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

PLANNING CYCLE 2016-2019

New Jersey Department of Human Services
Division of Mental Health and Addiction Services
P.O. Box 362
Trenton, New Jersey 08625-0362

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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

Sussex County's 2010-2012 CCP recognized that illicit drug use among middle school aged youth through the 18-25 year old population was of significant concern. This was determined by reviewing the data presented in the New Jersey Middle School Risk and Protective Factor Survey conducted by DMHAS and the NJSAMS data for Sussex County. 9.6% of middle school students reported past year use of illicit drugs and Sussex County had the 10th highest prevalence of past year illicit drug use among them. 18-25 year olds represented 9% percent of Sussex County's overall population but comprised one-third of the IDRC population, one-third of all treatment admissions, and almost one-half of those arrested in the county.

The stated goal for the 2010-2012 CCP was to reduce illicit drug use among those people in the middle school age range up to 25 year olds by 5% over 3 years. It monitored the progress of SPF-SIG and other grants awarded to prevention agencies and organizations within the county that address substance abuse prevention. As a result, Illicit Drug use among the middle school students declined by 0.78% with the exception of alcohol (4.7% increase) and marijuana (2.9% increase). This is evidenced by the data presented in the 2012 New Jersey Middle School Risk and Protective Factor Survey.

The county has been active in the Regional Coalition by attending monthly meetings, assisting with the coordination of events and programs, and attending planning sessions conducted by the regional coalition.

B. EARLY INTERVENTION

There is no available data regarding Early Intervention services within the county. Services are provided under the following programs: SAI evaluator; IDRC program; DCP&P evaluator; Drug Court/Probation evaluator; and the Center for Prevention and Counseling of Newton through a contract from the Youth Services Commission. The collection of relevant data regarding Early Intervention programs was determined to not be possible. The county tried to determine if additional E.I. programs were needed and if any gaps existed. The number of residents that benefitted from E.I. and/or the benefit to the community was determined to not be measurable. Early Intervention was not a priority of the 2010-2012 CCP.

C. TREATMENT (Including Detoxification)

The Sussex County Department of Human Services is committed to developing a continuum of services for adults and adolescents by utilizing substance abuse treatment providers within and out-of-county. There are currently service gaps along the treatment continuum. Sussex County has limited treatment providers located within the county. Although there are providers out of the county which provide

services to our residents, lack of transportation in our rural community and insufficient funding for the indigent population leaves us with a consistent inaccessibility to services. The county will continue to update the county/state funded substance abuse treatment resource list to identify all available substance abuse treatment options that provide access to the highest quality care, across the continuum of services in a timely and cost-effective manner.

The 2010-2012 CCP reported that statistics indicated that 50% of County residents who have identified themselves as needing treatment had not been able to receive it and that Sussex County was the 6th worst in the State for meeting the need for treatment. Sussex County ranks 17th in the State for population size but was 9th in estimated treatment need. The CCP sought to maintain treatment services for detox, in-patient and outpatient levels of care by monitoring the providers' use of funds and exploring options to increase the efficient use of funds.

D. RECOVERY SUPPORT SERVICES

The 2010-2012 CCP indicated the need to provide more continuum of care for individuals who participate in detox services. It was determined that many clients who complete a detox program are not receiving any formalized treatment or recovery support. The CCP called for the requirement of case management services for those who receive detox services. Its strategy included the reallocation of resources to develop case management services in order to improve the client's level of functioning thereby reducing repeated detox visits. As a result, more people entered inpatient programs after receiving detox services. At Sunrise House in 2014, 28 out of 33 clients completed detox and entered short term inpatient treatment and in 2015 there were 15 out of 20 clients that completed detox and entered short term inpatient treatment.

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.

The county will continue to attend and participate in DMHAS sponsored trainings, forums, etc. to gain the most up to date information on issues related to Medicaid enrollment, system capacity, and challenges as the DMHAS moves forward with the Interim Management Entity (IME).

1. The Sussex County Department of Human Services will discuss the number of county residents with Medicaid with PACADA, LACADA and funded providers. This information will be obtained from the Sussex County Division of Social Services. The county will continue to monitor through the provider monthly contract performance reports changes in the numbers of residents relying on county funding for treatment.

1. The county will be reviewing the database for Medicaid enrollees on the DMHAS website and within their monthly enrollment reports. We will monitor the monthly expense reports for the number of people using county funds.

2. The county will review and discuss the information supplied at the monthly County A&D Directors meetings, the updates from DMHAS regarding the IME data and updates from PACADA providers.

3. The county will collaborate with service providers to ensure that all county/Chapter 51 funded substance abuse programs are complying and benefiting from the most recent health care reforms, including utilization of the IME and data entry into NJSAMS. The County will review IME reports that may be available on a regular basis.

SECTION FOUR: THE 2016-2019 COUNTY COMPREHENSIVE PLAN

A. VISION

Sussex 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	YES	NO	YES	NO
2. GCADA	YES	NO	YES	NO
3. MOBILIZING ACTION THROUGH PLANNING AND PARTNERSHIPS, MAPP (CDC/NJDOH SPONSORED)	YES	NO	YES	NO
4. REGIONAL PREVENTION COALITIONS	YES	NO	YES	NO
5. COUNTY PLANNING BODIES	YES	NO	YES	NO
6. HOSPITAL CATCHMENT AREA NEEDS ASSESSMENTS FOR IRS	YES	NO	YES	NO
7. MUNICIPAL ALLIANCES	YES	NO	YES	NO
8. TREATMENT PROVIDERS	YES	NO	YES	NO
9. FOUNDATIONS	YES	NO	YES	NO
10. FAITH-BASED ORGANIZATIONS	YES	NO	YES	NO
11. ADVOCACY ORGANIZATIONS	YES	NO	YES	NO
12. OTHER CIVIC ASSOCIATIONS	YES	NO	YES	NO

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 conducted a survey of its residents in both a web-based and hard copy format. The survey was made available at all Human Services events, meetings, and activities as well as advertised in the area newspaper. There was also outreach conducted to all the self-help meetings within the County. When it was completed we had received 536 responses.

   Planning meetings have also been held with the Professional Advisory Committee on Alcoholism and Drug Abuse (PACADA) and the Local Advisory Committee on Alcoholism and Drug Abuse (LACADA). All meetings were advertised in the local paper and the public was invited to participate in the planning process at these meetings.

