COUNTY OF MERCER
COUNTY COMPREHENSIVE PLAN
2016-2019

COUNTY COMPREHENSIVE PLAN
FOR THE ORGANIZATION AND DELIVERY OF
ALCOHOL AND DRUG ABUSE SERVICES

PLANNING CYCLE 2016-2019

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SECTION ONE: FOUNDATIONS, PURPOSE AND PRINCIPLES

A. STATUTORY AND POLICY FOUNDATIONS

Every four years, New Jersey's 21 counties prepare a County Comprehensive Plan (CCP) for Alcoholism and Drug Abuse Prevention, Treatment and Recovery Support Services according to a) the statutory requirements of state legislation establishing the Alcoholism, Education, Rehabilitation and Enforcement Fund (AEREF), (P.L.1983, c.531, amended by chapter 51 of P.L.1989) and b) the requirements of state planning policy. The CCP documents the county's current and emergent drug use trends as well as both the availability and organization of substance abuse services across the county's continuum of prevention, early intervention, treatment and recovery support. The enabling legislation further stipulates that the CCPs pay special attention to the needs of youth, drivers under the influence, women, persons with a disability, employees, and criminal offenders. Since 2008, Division policy requires the counties to add persons with co-occurring disorders and senior citizens to that list. On the basis of this documented need and analysis of measurable service "gaps," counties are charged with the responsibility to propose a rational investment plan for the expenditure of AEREF dollars plus supplementary state appropriations, both of which are distributed to the counties according to the relative weight of their populations, per capita income, and treatment needs, in order to close the identified service "gaps."

B. ADMINISTRATIVE FOUNDATIONS

Every four years, counties prepare a CCP and submit it for review to the Assistant Director for Planning, Research, Evaluation, and Prevention, or PREP, in the Division of Mental Health and Addiction Services (DMHAS) of the New Jersey Department of Human Services (DHS). PREP reviews each CCP for compliance with all aforementioned requirements, a process that provides counties technical assistance in the use of data in decision-making as well as in the articulation of clear and logical relationships between county priorities and proposed investments in service programs. Each year, counties evaluate their progress implementing the CCP and report that evaluation to PREP. Allowance is made for the counties to adjust the CCP according to "lessons learned" from whatever obstacles were encountered in any given year.

The CCP is also submitted to the Governor's Council on Alcoholism and Drug Abuse (GCADA). Thus, in the domain of prevention, the CCP is designed to coordinate with the strategic plans of both the Regional Prevention Coalitions and Municipal Alliances.

C. PURPOSE AND PRINCIPLES

Purpose: The purpose of the CCP is to rationally relate existing county resources to the behavioral health needs of persons using legal drugs like alcohol and prescription medicines or illegal drugs like marijuana, heroin, cocaine and various hallucinogens. The DMHAS, in collaboration with the state's 21 Local Advisory Committees on Alcoholism and Drug Abuse as represented by the 21 county alcoholism and drug abuse directors, CADADs, recognizes that this purpose is best achieved by involving county residents and treatment providers, called "community stakeholders", in both identifying the strategic priorities of the plan and monitoring its successful implementation. Thus, the CCP is the product of a community-based process that recommends to county authorities the best ways to ensure that county resources serve to: 1) protect county residents from the bio-psycho-social disease of substance abuse, 2) ensure access for county residents to client-centered detoxification and rehabilitative treatment, and 3) support the recovery of persons after treatment discharge.

Principles: County Comprehensive Planning is grounded in:

1) *Epidemiological community surveillance*. As a local public health authority, the county will both *observe* the changing prevalence of substance abuse and *monitor* the changing capacity of the local health care system to respond to it.

2) "*Gap analysis*." As the product of *surveillance*, the CCP will evaluate "gaps" both in coverage of total treatment demand and in the county's continuum of care. Because treatment need and demand always exceed treatment capacity, the CCP seeks to reduce disease incidence (prevention, early intervention, and recovery support services) and expand access to treatment services over the short, medium, and long terms.

3) *Resource allocation*. As the product of "gap analysis", the CCP will recommend "best uses" of AEREF and other state and county resources to meet *feasible* goals and objectives for the maintenance and continuous improvement of the county's substance abuse continuum of care. [1]

[1] For a glossary of planning terminology used in the CCP, please see Appendix One.

SECTION TWO: LOOKING BACK AT THE OUTCOMES OF THE 2010-2012 CCP AND ITS EXTENSION FROM 2013 TO 2015 (2 PG)

INSTRUCTIONS: In one or two paragraphs of 5 to 7 sentences each, summarize your county's 2010-2012 plan for each domain of the continuum of care. What was the county trying to achieve, how many residents benefitted from the county's actions, and what were the measurable benefits for the community? For prevention and early intervention, be sure to describe your county's participation in its regional coalition. Repeat for the extension years, 2013-2015.

A. PREVENTION

In the area of prevention, the goal of the 2010-2012 CCP was the following: To reduce the use of alcohol among the senior population and their caregivers of Mercer County. The outcome described in the plan would decrease alcohol use among senior citizens and caregivers. In 2012 and 2013, the Office on Addiction Services did not issue a competitive contract for education and prevention services specifically for the senior population. Instead, general programming occurred with various community groups and schools, providing programs to over 3,000 individuals.

For the years 2014 and 2015, the goal remained the same. The Office on Addiction Services did issue a competitive contract specifically for the senior population for a grant cycle of 2014 and 2015. The award was made to an agency in Mercer County. The program is expected to reach approximately 1,000 seniors and educate and bring awareness to the senior population.

B. EARLY INTERVENTION

In the area of Early Intervention, the goal of the previous CCP was the following: To organize services which are designed to explore and address problems or risk factors that appear to be related to substance abuse. The outcome described in the plan would increase the number of screenings and early education programs to Mercer County residents. As a result, in the years 2010-2013 there were an additional 200 screenings that occurred at a contracted provider agency that helped with addressing substance abuse problems or risk factors and referring the individual to treatment if necessary. Similarly in 2013, 2014 and 2015, there was approximately 250 addiction screening that occurred helping individuals receive the appropriate level of care and access treatment.

C. TREATMENT (Including Detoxification)

In the area of treatment, the goal of the 2010-2012 CCP, and the 2013, 2014, 2015 extension years, was the following: To ensure Mercer County residents will have access to step down care from detoxification to residential treatment. The objective was to include funding in the RFP for step down care from detoxification to residential treatment within the same facility. Both contracted providers offer detoxification treatment as well as residential programming, resulting in offering step down care to 100% of eligible Mercer County clients.

D. RECOVERY SUPPORT SERVICES

In the area of recovery support services, the goal of the 2010-2012 CCP was the following: To decrease the number of Mercer County residents that need repeat outpatient care due to lack of transportation to a residential or detoxification treatment. The outcome was to increase the number of residents who get transportation to residential and detoxification treatment agencies. Also, the goal was to decrease the number of Mercer County residents who return to outpatient care due to the barrier of no transportation to residential or detoxification treatment agencies. During this initial grant cycle no one applied for the separate funding category. However, in years 2013, 2014, 2015, contracted residential and detoxification providers have made transportation available to those in need on a limited basis.

