State of New Jersey

DHS Department of Human Services

Inventory and Need Assessment for New Jersey Behavioral Health

Pursuant to *New Jersey Statute 30:4-177.63*, this is a report to the Governor, the Senate Health, Human Services and Senior Citizens Committee, and the Assembly Human Services Committee concerning activities of the Departments of Human Services (DHS) with respect to available mental health services for adults in New Jersey.

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

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

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

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

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

E. Consult with the Community Mental Health Citizens Advisory Board and the Behavioral Health Planning Council, the Division of Developmental Disabilities of the DHS, the Department of Corrections, the Department of Health, and family consumer and other mental health constituent groups, to review the inventories and

make recommendations to the DHS and DCF regarding overall mental health services development and resource needs;

F. Consult with the New Jersey Hospital Association, the Hospital Alliance of New Jersey, and the New Jersey Council of Teaching Hospitals in carrying out the purposes of this act. The commissioners also shall seek input from Statewide organizations that advocate for persons with mental illness and their families; and

G. Annually report on departmental activities in accordance with this act to the Governor and to the Senate Health, Human Services and Senior Citizens Committee and the Assembly Human Services Committee, or their successor committees. The first report shall be provided no later than 18 months after the effective date of this act.

A. Inventory of Behavioral Health Services

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

Mental Health.

An inventory of all New Jersey mental health treatment and service providers under contract with the DMHAS has been prepared which lists every agency , the agency's address and type of service provided (e.g., inpatient, outpatient, residential, etc.) by county. Information pertaining to the mental health treatment and service providers under contract with the DMHAS is available in the form of a Mental Health Services Treatment Directory. This is available on the DMHAS website at http://www.state.nj.us/humanservices/dmhs/news/publications/mhs/index.html.

The Substance Abuse and Mental Health Services Administration (SAMHSA) hosts a Mental Health Treatment Facility Locator on its website at http://findtreatment.samhsa.gov/ for all mental health programs nationally which can be searched by state.

In addition, the listing of Short Term Care Facilities (STCFs) may be found at http://www.state.nj.us/humanservices/dmhs/news/publications/mhs/directory_by_program.html#21, on the DMHAS website. STCFs are acute care adult psychiatric units. They are located in a general hospital for the short term admission of individuals who meet the legal standards for commitment and require intensive treatment. All admissions to STCF's must be referred through an emergency or designated screening center. STCF's are designated by DMHAS to serve a specific geographic area, usually a county.

Substance Abuse.

An inventory of all New Jersey licensed substance use disorder treatment providers is available on the DMHAS website. The inventory is in the form of a searchable, Substance Abuse Treatment Directory. The Directory includes information regarding the agency's address, type

of care and treatment provided and the identification of any special populations served. The Directory is available on the DMHAS website at https://njsams.rutgers.edu/dastxdirectory/txdirmain.htm.

SAMHSA hosts a Substance Abuse Treatment Facility Locator on its website at http://findtreatment.samhsa.gov/ for all substance abuse programs nationally which can be searched by state.

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

An inventory of all funded substance abuse prevention programs also has been prepared by DMHAS and is available on the internet at http://www.state.nj.us/humanservices/das/prevention/provider/Prevention_Dir_2013.pdf.

B. Methodology to Estimate Behavioral Health Services Need

Substance Abuse.

As a participant in the SAMHSA, CSAT-sponsored "State Treatment Needs Assessment Program" from 1993 through 2006, the former Division of Addiction Services (DAS) developed its capacity to employ a variety of scientifically-valid methods for estimating substance abuse treatment needs. Primary among these are 1) surveys, 2) social indicator analysis, and 3) "synthetic" statistical estimation techniques, called modeling. DAS was merged with the former Division of Mental Health Services in 2011 into the Division of Mental Health and Addiction Services and will be referenced as DMHAS.

In 1993, DMHAS established a periodic telephone household survey of drug use and health and a periodic survey of middle school students. Originally, the household survey supported statewide needs assessments with a sample of 3,336 completed interviews of residents 18 years of age or older. By 2003, DMHAS expanded the household survey sample size to its current standard sampling plan of 700 household interviews per county. The latest survey was conducted in 2009 and plans are underway for another survey. The household survey yields sample proportions that are applied to the New Jersey or county adult population to obtain estimates of alcohol treatment need and illicit drug use at both the state and county levels. In addition, every three years since 1999, DMHAS conducts a statewide survey of middle school students that measures prevalence of student use of alcohol and illicit drugs as well as student perceptions of risk and protective factors for substance abuse operative in their lives.