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

1. Members of the County Board of Freeholder	YES	NO
2. County Executive (If not applicable leave blank)	YES	NO
3. County Department Heads	YES	NO
4. County Department Representatives or Staffs	YES	NO
5. LACADA Representatives	YES	NO
6. PACADA Representatives	YES	NO
7. CASS Representatives	YES	NO
8. County Mental Health Boards	YES	NO
9. County Mental Health Administrators	YES	NO
10. Children System of Care Representatives	YES	NO
11. Youth Services Commissions	YES	NO
12. County Interagency Coordinating Committee	YES	NO
13. Regional Prevention Coalition Representatives	YES	NO
14. Municipal Alliances Representatives	YES	NO
15. Other community groups or institutions	YES	NO
16. Organizationally unaffiliated individuals	YES	NO

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 main source of outreach that was conducted was a web-based and hard copy survey. The Sussex County LACADA reviewed the survey before it was released and made suggestions to improve certain questions and how and where to distribute it. After the survey period was completed, LACADA reviewed the responses and the data that was collected in the survey.

   The survey worked very well and gave us input from the population at large. We had considered conducting focus groups and key informant interviews but the Sussex County Human Services Advisory Council was also conducting a needs assessment and it included an assessment of the needs regarding substance abuse and included a focus group. Because of this, we felt that another focus group was not necessary.

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?

   There is nothing that is recommended to be done differently for 2018-2019 at this time. We will need to wait until the time is near to determine the best methods to engage the community.

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	**NO**	1	2	3	4	5
2. Within-County Regional Town Hall Meeting	YES	**NO**	1	2	3	4	5
3. Key Informant Interviews	**YES**	NO	1	2	3	4	**5**
4. Topical Focus Groups	YES	**NO**	1	2	3	4	5
5. Special Population Focus Groups	**YES**	NO	1	2	3	4	**5**
6. Social Media Blogs or Chat Rooms	YES	**NO**	1	2	3	4	5
7. Web-based Surveys	**YES**	NO	1	2	3	4	**5**
8. Planning Committee with Sub-Committees	**YES**	NO	1	2	3	**4**	5
9. Any method not mentioned in this list?	YES	**NO**	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?

   We were satisfied with the methods we used and felt it was comprehensive to formulating a Needs Assessment for Sussex County. We may conduct more Key Informant Interviews, Topical Focus Groups, or Special Population Focus Groups in the future, if needed.

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

a. Offenders: NJSAMS, Key Informant Interviews, Probation Data. **This is not a priority at this time.
b. Intoxicated Drivers: NJSAMS data, IDRC data, IDRC director. **This is not a priority at this time.
c. Women: NJSAMS data, DMHAS data, Key Informant Interviews **This is not a priority at this time.
d. Youth: NJSAMS data. **This is not a priority at this time.
e. Disabled: NJSAMS data, DMHAS Treatment Demand Data. **This is not a priority at this time.
f. Workforce: NJSAMS data, DMHAS treatment demand data **This is not a priority at this time.
g. Seniors: NJSAMS data. **This is not a priority at this time.
h. Co-occurring: NJSAMS data, anecdotal data from providers, survey results. **This is the priority.

***No other priorities presented themselves in the Survey Results.

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.**

Collaborative relationships did not need to be built or strengthened in Sussex County as there already exists a strong collaborative relationship with our partners who give feedback and participate when they are requested to do so.

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 SUSSEX COUNTY REGIONAL PREVENTION COALITION IMPLEMENTATION PLAN

The Coalition for Healthy and Safe Communities of Sussex County works to effect prevention concerns in 5 main areas: (1) Prescription Drug Abuse (2) Underage Drinking (3) Illegal Substances (4) New & Emerging Drugs of Abuse (5) Tobacco, E-Cigarette and Vape Use (6) NJ Returning Veterans

Prevention of Prescription Drug Use

☐ Promote National Drug Facts Week every January in Sussex County schools

☐ Utilize SAMHSA's Rx Prevention Toolkit with media and messages for community

☐ Promote use of PMP and educate physicians of new law passed July 20, 2015 regarding required registration and utilization

☐ Pharmacy Workshops for local pharmacists w/addiction, brain science, prevention, treatment and recovery resources

☐ Continued promotion of 7 county Rx disposal boxes in local police station lobbies with twice yearly campaign to encourage community to rid homes of unused, expired & unwanted drugs

☐ Campaigns to educate realtors and funeral homes regarding safe disposal of Rx

☐ Educate businesses to adopt healthy workplace initiatives

Underage Drinking

☐ Outreach to bars, restaurants & liquor stores to conduct quarterly TiPs trainings for county alcohol servers

☐ Sticker Shock implemented during holiday and high-risk drinking times of the year (Super Bowl, etc.)

☐ Seasonal Parents Who Host Messages engaging guardians with uniquely personalized messages along with yearly letter to graduating senior parents & community prevention tools for prom and graduation time

☐ Advocate Underage Drinking Ordinance Information at Local Drug Trend Updates in schools, doctor offices, and other community organizations

☐ Implement best practices, advocating for changes in policies for community events that serve alcohol

☐ Promote Domino Strategy &/or Rethinking Drinking at area three colleges

☐ Collaborate with other Regional Coalitions to advocate for statewide changes to policies and practices designed to reduce underage drinking

Marijuana

☐ Implement multi-media campaign, including use of social media, to inform public of the legal and physical consequences of illicit drug use and dispel myths surrounding medical marijuana

☐ Advocate for adoption of policies in worksites designed to promote healthy lifestyles

☐ Educate property owners, local policy makers and law enforcement about how and why to adopt and enforce codes/policies designed to reduce use of properties for illicit drug activity

New and Emerging Drugs

☐ Hidden in Plain Sight interactive/hands-on event featuring prosecutor, lawyer and local law enforcement educating community about local drug trends, synthetic drugs and other new and emerging drugs of abuse

☐ Working collaboratively with local law enforcement, other counselors and agencies as well as connecting with schools, parents and young adults to address new drug trends with email alerts, social media posts and drug trend updates

Tobacco, E-Cigarette, Vape Prevention

☐ Providing education to community groups, municipalities, schools, youth and parents regarding tobacco prevention for minors and the concerns regarding recent surge in use of vapes and e-cigarettes

☐ Promotion of smoking cessation tools available free throughout the state

☐ Working with schools to modify/update policies to include e-cigarettes and vaping

NJ Returning Veterans

☐ Maintain group of NJRVs and providers of services as virtual advisory board

☐ Connect region's NJRV with support services via online and paper resources

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

The Sussex County Municipal Alliance includes eleven Municipal Alliance Committees representing 21 of the 24 communities within Sussex County. The DEDR allocation for the County based on the formula determined by GCADA is $210,366.00. Cash Match and In-Kind contributions by the communities participating in the Alliance program bring the total budget for the Municipal Alliance program to $340,567.00 for the Fiscal Year 2016 (July 1, 2015 –June 30, 2016).

The eleven Municipal Alliance Committees will present approximately 90 individual programs to the members of their respective communities. There are 7 Countywide programs that will be presented through the County Alliance Coordinator. These include programs designed for children, teens, parents, senior citizens, and military veterans. Each Municipal Alliance Committee has included evidence-based programs in their FY2016 plans and will work collaboratively with several prevention professionals.