SECTION THREE: LOOKING FORWARD AT THE BEHAVIORAL HEALTH CARE ENVIRONMENT IN 2016-2019 (PG 6-7)

INTRODUCTION: The 2016-2019 CCP was researched and written in anticipation of many changes to New Jersey's health care system. Both the federal and state governments have initiated major health care reforms since the 2010-2012 CCP, including the 2010 Patient Protection and Affordable Care Act (PPACA), the 2015 New Jersey Interim Management Entity, IME, the adoption of a fee-for-service reimbursement model based on revised treatment reimbursement rates for Medicaid and state treatment programs. Super Storm Sandy, the second most costly hurricane in United States history, struck New Jersey in the fall of 2012 devastating communities in 10 of New Jersey's 21 counties has also shaped the context of the 2016-2019 CCP. The desire to coordinate the next CCPs with the adoption of five major system changes and the planning requirements of federal disaster relief delayed the production of new CCPs for three years.

The 2016-2019 CCP assumes gradual implementation of the reforms such that, in the initial plan year, county AEREF and state discretionary dollars are expected to continue supporting treatment access for numbers of county residents similar to those in the immediately preceding years. Further, the number of county residents relying on county funding for treatment access is expected to decline in each successive year of the plan by an as yet indeterminate amount. As the need for county funded treatment is offset by the expansion of Medicaid, counties may experience opportunities to reallocate larger portions of its available resources to other modalities of care, such as, detoxification followed by short-term residential care that are not going to be funded by Medicaid, or into the county's developing recovery support system. This strategy of reallocating treatment dollars to other treatment modalities that continue to be underfunded despite the reforms already mentioned or into long-term, post-treatment recovery support services will require close monitoring of the impacts of the PPACA, IME, and surpluses accrued at the provider level.

INSTRUCTION: Describe the county's plans to monitor (1) enrollments of county residents in Medicaid, (2) changes in the number of county residents relying on county funding, (3) the effects of the IME on both residents' access to quality substance abuse treatment and the financial outlook of county treatment providers serving county residents. Be sure to describe the methods you will use.

Historically, addiction services have never been covered nor accessed through the NJ State Medicaid plan. As a result of New Jersey's decision to expand Medicaid coverage to include low-income consumers, effective January 1, 2014, some substance abuse services were made available to this "expansion" population. At this same time, DMHAS required that all contracted agencies must enroll in the NJ Family Care provider network (Medicaid) and obtain a provider number by September 1, 2014. In addition, DMHAS now requires that all agencies screen and assist individuals in enrolling in NJ Family Care and subsequently, bill Medicaid for any eligible services for those eligible consumers. At the time when this plan was written, DMHAS was also embarking on the implementation of the Interim Managing Entity (IME). With the execution of the IME, for the first time in NJ, there will be a 24 hour hotline providing screening for callers, referrals to treatment agencies, and care coordination to assist individuals entering into treatment. With the IME, this change to the system of care on July 1, 2015, will change how services are "accessed" in NJ with regard to this 24 hour hotline and screening center. However, the IME is only managing a very limited amount of resources for the State of NJ, with plans to expand in the future. With the recent Medicaid expansion system change in 2014 and the possibility that all Medicaid eligible individuals will have some substance abuse covered services in the near future, these changes will impact how services are financed and will be a slow process of change. As a result of

being a slower process, the County will monitor the enrollment in Medicaid, changes in the number of clients that access county funding and the effects of the IME to "access" issues.

The Mercer County, Office on Addiction Services, plans to monitor the NJ Family Care enrollment process as it relates to working with our grantees. As required by DMHAS, a financial status and income verification process must occur with every individual. Also required at intake, individuals will be screened for NJ Family Care eligibility and will receive assistance in completing the online application. During the 2015 annual site visit with every agency and going forward, the Mercer County Office on Addiction Services will formally review this process with the agency to ensure an effective and efficient way of screening individuals. The County will be monitoring invoices from agencies on a monthly and/or quarterly basis. The expectation is that with the offset of Medicaid billable services, agencies will see a decrease in the number of requests for county funding. At the same time, this financial oversight and monitoring will allow the County to utilize unexpended dollars and reallocate the funds to services that are not reimbursed by Medicaid

Mercer County will establish a baseline with regard to the number of county residents relying on county funding. This information will be collected for years 2013, 2014 and 2015, and compared to the years going forward. As stated earlier, in the future, it is expected that many more residents access treatment through the implementation of the IME. This will allow the IME and the DMHAS to track and monitor the current needs and trends for substance use disorders. This will potentially also measure capacity gaps for substance abuse agencies within the State of NJ. As a result, the County will also be able to use this knowledge gained through the implementation of the IME and make planning decisions based on the needs of the community.

SECTION FOUR: THE 2016-2019 COUNTY COMPREHENSIVE PLAN

A. VISION

Mercer County envisions a future for all residents facing the chronic disease of substance abuse in which there is a fully developed, client centered, recovery oriented system of care comprised of prevention, early intervention, treatment and recovery support services that reduces the overall risk for substance abuse in the local environment, meets the clinical treatment needs of the county's residents, and reduces the frequency and severity of disease relapse.

B. PLANNING PROCESS (5 PG)

INSTRUCTIONS: Answer the following questions either by circling your answers in a table or by summarizing your answers in a few brief paragraphs containing up to five sentences.

1. Indicate the source and kind of the data that was used in conducting the county needs assessment.

SOURCE	QUANTITATIVE		QUALITATIVE	
1. NEW JERSEY DMHAS	(Y)	NO	YES	(N)
2. GCADA	(Y)	NO	YES	(N)
3. MOBILIZING ACTION THROUGH PLANNING AND PARTNERSHIPS, MAPP (CDC/NJDOH SPONSORED)	YES	(N)	YES	(N)
4. REGIONAL PREVENTION COALITIONS	(Y)	NO	(Y)	NO
5. COUNTY PLANNING BODIES	YES	(N)	(Y)	NO
6. HOSPITAL CATCHMENT AREA NEEDS ASSESSMENTS FOR IRS	(Y)	NO	(Y)	NO
7. MUNICIPAL ALLIANCES	(Y)	NO	(Y)	NO

8. TREATMENT PROVIDERS	YES	N	Y	NO
9. FOUNDATIONS	Y	NO	YES	N
10. FAITH-BASED ORGANIZATIONS	YES	N	Y	NO
11. ADVOCACY ORGANIZATIONS	YES	N	YES	N
12. OTHER CIVIC ASSOCIATIONS	YES	N	YES	N

2. How did the county organize and conduct outreach to its residents, service providers and their consumers, civic, church and other community and governmental leaders to inform them about the county's comprehensive alcoholism and drug abuse planning process and invite their participation?

The County held several focus groups and invited participation from the following groups: community treatment providers, the prevention coalition members, parents from a Nar-anon group, and individuals in recovery. The County also issued a press release to solicit additional participation in completing an electronic survey. We received approximately one hundred (100) surveys as a result of the press release.

3. Which of the following participated directly in the development of the CCP?

1. Members of the County Board of Freeholder	YES	N
2. County Executive (If not applicable leave blank)	YES	N
3. County Department Heads	Y	NO

4. County Department Representatives or Staffs	Y	NO
5. LACADA Representatives	Y	NO
6. PACADA Representatives	Y	NO
7. CASS Representatives	Y	NO
8. County Mental Health Boards	Y	NO
9. County Mental Health Administrators	Y	NO
10. Children System of Care Representatives	YES	N
11. Youth Services Commissions	Y	NO
12. County Interagency Coordinating Committee	Y	NO
13. Regional Prevention Coalition Representatives	Y	NO
14. Municipal Alliances Representatives	Y	NO
15. Other community groups or institutions	Y	NO
16. Organizationally unaffiliated individuals	YES	N

4. Briefly evaluate your community outreach experience over the last three years of preparing your 2016-2019 CCP. What role did the LACADA play in the community participation campaign? What approaches worked well, less than well, or not at all to generate community participation and a balance of "interests" among the participants?

