INTEGRATED CASE MANAGEMENT SERVICES (ICMS)

Integrated Case Management is an assertive outreach program which emphasizes assessment, advocacy, empowerment, referral, linkage, and supportive counseling. This voluntary program is designed to assist people in their recovery based on individual needs and interests. Case management consists of four primary goals: (1) engage and provide referrals, linkages and support to individuals with mental illness; (2) enable a smooth transition through all phases of illness and recovery; (3) empower persons with mental illness to independently manage their own lives in the way they choose; and (4) address the specific needs of the person and assist in service procurement, delivery, coordination, and integration.

Services are designed to assist adults in their recovery by helping them gain access to needed medical, social, educational, housing and other services and resources. These services are consumer-centered and provided predominantly off-site in the consumer's natural environment ("in-vivo").

Personnel

ICMS is made up of three teams serving the counties of Essex, Morris and Passaic while based out of a satellite office in their corresponding county. Program staffing consists of two Program Directors, three Program Coordinators, six Senior Case Managers, two Case Manager-Co-Occurring, 22 Case Managers, and 3 administrative staff. This impressive group shares over 220 years of outreach experience, collectively, and remains culturally diverse and representative of the persons served. ICMS is staffed with bi-lingual Case Managers who are fluent in Spanish Kru Yiddish/Hebrew, Georgian and Haitian Creole. Multiple staff are currently enrolled in continuing education courses as well as pursuing additional licensing for both professional and personal growth.

Caseload

ICMS serves adult individuals diagnosed with a serious and persistent mental illness, specifically under two primary disorders - the psychotic disorders (Schizophrenia, Schizoaffective and Delusional), and the mood disorders (Bipolar and Major Depressive). Case management services are initially offered for 12 months to individuals referred from a state or county hospital, and six months for all others. A consumer's length of program stay is reassessed during service planning and can be extended if there is a justified need. The current average length of stay is 1.5 years. As of June 30, 2023, the ICMS ending caseload was 1262 consumers. Please refer to the detailed grid and descriptors for a breakdown of the 2022-2023 ICMS caseload.

2021-2022	Essex	Morris	Passaic	Totals
Total Enrolled Consumers Served	323	226	300	**849**
Newly Enrolled	108	68	124	**300**
Discharged	158	108	123	**389**
Ending Caseload	186	91	176	**453**
Total Face-to-Face Units	23485	15616	23779	**62880**
Risk Level				
High	27	3	66	**96**
At	102	32	101	**235**
Low	57	56	9	**122**

- Admissions/Referrals are received from a variety of sources including state and county hospitals, Short Term Care Facilities (STCF), voluntary psychiatric inpatient units, community treatment providers, families and consumers themselves. ICMS served 164 enrolled individuals in the community hospitals.

- Discharge/"Graduation" occurs primarily once a client has achieved their individualized set goals and are linked accordingly. Other reasons for discharge may include moving out of the county, being referred to more appropriate services such as PACT, CSS, and other mental health residential services, requiring continued hospitalization for more than six months, declination of services or inability to establish contact. All ICMS discharges must be approved by DMHAS, which are submitted on a web-based portal. For this reporting year, ICMS discharged 389 consumers.

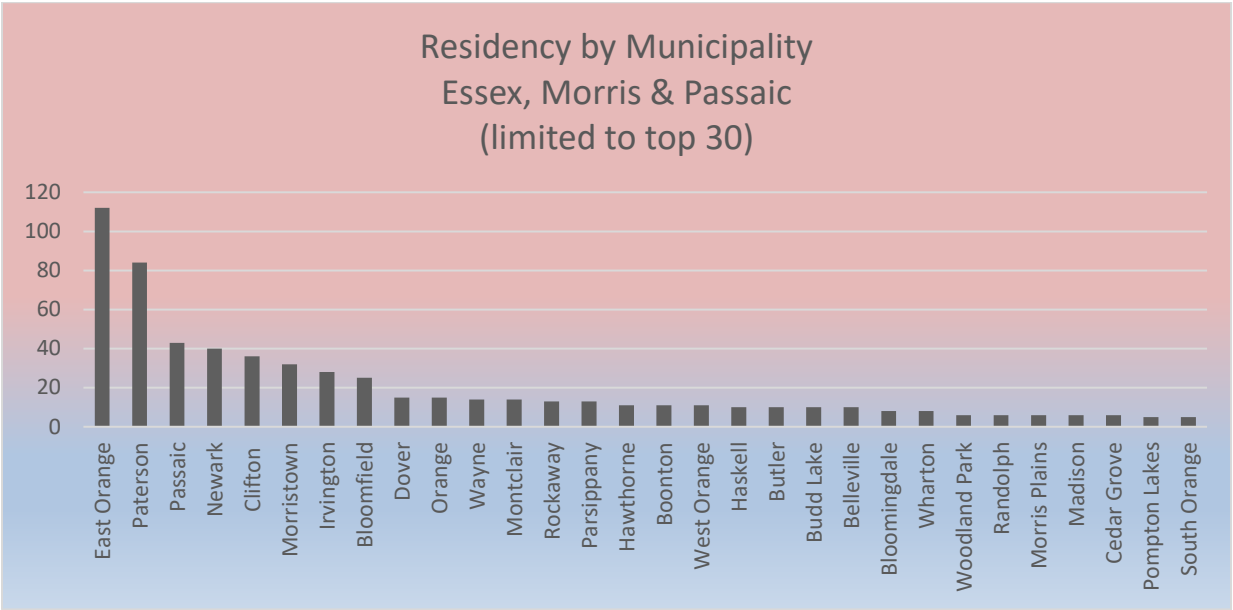
- Units of service are defined as a continuous face-to-face contact with an enrolled consumer or on behalf of an enrolled consumer, which lasts 15 minutes, not including travel time. For this reporting year, ICMS total units of service include both face-to-face contact and telecommunication contact and was a remarkable 62,880 units, which is over 15,500 hours of contact.

- Risk category refers to the three levels of case management involvement, based upon assessed risk of hospitalization, functional level and willingness and/or ability to access

needed services. The three risk categories are: high-risk or intensive case management; at-risk or supportive case management; and low-risk or maintenance level case management. This risk assessment is completed routinely along with a consumer's service plan and services are tailored accordingly.

Demographics

MHA ICMS consumers reside throughout Essex, Morris and Passaic counties. East Orange, Morristown and Paterson are each county's most consumer-populated municipality at the current time, respectively. There are a total of 76 municipalities served overall.