3. SUSSEX 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.

In 2014 Sussex County advocated to use prevention funds for Relapse Prevention/Recovery Support Services. This was submitted to DMHAS in August 2014 in the Updated Progress Report (UPR) and RFP'd for services beginning in 2015. Sussex County will continue to use prevention funds for Relapse Prevention/Recovery Support Services unless or until needs warrant utilization of additional prevention funding.

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.**

   There is no in-county detox/in-patient rehabilitation provider for State/County-funded recipients in Sussex County for medically indigent residents.

   Key Word or Phrase for [LM COL. A, ROW 2] No in-county detox/in-patient rehab for Medicaid recipients

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

   Sussex County residents who are receiving Medicaid or County funding will have to travel out of county for detox/rehab care and many of those will be placed on a waiting list for services due to multiple counties and other programs utilizing a limited number of beds.

   Key Word or Phrase for [LM COL. A, ROW 3] Residents will have to travel out of county for detox/rehab and be likely will be placed on a waiting list.

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

   The sole provider of treatment/detox located in Sussex County has been changed to a for-profit facility and announced that they will no longer accept County or State funding as of Autumn 2015. This impacts our ability to provide services within the County. There is currently no data to reflect this change until FY2016 or CY2016 data is determined.

   In FY2014 71% of Sussex County residents were treated in their home County (NJSAMS). This number will be significantly less due to the Need-Capacity previously identified.

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….contract with another provider of services that is most accessible to Sussex County residents.

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]
In 2016 Sussex County will seek out providers of inpatient/detox care to clients from Sussex County.

Objective 2, year 2017. To… [LM COL. D, ROW 3
In 2017 the county will review and monitor the 2016 accessibility and availability of services through the contracted provider.

Objective 3, year 2018. To… [LM COL. D, ROW 4] **to be determined**

Objective 4, year 2019. To… [LM COL. D, ROW 5] **to be determined**

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

Strategy for Objective 1, year 2016.

RFP for services and monitor use of those services. Raise community awareness of how/where to access service.

Strategy for Objective 2, year 2017.

Continue to monitor the use of those services.

Strategy for Objective 3, year 2018.

To be determined

Strategy for Objective 4, year 2019.

To be determined

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]

Detox - $46,489.00
In-Patient- $45,000.00

Cost of Strategy for Objective 2, year 2017. [LM COL. F, ROW 3]

Detox - $46,489.00
In-Patient- $45,000.00

Cost of Strategy for Objective 3, year 2018. [LM COL. F, ROW 4]

To be determined

Cost of Strategy for Objective 4, year 2019. [LM COL. F, ROW 5]

To be determined

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]

Given the substantial change in the available provider for detox/in-patient treatment, our outputs cannot be projected at this time. Being that 2016 will be the first year that this change has occurred we will alter our projections for the subsequent years accordingly. It is anticipated that this change will take time for the new procedural system to establish itself. Therefore, any projections will be meaningless at this time.

Outputs of Strategy for Objective 2, year 2017. [LM COL. G, ROW 3]

In the year 2017 we will apply the actual numbers from 2016 and adjust them accordingly based on the belief that the number of recipients will increase as this new provider is established.

Outputs of Strategy for Objective 3, year 2018. [LM COL. G, ROW 4]

To be determined

Outputs of Strategy for Objective 4, year 2019. [LM COL. G, ROW 5]

To be determined

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]
A community benefit will be that an undetermined number of county-funded residents will have access to detox/in-patient treatment giving a chance for successful recovery and a sober future lifestyle.

Outcomes of Strategy for Objective 2, year 2017. [LM COL. H, ROW 3]
A community benefit will be that an undetermined number of county-funded residents will have access to detox/in-patient treatment giving a chance for successful recovery and a sober future lifestyle.

Outcomes of Strategy for Objective 3, year 2018. [LM COL. H, ROW 4]
A community benefit will be that an undetermined number of county-funded residents will have access to detox/in-patient treatment giving a chance for successful recovery and a sober future lifestyle.

Outcomes of Strategy for Objective 4, year 2019. [LM COL. H, ROW 5]
A community benefit will be that an undetermined number of county-funded residents will have access to detox/in-patient treatment giving a chance for successful recovery and a sober future lifestyle.

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 Sussex County Substance Abuse Coordinator and Provider to be determined.

Responsible Executive Agent or Agency, Strategy for Objective 2, year 2017. [LM COL. I, ROW 3]
The Sussex County Substance Abuse Coordinator and Provider to be determined.

Responsible Executive Agent or Agency, Strategy for Objective 3, year 2018. [LM COL. I, ROW 4]
The Sussex County Substance Abuse Coordinator and Provider to be determined.

Responsible Executive Agent or Agency, Strategy for Objective 4, year 2019. [LM COL. I, ROW 5]
The Sussex County Substance Abuse Coordinator and Provider to be determined.

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: There is no in-county detox/in-patient rehabilitation provider in Sussex County for medically indigent residents.	The sole provider of treatment/detox located in Sussex County has been changed to a for-profit facility and announced that they will no longer accept County or State funding as of Autumn 2015. This impacts our ability to provide services within the County. There is currently no data to reflect this change until FY2016 or CY2016 data is determined. In FY2014 71% of Sussex County residents were treated in their home County (NJSAMS). This number will be significantly less due to the Need-Capacity previously identified.	**To:** contract with another provider of services that is most accessible to Sussex County residents.	2016: Sussex County will seek out providers of inpatient/detox care to clients from Sussex County.	2016: RFP for services and monitor use of those services. Raise community awareness of how/where to access service.	**County: $00:00 AEREF/State: $309,128.00 Total: $309,128.00**	Given the substantial change in the available provider for detox/in-patient treatment, our outputs cannot be projected at this time. Therefore, any projections will be meaningless at this time.	Short Term: A community benefit will be that an undetermined number of county-funded residents will have access to detox/in-patient treatment giving a chance for successful recovery and a sober future lifestyle	The Sussex County Substance Abuse Coordinator and Provider to be determined
			2017: The county will review and monitor the 2016 accessibility and availability of services through the contracted provider.	2017: Continue to monitor the use of those services.	**Total: Unable to be determined until state allocation is released**	In the year 2017 we will apply the actual numbers from 2016 and adjust them accordingly based on the belief that the number of recipients will increase as this new provider is established.	Middle Term: A community benefit will be that an undetermined number of county-funded residents will have access to detox/in-patient treatment giving a chance for successful recovery and a sober future lifestyle.	The Sussex County Substance Abuse Coordinator and Provider to be determined
Associated Community Problem: Sussex County residents will have to travel out of county for detox/rehab care and many of those will be placed on a waiting list for services due to multiple counties and other programs utilizing a limited number of beds.			2018: To be determined	2018: To be determined	**Total: Unable to be determined until state allocation is released**	To be determined	Middle Term: A community benefit will be that an undetermined number of county-funded residents will have access to detox/in-patient treatment giving a chance for successful recovery and a sober future lifestyle.	The Sussex County Substance Abuse Coordinator and Provider to be determined
			2019: To be determined	2019: To be determined	**Total: Unable to be determined until state allocation is released**	To be determined	Long Term: A community benefit will be that an undetermined number of county-funded residents will have access to detox/in-patient treatment giving a chance for successful recovery and a sober future lifestyle.	The Sussex County Substance Abuse Coordinator and Provider to be determined

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.**

   There had been no recovery support services prior to 2015. This created an overall need-capacity gap that brought about the change to the plan. On June 5, 2014 the Sussex County LACADA approved the use of funds for Relapse Prevention/Recovery Support Services. Its strategic significance to the overall success of the plan is the provision of on-going support and assistance to those individuals who have taken their first steps toward successful and long-term recovery.