Since the household survey underestimates drug treatment need, a statistical technique known as the two-sample capture-recapture model, is applied to treatment admissions data to estimate drug treatment need at both the state and county levels. The admissions data for the model are obtained from the web-based New Jersey Substance Abuse Monitoring System (NJ-

SAMS), DMHAS' real-time, administrative, client information system for substance abuse treatment. Together with the estimated alcohol treatment need obtained from the household survey, DMHAS produces an annual estimate of treatment need that is used in the distribution of all alcohol and drug abuse treatment funds. Table 1 below presents the 2013 estimates of substance abuse treatment need for the state and each county.

Table 1					
Estimate of Treatment Need for Alcohol and Drug Addiction, New Jersey, 2013					
County	Adult Population 2013	Need for Alcohol Treatment	Need for Drug Treatment	Total Need for Alcohol and Drug	Total Need as % of Adult County Population
	[1]	[2]	[3]	[4]	[5]
Atlantic	211,586	23,867	16,829	40,696	19.2
Bergen	716,204	64,458	24,639	89,097	12.4
Burlington	346,244	23,822	18,515	42,337	12.2
Camden	387,718	30,242	31,154	61,396	15.8
Cape May	77,772	6,751	7,911	14,662	18.9
Cumberland	119,572	10,654	9,132	19,786	16.5
Essex	592,963	46,133	41,524	87,657	14.8
Gloucester	219,440	20,342	16,737	37,079	16.9
Hudson	523,604	32,882	23,444	56,326	10.8
Hunterdon	96,581	9,378	10,634	20,012	20.7
Mercer	286,700	37,902	16,134	54,036	18.8
Middlesex	639,097	42,756	27,992	70,748	11.1
Monmouth	479,810	59,161	42,378	101,539	21.2
Morris	380,041	44,731	15,538	60,269	15.9
Ocean	446,895	39,103	27,088	66,191	14.8
Passaic	379,760	21,760	16,981	38,741	10.2
Salem	49,852	3,933	4,442	8,375	16.8
Somerset	247,939	20,951	11,743	32,694	13.2
Sussex	110,954	12,460	8,488	20,948	18.9
Union	413,933	31,045	20,569	51,614	12.5
Warren	82,038	6,776	6,785	13,561	16.5
Total	**6,808,703**	**589,106**	**398,657**	**987,763**	**14.5**

[1] Source: U.S. Census Bureau, Population Division. Average Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2013

[2] Alcohol treatment needs derived from the 2009 New Jersey Household Survey on Drug Use and Health.

[3] Drug treatment need is estimated by applying a two-sample Capture-Recapture statistical model using the 2010 and 2012 NJ-SAMS data.

[4] Percent of Drug treatment need was derived by dividing the population in need of treatment in each county (column 4) by the adult population in that county times 100.

In addition to survey data, the DMHAS addiction research team developed methods for using social indicators to supplement estimates of need obtained through other methods. Because social indicator data are compiled by their primary users and archived for use by others, indicator data are somewhat convenient to obtain, especially when random samples surveys are not feasible to undertake.

One such method of social indicator analysis, the Relative Needs Assessment Scale (RNAS), developed by DMHAS researchers, Mammo & French (1996), using social indicators with known

correlations to the incidence and prevalence of substance abuse. The scale calculates an index of risk for each jurisdiction of the same size (county, municipal, zip code, etc.) for which the indicators can be obtained. Because the scale is an interval level of measurement that sums to one, scores are comparable and easily interpreted across jurisdictions.

The RNAS methodology has been used since 2003 to estimate the need for the prevention of alcohol and other drug abuse. It was updated in 2008 and utilized to facilitate the evaluation of proposals submitted to DMHAS as part of the state's Substance Abuse Prevention and Treatment Block Grant (SAPT BG) funded prevention RFP. In the current county comprehensive planning process for 2014 to 2017, the RNAS model, updated to include data from the 2010 U.S. Census, will be used to identify areas within counties with potentially high concentrations of people with substance abuse prevention, treatment and recovery support service needs.

Mental Health.