The current ICMS census ranges from age 18 to 81, the average age being 50. Gender identity was 71% female, 25% male and 4% transgender male. Self-reported races of consumers enrolled are as follows: White/Caucasian (50%), Black or African-American (30%); Black or African-American & White (8%); Asian (1%); American-Indian or Alaskan Native (1%); other (6%); other multi-racial (2%); declined to specify (1%); unknown (1%). The primary spoken language of consumers is predominately English; however, ICMS is able to serve all clients with assistance from bi-lingual staff, family and use of a paid translation service, when needed. Consumer languages spoken are as follows: English (89%); Spanish (9%); Creole (1%); French, Russian, Polish, Portuguese, Arabic and other (1%).

Performance Outcomes

Performance outcomes are measured and monitored through MHA's Quality Assurance Committee (QA). Performance indicators specific to ICMS measure effectiveness and access: hospitalization recidivism rates, employment rates, and contact rates.

- Hospitalization Recidivism *(effectiveness)*

**Benchmark ≤ 20% Annually	Essex	Morris	Passaic
Total Hospital Recidivism	7%	3%	4%
State/County Hospitalizations	0%	0%	1%
Short Term Care Facility Hospitalizations (STCF)	6%	1%	1%
Voluntary Hospitalizations	1%	0%	2%

- Employment Rates *(effectiveness)*

MHA ICMS collaborates with both internal and external county-based Supported Employment Services (SES) to increase employment rates and opportunities for individuals with severe mental illness. In FY2023, Passaic ICMS identified an average of 21% of the active caseload as employed, Essex ICMS identified 10%, and Morris ICMS identified 5%.

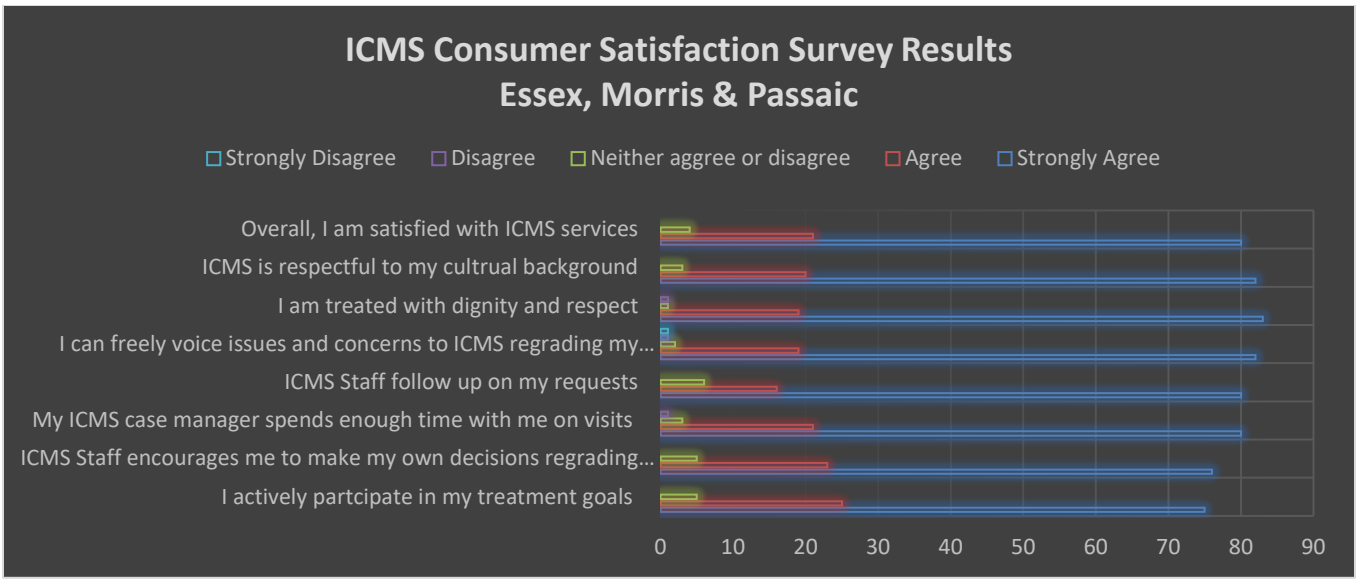
- Contact within 72 hours *(access)*

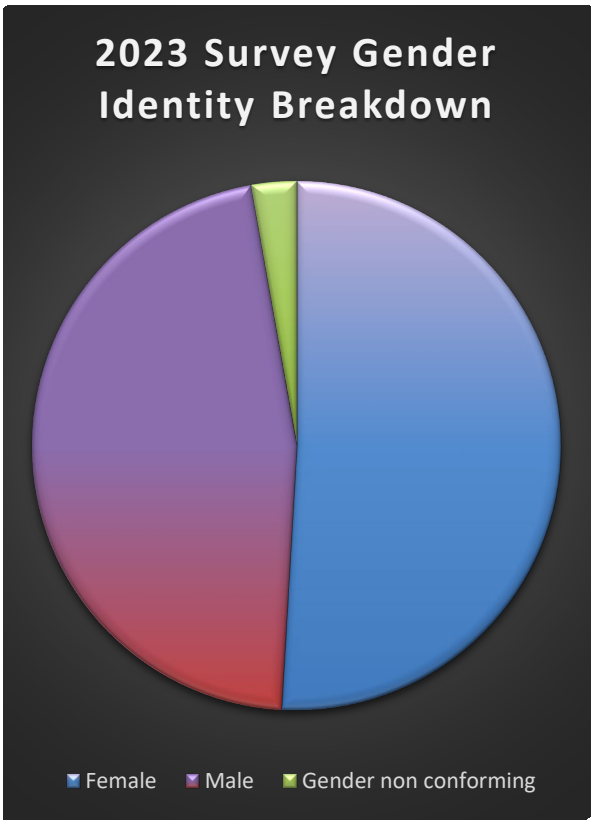
Access was measured in the time lapse between a person's discharge from a state or county hospital and the first contact by a case manager. The threshold for this indicator is more than 80% of the consumers enrolled into ICMS being seen within 72 hours of discharge from a hospital.

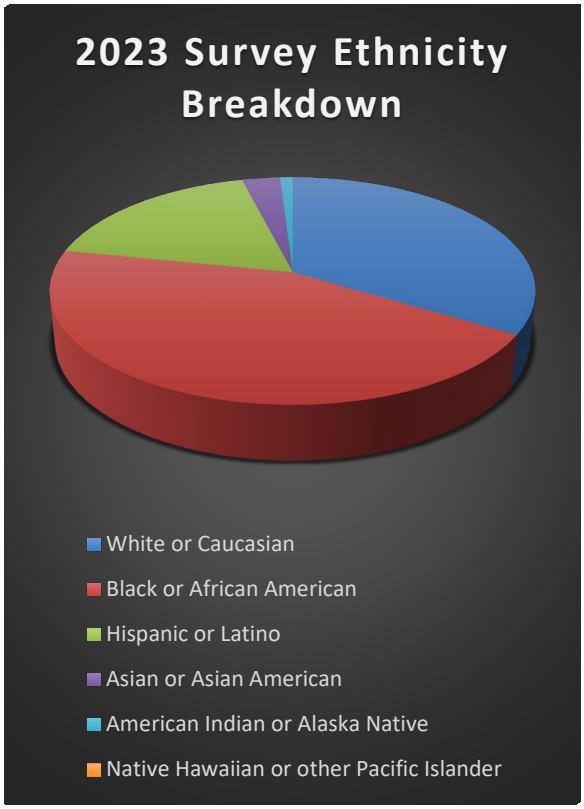
**Benchmark ≥80%	Essex	Morris	Passaic
County/State discharges seen within 72 hours	100%	100%	100%

Consumer Satisfaction Survey

In May 2023, ICMS consumers were given the opportunity to participate in a consumer satisfaction survey. The confidential survey included a total of nine questions formatted in a five point Likert scale, demographic collection and optional comment area. The survey was prepared in both English and Spanish and offered in a paper format as well as a web-based link (SurveyMonkey). In total, there were 108 surveys submitted, giving a 25% response rate, with an overall satisfaction score of 98%.