   Key Word or Phrase for [LM COL. A, ROW 2] The provision of on-going support and assistance to individuals in recovery.

2. **What social costs or community problem(s) does this "gap" impose on your county?**
   Individuals in recovery often need assistance with finding sober housing.
   Individuals in recovery need a sober social environment.
   Individuals in recovery need to remain/gain employment.
   Individuals without support have a higher tendency to relapse.
   Sussex County has found that individuals in recovery often need additional life skills training, such as anger management and trauma recovery.
   Incidents of domestic violence have been linked to alcohol and drug abuse.

   Key Word or Phrase for [LM COL. A, ROW 3]Social Costs imposed by gap.

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

Prior to 2015 there were no recovery support services provided for individuals in the county.
Sussex County residents responded to a survey in 2013 conducted by the Department of Human Services that addressed Access to Treatment and Recovery Supports. A combined 51.85% of the respondents identified regularly scheduled meetings for people in recovery as a significant factor in remaining sober. 40.91% of family members identified regularly scheduled meetings as significant to recovery. The lack of relapse prevention services is evidenced by a response of 13.33% for those in recovery and 9.09% for their families in response to a survey questions related to recovery support. One of the comments in the survey was, "Although my friend completed the course of treatment she did not maintain sobriety. The treatment seemed too little and not intensive enough to stick. What comes after outpatient?"

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…. Provide recovery support services to those in need.

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] Sussex County will implement new recovery support services based on 2015 RFP applications.

Objective 2, year 2017. To… [LM COL. D, ROW 3] Sussex County will monitor the services, programs, and use of funds implemented in 2016

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

Objective 4, year 2019. To… [LM COL. D, ROW 5] To be determined.

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

Strategy for Objective 1, year 2016. Sussex County will evaluate and choose the proposals received during the RFP process based upon the highest score achieved by the respondent agency. Increase funding to create more opportunities for additional providers of services.

Key Word or Phrase for [LM COL. E, ROW 2] _____

Strategy for Objective 2, year 2017. Sussex County will monitor and evaluate the services, programs, and use of funds that have been implemented.

Key Word or Phrase for [LM COL. E, ROW 3] _____

Strategy for Objective 3, year 2018. To be determined.

Key Word or Phrase for [LM COL. E, ROW 4] _____

Strategy for Objective 4, year 2019. To be determined.

Key Word or Phrase for [LM COL. E, ROW 5] _____

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]
$54,065.00

Cost of Strategy for Objective 2, year 2017. [LM COL. F, ROW 3]
To be determined based on state appropriation

Cost of Strategy for Objective 3, year 2018. [LM COL. F, ROW 4]
To be determined based on state appropriation

Cost of Strategy for Objective 4, year 2019. [LM COL. F , ROW 5]
To be determined based on state appropriation

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

Outputs of Strategy for Objective 1, year 2016. [LM COL. G, ROW 2]
Substantial increase in the number of individuals who will receive recovery support services.

Outputs of Strategy for Objective 2, year 2017. [LM COL. G, ROW 3]
3% increase over the number served in 2016.

Outputs of Strategy for Objective 3, year 2018. [LM COL. G, ROW 4]
3% increase over the number served in 2017.

Outputs of Strategy for Objective 4, year 2019. [LM COL. G, ROW 5]
3% increase over the number served in 2018.

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]
More people will maintain long term recovery.

Outcomes of Strategy for Objective 2, year 2017. [LM COL. H, ROW 3]
3% more people will maintain long term recovery over 2016.

Outcomes of Strategy for Objective 3, year 2018. [LM COL. H, ROW 4]
3% more people will maintain long term recovery over 2017.

Outcomes of Strategy for Objective 4, year 2019. [LM COL. H, ROW 5]
3% more people will maintain long term recovery over 2018.

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]
C A&D Coordinator
Provider TBD

Responsible Executive Agent or Agency, Strategy for Objective 2, year 2017. [LM COL. I, ROW 3]
C A&D Coordinator
Provider TBD

Responsible Executive Agent or Agency, Strategy for Objective 3, year 2018. [LM COL. I, ROW 4]
C A&D Coordinator
Provider TBD

Responsible Executive Agent or Agency, Strategy for Objective 4, year 2019. [LM COL. I, ROW 5]
C A&D Coordinator
Provider TBD

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: There had been no recovery support services prior to 2015. This created an overall need-capacity gap that brought about the change to the plan. On June 5, 2014 the Sussex County LACADA approved the use of funds for Relapse Prevention/Recovery Support Services. Its strategic significance to the overall success of the plan is the provision of on-going support and assistance to those individuals who have taken their first steps toward successful and long-term recovery.	Prior to 2015 there were no recovery support services provided for individuals in the county. Sussex County residents responded to a survey in 2013 conducted by the Department of Human Services that addressed Access to Treatment and Recovery Supports. A combined 51.85% of the respondents identified regularly scheduled meetings for people in recovery as a significant factor in remaining sober. 40.91% of family members identified regularly scheduled meetings as significant to recovery. The lack of relapse prevention services is evidenced by a response of 13.33% for those in recovery and 9.09% for their families in response to a survey question related to recovery support. One of the comments in the survey was, "Although my friend completed the course of treatment she did not maintain sobriety. The treatment seemed too little and not intensive enough to stick. What comes after outpatient?"	**To:** Provide recovery support services to those in need	2016: Sussex County will implement new recovery support services based on 2015 RFP applications	2016: Sussex County will evaluate and choose the proposals received during the RFP process based upon the highest score achieved by the respondent agency. Increase funding to create more opportunities for additional providers of services.	**County: $38,842.00 AEREF/State: $15,223.00 Total: $54,065.00**	Substantial increase in the number of individuals who will receive recovery support services.	Short Term: More people will maintain long term recovery.	C A&D Coordinator Provider TBD
			2017: Sussex County will monitor the services, programs, and use of funds implemented in 2016	2017: Sussex County will monitor and evaluate the services, programs, and use of funds that have been implemented.	**Total: Unable to be determined until state allocation is released**	3% increase over the number served in 2016.	Middle Term: 3% more people will maintain long term recovery over 2016.	C A&D Coordinator Provider TBD
Associated Community Problem: Individuals in recovery often need assistance with finding sober housing. Individuals in recovery need a sober social environment. Individuals in recovery need to remain/gain employment. Individuals without support have a higher tendency to relapse. Sussex County has found that individuals in recovery often need additional life skills training, such as anger management and trauma recovery. Incidents of domestic violence have been linked to alcohol and drug abuse.			2018: To be determined	2018: To be determined.	**Total: Unable to be determined until state allocation is released**	3% increase over the number served in 2017.	Middle Term: 3% more people will maintain long term recovery over 2017.	C A&D Coordinator Provider TBD
			2019: To be determined	2019: To be determined.	**Total: Unable to be determined until state allocation is released**	3% increase over the number served in 2018.	Long Term: 3% more people will maintain long term recovery over 2018.	C A&D Coordinator Provider TBD