   The County Comprehensive Plan (CCP) 2016-2019 documents the county's current and emergent substance abuse trends, provides goals, and highlights gaps in services for the county's continuum of care, which include prevention, early intervention, treatment and recovery support services. The Mercer County Department of Human Services, Office on Addiction Services, conducted their County Comprehensive Plan, according to the N.J. Chapter 51 of the Public Laws of 1989 and the planning policies of DMHAS, in 2013 and 2014. An Oversight Planning Committee was assembled to provide guidance and supervision during the process, ensuring a transparent and inclusive process. The Oversight Planning Committee consisted of 3 members of the Local Advisory Committee on Alcohol and Drug Abuse (LACADA), the Director of the Department of Human Services, the Mercer County Public Health Officer and the Mercer County Mental Health Administrator. The Oversight Planning Committee met five times during the process to review the DMHAS guidelines and outcomes from the 2010-2012 plan, to supervise the process, examine focus group and electronic survey data, make decisions based on the available data and take into consideration other needs assessments occurring simultaneously in the community. This County Comprehensive Plan is the result of a community-based process that prioritizes the County's greatest gaps in services and represents our commitment to our residents' well-being.

   The Mercer County Department of Human Services is extremely committed to collaborating with community partners. During 2012 and 2013, there were several needs assessment processes occurring simultaneously. The Prevention Coalition of Mercer County (PCMC), the Municipal Alliance Program, the Greater Mercer Public Health Partnership (GMPHP), and the Trenton Health Team were all collecting data on specific social, health and economic indicators within the community. All four entities were concentrated on developing a plan to help make the Mercer County community healthier. The Department of Human Services, Office on Addiction Services played an essential role in developing strategic plans with these community stake holders. As a result of participating in these processes and overseeing the Municipal Alliance community needs assessment, the available data, resources and analysis, has provided a valuable platform for the production of the County Comprehensive Plan 2016-2019.

   The production of the CCP was an eighteen month (18) month process, beginning in 2014 and ending in July of 2015, in which the Oversight Planning Committee surveyed the local landscape of addiction services, analyzed gaps within the continuum of care, and made decisions on resource allocations. During the development of the CCP, dates of four focus groups were established with respect to community providers, residents, consumers, community leaders and individuals in recovery. Participants in the focus groups were given specific data to describe the landscape of substance abuse services currently within the system of care. Participants reviewed the 8 special subpopulations, as legislated and referenced throughout this document. Each focus group represented an area within the county's continuum of prevention, early intervention, treatment and recovery support. A total of 86 individuals attended the four focus groups. Along with conducting focus groups, we created an electronic questionnaire, made available to all county residents to help gather additional information on the county's continuum of care. A press release highlighted the electronic questionnaire that was created to obtain more information from county residents and it was available on the County's website. The feedback from the focus groups and questionnaire provided us with tremendous information on ways to improve the system of care, ideas about prevention activities, treatment needs and barriers to treatment and recovery services.

During this process, it was announced that the landscape of addiction services would drastically change on July 1, 2015. This required the Oversight Committee to understand and examine how this system change would affect services in Mercer County now and in the future.
The Oversight Planning Committee examined the data obtained from the CCP process, considered the changes with the IME, and analyzed the top greatest needs in each category. The group made decisions based on need-capacity gaps, and feasible goals and objectives for each area.

5. What would you recommend the county do differently in 2018 and 2019 to engage community participation in planning the 2020 – 2023 CCP? Would you recommend that the county hire a professional community campaign organizer to generate greater community participation in developing the 2020 – 2023 CCP?

The Mercer County Office on Addiction Services contributed to the Trenton Health Team (THT) and the Greater Mercer Public Health Partnership (GMPHP), in which both entities recently embarked on community health assessments (CHA). Both of these entities hired professional community organizers and as a result, the County embraced the findings and benefitted from participating in both CHAs. In addition, the Mercer County Office on Addiction Services incorporated the findings in relation to substance abuse issues in the development of this CCP. We will continue to work together with these coalitions to find strategies to address the needs of all youth, adults and families within Mercer County.

At this time, we would not recommend hiring a community campaign organizer for the 2020-2023 CCP. We were successful in achieving community participation and are engaged in every organization that completes a community health assessment in Mercer County as an ongoing process.

6. What methods were used to enable participants to voice their concerns and suggestions in the planning process? On a scale of 1 (lowest) to five (highest), indicate the value of each method you used for enabling the community to participate in the planning process?

1. Countywide Town Hall Meeting	YES	(N)	1	2	3	4	5
2. Within-County Regional Town Hall Meeting	YES	(N)	1	2	3	4	5
3. Key Informant Interviews	(Y)	NO	1	2	3	4	**5**
4. Topical Focus Groups	(Y)	NO	1	2	3	4	**5**

5. Special Population Focus Groups	YES	(N)	1	2	3	4	5
6. Social Media Blogs or Chat Rooms	YES	(N)	1	2	3	4	5
7. Web-based Surveys	(Y)	NO	1	2	3	4	**5**
8. Planning Committee with Sub-Committees	(Y)	NO	1	2	3	4	**5**
9. Any method not mentioned in this list?	YES	(N)	1	2	3	4	5

If you answered "Yes" to item 9, briefly describe that method.

7. Briefly discuss your scores in the previous table? Knowing what you know now, would you recommend any different approaches to engaging participants when preparing the next CCP?

Our efforts to engage the community for the developmental of the 2016-2019 County Comprehensive Plan were very successful. We had a combination of focus groups with resident and community providers. We examined the current landscape of addiction services in the State of New Jersey in key informant interviews to further explore gaps in services. As well, we conducted an electronic survey and a press release in order to solicit responses from concerned citizens in Mercer County.

8. How were the needs of the C51 subpopulations identified and evaluated in the planning process?

a. Offenders
b. Intoxicated Drivers
c. Women
d. Youth
e. Disabled

f. Workforce
g. Seniors
h. Co-occurring

During every focus, each participant was asked to think about every subpopulation above and whether there was a specific need and/or gap in service. Participants were given this list of subpopulations and it was emphasized that our goal was to think through what the needs are with respect to any gaps in service within the continuum of care. When the Oversight Committee reviewed the quantitative and qualitative data, it was examined with respect to these eight (8) subpopulation groups as identified in Chapter 51.

9. **Overall, did your planning process help to build and strengthen collaborative relationships among the county, other departments or offices of government, or other stakeholders in the community? Please elaborate.**

Yes, overall, this planning process helped to build and strengthen our relationship with other planning bodies, County Divisions and stakeholders. The Mercer County Office on Addiction Services regularly participates in the Regional Prevention Coalition funded by DMHAS as well as other coalitions such as the Trenton Health Team (THT) and the Greater Mercer Public Health Partnership (GMPHP). These coalitions examine substance abuse issues, as well as other health issues and work together to embrace strategies to address the needs of all youth, adults and families within Mercer County.

