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) and Children and Families (DCF) with respect to available mental health services here in New Jersey.

The following are some of the statute's key provisions applicable to the Commissioners of Human Services and Children and Families:

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 persons who are voluntarily admitted or involuntarily committed to inpatient facilities for persons with mental illness in the State, and for persons 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 Mental Health Planning Council, the Divisions of Developmental Disabilities and the Division of Mental Health and Addiction Services in the Department of Human Services, 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 Departments of Human Services and Children and Families 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 shall also 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 licensed mental health treatment providers has been prepared which lists every agency with all its sites, license numbers, address, type of service (e.g., inpatient, outpatient, residential, etc.) by county and bed capacity for residential programs. This information was derived from several sources in order to ensure the completeness of this inventory. The Department of Human Services (DHS) Licensing Information system (LIS) was utilized. In addition, the DMHAS Contracts Database was useful, especially for those programs not licensed by DHS. It is noteworthy that information from the contracts database 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. DMHAS also utilized the Quarterly Contracts Monitoring Report (QCMR) as a resource in pulling together the data for this inventory.

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#19, 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 abuse treatment providers has been prepared which lists every agency with all its sites, license numbers, address, type of service (e.g., inpatient, outpatient, residential, etc.) by county and bed capacity for residential programs. This information is derived from the Department of Human Services (DHS) Licensing Information system (LIS). In addition, a searchable Substance Abuse Treatment Directory is available on the DMHAS website at https://njsams.rutgers.edu/dastxdirectory/txdirmain.htm.

The Substance Abuse and Mental Health Services Administration (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 substance abuse prevention programs has also been prepared.

Child Behavioral Health. Information on children's mental health services can be obtained through the New Jersey Department of Children and Families website at http://www.state.nj.us/dcf/families/csc/. An inventory of the Division of Children's System of Care (DCF CSOC; formerly the Division of Child Behavioral Health Services) in-state Out-of-Home Behavioral Health Programs can be found at http://www.performcarenj.org/families/find-prov.aspx. Information on Specialty (SPEC), Psychiatric Community Homes (PCH), Detention Alternative Programs (DAP), and Medical Needs Programs (Pregnancy/Diabetes), which are exclusively managed by the Specialized Residential Treatment Services Unit (SRTU) is provided.

The inventory includes the address, gender, age range and capacity for each program. PerformCare maintains a listing of children's Medicaid enrolled outpatient providers by county at the following website: http://www.performcarenj.org/families/find-prov.aspx. Lists of outpatient and residential service providers may be found on the website of the Administrative Service Organization (ASO) for the children's system, PerformCare.

The Department of Children and Families – Division of Children's System of Care (DCF CSOC; formerly the Division of Child Behavioral Health Services) is responsible for overseeing the public system of providers who serve children with emotional and behavioral health care challenges[1]. The DCF CSOC is committed to providing these services based on the needs of the child and family in a family-centered, community-based environment[2].

The DCF CSOC offers a statewide continuum of care, which includes case management, a mobile response service, in community services (e.g. outpatient and in home therapy), as well

[1] Beginning January 1, 2013, the DCF CSOC will become responsible for providing all of the services that are currently being provided by the Department of Human Services - Division of Developmental Disabilities to youth under the age of 21 with developmental disabilities.

[2] Please see the DCF CSOC website at http://www.state.nj.us/dcf/about/divisions/dcsc/.

as a range of residential services of varying intensities. The single portal for access to all services available through the DCF CSOC is the Administrative Service Organization, for the children's system, PerformCare. For more information about the services available through the DCF CSOC, please contact PerformCare at 877-652-7624 or visit http://www.performcarenj.org/. For more information about the DCF CSOC, visit http://www.state.nj.us/dcf/about/divisions/dcsc/.

Services available through the DCF CSOC are authorized without regard to income, private health insurance or eligibility for Medicaid/NJ FamilyCare or other health benefits programs. Families with private insurance, or other means, may choose to access services outside of the public system.

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.

In 1993, DAS 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, DAS 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 a 2013-2014 survey. The household survey yields sample proportions that are applied to the NJ 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 2010 estimates of substance abuse treatment need for the state and each county.