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

NJ DMHAS NJSAMS Sussex County Overview, 2012
NJ DMHAS NJSAMS Sussex County Overview, 2013
NJ DMHAS NJSAMS Sussex County Overview, 2014
NJ DMHAS 2012 NJ Middle School Risk & Protective Factor Survey
Sussex County Access to Substance Abuse Treatment and Recovery Supports Survey, 2013
Sussex County Substance Abuse Treatment Demand Profile (prepared by R. Culleton)
2009 NJ Household Survey on Drug Use and Health (commissioned by DMHAS)
Newton Medical Center Hospital Data for 2012 – 2014

APPENDIX 4: NEEDS ASSESSMENT

The Needs Assessment encompassed the Access to Substance Abuse Treatment and Recovery Supports Survey which took place in 2013, focus groups with particular partner agencies (DCP&P, etc.), and multiple planning meetings with Municipal Alliance Network members, LACADA, PACADA, and concerned citizens.

SUSSEX COUNTY 2016-2019 COMPREHENSIVE PLAN
NEEDS ASSESSMENT FOR
SUBSTANCE ABUSE TREATMENT

INSTRUCTIONS:
USING (A) QUANTITATIVE DATA WITH CITATIONS AND (B) QUALITATIVE ASSESSMENTS OF THE DATA TO SUPPORT YOUR STATEMENTS, PLEASE DESCRIBE:

A. YOUR COUNTY'S PRIMARY TREATMENT NEED

a. FOR THE COUNTY AS A WHOLE

As a whole, Sussex County's need for substance abuse treatment for its adult population is 19,308, which is a 16.8% need of the overall county population[2]. This is the 6th highest "need for treatment" in the State of New Jersey. The overall adult population of Sussex County in 2014 is 114,896. The estimated need for alcohol and drug addiction treatment in Sussex County is 19,308 or 16.8% of the adult population. Sussex County is ranked 5th in the state for alcohol treatment and 9th in the state for treatment for drug addiction. 12,903 individuals require treatment for alcohol abuse in Sussex County and 6,405 require treatment for drug addiction[3].

According to data obtained from Newton Medical Center's Emergency Department, visits to the emergency department for substance use increased by over 13% in 2014 (697 visits) as compared to 2013 (615 visits) and overdoses increased by 9% (97 in 2014 vs.89 in 2013). "In 2014 all alcohol-related ED visits comprised 60.7% of substance- related visits while all drug-related visits comprised 39.3% of these visits."[4]

According to the 2012 New Jersey Middle School Risk and Protective Factor Survey[5], Sussex County is higher than the state's response in the following areas:

Annual use of OxyContin, 1.2% higher than the State
Annual binge use of Alcohol, 1.1% higher than the State
Annual use of Marijuana, 1.0% higher than the State
Past 30 days use of Prescription Drug w/o a Prescription, 0.5% higher than the State
Lifetime use of Steroids, 0.1% higher than the State
Annual use of Hallucinogens, 0.1% higher than the State
Annual use of Amphetamines, 0.1% higher than the State

[2] 2014 Estimate of Total Need and Demand for Substance Abuse Treatment among the Adult Population in NJ
[3] Estimate of Treatment Need for Alcohol and Drug Addiction New Jersey, 2014
[4] NMC Emergency Department (ED) Visits due to Substance Use/Abuse, 2015
[5] 2012 New Jersey Middle School Risk and Protective Factor Survey

In terms of treatment admissions, from 2005 to 2012 there were a total of 10,620 admissions. These could be duplications or is not specifically identified as different individuals. Alcohol admissions were 8.3% above New Jersey's admission rate for this time period.[6]

b. FOR ONE OR MORE "SPECIAL POPULATIONS" THAT REQUIRE THE COUNTY'S SPECIAL ATTENTION DURING THE NEXT PLANNING CYCLE.

According to the data from Newton Medical Center, admissions due to Co-Occurring Disorders accounted for 44% (254 of 577) of the 2014 admissions to the Inpatient Behavioral Health Unit had co-occurring substance use and mental health disorders. 2013 also saw 44% of the admissions were for co-occurring substance use and mental health disorders. [7]

During calendar year 2012, 66% (900) of residents of Sussex County NJSAMS Substance Abuse Treatment Discharges were identified as having a co-occurring substance use and mental health disorders. During calendar year 2013, 74% (978) of residents of Sussex County NJSAMS Substance Abuse Treatment Discharges were identified as having a co-occurring substance use and mental health disorders.[8]

Based on Sussex County's Trend Line Analysis, the co-occurring population is projected to increase by 476% from 2013 to 2018[9].

[6] Sussex County Treatment Demand Analysis, Culleton 2014, p.22
[7] NMC Emergency Department (ED) Visits due to Substance Use/Abuse, 2015
[8] NJSAMS
[9] Sussex County Treatment Demand Analysis, Culleton 2014, p. 38

INSTRUCTIONS:
USING (A) QUANTITATIVE DATA WITH CITATIONS AND (B) QUALITATIVE ASSESSMENTS OF THE DATA TO SUPPORT YOUR COUNTY'S ASSESSMENT OF ITS NEEDS, PLEASE DESCRIBE:

B. YOUR COUNTY'S SECONDARY TREATMENT NEED

a. FOR THE COUNTY AS A WHOLE

b.

Based on NJSAMS data, Sussex County ranked 9.1% above New Jersey for DUI Offender admissions. This equates to 2,315 admissions of 26.1%.[10]

According to data presented in the NJSAMS Substance Abuse Treatment Admissions for 2013, DUI Offenders accounted for 36% of 1,363 admissions. This equates to 487 admission episodes.[11]

According to data presented in the NJSAMS Substance Abuse Treatment Admissions for 2012, DUI Offenders accounted for 30% of 2,302 admissions. This equates to 684 admission episodes.[12]

Sussex County is not funding this identified secondary treatment need. There is funding for this need from other resources, such as DUII.

b. FOR ONE OR MORE "SPECIAL POPULATIONS" THAT REQUIRE THE COUNTY'S SPECIAL ATTENTION DURING THE NEXT PLANNING CYCLE.