C. PREVENTION AND EARLY INTERVENTION (3 PG)

INSTRUCTIONS: In a few short paragraphs of 5 to 7 sentences each, describe your county's plan for the use of its AEREF prevention set-aside in each of the four years from 2016 to 2019. Indicate that you will spend your required set-aside to purchase and implement an evidence-based prevention education program such as Mental Health First Aid, Parenting Wisely, Strengthening Families or SBIRT, or another evidence-based program including a link to the list of EBPs where the program may be found. Additionally, describe the prevention plans of your county's regional prevention coalition and county alliance steering subcommittee. Request help from both groups to describe the plans they are implementing in 2016-2019.

1. SUMMARY OF THE MERCER COUNTY REGIONAL PREVENTION COALITION IMPLEMENTATION PLAN

The Prevention Coalition of Mercer County (PCMC), funded through a grant from the Division of Mental Health and Addiction Services, is coordinated by a community prevention agency, Mercer Council on Alcoholism and Drug Addiction. The Coalition is made up of a group of diverse individuals from the community dedicated to the prevention and treatment of substance abuse. The Coalition is inclusive of key sectors of the community including law enforcement, educators, parents, youth, business leaders, healthcare professionals, municipal alliance coordinators, community treatment organizations, County leadership, faith organizations and individual members of the community.

In 2012, the PCMC, embarked on a needs assessment in order to develop a five year strategic plan for prevention services in Mercer County. These prevention services are based upon specific data-driven priorities that will measure change over a period of time. Through a comprehensive needs assessment process, including sorting through data, social, economic and health indicators, conducting focus groups and town hall meetings, the coalition decided on three priorities. The three priorities the coalition has committed to are:

1. Reduce underage drinking
2. Reduce the illegal use of Marijuana
3. Reduce Prescription Medication Misuse

Each priority was developed into a logic model illustrating the problem statement, root causes, local conditions contributing to the problem statement and interventions to address the issue with an emphasis on environmental changes. The Mercer County Office on Addiction Services participated in this decision making, embraced this process and supports the efforts of the Coalition.

2. SUMMARY OF THE MERCER COUNTY ANNUAL ALLIANCE PLAN FOR THE EXPENDITURE OF FUNDS DERIVED FROM THE "DRUG ENFORCEMENT AND DEMAND REDUCTION FUND."

The Municipal Alliance Program, funded by the Governor's Council on Alcohol and Drug Abuse (GCADA), also conducted their needs assessment in their respective municipalities in order to plan for their prevention programming within their communities. Unique to the Municipal Alliance program, the local committees that represent the key stakeholders and community members play a fundamental role in assessing their community and developing a logic model. This committee, a true grass roots effort, decides on a problem statement based on local data available, information from focus groups and key stakeholder interviews. Then, they examine the problem statement, root causes, local conditions and develops interventions/strategies to address the indicated problems. Both the PCMC and Municipal Alliance program utilize a Strategic Prevention Framework (SPF) that emphasizes a public health strategy to build capable, competent communities. The key SPF skills are assessment, capacity, planning, implementation and evaluation. These core competencies help guide a group of individuals in being effective in community problem solving.

The Municipal Alliance committees submitted their five year 2014-2018 Strategic Plan Application to Mercer County in January of 2014. The committees were able to choose between four priorities, as identified by GCADA, as the focus of their problem statement. The four priorities they chose from are the following:

1. Reduce Problem Drinking/Binge Drinking/Underage Drinking
2. Reduce the Use of Illegal Substances
3. Reduce Medication Misuse
4. Reduce the Use of New and Emerging Drugs of Abuse

Each municipality submitted an application, choosing one of these four priorities, examining the root causes and local conditions, then developing interventions and strategies to reduce use within their community. As a result of this process, the Office on Addiction Services, submitted the County application to GCADA in March 2014 after the County Alliance Steering Subcommittee (CASS) and LACADA approved the plans. The following are a list of the 9 Municipal Alliance Programs and the priority they choose for their community:

East Windsor- Reduce the Use of Illegal Substances
Ewing- Reduce Problem Drinking/Binge Drinking/Underage Drinking
Hamilton- Reduce Problem Drinking/Binge Drinking/Underage Drinking
Hopewell Valley/Pennington- Reduce Problem Drinking/Binge Drinking/Underage Drinking
Lawrence- Reduce Problem Drinking/Binge Drinking/Underage Drinking
Princeton- Reduce Problem Drinking/Binge Drinking/Underage Drinking
Robbinsville- Reduce Problem Drinking/Binge Drinking/Underage Drinking
Trenton- Reduce Problem Drinking/Binge Drinking/Underage Drinking
West Windsor/Plainsboro- Reduce Problem Drinking/Binge Drinking/Underage Drinking

The County Alliance Steering Subcommittee (CASS) is a group of individuals that oversee the Municipal Alliance strategic plan process and overall program. We have seven members on the CASS and several of the members are already members in the PCMC Coalition. All of the CASS members are encouraged to participate in the coalition and in the development of the CCP. Collaborating in these various prevention efforts helps to coordinate efforts and truly develop a comprehensive plan to make a healthier community.

3. MERCER COUNTY'S SELECTED EVIDENCE-BASED, PREVENTION EDUCATION PROGRAM(S) FOR 2016-2019.

INSTRUCTIONS: Answer the following questions for each evidence-based program you will be supporting with the county's AEREF Prevention dollars.

a) Target population (Who is it for?): Parents/families within Mercer County

b) Name of the program: Footprints for Life and Parenting Wisely

c) Description (What does it do?): Footprints for Life helps young children build a strong foundation of life skills rooted in key social competencies; planning and decision-making practice, interpersonal skills, cultural competence, peer pressure and peaceful resolution. Parenting Wisely uses an interactive CD-ROM to train parents in relationship enhancement and child management skills.

d) Administration (Who will provide the program?): Based on the competitive contracting process, the award was given to Mercer Council on Alcoholism and Drug Addiction.

e) Benefits to participants (How will this help participants?): Evidence-based prevention programs are effective interventions targeting risk and protective factors at the individual, family, and/or community levels and are guided by relevant psychosocial theories regarding the etiology of substance use and abuse.

f) Expected Number of People To Be Served:
Footprints for Life- 200 individuals
Parenting Wisely- 50 individuals

g) Social Benefits (How will this reduce direct or indirect disease-related costs to the larger community?): This will provide education and information in the community, increase awareness of substance use disorders and potentially increase referrals to treatment and early detection.

h) Cost of Program: $50,000

Mercer County Prevention Education Plan for the CCP 2016-2019

The Oversight Planning Committee reviewed the data from the County's prevention focus group, electronic survey and DMHAS's data, and considered the efforts from the PCMC (2013-2017 plan) and the Municipal Alliance program (2014-2018 plan) in order to examine and identify the gaps in services. The committee found that there is a lack of prevention programs currently targeting parents. Parenting programs provide awareness, education on substance use disorders and parenting skills, helping build resiliency within the family. During the needs assessment process it became evident that what was lacking in the community was programming targeting parents and families. The County will adhere to the New Jersey Legal requirements of the competitive procurement process, through a Request For Proposal (RFP), in order to secure an agency to provide these prevention services.

D. CLINICAL TREATMENT INCLUDING DETOXIFICATION (5 PG)

INSTRUCTIONS: Answer the following questions in one to five sentences. Provide a key word or phrase that can be used in the logic model to refer to your answer. Place the key word or phrase in the logic model (LM) in the appropriate cell. FOR EACH GOAL, COPY THESE FIVE PAGES AND PASTE THEM INTO THE NEXT FIVE PAGES. List multiple goals in their order of importance: "FIRST", "SECOND", etc.