Table 1

Estimated Statewide Alcohol and Drug Treatment Need by County, 2010					
New Jersey Counties	Treatment Need in 2010				
	Adult Population 2010 [1]	Alcohol Treatment [2]	Drug Treatment [3]	Total	Percent [4]
Atlantic	206,375	23,279	19,482	42,761	20.7
Bergen	698,967	62,907	25,542	88,449	12.7
Burlington	343,687	23,646	15,840	39,486	11.5
Camden	389,697	30,396	29,339	59,735	15.3
Cape May	76,794	6,666	8,157	14,823	19.3
Cumberland	118,529	10,561	10,909	21,470	18.1
Essex	575,083	44,741	36,587	81,328	14.1
Gloucester	221,381	20,522	15,600	36,122	16.3
Hudson	465,081	29,207	22,451	51,658	11.1
Hunterdon	99,682	9,679	9,372	19,051	19.1
Mercer	281,197	37,174	14,158	51,332	18.3
Middlesex	606,778	40,593	26,018	66,611	11
Monmouth	490,431	60,470	37,138	97,608	19.9
Morris	372,340	43,824	14,352	58,176	15.6
Ocean	437,322	38,266	28,175	66,441	15.2
Passaic	364,055	20,860	17,501	38,361	10.5
Salem	51,155	4,036	4,161	8,197	16
Somerset	244,029	20,620	10,791	31,411	12.9
Sussex	115,167	12,933	8,931	21,864	19
Union	393,528	29,515	19,260	48,775	12.4
Warren	83,801	6,922	6,672	13,594	16.2
Total	**6,635,079**	**576,819**	**380,436**	**957,255**	**14.4**

Division of Mental Health and Addiction Services, New Jersey Department of Human Services
Prepared: May, 2011

[1] Source: Source: U.S. Census Bureau, American Fact Finder (2005-2009 American Community Survey 4/14/2011

[2] Alcohol treatment need is 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 2008 & 2010 NJSAMS data.

[4] Percent of the adult population in need of treatment in each county is calculated by dividing the total treatment need in each county by the total adult population of each county and multiplied by 100.

In addition to survey data, the DAS 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), was developed by DAS 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 DAS 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 likely high concentrations of persons with substance abuse prevention, treatment and recovery support service needs.

Mental Health.

The aforementioned planned 2013-2014 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
• No high school education [B]	Number of people age 25 years & over, with no high school diploma, 2010
Marital status	
• Divorced families [B]	Adults 15 and over in 2010 who were separated or divorced.
• Female householder [B]	Female householder, no husband present with own children less than 18 years, 2010.
• Living alone, 2010 [B]	Nonfamily householder living alone, 2010.
Environmental and Other Social Factors	
• Unemployment [B]	Population 16 and over unemployed in 2010
• Housing tenure [B]	Ratio of occupied housing which are renter occupied, 2010
• Population density [A]	County population per square mile, 2010
• Suicide [C]	Death with suicide as underlying cause. Suicide is defined as death resulting from the intentional use of force against oneself.

Source:
A U.S. Census Bureau, Quick Facts, 2006-2011.
B U.S. Census Bureau, 2010 Census
C New Jersey Death Certificate Database, Bureau Vital Statistics and Registration, NJ-DHSS, (http://nj.gov/health/shad)

The DMHAS will further explore 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. At this time, the publically funded behavioral health system in New Jersey is currently undergoing a significant change, specifically due to the Center for Medicaid and Medicare's recent approval of the 1115 Comprehensive Waiver application submitted by the DHS, 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 a better distribution of services

across the entire care continuum[3]" based on utilization and demonstrated need. The DHS will be securing a contract with an ASO to manage the continuum of behavioral health services in fiscal year 2014.