Sussex County is not funding a "special population" secondary treatment need.

[10] Sussex County Treatment Demand Analysis, Culleton 2014, p.32
[11] NJSAMS
[12] NJSAMS

INSTRUCTIONS:
USING (A) QUANTITATIVE DATA WITH CITATIONS AND (B) QUALITATIVE ASSESSMENTS OF THE DATA TO SUPPORT YOUR COUNTY'S ASSESSMENT OF ITS NEEDS, PLEASE DESCRIBE:

A. YOUR COUNTY'S TERTIARY TREATMENT NEED

    a. FOR THE COUNTY AS A WHOLE

Sussex County has not identified and is not funding a tertiary treatment need.

    b. FOR ONE OR MORE "SPECIAL POPULATIONS" THAT WILL REQUIRE THE COUNTY'S SPECIAL ATTENTION DURING THE NEXT PLANNING CYCLE.

Sussex County has not identified and is not funding a "special population" tertiary treatment need.

INSTRUCTIONS: DRAWING ON THE POWERPOINT ANALYSIS OF TREATMENT DEMAND,

1. COMPARE AND CONTRAST YOUR COUNTY'S ADMISSION TRENDS WITH ADMISSION TRENDS FOR NEW JERSEY FROM 2005 TO 2012 WITH REGARD TO 1) LEVELS OF CARE, 2) PRIMARY DRUGS, 3) SPECIAL POPULATIONS, AND 4) PRIMARY DRUGS DRIVING ADMISSIONS BY SPECIAL POPULATIONS.
2. DESCRIBE HOW ADMISSION TRENDS WILL IMPACT YOUR COUNTY'S IMMEDIATE FUTURE AND FOR WHICH OF THESE IMPACTS THE COUNTY PLANNING COMMITTEE RECOMMENDS PREPARING?

[REMEMBER THAT COUNTS OF ADMISSIONS ARE NOT COUNTS OF INDIVIDUALS. ADMISSIONS INDICATE "DOLLARS SPENT." ADMISSIONS DEMONSTRATE WHAT SERVICES ARE CONSUMING THE AVAILABLE RESOURCES. ALSO, FOR DEFINITIONS OF LOC, PRIMARY DRUG AT ADMISSION, AND SPECIAL POPULATION CLASSIFICATIONS, SEE INTRODUCTORY SLIDES IN THE POWERPOINT PRESENTATION.]

A. ADMISSIONS CLASSIFIED INTO THREE BASIC LEVELS OF CARE:

   a. OUTPATIENT

In Sussex County there were 5,539 total admissions for Outpatient services between 2005 and 2012. This averages out to 692 per year. Outpatient services consisted of 52.3 % of available resources which was 7.7% below the State average.

   b. RESIDENTIAL

In Sussex County there were 2,193 total admissions for Residential services between 2005 and 2012. This averages out to 274 per year. Residential services consisted of 20.7% of available resources which is 2.8% higher than the State average.

   c. DETOXIFICATION

In Sussex County there were 2,861 total admissions for Detox services between 2005 and 2012. This averages out to 358 per year. Detox services consisted of 27% of available resources which is 5.0% higher than the State average.

B. PRIMARY DRUGS AT ADMISSION CLASSIFIED INTO SIX MAJOR GROUPS:

a. ALCOHOL

In Sussex County there were 4,225 admissions with the primary substance of alcohol between 2005 and 2012. This averages out to 528 per year or 39.8% of the total. This is 8.3% higher than the State average.

b. MARIJUANA

In Sussex County there were 964 admissions with the primary substance of marijuana between 2005 and 2012. This averages out to 121 per year or 9.1% of the total. This is 5.9% lower than the State average.

c. HEROIN

In Sussex County there were 3,966 admissions with the primary substance of heroin between 2005 and 2012. This averages out to 496 per year or 37.3% of the total. This is 2.5% higher than the State average.

d. COCAINE/CRACK

In Sussex County there were 465 admissions with the primary substance of cocaine/crack between 2005 and 2012. This averages out to 58 per year or 4.4% of the total. This is 4.0% lower than the State average.

e. PRESCRIPTION DRUGS

In Sussex County there were 918 admissions with the primary substance of prescription drugs between 2005 and 2012. This averages out to 115 per year or 8.6% of the total. This is 0.2% lower than the State average.

f. OTHER ILLICIT DRUGS

In Sussex County there were 82 admissions with the primary substance of other illicit drugs between 2005 and 2012. This averages out to 10 per year or 0.8% of the total. This is 0.8% lower than the State average.

C. ADMISSIONS CLASSIFIED INTO EIGHT SPECIAL POPULATION GROUPS:

a. OFFENDERS (42.2% OF ADMISSIONS FROM 2005 TO 2012)

In Sussex County there were 3,393 admissions episodes where the individual identified as being an "offender" between 2005 and 2012. This averages out to 424 per year or 38.2% of the total. This is 4.0% lower than the State average.

b. WOMEN (20.0%)

In Sussex County there were 1,296 admissions episodes where the individual identified as being female between 2005 and 2012. This averages out to 162 per year or 14.6% of the total. This is 5.4% lower than the State average.

c. DUI ARRESTEES (17.0%)

In Sussex County there were 2,315 admissions episodes where the individual identified as being the "DUI arrestees" between 2005 and 2012. This averages out to 289 per year or 26.1% of the total. This is 9.1% higher than the State average.

Sussex County was ranked #2 in the State for IDRC attendees between the ages of 18-25 in 2013. There were 472 total attendees and 143 of them were 18-25 year olds which represents 30.3% of the total. Morris County ranked #1 with 30.6% of the total being the same age group. This is only a 0.3% difference.[13]

d. PERSONS WITH CO-OCCURRING SUBSTANCE ABUSE AND MENTAL HEALTH DISORDERS (12.8%)

In Sussex County there were 1,087 admissions episodes where the individual identified as having a "co-occurring" disorder between 2005 and 2012. This averages out to 136 per year or 12.2% of the total. This is 0.6% lower than the State average.

e. YOUTH (5.3%)

In Sussex County there were 602 admissions episodes of "youth" between 2005 and 2012. This averages out to 75 per year or 6.8% of the total. This is 1.5% higher than the State average.

f. SENIORS (less than 1%)

In Sussex County there were 20 admissions episodes where the individual identified as a "senior" between 2005 and 2012. This averages out to 3 per year or 0.2% of the total. This is 0.1% lower than the State average.

g. WORKFORCE (less than 1%)

In Sussex County there were 53 admissions episodes where the individual identified as a referral from the "workforce" between 2005 and 2012. This averages out to 7 per year or 0.6% of the total. This is 0.1% lower than the State average.

h. PERSONS WITH DISABILITY (1.9%)

In Sussex County there were 111 admissions episodes where the individual identified as having a "disability" between 2005 and 2012. This averages out to 14 per year or 1.3% of the total. This is 0.6% lower than the State average.