ICMS Consumer Satisfaction Survey Results
Essex, Morris & Passaic
Strongly Disagree
Disagree
Neither aggree or disagree
Agree
Strongly Agree
Overall, I am satisfied with ICMS services
ICMS is respectful to my cultrual background
I am treated with dignity and respect
I can freely voice issues and concerns to ICMS regrading my...
ICMS Staff follow up on my requests
My ICMS case manager spends enough time with me on visits
ICMS Staff encourages me to make my own decisions regrading...
I actively partcipate in my treatment goals
0
10
20
30
40
50
60
70
80
90


2023 Survey Gender Identity Breakdown
Female
Male
Gender non conforming


2023 Survey Ethnicity Breakdown
White or Caucasian
Black or African American
Hispanic or Latino
Asian or Asian American
American Indian or Alaska Native
Native Hawaiian or other Pacific Islander

ICMS Highlights

ICMS transitioned back to pre-pandemic services to clients. With that being said, ICMS consumers and staff were able to face those challenges together to achieve goals and ensure needs were met. In-person visits continued throughout the year to all clients without disruption as well as telecommunication contact for additional support. All clients are provided with ongoing education on COVID-19 symptoms, what to look for and what steps to take if thought to be infected or exposed to the virus. Vaccine education was also provided routinely, and all ICMS consumers wanting the vaccine have been assisted in getting vaccinated through various community resources including at multiple vaccine clinics conducted by our agency at our various locations in Essex and Morris.

MHA was able to purchase and provide over 150 winter coats to ICMS consumers as well as hats and gloves, if needed. This assistance has been provided yearly with the understanding that some consumers may not have the means or ability to attain such basic but necessary items to get through a winter known to New Jersey. Food donations were received and distributed to consumers and families as well as "wellness" boxes that included a variety of items promoting wellness and self-care. PPE gear and products were readily available and provided to consumers, families and staff to ensure the safety and protection of all during ongoing face-to-face contacts.

Clients were able to participate in agency run social events such as, "Operation Holiday," "Gifts for the Season," and "Holiday Express Virtual Concert." These events/donors were able to gift our consumers and families with various items such as clothes, personal care products and toys.

In June 2023, MHA was able to hold the annual Consumer Picnic at two locations, Eagle Rock Reservation in Essex and Hedden Park in Morris. ICMS consumers from all three counties were able to attend the picnic and enjoy the beautiful weather, good food, and great company amongst their peers.

Many external resources and services were limited or unavailable during the pandemic, including transportation. MHA was able to initiate and fund transportation through Uber Health for consumers, if needed, to ensure all necessary medical and mental health appointments were attended.

Training

All staff are trained annually in the core areas of case management required by DMHAS and provided by the Rutgers UBHC Technical Assistance Center as well as through Relias web-based learning. These core trainings include Motivational Strategies for Implementing EBPs and Cognitive Behavioral Strategies: Shaping Behavior from the Inside Out, Person-Centered Strategies for Successful Engagement, Considering the Causes of Aggression, The Challenge of Documentation, Suicide and Risk Assessment, Addictive Behavior and Substance Use, and Practical Applications for Being Trauma Informed. All staff attended a mandatory live or virtual

training for Medication/Sun Risk Education and Community Workplace Violence. In addition, ICMS staff had the opportunity to continue participation in the virtual educational training sessions provided through the Department of Labor grant that MHA received for the year 2020. Finally, staff are required to maintain a valid CPR status, which is offered at no cost to employees.

Systems Advocacy Activities

ICMS participated on the following committees, boards, and task forces, during the past year:

- ***Essex, Morris and Passaic Systems Review Committees (SRC) -*** This monthly meeting is convened by the Mental Health Administrator and Screening Center of the respective county. The purpose of these meetings is to identify countywide gaps in services and breakdowns in services between providers and/or mental health treatment systems. The Committees provide education and advocacy to the community, mental health providers, consumers of mental health services and their families, and provides advocacy on the needs of the mental health system in the county.

- ***Essex Children Systems Review Committee (CSRC) -*** ICMS participates in these monthly meetings convened by the Mental Health Administrator of Essex County. The purpose of these meetings is to identify countywide gaps of clients transitioning or aging out of services of Department of Child Protection and Permanency and identify breakdowns in services between providers and/or mental health treatment systems. The Committee provides education and advocacy to mental health providers, consumers of mental health services and their families on systems in the county.

- ***ICMS Statewide Quarterly Meeting (NRQM) –*** This leadership meeting is scheduled on a quarterly or as needed basis by the DMHAS ICMS Coordinator to discuss any system issues, identify service gaps, and for DMHAS to provide support and guidance to the ICMS programs statewide.

- ***Essex, Morris and Passaic Professional Advisory Committee (PAC), Mentally Ill Chemical Abuser/MICA Task Force Meeting -*** ICMS/Agency leadership participates in a monthly meeting with the counties Drug and Alcohol Task Force to develop ways in which community providers can serve individuals with mental health, addictions, and co-occurring mental health and addiction disorders in a unified manner.

- ***Essex, Morris and Passaic Residential Meeting -*** ICMS participates in a monthly meeting along with DMHAS, County Administrator, and hospital and residential housing professionals to collaborate on safe and appropriate discharge planning for persons primarily in state and county psychiatric facilities.

- ***ICMS Statewide Practice Meeting -*** This meeting is convened by NJAMHAA with a priority goal of promoting leadership support, communication, collaboration and information sharing (i.e., program management, operations, data tracking, FFS, nuances of each ICMS program) in

order to develop uniformity and ensure quality service delivery across NJ.

- ***Passaic County Behavioral Health/Opioid Task Force –*** The Task Force was established by the Passaic County Collective Impact Council to undertake a process of designing and implementing an organized system of services for individuals and families, including strategies for enhancing prevention, early intervention, and aftercare services, in addition to crisis-based services. Monthly virtual meetings are attended by the Passaic ICMS Director.