1. Describe a treatment need-capacity "gap" in the substance abuse treatment system of care that impedes county residents' access to appropriate and effective treatment on demand? Describe its strategic significance to the overall success of the 2016-2019 CCP.

As a whole, Mercer County's need (for an adult population) for substance abuse treatment is 53,722, which is an 18.9% need of the overall county population[2]. This is the third highest "need for treatment" in the State of NJ. In other words, this estimates that out of the total population for Mercer County (284,330 Adults), 18.9 % or 53,722 individuals need treatment for substance use disorders. More specifically, Mercer County is the number one county for the need for alcohol treatment, at 13.2 %, or approximately 37,588 individuals need treatment for alcohol use[3]. Mercer County ranks 15th out of 21 counties in "need" for drug treatment at 4.9%, or 13,873 individuals need treatment for drug addiction[4]. Mercer County is the third highest county in the State of NJ for alcohol related emergency room admissions[5]. In addition, close to 10% of all emergency room visits in Mercer County are related to substance abuse[6].

With such a high level of "need for treatment" issues of access become a critical concern. During the CCP process, issues of "access to services" were a repetitive theme. In the years prior, Mercer County implemented an "Assessment and Referral" initiative, where individuals needing addiction services were able have a comprehensive Addiction Severity Index (ASI) assessment. This assists individuals within a 72 hour timeframe, and helps determine the appropriate level of care. Mercer County will continue to provide this service for this planning cycle.

With regard to access to treatment, the subpopulation "offenders" was identified as having poor to little access to treatment services. And in Mercer County, this subpopulation ranks as the #1 identified subpopulation at 45% of all NJSAMS admissions in 2014[7]. In discussing and strategizing around these issues, key informant interviews with the staff at the Mercer County Correction Center (MCCC) focused on the importance of engaging individuals while incarcerated, specifically targeting substance abuse treatment. Many individuals in the MCCC recognize that they have addiction issues but there are limited services and must qualify for programs such as drug court. Our plan is to target individuals who are in the MCCC and have

[2] Estimate of Total Need and Demand for substance abuse treatment among the adult population in NJ, 2012
[3] Estimate of Treatment Need for Alcohol and Drug Addiction New Jersey, 2014
[4] Estimate of Treatment Need for Alcohol and Drug Addiction New Jersey, 2014
[5] New Jersey Chartbook of Substance Abuse Related Social Indicators, Mercer County, p.95
[6] New Jersey Chartbook of Substance Abuse Related Social Indicators, Mercer County, p.95
[7] Mercer County Substance Abuse Treatment Demand, p. 63

identified a substance use disorder, perform a level of care assessment and determine a discharge plan. Our plan is to provide clinical case management services to individuals leaving the MCCC, identifying an addiction treatment plan, determining a need for general assistance, housing issues, legal obligations and other social services to will help stabilize an individual and move towards recovery.

Key Word or Phrase for [LM COL. A, ROW 2] **Access**

2. What social costs or community problem(s) does this "gap" impose on your county?

The identified gap in service, incarcerated individuals with little to no access to substance abuse services, will help individuals connect with treatment options when they reintegrate back in to the community. This gap causes instability in the lives of those incarcerated and their families. Addressing this gap will potentially help in assisting individuals and families recover from addiction issues, preserve families from trauma or disintegration, and with stabilization from addiction issues, it may prevent recidivism back into the Corrections Center.

Key Word or Phrase for [LM COL. A, ROW 3] **Addiction and Incarceration**

3. What quantitative and qualitative evidence did you find that helped you to identify this gap and evaluate its significance? [LM COL. B]

45% of all NJSAMS admissions identify as being "offenders". Focus group information and key informant interviews with staff from the MCCC also indicate the need for substance abuse treatment efforts targeted at individuals leaving the corrections center.

4. Restate this "gap" and related community problem as a treatment goal to be achieved during the 2016-2019 CCP. [LM COL. C]

Goal Statement: To….

To increase access to addiction services to individuals in the Mercer County Corrections Center

5. What annual tasks or targets has your county set for itself to achieve this goal in whole or in part over the next four years?

Objective 1, year 2016. To… [LM COL. D, ROW 2]

To assess a baseline of the number of people that complete a treatment episode

Objective 2, year 2017. To… [LM COL. D, ROW 3]

To increase the number of people that complete treatment by 10% over the prior year success

Objective 3, year 2018. To… [LM COL. D, ROW 4]

To increase the number of people that complete treatment by 20% over the prior year success

Objective 4, year 2019. To… [LM COL. D, ROW 5]
To increase the number of people that complete treatment by 30% over the prior year success

6. What strategy will the county employ to achieve each annual objective?

Strategy for Objective 1, year 2016.

The county will utilize a competitive procurement process to secure a DMHAS licensed agency to provide these treatment services.

Key Word or Phrase for [LM COL. E, ROW 2] **Competitive procurement process**

Strategy for Objective 2, year 2017.

The county will utilize a competitive procurement process to secure a DMHAS licensed agency to provide these treatment services.

Key Word or Phrase for [LM COL. E, ROW 3] **Competitive procurement process**

Strategy for Objective 3, year 2018.

The county will utilize a competitive procurement process to secure a DMHAS licensed agency to provide these treatment services.

Key Word or Phrase for [LM COL. E, ROW 4] **Competitive procurement process**

Strategy for Objective 4, year 2019.

The county will utilize a competitive procurement process to secure a DMHAS licensed agency to provide these treatment services.

Key Word or Phrase for [LM COL. E, ROW 5] **Competitive procurement process**

7. How much will it cost each year to meet the annual objectives?

Cost of Strategy for Objective 1, year 2016. [LM COL. F, ROW 2]
For a 12 month period $75,000.00

Cost of Strategy for Objective 2, year 2017. [LM COL. F, ROW 3]
For a 12 month period $75,000.00

Cost of Strategy for Objective 3, year 2018. [LM COL. F, ROW 4]
For a 12 month period $75,000.00

Cost of Strategy for Objective 4, year 2019. [LM COL. F, ROW 5]
For a 12 month period $75,000.00

8. If successful, what do you think will be the annual outputs of the strategy?

Outputs of Strategy for Objective 1, year 2016. [LM COL. G, ROW 2]
The number of completed addiction treatment episodes will indicate successfully engaging with individuals and connecting them to services.

Outputs of Strategy for Objective 2, year 2017. [LM COL. G, ROW 3]
The number of completed addiction treatment episodes will indicate successfully engaging with individuals and connecting them to services.

Outputs of Strategy for Objective 3, year 2018. [LM COL. G, ROW 4]
The number of completed addiction treatment episodes will indicate successfully engaging with individuals and connecting them to services.

Outputs of Strategy for Objective 4, year 2019. [LM COL. G, ROW 5]
The number of completed addiction treatment episodes will indicate successfully engaging with individuals and connecting them to services.

9. What will be the annual outcomes, or community benefits, of the strategy?
(Estimated Social Cost-offsets for the community)

Outcomes of Strategy for Objective 1, year 2016. [LM COL. H, ROW 2]
To build relationships between the MCCC and providers

Outcomes of Strategy for Objective 2, year 2017. [LM COL. H, ROW 3]
To provide access to social support services

Outcomes of Strategy for Objective 3, year 2018. [LM COL. H, ROW 4]
To increase and improve access to social services

Outcomes of Strategy for Objective 4, year 2019. [LM COL. H, ROW 5]
To reduce recidivism rates of incarceration and increase rates of completed treatment episodes

10. Who is taking responsibility to execute the strategy or any of its parts?

Responsible Executive Agent or Agency, Strategy Objective 1, year 2016. [LM COL. I, ROW 2]
The Mercer County, Office on Addiction Services will issue a Request for Proposal (RFP) and secure an agency to provide the treatment services.