[13] Intoxicated Driving Program 2013 Statistical Summary Report, DMHAS

D. SIX MAJOR CLASSIFICATIONS OF PRIMARY DRUGS CHARACTERIZING THE ADMISSIONS OF FIVE MAJOR SPECIAL POPULATIONS:

a. **OFFENDERS**

i. ALCOHOL

Alcohol is the third highest substance among “offenders”. Heroin and marijuana are first and second, respectively. Prescription drugs are projected to slightly overcome alcohol as the third substance by 2018.

ii. MARIJUANA

Marijuana is the second highest substance among “offenders”. There is significant difference between marijuana and heroin (the highest ranked substance). It is not projected to increase through 2018.

iii. HEROIN

Heroin is the highest ranked substance among “offenders”. It is significantly higher than all other substances. This remains consistent throughout the actual and projected timespans beginning in 2005.

iv. COCAINE/CRACK

Cocaine/crack is the fifth highest ranked substance among “offenders”. It is projected to remain relatively flat throughout the timespan.

v. PRESCRIPTION DRUGS

Prescription drugs are the fourth highest ranked substance among “offenders”. It is projected to overcome alcohol slightly by 2018.

vi. OTHER ILLICIT DRUGS

Other illicit drugs are the lowest ranked substance among “offenders”. It is not projected to increase through 2018.

b. **WOMEN**

i. ALCOHOL

Alcohol was the primary substance at admission into treatment by women through 2011. It became second to heroin beginning in 2012. It's projected to decrease slightly but remain the second substance of abuse at admission into treatment through 2018.

ii. MARIJUANA

Marijuana is currently the fourth highest substance at admission into treatment by women. It was fifth through 2009 but overtook cocaine/crack in 2010. Its use is projected to increase slightly through 2018 but will remain fourth highest at admission into treatment.

iii. HEROIN

Heroin was the second highest substance at admission into treatment by women through 2011. In 2012 it became the highest substance abused by women following a significant increase during the period 2011 and 2012. It is projected to continue to increase through 2018 and remain the highest abuse substance at admission into treatment.

iv. COCAINE/CRACK

In 2005/2006 cocaine/crack abuse increased among women and was the third highest substance at admission into treatment. Since 2006 its use has decreased consistently. It is projected to remain the sixth highest substance at admission into treatment by women through 2018.

v. PRESCRIPTION DRUGS

Prescription drugs use/abuse by women have increased steadily through 2009. In 2009 it began to decrease slightly but remains projected to be the third highest substance at admission into treatment by women.

vi. OTHER ILLICIT DRUGS

Other illicit drugs have consistently been at or near the bottom of the chart at admission into treatment by women. They increased slightly in 2012 and have replaced cocaine/crack as the fifth highest substance at admission. They are projected to remain relatively flat through 2018.

c. **DUI ARRESTEES**

i. ALCOHOL

It should be obvious that alcohol is the primary substance for DUI arrestees and the numbers bear witness to this statement. In Sussex County alcohol remained consistently highest as the primary substance identified by DUI arrestees. It is projected to remain the most significant substance abused through 2018.

ii. MARIJUANA

Marijuana has been identified as the third highest substance abused by DUI arrestees and is projected to remain in that positon. However, prescription drugs are being projected to tie marijuana as the third from 2013 through 2018.

iii. HEROIN

Heroin is the second highest substance abused by DUI arrestees and will remain so throughout 2018.

iv. COCAINE/CRACK

Cocaine/crack is projected to be a substance of abuse for four DUI arrestees per year from 2012 through 2018.

v. PRESCRIPTION DRUGS

From 2005 through 2009 prescription drugs were the fifth substance abused by DUI arrestees. In 2010 it became the fourth substance abused, overtaking cocaine/crack. It is projected to tie with marijuana as the third highest substance abused through 2018.

vi. OTHER ILLICIT DRUGS

Other illicit drugs are very insignificant to this special population group.

d. **PERSONS WITH CO-OCCURRING SA AND MH**

i. ALCOHOL

Alcohol was the highest substance of abuse among the "co-occurring" population through 2010 when it was overtaken by heroin. It remains the second highest substance and is projected to be second highest through 2018.

ii. MARIJUANA

Marijuana is the fourth highest substance of abuse among the "co-occurring" population. It is projected to be fourth highest through 2018.

iii. HEROIN

Heroin was the second highest substance of abuse among the "co-occurring" population through 2010 when it was overtook alcohol as the highest. It is projected to be the highest through 2018.

iv. COCAINE/CRACK

Cocaine/crack became the fifth highest substance of abuse among the "co-occurring" population in 2010 and is projected to remain the fifth highest through 2018.

v. PRESCRIPTION DRUGS

Prescription drugs were the fifth highest substance of abuse among the "co-occurring" population through 2007. In 2008 it became the third highest. It is projected to be the third highest through 2018.

vi. OTHER ILLICIT DRUGS

Other illicit drugs are very insignificant to this special population group.

e. **YOUTH**

i. ALCOHOL

Alcohol was the third highest substance of abuse for youth in treatment. It has fluctuated throughout the timespan from 2005 through 2012. It is projected to decline and become the lowest reported substance of abuse for youth by 2018.

ii. MARIJUANA

Marijuana has fluctuated significantly from 2005 through 2010 as the highest or second highest substance of abuse for youth in treatment. It is projected to be the fourth highest substance of abuse by 2018.

iii. HEROIN

Heroin has fluctuated significantly from 2005 through 2011. It has been the highest substance of abuse at admission for youth since 2008 and is projected to remain the highest through 2018.

iv. COCAINE/CRACK

Cocaine/crack has consistently been at the bottom of the scale for substances abused by youth in treatment since 2005 and is projected to remain low through 2018.

v. PRESCRIPTION DRUGS

Prescription drugs fluctuated significantly until 2009 when they became the second highest substance of abuse for youth in treatment. It dropped below marijuana from 2010 through 2012 but has risen back to second highest since 2013 and is projected to continue to be the second highest through 2018.

vi. OTHER ILLICIT DRUGS

Other illicit drugs are projected to be the third highest substance of abuse for youth n treatment through 2018.