- ***Passaic County Crisis Intervention Training Board*** - The task force was established by Passaic County in order to provide training to police officers in Crisis Intervention Training.

- **Passaic County Overdose Fatality Review Team (OFRT) Committee** - The Passaic County OFRT meets monthly and through the decedent cases we receive, review factors, trends, gaps, and barriers that cause or play a role with fatal overdoses. From there we identify any and all gaps or barriers to services, promote and engage in cross sector coordination and collaboration, engage in thorough discussions, and develop then provide recommendations and implementations for change that will support the team's ultimate goal in reducing fatal overdoses in Passaic County and saving lives. ICMS Director participates in Resource Subcommittee.

ASSISTED OUTPATIENT TREATMENT (AOT)

The mission of Assisted Outpatient Treatment (AOT), also known as Involuntary Outpatient Commitment (IOC) program is to provide court ordered mental health treatment, intensive case management and assistance to a select group of mental health consumers who have been resistant and have had difficulty engaging in outpatient treatment. AOT helps these consumers live safely in the community, avoid repeated inpatient hospitalizations, arrests or incarcerations, and ensures they have access to comprehensive outpatient services. By adherence to a court-ordered treatment plan, consumers have the opportunity to better engage in consistent, ongoing treatment and to ultimately graduate to less restrictive mental health services.

Personnel

AOT Essex is currently staffed by one full-time Program Director, three full-time Master's Level Case Managers, one part-time Administrative Assistant, and two part-time Psychiatrists.

AOT Sussex is currently staffed by one part-time Program Director, two full-time Master's Level Case Managers, and one part-time Psychiatrist.

AOT Morris is currently staffed by one part-time Program Director, two full-time Master's Level Case Managers, and one part-time Psychiatrist.

The AOT staff is culturally diverse and is representative of the population served.

Caseload

Essex
As of June 30, 2023, there were 40 active cases. During FY 2023, 38 referrals were enrolled into the AOT program. 68% of the referrals were made through Short Term Care Facilities (STCF) and/or private hospitals via conversion or amended hearings. 26% were made through conversion hearings at long-term care facilities, i.e., Essex County Hospital Center (ECHC) and/or state hospitals. 6% we referrals made from out of county IOC providers for individuals transferring to Essex County. There were no referrals enrolled through the designated screening centers.

Sussex
As of June 30, 2023 there were 13 active cases. During FY2023, 14 referrals were enrolled into the AOT program. 42% of the enrollee referrals were made through STCF via conversion hearings. 42% were made through conversion hearings at other hospitals. 9% were state hospital referrals and 7% of the referrals were made through the designated screening facility.

Morris
As of June 30, 2023, there were 17 active cases. During FY2023, 19 referrals were enrolled into the AOT program. 5% of the enrollee referrals were made through STCF via conversion hearings. 68% were made through conversion hearings at other hospitals, 0% were made through screening, and 27% were state hospital referrals. There were no referrals enrolled through the designated screening centers.

Demographics

The AOT programs provide services to residents of Essex, Sussex and Morris counties who are 18 years of age and older, diagnosed with a serious and persistent mental illness (SPMI) and who are a danger to self, others and/or property in the foreseeable future.

Gender

At the end of the fiscal year, the Essex caseload was 43% female, 53% male, and 4% transgender female; the Sussex caseload was 53% male, 7% transgender, and 40% female; and the Morris caseload was 47% female and 53% male.

Ethnicity

At the end of the fiscal year, AOT Essex provided services for 55% African-Americans, 2% Hispanics, 17% Caucasians, 9% unknown and 17% individuals who identified as multiracial. AOT Sussex provided services for 85% Caucasians, 0% other multiracial, 8% Asian, 0% other and 7% Black. AOT Morris provided services for 61% Caucasians, 10% African-Americans, 6% unknown, 11% Hispanic and 12% Asian.

This is reflective of the diverse population in all three counties.

Age

AOT Essex serviced 41% of individuals between the ages of 18-29, 22% were between the ages of 30-39, 12% were between the ages of 40-49, 5% were between the ages of 50-59, and 20% were above the age of 60.

AOT Sussex serviced 15% of individuals between the ages of 18-29, 38% were between the ages of 30-39, and 47% were above the age of 40.

AOT Morris serviced 33% of individuals between the ages of 18-29, 28% were between the ages of 30-39, and 39% were above the age of 40.

Performance Outcomes

All AOT consumers are identified as high risk for decompensation and have a history of frequent inpatient hospitalizations, emergency room visits, arrests and incarcerations. AOT closely monitored these indicators and established baselines to help measure the effectiveness of the program. For this past fiscal year, AOT has clearly demonstrated its effectiveness as evidenced by the number of consumers who showed a reduction in the following areas: emergency room screenings, admissions to long-term care, arrest, incarcerations, and voluntary hospitalizations.

Essex

In its eleventh year of operation, AOT Essex has collected data in an effort to establish thresholds and baselines for several performance indicators. AOT developed a baseline measure for the number of consumers referred from each of the three referral sources. Based on the data, it is expected that for FY 2024, each month one individual will be referred from local screening centers, five will be referred from Short Term Care Facilities (STCF), and three individuals will be referred from Long Term Care facilities.

- 18 enrollees went to a local ER for screening: Yearly Threshold ≤ 72
- 0 enrollees were admitted to Long Term Care: Yearly Threshold ≤ 36
- 0 enrollees were arrested: Yearly Threshold ≤ 36
- 1 enrollee were incarcerated: Yearly Threshold ≤ 36
- 22 enrollees were voluntarily hospitalized: Monthly Threshold < 36
- 2 enrollees were homeless: Yearly Threshold < 36
- 100% of AOT consumers were educated on "Summer Heat and Sun Risks for Antipsychotic Medication Users."

Sussex

In its eighth year of operation, AOT has collected data in an effort to establish thresholds and baselines for several performance indicators. AOT developed a baseline measure for the number of consumers referred from each of the three referral sources. Based on the data, it is expected that for FY2024, each month one individual will be referred from local screening centers, four will be referred from Short Term Care Facilities (STCF), and two individuals will be referred from Long Term Care facilities.

- 20 enrollees went to a local ER for screening: Yearly Threshold ≤ 36
- 1 enrollee was admitted to Long Term Care: Yearly Threshold ≤ 24
- 0 enrollees was arrested: Yearly Threshold ≤ 12
- 0 enrollees was incarcerated: Yearly Threshold ≤ 12
- 10 enrollees were voluntarily hospitalized: Yearly Threshold < 12
- 0 enrollees were homeless: Yearly Threshold < 12
- 100% of AOT consumers were educated on "Summer Heat and Sun Risks for Antipsychotic Medication Users."