Responsible Executive Agent or Agency, Strategy for Objective 2, year 2017. [LM COL. I, ROW 3]
The Mercer County, Office on Addiction Services will issue a Request for Proposal (RFP) and secure an agency to provide the treatment services.

Responsible Executive Agent or Agency, Strategy for Objective 3, year 2018. [LM COL. I, ROW 4]
The Mercer County, Office on Addiction Services will issue a Request for Proposal (RFP) and secure an agency to provide the treatment services.

Responsible Executive Agent or Agency, Strategy for Objective 4, year 2019. [LM COL. I, ROW 5]

The Mercer County, Office on Addiction Services will issue a Request for Proposal (RFP) and secure an agency to provide the treatment services.

LOGIC MODEL: TREATMENT

Need-capacity **gap and** associated community **problem** **(A)**	**Evidence** of problem **and** its **significance** for the county (B)	**Goal** For 2016-2019 (C)	**Objectives** Targets Per Annum (D)	**Strategy** To Achieve Objective (E)	**Inputs** Financial or Other Resources (F)	**Outputs** Expected product (G)	**Outcomes** Expected Community Benefits (H)	**Agency** Responsible (I)
Need-capacity Gap: Access	45% of all NJSAMS admissions identify as being "offenders". Focus groups and key informant interviews with staff from the MCCC also indicate the need for substance abuse treatment efforts targeted at individuals leaving the corrections center	To increase access to addiction services for individuals in the Mercer County Corrections Center (MCCC)	2016: To assess baseline for number of people that complete treatment episode	2016: Competitive procurement process	**County: $75,000.00 AEREF/State: $00:00 Total: $75,000.00**	Number of completed addiction treatment episodes	Short Term: To build relationships between the MCCC and treatment providers	Mercer County and agency
			2017: To increase the number of people that complete treatment by 10% over prior year success rate	2017: Competitive procurement process	**County: $75,000.00 AEREF/State: $00:00 Total: $75,000.00**	Number of completed addiction treatment episodes	Middle Term: To improve access to social support services	Mercer County and agency
Associated Community Problem: Addiction and Incarceration			2018: To increase by 20%	2018: Competitive procurement process	**County: $75,000.00 AEREF/State: $00:00 Total: $75,000.00**	Number of completed addiction treatment episodes	Middle Term: To increase and improve access to social services	Mercer County and agency
			2019: To increase by 30%	2019: Competitive procurement process	**County: $75,000.00 AEREF/State: $00:00 Total: $75,000.00**	Number of completed addiction treatment episodes	Long Term: To reduce recidivism rates of incarceration and increase completion of treatment episodes	Mercer County and agency

D. RECOVERY SUPPORT SERVICES (5 PG)

INSTRUCTIONS: Answer the following questions in one to five sentences. Provide a key word or phrase that can be used in the logic model to refer to your answer. Place the key word or phrase in the logic model (LM) in the appropriate cell. FOR EACH GOAL, COPY THESE FIVE PAGES AND PASTE INTO THE NEXT FIVE PAGES. List multiple goals in their order of importance: "FIRST", "SECOND", etc.

1. **Describe a recovery support services need-capacity "gap" in the substance abuse treatment system of care that impedes county residents' access to appropriate and effective post-treatment recovery support? Describe its strategic significance to the overall success of the 2016-2019 CCP.**

   Transportation has been indicated as a gap in service within the treatment system of care that impedes an individual's recovery process. Key informant interviews, focus group data and the results of the electronic survey all indicate that transportation to and from treatment become a barrier to the recovery process. In addition, the majority of inpatient residential and detoxification services that respond to the competitive procurement process are outside of Mercer County. This makes it difficult for individuals to seek that level of care if needed.

   Key Word or Phrase for [LM COL. A, ROW 2] Transportation

2. **What social costs or community problem(s) does this "gap" impose on your county?**

   When an individual does not have access to treatment due to transportation issues, it becomes a barrier to treatment. This barrier will prevent individuals from accessing care and ultimately, advancing in the stages of the disease of addiction.

   Key Word or Phrase for [LM COL. A, ROW 3] Advancement of the Disease of Addiction

3. **What quantitative and qualitative evidence did you find that helped you to identify this gap and evaluate its significance?** [LM COL. B] Focus groups and interviews

   Key informant interviews, focus group data and the results of the electronic survey all indicate that transportation to and from treatment become a barrier to the recovery process.

4. Restate this "gap" and related social cost or community problem as a treatment goal to be achieved during the 2016-2019 CCP. [LM COL. C]

First Goal Statement: To….

To increase availability of transportation for Mercer County residents to and from addiction treatment agencies.

5. What annual tasks or targets has your county set for itself to achieve this goal in whole or in part over the next four years?

Objective 1, year 2016. To… [LM COL. D, ROW 2]
To establish a baseline of transportation need

Objective 2, year 2017. To… [LM COL. D, ROW 3]
To increase transportation by 5% over the prior year success

Objective 3, year 2018. To… [LM COL. D, ROW 4]
To increase transportation by 10% over the prior year success

Objective 4, year 2019. To… [LM COL. D, ROW 5]
To increase transportation by 15% over the prior year success

6. What strategy will the county employ to achieve each annual objective?

Strategy for Objective 1, year 2016.

The county will utilize a competitive procurement process to secure a DMHAS licensed agency to provide treatment services with transportation.

Key Word or Phrase for [LM COL. E, ROW 2] **Competitive procurement process**

Strategy for Objective 2, year 2017.

The county will utilize a competitive procurement process to secure a DMHAS licensed agency to provide treatment services with transportation.

Key Word or Phrase for [LM COL. E, ROW 3] **Competitive procurement process**

Strategy for Objective 3, year 2018.

The county will utilize a competitive procurement process to secure a DMHAS licensed agency to provide treatment services with transportation.

Key Word or Phrase for [LM COL. E, ROW 4] **Competitive procurement process**

Strategy for Objective 4, year 2019.

The county will utilize a competitive procurement process to secure a DMHAS licensed agency to provide treatment services with transportation.

Key Word or Phrase for [LM COL. E, ROW 5] **Competitive procurement process**

7. How much will it cost each year to meet the annual objectives?

Cost of Strategy for Objective 1, year 2016. [LM COL. F, ROW 2]
County: $20,000.00
AEREF/State: $10,000.00
Total: $30,000.00

Cost of Strategy for Objective 2, year 2017. [LM COL. F, ROW 3]
County: $30,000.00
AEREF/State: $10,000.00
Total: $40,000.00

Cost of Strategy for Objective 3, year 2018. [LM COL. F, ROW 4]
County: $40,000.00
AEREF/State: $10,000.00
Total: $50,000.00

Cost of Strategy for Objective 4, year 2019. [LM COL. F , ROW 5]
County: $50,000.00
AEREF/State: $10,000.00
Total: $60,000.00

8. What will be the annual outputs of the strategy?

Outputs of Strategy for Objective 1, year 2016. [LM COL. G, ROW 2]
The annual outputs of the strategy will be the number of individuals needing transportation services and the number of individuals that received those services.

Outputs of Strategy for Objective 2, year 2017. [LM COL. G, ROW 3]
The annual outputs of the strategy will be the number of individuals needing transportation services and the number of individuals that received those services.