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

Table 3
Relative Need Assessment Scale By County

County	Index	Percent
Atlantic	0.031	3.1
Bergen	0.103	10.3
Burlington	0.051	5.1
Camden	0.058	5.8
Cape May	0.011	1.1
Cumberland	0.018	1.8
Essex	0.089	8.9
Gloucester	0.033	3.3
Hudson	0.072	7.2
Hunterdon	0.015	1.5
Mercer	0.042	4.2
Middlesex	0.092	9.2
Monmouth	0.072	7.2
Morris	0.056	5.6
Ocean	0.066	6.6
Passaic	0.057	5.7
Salem	0.008	0.8
Somerset	0.037	3.7
Sussex	0.017	1.7
Union	0.061	6.1
Warren	0.012	1.2
TOTAL OF INDEX =	**1.0**	**100.0**

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

Child Behavioral Health. The County Needs Assessment (CNA) is a mechanism for gathering county information to assist the County Interagency Coordinating Council (CIACC) in serving their constituents. The Needs Assessment serves to challenge, dismiss or corroborate the opinions, assumptions, key issues, challenges and assets that exist within the county. It also provides a basis for resource planning and supports continuous quality improvement projects (CQI). The CIACC begins by appointing a CNA Committee whose members who are familiar with local community resources. The committee then selects several community needs assessment tools which must include at least one from Category A (interviews, focus group, or public forum) and Category B (survey, secondary data analysis, or asset mapping). The next step is to then analyze the findings. DCF and its system partners employ several methodologies to quantify the usage of and need for inpatient, outpatient, and residential behavioral health services throughout the State.

One key method involves the County Interagency Coordinating Councils (CIACCs). Established by statute[4], CIACCs are county-based planning and advisory groups composed of individuals from government and private agencies that advise counties and DCF regarding children, youth and young adults with serious emotional and behavioral health challenges.

The mission of the CIACCs includes working in collaboration with DCF to create a seamless array of services. CIACCs also serve as the counties' mechanism to advise DCF on the development and maintenance of a responsive, accessible, and integrated system of care for youth with emotional and behavioral challenges and their families, through the involvement of parents, children, youth and young adults, child-serving agencies, and community representatives. Through enhanced coordination of system partners, CIACCs also identify service and resource gaps and priorities for resource development.

In order to fulfill their duties to identify service and resource gaps and priorities for resource development, CIACCs are charged with conducting an annual County Needs Assessment[5]. The CIACC needs assessment process, which is prescribed by DCF policy, is conducted through a combination of interviews with community leaders and others affiliated with organizations or agencies, public forums, focus groups, surveys, data analysis, and asset mapping. The results of the needs assessments are provided to the DCF CSOC and help to inform resource decision-making and allocation at both the state and county level. Using the needs assessments as a guide, the DCF CSOC may allocate funds to establish a statewide service. Each year, DCF also makes community development funds available to the CIACCs in order to assist counties with procuring outpatient or other services designed to meet mental health needs within a

[4] N.J.S.A. 30:4C-66 et seq.

[5] DCF did not require CIACCs to conduct County Needs Assessments in 2012 in order to allow the DCF CSOC and the CIACCs to make necessary changes to the Needs Assessment process in anticipation of the transition of services from the Department of Human Services of services for youth with developmental disabilities and substance abuse challenges to DCF.

particular county[6]. The most recent CIACC needs assessments from several counties identified access to child psychiatric services, including psychiatric evaluations and medication monitoring as an urgent need. As it did within the last two years, in response to concerns about the lack of outpatient treatment options in certain parts of the state, the DCF CSOC will explore providing resources to help ease whatever difficulties exist in certain counties regarding access to psychiatric services.

To quantify the usage of and the need for residential services in the children's system, the DCF CSOC utilizes an electronic bed-tracking system jointly developed with the ASO. The system allows DCF CSOC staff to monitor utilization of DCF-contracted residential programs in real-time. The data generated by the bed-tracking system (utilization rates and admission wait times) enables the DCF CSOC to identify where there is unmet need for specific types of residential services. When the need for a particular type of service is identified, the information is communicated to senior DCF staff with authority to authorize the issuance of a Request for Proposals to meet that need. This process enables the DCF CSOC to stand up new residential programs at any time throughout the year, depending upon the availability of resources.

With respect to quantifying the usage of and the need for inpatient and outpatient services, the methods for accomplishing these tasks will soon undergo marked changes. While inpatient and outpatient services have always been vital components of the children's system, these services were not fully integrated the system. However, as the provisions of the recently approved Comprehensive Medicaid Waiver are implemented over the coming months, the ASO for the DCF CSOC will assume responsibility for utilization management of inpatient and outpatient programs. Consequently, the data the ASO generates from its utilization management of these services will enable the DCF CSOC to better quantify inpatient and outpatient service needs and to plan accordingly.