Morris

In its eighth year of operation, AOT has collected data in an effort to establish thresholds and baselines for several performance indicators. AOT developed a baseline measure for the number of consumers referred from each of the three referral sources. Based on the data, it is expected that for FY2024, each month one individual will be referred from local screening centers, five will be referred from STCF, and three individuals will be referred from Long Term Care facilities.

- 16 enrollees went to a local ER for screening: Yearly Threshold ≤ 48
- 0 enrollee were admitted to Long Term Care: Yearly Threshold ≤24
- 0 enrollee were arrested: Yearly Threshold ≤ 24
- 0 enrollees were incarcerated: Yearly Threshold ≤ 24
- 4 enrollees were voluntarily hospitalized: Yearly Threshold < 24
- 0 enrollees were homeless: Yearly Threshold < 24
- 100% of AOT consumers were educated on "Summer Heat and Sun Risks for Antipsychotic Medication Users."

Consumer Satisfaction Survey

All AOT programs distributed and tallied satisfaction surveys. All consumers were informed that answers would remain confidential. Consumers were provided with a sealed envelope to protect anonymity and informed of several ways on how to return the surveys:

1. Complete it while your case manager is visiting and return to them in the sealed envelope.
2. Complete it at a later time and ask case manager to pick it up at the next scheduled visit.
3. Complete it at your leisure and mail back in a self-addressed stamped envelope provided for your convenience.
4. Complete it with the assistance of a case manager if unable to read or comprehend the questions and submit back to Program Director.

Essex

Approximately 40 surveys were delivered to consumers (hand delivered, mailed and/or left at residence). Out of the 40 surveys, 11 consumers responded. This accounts for a 27% response rate.

Gender

Of the 11 consumers that responded to the surveys; 27% were male and 64% were female, and 9% were gender non-conforming.

Ethnicity

Of the 11 consumers surveyed, 18% identified as African-American, 27% identified as Caucasian, 9% identified as Hispanic or Latino, 18% Asian or Asian American, 9% identified as Native Hawaiian or other Pacific Islander, and 18% preferred not to answer.

Age

The age range of consumers surveyed was collected; 27% were 18-24 years old, 27% were 25-34 years old, 18% were 35-44 years old, 9% were age 45-54, and 18% were 55-64 years old.

Included in Decisions Regarding Treatment

- 100% of consumers indicated that they "strongly agree" or "agree" that they are included in decisions regarding treatment.

Results indicate that both staff and consumers are collaborating when discussing treatment.

Able to Freely Voice Issues and Concerns Regarding Treatment

- 90% of consumers indicated they "strongly agree" or "agree" they are able to freely voice issues and concerns regarding their treatment.

The results align with the AOT philosophy of working closely with consumers to ensure they are able to express their concerns regarding treatment. This will allow case managers to help shape how consumers achieve their goals.

Treats Me With Respect

- 100% of consumers indicated they "strongly agree" or "agree" they are treated with respect.

The results indicate that case managers are working closely with consumers to ensure genuine concern and respect is being conveyed in all interactions.

Overall Satisfaction (AOT)

- 80% of consumers indicated that they "strongly agree" or "agree" that they are satisfied with AOT services.

Received Assistance With Achieving Their Goals

- 100% of consumers surveyed indicated that they "strongly agree" or "agree" that AOT provides support and assistance with achieving their goals.

Sussex

Approximately three surveys were delivered to consumers (hand delivered, mailed and/or left at residence). Out of the three surveys, three consumers responded. This accounts for a 100% response rate.

Gender

Of the three consumers that responded to the surveys; two are male (66.67%) and one is female (33.33%).

Ethnicity

Of the three consumers surveyed, two identified as Caucasian (66.67%) and one identified as African-American (33.33%).

Age

The exact age of the consumers was collected. The ages ranged from 25-44 years old. The mean age for the consumers was 34 years old.

Included in Decisions Regarding Treatment

- 33.33% of consumers indicated that they "strongly agree" that they are included in decisions regarding treatment.
- 66.67% of consumers indicated that they "agree" that they are included in decisions regarding treatment.

Results indicate that both staff and consumers are collaborating when discussing treatment.

Able to Freely Voice Issues and Concerns Regarding Treatment

- 33.33% of consumers indicated they "strongly agree" they are able to freely voice issues and concerns regarding their treatment.
- 66.67% of consumers indicated they "agree" they are able to freely voice issues and concerns regarding their treatment.

The results align with the AOT philosophy of working closely with consumers to ensure they are able to express their concerns regarding treatment. This will allow case managers to help shape how consumers achieve their goals.

Treats Me With Respect

- 66.67% of consumers indicated they "strongly agree" they are treated with respect.
- 33.33% agree they are treated with respect.

The results indicate that case managers are working closely with consumers to ensure genuine concern and respect is being conveyed in all interactions.

Overall Satisfaction (AOT)

- 66.67% of consumers indicated that they "strongly agree" they are satisfied with AOT services.

Morris
Approximately four surveys were delivered to consumers (hand delivered, mailed and/or left at residence). Out of the four surveys, approximately four consumers responded. This accounts for a 100% response rate.

Gender

Of the four consumers that responded to the surveys; three are male (75%) and one is female (25%).

Ethnicity

Of the four consumers surveyed, one identified as Caucasian (25%), two identified as African-American (50%), and one (25%) identified as Hispanic/Latino. The ethnicity of the respondents mirrors that of our caseload.

Age

The exact age of the consumers was collected. The ages ranged from 33-65 years old. The mean age for the consumers was 43 years old.

Included in Decisions Regarding Treatment

- 66.67% of consumers indicated that they "strongly agree" that they are included in decisions regarding treatment.
- 33.33% of consumers indicated that they "agree" that they are included in decisions regarding treatment.

The results indicate that both staff and consumers are collaborating when discussing treatment.

Able to Freely Voice Issues and Concerns Regarding Treatment

- 66.67% of consumers indicated they "strongly agree" they are able to freely voice issues and concerns regarding their treatment.
- 33.33 of consumers indicated that the "agree" they are able to freely voice issues and concerns regarding their treatment.

The results align with the AOT philosophy of working closely with consumers to ensure they are able to express their concerns regarding treatment. This will allow case managers to help shape how consumers achieve their goals.

Treats Me With Respect

- 100% of consumers indicated they "strongly agree" they are treated with respect.

The results indicate that case managers are working closely with consumers to ensure genuine concern and respect is being conveyed in all interactions.

Overall Satisfaction (AOT)

- 100% of consumers indicated that they "strongly agree" they are satisfied with AOT services.