Outputs of Strategy for Objective 3, year 2018. [LM COL. G, ROW 4]
The annual outputs of the strategy will be the number of individuals needing transportation services and the number of individuals that received those services.

Outputs of Strategy for Objective 4, year 2019. [LM COL. G, ROW 5]
The annual outputs of the strategy will be the number of individuals needing transportation services and the number of individuals that received those services.

9. What will be the annual outcomes, or community benefits, of the strategy?
(Estimated Social Cost-offsets for the community)

Outcomes of Strategy for Objective 1, year 2016. [LM COL. H, ROW 2]
To reduce barriers to treatment by providing transportation services

Outcomes of Strategy for Objective 2, year 2017. [LM COL. H, ROW 3]
To improve access to treatment services

Outcomes of Strategy for Objective 3, year 2018. [LM COL. H, ROW 4]

To improve access to treatment services

Outcomes of Strategy for Objective 4, year 2019. [LM COL. H, ROW 5]
To prevent the advancement of the disease of addiction services

10. Who is responsible to execute the strategy or its various parts?

Responsible Executive Agent or Agency, Strategy Objective 1, year 2016. [LM COL. I, ROW 2]
The Mercer County, Office on Addiction Services and treatment agencies that provide the transportation services will execute the strategy.

Responsible Executive Agent or Agency, Strategy for Objective 2, year 2017. [LM COL. I, ROW 3]
The Mercer County, Office on Addiction Services and treatment agencies that provide the transportation services will execute the strategy.

Responsible Executive Agent or Agency, Strategy for Objective 3, year 2018. [LM COL. I, ROW 4]
The Mercer County, Office on Addiction Services and treatment agencies that provide the transportation services will execute the strategy.

Responsible Executive Agent or Agency, Strategy for Objective 4, year 2019. [LM COL. I, ROW 5]

The Mercer County, Office on Addiction Services and treatment agencies that provide the transportation services will execute the strategy.

LOGIC MODEL: RECOVERY SUPPORT

Need-capacity **gap and** associated community **problem (A)**	**Evidence** of problem **and** its **significance** for the county (B)	**Goal** For 2016-2019 (C)	**Objectives** Targets Per Annum (D)	**Strategy** To Achieve Objective (E)	**Inputs** Financial or Other Resources (F)	**Outputs** Expected product (G)	**Outcomes** Expected Community Benefits (H)	**Agency** Responsible (I)
Need-capacity Gap: Transportation	Key informant interviews, focus group data and the results of the electronic survey all indicate that transportation to and from treatment become a barrier to the recovery process.	To increase availability of transportation for Mercer County residents to and from addiction treatment agencies.	2016: To establish a baseline of transportation need	2016: Competitive procurement process	**County: $20,000.00 AEREF/State: $10,000.00 Total: $30,000.00**	Number of individuals needing transportation services	Short Term: Reduce barriers to treatment	Mercer County and treatment agencies providing services
			2017: To increase transportation by 5% over the prior year success	2017: Competitive procurement process	**County: $30,000.00 AEREF/State: $10,000.00 Total: $40,000.00**	Number of individuals needing transportation services	Middle Term: Improve access to treatment services	Mercer County and treatment agencies providing services
Associated Community Problem: Advancement of the disease of addiction			2018: To increase by 10%	2018: Competitive procurement process	**County: $40,000.00 AEREF/State: $10,000.00 Total: $50,000.00**	Number of individuals needing transportation services	Middle Term: Improve access to treatment services	Mercer County and treatment agencies providing services
			2019: To increase by 15%	2019**:** Competitive procurement process	**County: $50,000.00 AEREF/State: $10,000.00 Total: $60,000.00**	Number of individuals needing transportation services	Long Term: Prevent advanced stages of the disease	Mercer County and treatment agencies providing services

APPENDIX 1: DEFINITIONS OF PLANNING CONCEPTS

County Comprehensive Plan (CCP) is a *document* that describes the *future* relationship between the substance abuse risks and treatment needs of county residents and all existing resources available to county residents for meeting those needs. It presents the results of a community-based, deliberative *process* that prioritizes those resource gaps most critical to residents' well-being and proposes an *investment strategy* that ensures both the maintenance of the county's present system of care and the development of a relevant future system. Finally, a CCP represents a commitment of the county and community stakeholders to sustained, concerted action to achieve the goals and corresponding community-wide benefits established by the plan.

Client-centered care is a widely recognized standard of quality in the delivery of substance abuse treatment. It is based on the principle that treatment and recovery are effective when individuals and families assume responsibility for and control over their personal recovery plans. Thus, client-centered care respectfully incorporates individual client preferences, needs, and values into the design of an individual's recovery plan by empowering clients and their families with the information necessary to participate in and ultimately guide all clinical decision-making pertaining to their case.

Recovery-oriented care views addiction as a *chronic* rather than an *acute* disease. Correspondingly, recovery oriented care adopts a *chronic disease* model of sustained recovery management rather than an *acute care* model premised on episodes of curative treatment. Recovery-oriented care focuses on the client's acquisition and maintenance of recovery capital, such as global health (physical, emotional, relational, and spiritual), and community integration (meaningful roles, relationships, and activities).

Continuum of Care For purposes of community-based, comprehensive planning, the full service continuum of care is defined as inter-related county systems of substance abuse prevention and education, early, or pre-clinical, intervention, clinical treatment and long term recovery support.

Co-occurring Disorder is a term that describes those persons who suffer treatment needs for substance use and mental health related disorders simultaneously such that care of the whole person requires both disorders be addressed in an integrated treatment plan.

Need Assessments are carefully designed efforts to collect information that estimates the number of persons living in a place with clinical or pre-clinical signs of present or future treatment need. Typically, an assessment will also describe need according to the socio-demographic characteristics of the population. If the care being planned is preventive in nature, then the assessment focuses on the number of residents at risk of presenting for clinical interventions. If the care being planned is in the nature of chronic disease management, then the assessment focuses on the number of residents completing clinical care for an acute disease episode. Typically, a need assessment will also evaluate the significance of an identified need according to the expected personal and social costs that can be anticipated if the identified need is left unaddressed.

Demand Assessments seek to convert an assessed need into an estimate of the number of persons who can be expected to seek the planned care. The purpose of demand assessment is to anticipate how many persons with the need will actually use the care if it is offered. Treatment need may or may not convert to treatment demand. That portion that seeks and obtains treatment is called "Met demand" and that portion which does not is called "Unmet demand" when any individuals in this group indicate a desire to obtain treatment. The remainder are persons in need with no indicated demand for care.

Gap Analysis describes needs that are not being met because of a shortfall in resources available to meet them. By comparing the number and characteristics of residents who are likely to present for care, Demand, with the number and characteristics of care providers available to treat them, a "gap" in services may be identified. In the first instance, a "gap" is the arithmetic difference between a projected service need and the existing capacity of providers to meet the need. But a "gap" may also arise because of access issues called "barriers," such as a lack of insurance, transportation or child care.

Logic Model A logic model is tool for organizing thoughts about *solving a problem* by making explicit the rational relationship between means and ends. A *documented need* is converted into a problem statement. The *problem statement* must be accompanied by a *theory* that explains the problem's cause(s) and the corresponding actions required to "solve" it. The theory must be expressed in the form of a series of "If...Then" statements. For example, **If** "this" is the problem (*definition*) and "this" is its cause (*explanation*), **then** "this" action will solve it (*hypothesis*). Finally, when out of several possible "solutions" one is adopted, it must be accompanied by a *list of measures* for which data are or can be made available, and by which to determine if the targeted problem was indeed "solved," in what time frame, to what degree, at what cost to the community and for what benefit (outcome or payback) to the community.