C. Annual Assessment

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

[6] CIACCs are required to follow the Request for Proposal (RFP) procedure utilized by county government in order to receive Community Development funds.

D. Annual Funding for Existing Mental Health Programs

DMHAS

The appropriations that the DMHAS received for fiscal year 2013 are reflected in Table 4 below.

Table 4

DMHAS FISCAL SUMMARY FY 2013
(State, Fed & Other $)
(Amounts in Thousands - $000's)

Category	FY 2013
Direct State Services:	
State Psychiatric Hospitals	$ 332,003
MH/SA Division Admin. (Includes Fed. Grants)	$ 26,896
Total Direct State Services	$ 358,899
Grants-In-Aid:	
Contracts:	
MH Community Care	$ 258,924
MH Olmstead	$ 78,953
MH Block and PATH Grant & Other	$ 14,562
SA Community Services	$ 38,369
SA BG & Other Federal	$ 47,128
SA Dedicated funds & Other	$ 9,050
Subtotal Contracts:	$ 446,986
UMDNJ / UBHC Line-Items:	
UMDNJ, UBHC Newark	$ 6,165
UMDNJ, UBHC Piscataway	$ 11,780
Subtotal UMDNJ, UBHC's	$ 17,945
Total Grants-In-Aid	$ 482,876
State Aid - County Psychiatric Hospitals	$ 133,486
TOTALS DMHAS *(State, Fed & Other)*	$ 975,261

Child Behavioral Health

For State Fiscal Year 2013, funding directly appropriated to the DCF CSOC from State and Federal sources, and the funds contributed by Juvenile Justice Commission for the provision of behavioral services across all service lines totaled $395,228,000. See Table 5 below.

Table 5

Sources of Funding for Children's Behavioral Health Services[7]

Grants in Aid	$247,825,000
Title XIX (Federal)	$120,127,000
Title XXI (State and Federal)	$26,698,000
Juvenile Justice Commission	$578,000
	$395,228,000

Table 6 below lists the allocation of funds for children's behavioral health services by service type for State Fiscal Year 2013. Residential programs range from high-intensity hospital-based psychiatric services to low-intensity services like Treatment Homes[8]. Behavioral Assistance and Intensive In-Community therapy are short-term, home-based intensive treatments. Youth Incentive Programs represent CIACC community development funds.

Table 6

Allocation of funds for Children's Behavioral Health Services by Service Type

Residential	$225,275,000
Care Management Organizations	$65,867,000
Family Support Organizations	$8,244,000
Mobile Response & Stabilization Services	$21,095,000
Behavioral Assistance/Intensive In-Community therapy	$49,070,000
Youth Incentive Programs	$5,849,000
Outpatient	$11,842,000
Contracted System Administrator (ASO)	$7,986,000
	$395,228,000

[7] Funds appropriated for developmental disability services are not included. Funds for the administrative funding for Family Support Organizations and the Contracted Systems Administrator are included as they support the system of care.

[8] Please see the attached document entitled, *Descriptions of CSOC Residential Programs by Intensity of Service (IOS)* for more information on residential services available through the DCF CSOC.

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

The DMHAS meets with the Community Mental Health Citizens Advisory Board (Board) and the Mental Health Planning Council (Planning Council) as a joint advisory body on a monthly basis with the DMHAS and DCF. The role of the Board is to serve as advocate and advisory to the Department of Human Services. The Community Mental Health Citizens Advisory Board, in accordance with NJ DMHAS regulations[9] consists citizens of the State who, as consumers, have demonstrated an interest in the delivery of mental health services; one from persons recommended by the State League of Municipalities; two from providers of mental health services and one from persons recommended by the chairpersons of the standing Assembly and Senate Institutions, Health and Welfare Communities.

The Planning Council is convened in accordance with federal mandate. The Planning Council is charged with monitoring, reviewing and evaluating the allocation and adequacy of mental health services for adults diagnosed with a serious mental illness and children with a serious emotional disturbance in NJ. Additionally, the Planning Council oversees the development, annual review and evaluation of the State Mental Health Plan. Membership on the council includes citizens of the State who, as consumers, have demonstrated an interest in the delivery of mental health services, providers of children's and adult mental health services, advocacy organizations and NJ 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.