AOT Highlights

Essex

- During the past fiscal year, 15 consumers were able to successfully accomplish their goals, with the least amount of intervention from AOT, and graduate from the program.
- AOT provided individual psychoeducation for consumers transitioning or approaching graduation from AOT with a focus on raising consumers' self-awareness regarding their emotions, identifying and establishing social supports outside of AOT, and education on the importance of medication adherence.
- AOT continued to collaborate with and educate staff at all Essex County Screening Centers, six Short Term Care Facilities, Essex County Hospital Center (ECHC), state psychiatric institutions and private hospitals.
- AOT consumers, in collaboration with all other MHA adult programs, participated in a picnic at Eagle Rock Reservation and a holiday party.

Morris/Sussex

- AOT continued to collaborate with and educate staff at the Saint Clare's Behavioral Health inpatient unit and screening center, as well as Greystone Park Psychiatric Hospital (GPPH).
- AOT met with several outpatient mental health treatment providers to educate them on this program.
- During the past fiscal year, 10 consumers from Morris County, and eight consumers from Sussex County were able to successfully accomplish their goals and graduate from the program.
- AOT continued to collaborate with and educate staff at the Newton Medical Center's inpatient unit and screening center.
- Program Director provided trainings on AOT to several outpatient mental health treatment providers to educate them on this program.
- AOT consumers, in collaboration with all other MHA adult programs, attended a picnic at Hedden Park.

System Advocacy

AOT staff work closely with consumers to assist them in developing self-advocacy skills by keeping an open dialogue on various ways they can become involved in different levels of advocacy (self-help centers, NAMI-NJ). All counties participate in the Statewide IOC Directors' meeting convened by the Department of Health and Addiction Services (DMHAS). The purpose of these meetings is to meet with counterparts in other counties to discuss ways to increase effectiveness of the program, review service delivery concerns, and to obtain needed updates on practices and protocols of the IOC programs.

AOT also participates in the following county specific meetings, task forces, and committees:

Essex

- **High Recidivism Committee** is a subcommittee of the Systems Review Committee. It is designed to discuss those individuals that are frequenting many of the service providers. A collaborative discussion takes place to determine ways to effectively work to assist these consumers in maintaining stability.

- **Professional Advisory Committee (PAC), Mentally Ill Chemical Abuser/MICA Task Force Meeting** is a monthly meeting with Essex County Drug and Alcohol Task Force to develop ways in which to better assist MICA clients in Essex County through education and training programs.

Morris

- **Acute Care Meeting** is a monthly meeting convened by the Director of Screening Services at Saint Clare's Behavioral Health. The purpose of these meetings is to identify countywide gaps in services and breakdowns in services between providers and/or mental health treatment systems. The Committee provides education and advocacy to the community, mental health providers, consumers of mental health services and their families and provides advocacy on the needs of the mental health system in the county.

Sussex

- **Law Enforcement/Mental Health Meeting** is a quarterly meeting convened by the Sussex County Prosecutor's Office. The purpose of these meetings is to meet with community

providers, local law enforcement, and the court system to identify service gaps, and to provide education and advocacy on the needs of mental health consumers within the county.

- **Mental Health Board Meeting** is a monthly meeting convened by the Sussex County Mental Health Administrator to promote access to and availability of efficient, adequate, integrated health care services for adults with serious mental illness and/or substance use disorders.

- **System Review Committee** is a monthly meeting convened by the Director of Screening Services at Newton Medical Center. The purpose of these meetings is to identify countywide gaps in services and breakdowns in services between providers and/or mental health treatment systems. The committee provides education and advocacy to the community, mental health providers, consumers of mental health services and their families, and provides advocacy on the needs of the mental health system in the county.

Upcoming Year Recommendations

Essex, Morris & Sussex

- AOT staff will work on increasing the total number of contacts with consumers, their families and service providers.
- AOT will continue to work closely with the Public Defender's Office to increase collaboration for consumer success.
- AOT will continue to collect data and will closely monitor all performance indicators.
- AOT will continue to work closely with community providers and DMHAS to refine the process and legislation for IOC.
- AOT will continue to advocate for IOC consumers to be successfully linked to better housing.
- AOT will continue to work with consumers to empower them to reach their goals in order to successfully graduate from the program.
- AOT will conduct psychoeducation groups for consumers to increase awareness and knowledge.
- AOT will continue to complete psychiatric evaluations with focus on trauma informed care practices.
- AOT will attend any relevant trainings to increase their knowledge in best practice measures.
- AOT will continue to conduct trainings and presentations as needed to those wanting to learn the role of AOT.

MHA Co-Response

Beginning September 1, 2020, MHA began a collaboration with the West Orange Police Department to develop a pilot program focused on community co-responding, training to law enforcement, and body camera after-action review. The collaborative efforts of the Mental Health Association (MHA) and the West Orange Police Department (WOPD) has led to opportunities for success in managing mental health awareness and community related response calls in a manner that facilitates treatment and recovery while reducing involvement in the criminal justice system. MHA partnered with WOPD who applied for the Connect and Protect grant through the Bureau of Justice Assistance (BJA). WOPD was awarded the grant, allowing MHA to provide full-time Co-Response, Monday – Friday from 7am to 11pm. In March 2022, MHA began providing full-time Co-Response support to the WOPD. The MHA-WOPD Co-Response Department consists of two Co-Responders and the Essex AOT Director, who oversees the Co-Response programs. The Co-Responders are stationed at the WOPD Community Services Unit (CSU) substation where they work very closely with the CSU WOPD officers.

As a result of the collaboration, MHA was able to provide 15 trainings to WOPD in an effort to further enhance understanding and knowledge of mental illness. Topics included: mental health (signs, symptoms, de-escalation techniques, and crisis assessment), suicide prevention and awareness for the community, law enforcement and suicide awareness, co-occurring disorders and substance use and abuse for the community, law enforcement and mental health, mental health and racism/cultural awareness, and mental health and the family perspective. MHA was also able to provide trainings to West Orange Fire Department (WOFD) on the Co-Response Model, as the WOFD oversees the EMT/Paramedic services in West Orange.

Additionally, throughout the course of FY2023, MHA and WOPD worked in tandem to review body camera video footage on a bi-monthly basis. These efforts aimed to assess and provide feedback and recommendations for areas of improvement when responding to mental health-related calls, in addition to offering recognition and highlighting effective strategies and dispositions demonstrated through law enforcement interactions with community members. MHA was able to review 44 incidents throughout the fiscal year. Assessment of videos determined the following outcomes: one recommendations was made for performance improvement purposes, while 43 incidents had no further recommendations at the time.

MHA Co-Responders responded to mental health related and crisis calls in the community. Upon receiving calls from dispatch, MHA reported to the designated scene/incident. Throughout the fiscal year, MHA was able to provide practical support to officers responding to mental health-related crises. As a result of this collaboration, all parties were able to ensure that the individual received the appropriate level of care in order to promote treatment and recovery and prevent involvement in the criminal justice system. During FY2023, MHA co-responded to 183 incidents in West Orange. As a result of these efforts, the following outcomes were measured:

- 72 of 183 Co-Responses required transport to the hospital.
- 15 involuntary hospital transports
- 57 voluntary hospital transports
- 28 linkages (i.e., mental health services, substance services, community resources) were made in the community as a result of follow up.