Outputs are the numbers of persons served by any given program expressed in terms of both total persons served and per person costs of services delivered.

Outcomes are the community values resulting from the operation of any given program expressed as the percentage of a community problem "solved" and as a rate "per hundred thousand" of a county or target population.

Action Plans are also logic models. They are used to develop a coherent implementation plan. By breaking a problem's solution down into a series of smaller tasks, an action plan organizes the tasks, resources, personnel, responsibilities and time to completion around the hypothesized solution to the stated problem.

Evaluation Plans are also logic models. They are used to develop a coherent plan for establishing the value of the outcome of having "solved" a community problem associated with a service gap. The elements of an evaluation plan are a problem statement, an anticipated benefit to be captured by reducing the size and impact of the stated problem, measures that can inform the community if a problem has been reduced and by what proportion, a description of the type and availability of the data required to measure the intended change, a method for analyzing the data obtained, an estimate of the fiscal and other requirements of the method, and the findings from the evaluation.

APPENDIX 2: THE CHANGING POLICY ENVIRONMENT OF BEHAVIORAL HEALTH CARE SERVICE DELIVERY

The 2016-2019 CCP was researched and written in anticipation of many changes to New Jersey's health care system. Both the federal and state governments have initiated major health care reforms since the 2010-2012 CCP, including the Patient Protection and Affordable Care Act (PPACA), signed into law in March, 2010, and the New Jersey Interim Management Entity, effective July 1, 2015. Additionally, Super Storm Sandy, the second most costly hurricane in United States history, struck in the fall of 2012 devastating communities in 10 of New Jersey's 21 counties and eclipsing or replacing county staffs' time and energy devoted to community-based, comprehensive planning for the AEREF program.

New Jersey's Medicaid expansion was signed into law by Governor Christie in June, 2012 and enrollment levels began increasing in 2013 jumping 404,515, or 31%, from 1.3M in January 2013 to 1.7M by March of 2015. An additional 411,775 New Jersey residents purchased private health insurance through the New Jersey Health Insurance Exchange. Combined there are 816,290 residents that have obtained either publically provided or privately sold health insurance since 2013. Given the requirements of the Wellstone-Domenici Mental Health Parity and Addiction Equity Act of 2008, these newly insured low income persons will be able to obtain behavioral health care, should they ever need it, on a par with medical care without having to rely upon county resources.

In January, 2015, Governor Christie announced that New Jersey would take a fee-for-service, managed care approach to providing substance abuse treatment through the creation of the Interim Management Entity, or IME. Phase one of the IME roll out began on July 1, 2015 at which time New Jersey Medicaid reimbursement rates were reset to equal rates paid in three of New Jersey's fee-for-service initiatives: the South Jersey Initiative, or SJI, the Driving Under The Influence Initiative, or DUII, and the Medication Assisted Treatment Initiative, or MATI. Also, the IME began to authorize clinical assessments and placements of clients eligible for treatment under these initiatives.

In 2012, Governor Christie placed responsibility for the provision of substance abuse treatment for persons under the age of 21 with the NJ Department of Children and Families (DCF), Division of Child Behavioral Health Services (DCBHS). DCF also contracts with PerformCare Behavioral Health Solutions, a division of AmeriHealth Mercy Company, to provide it with the services of a managed care organization.

Given this environment of changing expectations about access to and delivery of behavioral health care, the 2016-2019 CCP is premised on the assumption of gradual implementation of reforms such that, county AEREF and state discretionary dollars will pay for continuous volumes of treatment for county residents in the initial plan year and decline in each successive year of the plan, thereby, permitting counties to invest an increasing share of total available resources into the county's recovery support system. To achieve this change in county spending priorities will require close monitoring of the impacts of the ACA and IME on both the demand for county resources to pay for treatment and the quality and effectiveness of care clients receive.

APPENDIX 3: REFERENCES

1. For a glossary of planning terminology used in the CCP, please see Appendix One.

2. Robert Culleton, Ph.D (2012). Estimate of Total Need and Demand for substance abuse treatment among the adult population in NJ, 2012.

3. Robert Culleton, Ph.D (2014). Estimate of Treatment Need for Alcohol and Drug Addiction New Jersey, 2014.

4. Robert Culleton, Ph.D (2014). Estimate of Treatment Need for Alcohol and Drug Addiction New Jersey, 2014.

2. Robert Culleton, Ph.D (2013). Mercer County Substance Abuse Treatment Demand.

3. Robert Culleton, Ph.D (2013). Mercer County Substance Abuse Treatment Demand.

4. Robert Culleton, Ph.D (2013). Mercer County Substance Abuse Treatment Demand.

5. Division of Mental Health and Addiction Services (2013). 2013 New Jersey Chartbook of Substance Abuse Related Social Indicators, p. 95. Retrieved from http://www.state.nj.us/humanservices/das/news/reports/epidemiological/

6. Division of Mental Health and Addiction Services (2013). 2013 New Jersey Chartbook of Substance Abuse Related Social Indicators, p. 95. Retrieved from http://www.state.nj.us/humanservices/das/news/reports/epidemiological/

7. Robert Culleton, Ph. D (2014). Mercer County Substance Abuse Treatment Demand, p. 63

APPENDIX 4: NEEDS ASSESSMENT

To obtain a copy of the needs assessment, please contact the Office on Addiction Services at 609-989-6897.

APPENDIX 5: LIST OF PARTICIPANTS IN THE PLANNING PROCESS

Dates of four focus groups were established with respect to community providers, residents, consumers, community leaders and individuals in recovery. A total of 86 individuals attended the four focus groups. Along with conducting focus groups, we created an electronic questionnaire, made available to all county residents to help gather additional information on the county's continuum of care. A press release highlighted the electronic questionnaire that was created to obtain more information from county residents and it was available on the County's website. In addition to those efforts, the LACADA and PACADA participated in the development of the County Comprehensive Plan.

LACADA Membership 2013-2016	PACADA /MOATES Membership 2013-2016
Lonnie Hutton – Chairperson	Mary Gay Abbott-Young and staff Rescue Mission of Trenton
Ann Suabedissen – Vice-Chairperson	Tracy Simmons-Hart and staff New Horizon Treatment Services
DuEwa Edwards-Dickson	Geetha Arulmohan and staff Mercer Council on Alcoholism and Drug Abuse
John Piepszak	Leslie Dona and staff UPI Trenton Treatment Center
Matthew Regulski	Lisa Ranieri Carrier Clinic
Andrew Salmon	Nancy Zorochin Princeton House Behavioral Health
Robyn Siminske	Kevin McHugh and staff Helping Arms
Timothy Johnson	Gary DeBlasio and staff Corner House
	Roman Karpiel and staff Maryville, Inc.
	Jeff Robbins and staff Family Guidance Center
	Chris Mussel and staff Catholic Charities
	Tony Comerford and staff New Hope Foundation, Inc.
	Linda Leyhane Daytop Village of NJ, Inc.
	Lisette Weiland and staff Signs of Sobriety
Thank you to the other Mercer County Departments and Human Services Divisions for their collaboration and assistance: Mercer County Corrections Center Human Services, Youth Services Human Services, Public Health Mercer County Prosecutor's Office Human Services, Division of Mental Health Human Services, Office on Aging	