The aforementioned planned New Jersey Household Survey of Drug Use and Health will include a new section of validated questions from the federal behavioral risk factor surveys with which to estimate mental health treatment needs throughout the New Jersey and county adult populations. In its place, meanwhile, a mental health version of the RNAS has been developed using correlates of mental health disorders with known predictive power to estimate state and county mental health treatment needs.

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

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

Table 2 Definition of Social Indicators Used in the RNAS Model to Calculate Mental Health Risk Index for New Jersey Counties	
Low socioeconomic status	
• Poverty [A]	Poor families below the poverty level, 2013
• No high school education [B]	Number of people age 25 years & over, with no high school diploma, averaged from 2008 to 2012.
Marital status	
• Divorced families [B]	Adults 15 and over in 2013 who were separated or divorced.
• Female householder [B]	Female householder, no husband present with own children less than 18 years, 2013.
• Living alone, 2010 [B]	Nonfamily householder living alone, 2013.
Environmental and Other Social Factors	
• Unemployment [C]	Population 16 and over unemployed in 2013
• Housing tenure [B]	Ratio of occupied housing which are renter occupied, 2013
• Population density [B]	County population per square mile, 2013
• Suicide [D]	Death with suicide as underlying cause. Suicide is defined as death resulting from the intentional use of force against oneself. 2011 data.
Source: A U.S. Census Bureau, American Community Survey, derived from 2006-2011 population estimate. B U.S. Census Bureau. Estimate based on 3-Year American Community Survey (2011 to 2013). C New Jersey Department of Labor Market & Workforce Development, April 2014. D New Jersey Death Certificate Database, Bureau Vital Statistics and Registration, NJ-DHSS, (http://nj.gov/health/shad), October, 2014	

The DMHAS will explore further needs assessment methodology that will enable the DMHAS to refine our mental health need assessment by level of care, e.g., inpatient, outpatient and residential services. The publicly funded behavioral health system in New Jersey currently is undergoing a significant change, specifically due to the Center for Medicaid and Medicare's October 1, 2013 approval of the 1115 Comprehensive Medicaid Waiver application submitted by the State. As a result the State will be able to braid non-Medicaid funding streams with Medicaid funds to develop a more integrated system of care. Introducing managed care technologies through contracting with an Administrative Services Organization (ASO) has been associated with improved access, better monitoring of quality outcomes, and enhanced distribution of services across the entire care continuum[1]" based on utilization and

[1] http://www.state.nj.us/humanservices/dmahs/home/NJ_1115_Demonstration_Comprehensive_Waiver_9-9-11.pdf

demonstrated need. The DHS will be securing a contract with an ASO to manage the continuum of behavioral health services in the future.

Also, Cagle's review of the research suggested that there may not be much difference in correlations between social indicators and the need for long term- vs. acute-care services. Cagle pointed out that the New York Office of Mental Health policy asserted that patients should be treated in the least restrictive setting and that focus on acute psychiatric beds could be shortsighted.

Table 3
Relative Need Assessment Scale By County

County	Index	Percent
Atlantic	0.032	3.2
Bergen	0.105	10.5
Burlington	0.052	5.2
Camden	0.058	5.8
Cape May	0.013	1.3
Cumberland	0.016	1.6
Essex	0.087	8.7
Gloucester	0.033	3.3
Hudson	0.078	7.8
Hunterdon	0.015	1.5
Mercer	0.041	4.1
Middlesex	0.089	8.9
Monmouth	0.073	7.3
Morris	0.057	5.7
Ocean	0.069	6.9
Passaic	0.051	5.1
Salem	0.008	0.8
Somerset	0.036	3.6
Sussex	0.017	1.7
Union	0.058	5.8
Warren	0.013	1.3
TOTAL OF INDEX =	**1.0**	**100.0**

C. Annual Assessment

With the establishment of a needs assessment methodology for mental health and the development of the inventory, it will be possible to annually assess the need for and availability of mental health services.

D. Annual Funding for Existing Mental Health and Addictions Programs

The appropriations that the DMHAS received for fiscal year 2015 are reflected in Table 4 below.