As evidenced by outcomes, MHA-WOPD Co-Response Program has allowed for an increase in the success rate of appropriate dispositions and interactions with individuals in the community living with mental illness. Through mental health awareness training, recommendations and analysis, and real-time Co-Response support, MHA has assisted WOPD with the important process of utilizing community resources in an effort to promote options of prevention, intervention, treatment, and overall wellness and recovery.

MHA was also able to implement Co-Response through a partnership with the Perth Amboy Police Department (PAPD) in Middlesex County. PAPD also received the Connect and Protect grant through the Bureau of Justice Assistance (BJA). The partnership allows MHA to provide Co-Response and follow up to individuals in crisis, as well as mental health related trainings to the PAPD. The program was staffed for the last two months of the FY2023 with one Co-Responder. During that time, MHA responded to 22 incidents in Perth Amboy.

- 15 of 22 Co-Responses required transport to the hospital.
- 1 involuntary hospital transports
- 15 voluntary hospital transports
- 19 linkages (i.e., mental health services, substance services, community resources) were made in the community as a result of follow up.

Projects for Assistance in Transition from Homelessness (PATH)

The mission of the PATH Program is to provide outreach, intensive case management and housing that will enable adults ages 18 and over, who are homeless or at imminent risk of homelessness and have a serious mental illness and co-occurring substance abuse disorders, to engage in community-based services. In doing so, we strive to improve consumer's health outcomes, participation in mental health and substance abuse treatment as well as expand their ability to gain affordable, permanent housing.

PATH is specifically designed to bring treatment and support to those who do not have access to traditional services and have little or no other support in the community. The goal of the PATH Program is to assist those who have been diagnosed with mental health and substance abuse disorders that are homeless or at imminent risk of homelessness by meeting them, "where they are" whether it be on the streets, train stations, under bridges, or wherever they may call home.

PATH's geographic region includes all areas in Essex and Morris counties where our outreach services are proactive in reaching those that may have fallen through the cracks of our mental health system of care. In addition to identifying housing opportunities, PATH offers flexible support services that are based on wellness and recovery principles. It is the belief of the program that with PATH's wraparound support and access to basic needs, our consumers will achieve a higher quality of life.

Essex and Morris PATH programs are fully participating in the respective counties Coordinated Entry System as required by the U.S. Department of Housing and Urban Development (HUD). This process is a systemic response to homelessness that strategically allocates resources and uses a Housing First approach to gaining access to shelter and permanent housing.

Caseload

Since July 1, 2022, PATH outreached 631 homeless individuals and those at imminent risk of homelessness across both counties. Of those outreaches, 289 consumers received case management services through the PATH Program. PATH provides weekly outreaches in the community including all townships spanning from the farthest corner of Essex County to the farthest point of Morris County wherever homeless are reported. Areas outreached include but are not limited to: Newark International Airport, Newark Penn Station, Morristown and Dover train stations, other local stations, local drop-in centers (including Salvation Army Montclair and NJCRI, Edna's Haven, Our Promise, Community Soup Kitchen, Dover Faith Kitchen), as well as other local churches and soup kitchens.

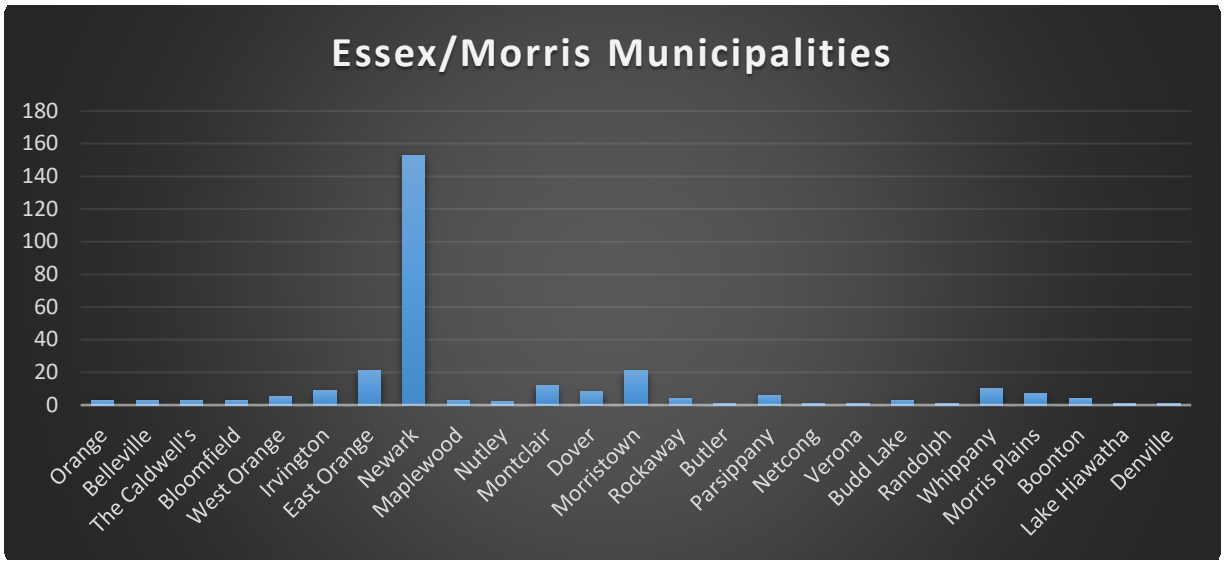
Referrals were received from all local Short Term Care Units (including Newark Beth Israel, East Orange General Hospital, University Hospital, Saint Michael's Medical Center, Morristown Medical Center, Saint Clare's Hospital, Summit Oaks, Bergen Regional, Chilton Hospital, as well as outpatient treatment centers), local police departments (including Montclair, East Orange, West Orange, Orange, Irvington, Maplewood, Caldwell, Verona, Nutley, Essex County Sheriff, NJ Transit Police, NJ/NY Port Authority Police, Morristown Police, Dover, Jefferson, Parsippany, Budd Lake, Netcong, Lake Hiawatha and any other municipalities that identify homeless) as well as other social service providers. Referrals are also obtained through the Coordinated Entry wait list.

Demographics

As of June 30, 2023, Essex and Morris PATH serviced 289 individuals. Of the individuals serviced, there were 169 males (58%), 118 females (41%), and 2 transgender (1%). The self-reported ethnicities of the consumers were as follows: 35 Hispanic/Latino (12%) and 254 Non-Hispanic/Latino (88%). The self- reported races of the enrolled consumers with PATH are as follows: 9 Multiple Race (3%), 75 Caucasian (26%), 188 African-American (65%), 4 Asian (1%), 4 Native Hawaiian or Other Pacific Islander (1%), and 9 American-Indian or Alaska Native (3%). Others serviced did not wish to provide this information.