The information yielded through an analysis of the needs identified through the needs assessment process articulated, as articulated in the current document, will become an integral part of the planning process required by the Substance Abuse and Mental Health Services Administration. Consequently, the Board and Council will have the opportunity to review the inventory of services, learn about the needs identified and participate in the development of the state plan for individuals diagnosed with a mental illness, substance use disorder or serious emotional disturbance.

Additionally, the DHS and/or DMHAS convene ongoing stakeholder meetings with constituency and advocacy groups such as the Mental Health Association of NJ, NJ Association of Mental Health and Addiction Agencies, NJ Psychiatric Rehabilitation Association, Coalition of Mental Health Consumer Organizations, County Mental Health Administrators, County Drug Abuse Directors, National Alliance on Mental Illness NJ, Disability Rights NJ, NJ Hospital Association, County Hospital Chief Executive Officers and Supportive Housing Association. In addition, the DMHAS participates in regular, ongoing meetings with the NJ Department of Health, Administrative Office of the Courts, NJ 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

[9] http://nj.gov/humanservices/dmhs/info/notices/regulations/REG_CMHC_exp_Dec_27_2013.pdf

system's review meetings, county advisory board meetings and county professional advisory committee meetings. It is in these meetings that local needs and plans will be discussed.

DCF is committed to maintaining close, interactive relationships with its system partners. Therefore, DCF staff meets regularly with families, CIACCs, the New Jersey Alliance for Children, New Jersey Association of Mental Health Agencies, New Jersey Youth Suicide Prevention Advisory Council, and other advocates and stakeholders. These interactions are invaluable to DCF decision-making. Further, as noted above, the DCF CSOC will soon become responsible for providing all of the services that are currently being provided by the DHS - Division of Developmental Disabilities (DDD) to youth under the age of 21 with developmental disabilities. In addition, the DCF CSOC will soon become responsible for providing addiction services to youth up to age 21 who are currently being served by DHS Division of Mental Health and Addiction Services (DMHAS). Accordingly, DCF is working more closely than ever with both DDD and DMHAS.

F. Looking Ahead

In September 2011, the New Jersey Department of Human Services (DHS), in cooperation with the Department of Health (DOH) and the Department of Children and Families (DCF), submitted a Comprehensive Medicaid Waiver application to the US Department of Health and Human Services' Centers for Medicare and Medicaid. The waiver application was approved October 2012. The Comprehensive Medicaid Waiver will enable the DHS to contract with an Administrative Services Organization (ASO) to manage behavioral health services for adults across the continuum. The ASO 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 the service needs to the DMHAS, supporting improved data-driven decision-making regarding funding and resource needs.

Based upon needs identified by the DCF CSOC and the CIACCs, the DCF CSOC is continually making new behavioral health services available and embarking on new initiatives to improve the children's system of care. In the coming months, the DCF CSOC will have capacity for an additional 25 girls and young women who require the intensity of service of a psychiatric community home. This added capacity will meet a growing demand. Likewise, the system will be standing up additional residential programs to serve youth who are dually diagnosed with both behavioral health and developmental disabilities/intellectual disabilities. There are also plans to establish behavioral health treatment services specifically for youth who are deaf.

Other exciting developments include the pediatric partnership pilot in Sussex County. The program is a collaboration among several system partners including the CIACC, county government, the Governor's Council on Mental Health Stigma, and the Traumatic Loss Coalition. Its goal is to create a more effective partnership between pediatricians and the

children's behavioral health system of care. It is hoped that pediatric partnerships can be initiated in other counties in the near future. Another development worth noting is the Department of Education (DOE) – DCF Educational Partnership. The DOE-DCF partnership is a cross-systems training and network-building program designed to bring together individuals representing education, behavioral health, and other child-serving systems with the goal of enhancing children's access to behavioral health services.

The New Jersey children's behavioral health system of care is a model for the rest of the nation. However, there is much more work to be done to make the children's system even more responsive to the needs of children, youth, and young adults. Likewise, with the implementation of the Comprehensive Medicaid Waiver and the adult ASO, the adult system is poised to become even better at managing behavioral health services for adults across the continuum. DHS and DCF will continue to work both independently and in collaboration to improve the overall mental health system in New Jersey in order to better serve New Jersey families.