Table 4

DMHAS FISCAL SUMMARY FY 2015
(State, Fed & Other $)
(Amounts in Thousands - $000's)

Category	FY 2015
Direct State Services:	
State Psychiatric Hospitals	$ 285,344
DMHAS Admin. (Includes Fed. Grants)	$ 17,494
Total Direct State Services	$ 302,838
Grants-In-Aid:	
MH Community Care	$ 259,326
MH Olmstead	$ 96,006
MH Block and PATH Grant & Other	$ 15,003
SA Community Services	$ 32,912
SA Block Grant & Other Federal	$ 48,289
SA Dedicated Funds & Other	$ 15,270
MH Dedicated Fund	$ 400
	$ 467,206
Rutgers / UBHC Line-Items:	
Rutgers, UBHC- CMHC Newark	$ 6,165
Rutgers, UBHC-CMHC Piscataway	$ 11,780
Subtotal Rutgers, UBHC	$ 17,945
Total Grants-In-Aid	$ 485,151
State Aid - County Psychiatric Hospitals	$ 130,165
Federal DSH (Disproportionate Share Hospital) to Supplement Hospitals	$ 53,000
GRAND TOTAL DMHAS *(State, Fed & Other)*	$ 971,154

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

The Community Mental Health Citizens Advisory Board (Board) and the Behavioral Health Planning Council (Planning Council) are distinct groups that meet monthly as a joint advisory body with the DMHAS and DCF. Members of the Board are appointed by the Governor of New Jersey and Planning Council members are appointed by the Assistant Commissioner of DMHAS. The Board and the Planning Council function together under the auspices of the New Jersey Behavioral Health Planning Council. The Planning Council fosters the interests of consumers and family members with substance use disorders, serious mental illness, serious emotional disturbance (for parents of youth) or co-occurring disorders; and/or prevention, early intervention, treatment or recovery support services. Accordingly, membership includes consumers, family members of consumers, other advocates, providers and State government staff, and the ratio of parents of children with serious emotional disturbances and/or addictions to other Council members shall be sufficient to provide adequate representation. In addition, not less than 50 percent of the members of the Planning Council are individuals who are not State employees or providers of behavioral health services.

The distinct Board consists of: eight citizens of the State who, as consumers, have demonstrated an interest in the delivery of mental health services; one person recommended by the Board of Chosen Freeholders, one person recommended by the League of Municipalities; two from providers of mental health services and one person recommended by the chairpersons of the standing Assembly and Senate committees on Human Services, and two persons from among persons currently serving as members of the Board of Trustees of the State psychiatric hospitals.

Membership on the distinct Planning Council includes citizens of the State who, as consumers, have demonstrated an interest in the delivery of behavioral health services, providers of children's and adult behavioral health services, advocacy organizations and New Jersey State agencies. The entities identified in N.J.S.A. 30:4-177.63 (e) required to "review the inventory and make recommendations to the Departments of Human Services and Children and Families" are members of the Board and Planning Council.

Since 2011, the Planning Council has broadened its purview to include substance abuse services, in response to the Substance Abuse and Mental Health Services Administration (SAMHSA) combined application for the Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grants application guidance and instructions (OMB No. 0930–0168). In 2014, the Planning Council voted to change its name from the Mental Health Planning Council to better reflect its purpose, and is now the New Jersey Behavioral Health Planning Council. With this name change and subsequent update to its bylaws, the Planning Council will broaden its membership to include more representatives with history and expertise in the substance use disorder field.

The purposes of the combined Planning Council include: (1) to review New Jersey's Federal Community Mental Health Services Block Grant and Substance Abuse Prevention and

Treatment Block Grant plans each year before submission and to make recommendations for improving the plans to the DMHAS Assistant Commissioner, (2) to serve as an advocate for consumers concerning State policy, legislation, and regulations affecting behavioral health, (3) to monitor, review, and evaluate the allocation and adequacy of behavioral health services in New Jersey,(4) to advise the DHS and DMHAS concerning the need for, and quality of, services and programs for persons with behavioral health disorders in the state, (5) to advise the DMHAS Assistant Commissioner concerning proposed and adopted plans affecting behavioral health services provided or coordinated by the DMHAS and the implementation thereof, (6) as appropriate, to assist in the development of strategic plans for behavioral health services in the State and advocate for the adoption of such plans to other state departments or branches of government, and (7) to exchange information and develop, evaluate, and communicate ideas about mental health, substance abuse and co-occurring planning and services. In accomplishing these purposes the Council shall avail itself of whatever staff assistance is provided by the Division, shall access information about planning and provision of behavioral health services by the Division and various state departments, shall inform itself on national and international perspectives, and shall advise the Division on coordination of services among various private and public providers.

