abused category of drugs. When clients cannot access these services, it impedes their ability to move through the continuum of treatment necessary for full recovery. Access to these specialized detoxification protocols is restricted to those clients who present in crisis through the emergency room. They receive an intensive level of services which is

costly, often unnecessary and does not treat the primary disease of addiction. These clients are acutely stabilized and released to the street, only to present again and repeat the cycle. DAS continues to consult on this approach with experts in the field.

Through the issuance of a Request for Letter of Interest (RLI) and the commitment of funds for start up of the intermediate medical detoxification service, DAS will explore how to best provide a service that will: accept and treat clients with co-occurring disorders, pregnant women, poly-addicted including those addicted to benzodiazepines, and individuals who may or may not be on opiate replacement therapy. The provision of unfettered, same day transport to treatment is a crucial component of this service. Clients receiving opiate replacement therapy must have the option to remain on medically assisted treatments throughout the detoxification. The facility providing intermediate medical detoxification services must accommodate clients regardless of the non life threatening medical condition(s) which they present. They must have an affiliation agreement and procedures in place with an acute care hospital that ensures the seamless transfer of the IVDU client to the acute care setting.

We anticipate the development of a minimum of approximately ten beds statewide of this highly specialized service. DAS may provide financial support for the initial development of the services, if needed, and the ongoing operational dollars for the service will be provided in the voucher program.

D. Voucher Program

Additional funding is being allocated for the development of a voucher based, fee for service network that will offer: intermediate medical detoxification, outpatient treatment for those in the Intensive Supportive Housing Program, and traditional residential treatment services. A voucher based system is a client centered approach to providing services. It maximizes client choice and the funds follow the client which allows for easy movement from provider to provider. New Jersey has a proven track record of providing voucher based services through its federally funded initiative called the New Jersey Access Initiative (NJAI).

At any point in the SEP, a client can be issued a treatment voucher. The voucher is issued after a full assessment that includes a determination of the correct level of treatment needed and a full assessment of the client's eligibility for current funding options. If no other funding options are available to the client, the client will become eligible for a voucher. The voucher is issued in the client's name and can be redeemed at any approved licensed provider in the SEP Treatment Network.

VI. STRATEGY FOR SOLICITING PROPOSALS

DAS will post Notices of Funding Availability in the New Jersey Register and their accompanying RFPs and RFIs on the Department of Human Services website in order to engage prospective applicants. After publication, DAS will use electronic mail to inform licensed nonprofit agencies and organizations in the State with experience in the

provision of long term care or outpatient substance abuse treatment services, of the availability of the contract. For all contracts, potential applicants will attend a Mandatory Bidders' Conference.

Eligibility for the mobile medication/office based and outreach services contracts is limited to applicants, in accordance with the legislation, who are either public or private non-profit organizations licensed by the State of New Jersey to provide substance abuse treatment. Non-public applicants must demonstrate that they are incorporated through the New Jersey Department of State, and provide documentation of their current non-profit status under Federal IRS 501(c) (3) regulations, as applicable. The Bidders' Conference for Part A is scheduled on May 1, 2007 at 1:30 p.m. at 222 South Warren Street in Trenton.

For the Intensive Supportive Housing Program, applicants will be encouraged to apply for construction monies through the New Jersey Housing and Mortgage Finance Agency, www.njhmfa.com, should they wish to construct any or all of the permanent housing units. Applicants **not** desiring to construct the housing units must be able to demonstrate how they will affiliate with any developers and/or construction projects that have applied and been awarded construction monies through HMFA to participate in the Intensive Supportive Housing Program.

Eligibility for the medical detoxification contracts is limited to applicants who are either public or private non-profit organizations licensed by the State of New Jersey to provide substance abuse treatment. Non-public applicants must demonstrate that they are incorporated through the New Jersey Department of State, and provide documentation of their current non-profit status under Federal IRS 501(c) (3) regulations, as applicable.

VII. EVALUATION

A comprehensive evaluation will be undertaken s part of the substance abuse treatment component. Plans include the hiring of an outside evaluator to assess the various components. The evaluator will work closely with DAS' research staff in developing the research questions, research protocols and evaluation design, outcome measures, data collection tools, and modifications to New Jersey Substance Abuse Monitoring System (NJ-SAMS) that may be needed to collect evaluation information.

Successful applicants for the various treatment RFPs/RFIs will be expected to participate with DAS in conducting a full evaluation of program outcomes and to comply with the Division's program evaluation by responding to data requests from the Division of Addiction Services, participating in NJ-SAMS data collection and any other monitoring activities.

VIII. APPENDICES

A. Treatment Services Flow Chart

A flow chart is attached to illustrate the relationship among the various components of the treatment continuum developed from the Bloodborne Disease Harm Reduction Act.

B. List of Professional Advisory Committee Members

A list of Professional Advisory Committee members in attendance at the January meeting where this project idea was first introduced is included to show the breadth of the field who was consulted on this project.

Appendix A -
Treatment Services Flow Chart

Appendix B -
Professional Advisory Committee Members in Attendance

Meeting January 19, 2007

- Mary Gay Abbott-Young
- Peter Basto
- Larry Ali Blake
- Richard Bowe
- Linda Chapman
- Anthony Comerford
- James Curtin
- Edward Diehl
- Roberto Flecha
- Marie Claire Florentino
- Joanne Furze
- John Hulick
- Sue Garkinkel Seidenfeld
- Manuel Guantez
- Barry Johnson
- David Kerr
- Jonathan Krejci
- Steven Liga
- Harry Morgan
- Ivana Pareja
- Mary Lou Powner
- Vera Sansone
- Barbara Schlichting
- Linda Voorhis
- Lewis Ware
- Ernestine Winfrey
- Marc Wurgaft