INSTRUCTIONS: RELYING ON THE DATA PROVIDED IN THE RINGBINDER OF PLANNING DATA RESOURCES PROVIDED BY THE OFFICE OF RESEARCH, PLANNING AND EVALUATION, INCLUDING ANY COMMENTS PROVIDED BY YOUR PLANNING COMMITTEE AND ANY FOCUS GROUP RESULTS, PLEASE DESCRIBE AND EVALUATE THE FOLLOWING:

A. YOUR COUNTY'S GAP BETWEEN TOTAL TREATMENT NEED AND "MET" TREATMENT DEMAND

Sussex County's need for treatment based on the information provided in the ringbinder is approximately 21,006 individuals. This represents 18.8% of the total County population. The need for alcohol treatment is approximately 12,518 individuals. This places Sussex County fifth in order of need for alcohol treatment among the 21 counties in the state. Sussex County met the needs of 926 individuals for treatment in 2012. This places Sussex County sixth in order of need for drug treatment among the 21 counties in the state. [14] The gap between the need of 21,006 per year and the met treatment demand of 926 is 20,080 individuals. The need for drug treatment for individuals in Sussex County is approximately 8,488.

B. PROBLEMS FOR THE COMMUNITY ASSOCIATED WITH THIS WAY OF FORMULATING THE GAP

Using this formula to determine the gap illustrates the significant lack of available treatment for individuals determined to be in need. Of the approximately 21,006 individuals identified by this formula, only 926 have had their needs met. This formula does not include data that represents individuals who receive treatment through alternate means (i.e. private insurance, self-pay, and out-of-state treatment providers). The lack of in-county treatment providers adds to the gap and contributes to a greater incidence of criminal activity associated with substance abuse. Mental health issues, homelessness, other societal problems may also have a greater incidence of occurrence.

C. COUNTY'S GAP BETWEEN TOTAL TREATMENT DEMAND AND "MET" TREATMENT DEMAND

There is a gap in Sussex County between total treatment demand and met treatment demand. In 2012, 1,439 individuals had a total treatment demand and 926 met the treatment demand with a gap of 35.6% of unmet demand[15]. The state average of the gap of unmet demand is 36.8%. Sussex County's gap is lower than the state average by 1.2%. It is ranked 9th highest in unmet demand in the state among the 21 counties.

D. PROBLEMS FOR THE COMMUNITY ASSOCIATED WITH THIS WAY OF FORMULATING THE GAP

As previously stated, this formula to determine the gap illustrates the significant lack of available treatment for individuals determined to be in need. This formula does not include data that represents individuals who receive treatment through alternate means (i.e. private insurance, self-pay, and out-of-state treatment providers).

[14] 2012 Estimates of Met and Unmet Demand for Substance Abuse Treatment of the Adult Population in NJ
[15] 2012 Estimates of Met and Unmet Demand for Substance Abuse Treatment of the Adult Population in NJ

E. IS THERE ANY OTHER WAY OF DESCRIBING THE GAP BETWEEN TREATMENT NEED AND ACCESS TO TREATMENT THAT HAS INFLUENCED YOUR COMPREHENSIVE PLAN? IF SO, WHAT IS THAT GAP AND WHAT HAS IT MEANT FOR YOUR PLAN?

When people need treatment but cannot access it they lose the motivation to proceed at that time and continue the cycle of abuse. This bears little influence to our plan because of the limited resources that are available in our county and this is a statewide capacity issue that should be addressed at the state level.

Recovery supports reduces the need for additional treatment or access to treatment. Sussex County will continue to advocate and support Recovery Support Services to our residents who need them. 65% (883) of NJSAMS treatment admissions in calendar year 2013 had prior treatment. [16] 68% (891) of NJSAMS treatment admissions in calendar year 2012 had prior treatment.[17] These statistics emphasize the need for Recovery Support Services.

[16] NJSAMS Substance Abuse Treatment Admissions, Sussex County, 2013
[17] NJSAMS Substance Abuse Treatment Admissions, Sussex County, 2012

INSTRUCTIONS: RELYING ON THE DATA PROVIDED IN THE RINGBINDER OF PLANNING DATA RESOURCES PROVIDED BY THE OFFICE OF RESEARCH, PLANNING AND EVALUATION, INCLUDING ANY COMMENTS PROVIDED BY YOUR PLANNING COMMITTEE AND ANY FOCUS GROUP RESULTS, PLEASE DESCRIBE AND EVALUATE THE ACCESS OF YOUR RESIDENTS TO THE FOLLOWING MODALITIES OF SUBSTANCE ABUSE TREATMENT IN TERMS OF CONDITIONS LIKE TRANSPORTATION, CHILD CARE, INSURANCE, WAITING LISTS, OR ANY OTHER BARRIERS:

A. OUTPATIENT:

Waiting lists and co-occurring treatment services have been identified as significant issues by the planning committee and focus group feedback. Transportation is, and will be for the foreseeable future, a barrier to Sussex County residents in need of outpatient services.

B. OPIOID MAINTENANCE PROGRAMS:

There are no opioid maintenance programs in Sussex County. That, alone, is an issue unto itself.

C. RESIDENTIAL:

The only residential treatment facility in Sussex County has recently changed to an insurance-only facility leaving the county with no residential treatment for residents without insurance. Transportation will be an issue as individuals will be forced to travel farther for residential services. They will also be required to wait for an available bed due to the lack of capacity statewide.

D. DETOXIFICATION:

The only detox facility in Sussex County has recently changed to an insurance-only facility leaving the county with no detox treatment for residents without insurance. Transportation will be an issue as individuals will be forced to travel farther for detox services. They will also be required to wait for an available bed due to the lack of capacity statewide.

APPENDIX 5: LIST OF PARTICIPANTS IN THE PLANNING PROCESS

No.	NAME	AFFILIATION	CONTACT INFO.
1.	Vance Mulholland	LACADA Community Member	
2.	Nicholas Loizzi	County Alliance Coordinator	
3.	Rachel Wallace	The Center for Prevention and Counseling of Newton, NJ	
4.	Christine Florio	Director, Sussex County Division of Children and Youth Services	
5.	Rachel Helt	Family Partners of Morris and Sussex Counties	
6.	Katie Calvacca		
7.	Michael Lasko	NJ Department of Probation	
8.	Annmarie Shafer	The Center for Prevention and Counseling of Newton, NJ	
9.	Francis Koch	Sussex County Prosecutor	
10.	Melissa Latronica	Director, Sussex County Division of Community and Youth Services	
11.	Kathryn Radcliffe		
12.	Chaplain Hank Tino		
13.	Budd Brown	LACADA Member	
14.	Carrine Kaufer	Franklin/Hardyston Municipal Alliance Committee	
15.	Ed Blevins	Central Municipal Alliance Committee	
16.	Julie Schuldner	LACADA	
17.	Monica Goscicki	Ogdensburg Municipal Alliance Committee	
18.	Jeanne Buffalino	Vernon Municipal Alliance Coalition	
19.	Barbara Miller	Sussex County Division of Community and Youth Services	
20.	Kerry Deckert	Action Municipal Alliance Committee	
21.	Diane Friedberg	Sussex/Wantage Municipal Alliance Committee	
22.	Anita Straway	Stillwater Municipal Alliance Committee	
23.	Cheryl Buxton	Sussex County Department of Health	
24.	Cindy Armstrong	Sussex County A&D Director	