Some highlights of Planning Council activities for SFY 2014 included: Discussion and approval of letter to Governor Christie regarding parity, letter of support on the 2014-2015 Combined Block Grant Application, overview of the DMHAS rate setting process, letter to SAMHSA regarding areas of concern and recommendations for changes to Block Grant Application, overview of the Traumatic Loss Coalition, workforce development initiatives at DMHAS, Disaster and Terrorism Branch response to Superstorm Sandy, boarding home discussions, behavioral health block grant reports, SAPT Synar Report and Coverage Study overview, review of CMHSBG Monitoring Visit Report, overview of DMHAS Strategic Plan, overview of effect of tobacco use on consumers, overview of PerformCare, managed care entity for Children's System of Care, completion of Behavioral Health IQ document, receipt of technical assistance from Advocates for Human Potential (AHP) on move to behavioral health planning council, overview of PATH grant changes, Children's System of Care overview, Mental Health Block Grant 5% Overview, MHA-NJ overview of recovery and rebuilding services, Division of Vocational Rehabilitation Services for the behavioral health population, and evaluation update on the closure of Hagedorn Psychiatric Hospital.

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

The Commissioner of the DHS and the Assistant Commissioner of DMHAS, along with senior staff, conduct ongoing meetings with stakeholder leadership groups, trade organizations and consumer/family advocacy groups, inclusive of the New Jersey Hospital Association, to discuss services currently available, service gaps, feedback on services working well and where services can improve to better meet the needs of individuals served. Ongoing stakeholder meetings are

held with constituency and advocacy groups such as the Mental Health Association of New Jersey, New Jersey Association of Mental Health and Addiction Agencies, New Jersey Psychiatric Rehabilitation Association, Coalition of Mental Health Consumer Organizations, County Mental Health Administrators, County Drug and Alcohol Abuse Directors, National Alliance on Mental Illness New Jersey, Disability Rights New Jersey, New Jersey Hospital Association, County Hospital Chief Executive Officers and Supportive Housing Association. Further, the DMHAS participates in regular, ongoing meetings with the New Jersey Department of Health, Administrative Office of the Courts, New Jersey Division of Medical Assistance and Health Services and the Division of Developmental Disabilities. The DMHAS is committed to consulting with these constituency and advocacy groups to discuss outcomes of needs assessment and plan development. This is in addition to the DMHAS' active, monthly participation in county-based system's review meetings, county advisory board meetings and county professional advisory committee meetings. It is in these meetings that local needs and plans are discussed.

G. Looking Ahead

The landscape of mental health services for adults in New Jersey continues to change and to improve as components of both the Comprehensive Medicaid Waiver and the restructuring of State government move forward.

As noted in last year's report, the Comprehensive Medicaid Waiver will enable the DHS to contract with an ASO to manage behavioral health services for adults across the continuum. The ASO for the adult system will facilitate the integration of behavioral health and primary care services, support community alternatives to institutional placement through the management of service utilization, improve access to appropriate physical and behavioral health care services, provide opportunities to rebalance rates and braid various funding streams to maximize access and improved monitoring of quality outcomes. The ASO will be able to provide utilization data and information regarding service needs to the DMHAS, supporting improved data-driven decision-making regarding funding and resource needs.

In accordance with the "Inventory and Need Assessment for New Jersey Behavioral Health" report issued November 2013, behavioral health services for adults were expanded for individuals who were impacted by Sandy and who resided in one of the following 10 counties (Atlantic, Bergen, Cape May, Essex, Hudson, Middlesex, Ocean, Monmouth and Union). These services are made available through funding from the US Department of Health and Human Services, Administration for Children and Families. The specific funding mechanism is the Social Services Block Grant (SSBG). This funding stream is time limited to support the disaster recovery efforts related to Superstorm Sandy. The DHS' DMHAS is administering the following

programs/services: detoxification and short term residential treatment services for individuals with a substance use disorder, outpatient services (for individuals with a substance use disorder and/or mental illness), supportive housing with support services (for individuals with a substance use disorder and/or mental illness), career services (supportive employment and supported education for individuals in supportive housing through this initiative), Early Intervention Support Services (for individuals with a mental illness and/or co-occurring mental illness and substance use disorder) and a media campaign, which informed the public of the services available. SSBG funding for the aforementioned treatment and services is available through September 30, 2015.

DHS will continue to assess the behavioral health needs of the residents of New Jersey on a regular basis in order to improve the behavioral health system in New Jersey.