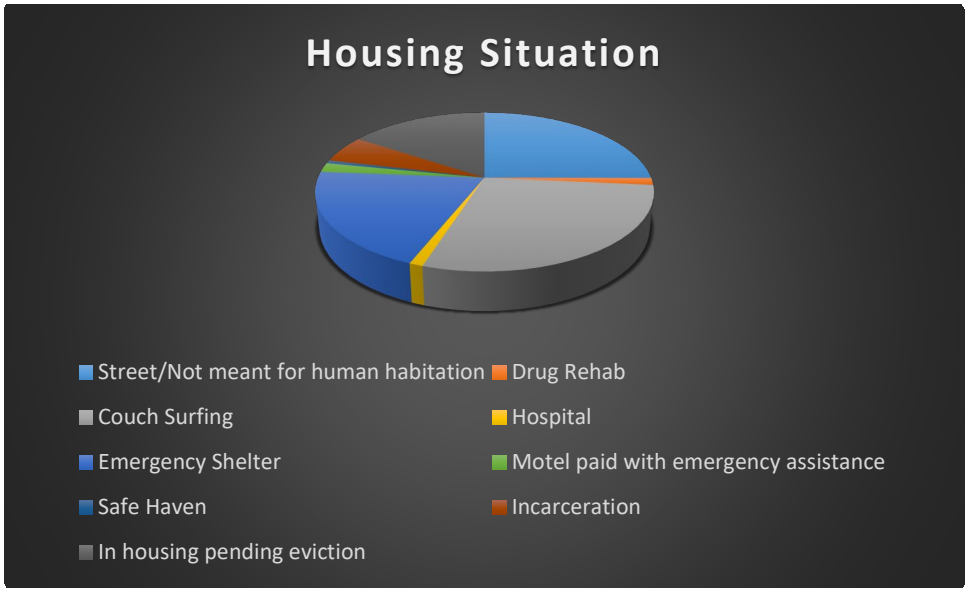
PATH makes every effort to provide services to homeless consumers throughout Essex and Morris Counties, with the understanding that homelessness does not only afflict consumers in the urban municipalities. The following reflects the municipality in Essex and Morris County where the consumers reported they slept the night before being outreached by PATH:

Belleville	3	Morristown	21
Bloomfield	3	Netcong	1
Boonton	4	Newark	153
Budd Lake	3	Nutley	2
Butler	1	Orange	3
Califon	1	Parsippany	6
Denville	1	Pine Brook	1
Dover	8	Randolph	1
East Orange	21	Rockaway	4
Irvington	9	The Caldwell's	3
Lake Hiawatha	1	Verona	1
Maplewood	3	West Orange	5
Montclair	12	Whippany	10
Morris Plains	7		



Consumers outreached by the PATH Program reported sleeping in the following locations the night before engagement. Street or place not meant for human habitation (158) (25%), Emergency Shelter (127) (20%), Safe Haven (4) (.6%), Drug Rehab (9) (1%), Motel paid with emergency assistance (12) (2%), couch surfing (180) (29%), inpatient hospital (7) (1%), incarceration (35) (6%) and housing pending eviction (99) (16%).

Of enrolled consumers, 292 (46%) met the definition of "chronically homeless" set forth by the Department of Housing and Urban Development (HUD), meaning being homeless for one year or more or having experienced four periods of homelessness in the past three years totaling at least 12 months.



Personnel

One Director, one Master's Level Coordinator, one Co-Occurring Counselor, three Outreach Case Managers, one Peer Outreach Case Manager, one part-time RN, and one part-time Administrative Assistant provide Essex PATH services. Staff are culturally diverse and represent the consumers served. PATH has one staff fluent in Spanish.

Morris PATH services are provided by one Master's Level Director, one Master's Level PATH Intake Coordinator, four part-time PATH Outreach Case Workers, two full-time Outreach Case Managers, one full-time Outreach Case Manager (County), and one part-time Resource Navigator for Coordinated Entry. Staff are culturally diverse and represent the consumers served. In the event a case manager is unavailable for live translation, staff utilize a Language Line, which is capable of translating 200 languages.

Performance Outcomes

PATH participates in the agency-wide Quality Assurance Committee (QA), which conducts monthly meetings and collects data on the utilization and quality of services provided by each MHA program.

As tracked by the QA Committee, PATH's performance indicators measure the number of homeless reached through outreach in the community and the number of homeless engaged in PATH services. PATH performance indicators also measure linkages for enrolled consumers to community mental health, substance abuse treatment, financial benefits, temporary housing, permanent housing, medical/dental treatment, and rehabilitation/habilitation services.

During this fiscal year, Essex and Morris PATH outreached 631 individuals or 93% of the contract commitment and serviced 289 individuals or 123% of the contract met. During the past fiscal year, PATH successfully linked to the following services: 156 to Community Mental Health, 21 to substance abuse treatment, 95 to financial benefits, 60 to temporary housing, 68 to permanent housing, 26 to medical/dental, and 23 to rehabilitation/habilitation services.

In addition, 100% of PATH enrollees in Essex and Morris Counties were educated on "Summer Heat and Sun Risk" and were provided at least quarterly or at medication change, medication education and support.

Consumer Satisfaction Survey

Approximately 50 satisfaction surveys were completed by consumers enrolled in the PATH Program. Many more surveys were offered but were declined. Consumers surveyed reported an overall 98% satisfaction with services provided by the PATH Program.

SURVEY DEMOGRAPHICS

Of the 50, 54% were female and 46% were male. The average age of respondents was 46 years old; 79% were African-American, 9% were Caucasian, 6% were Hispanic, 2% were Native Hawaiian or Other Pacific Islander, 2% were other mixed race, and 2% did not disclose race/ethnicity.

PATH Highlights

MHA's PATH Program has been servicing the homeless in both counties as one entity since August 1, 2017. This year, our most proud accomplishment is sixty-eight (68) chronically homeless individuals with severe and persistent mental illness and co-occurring substance abuse disorders have a place to call home.

Essex

- PATH Outreach staff participated in this year's Essex County Project Homeless Connect. During this event, PATH staff were able to outreach homeless individuals and provide care packages that included toiletries, snacks, and bus tickets.
- PATH Outreach staff participated in the HUD mandated Point-In-Time Count for the entire County of Essex.
- PATH Director worked closely with local police departments and health departments. Upon request from the police and health departments, PATH Outreach staff would engage homeless individuals throughout Essex County and would link individuals to shelter placement, detox programs, or mental health treatment, when appropriate.
- PATH Director participated in weekly development meetings with The City of Newark of the Newark Hope Village, a unique sheltering community. PATH Outreach staff engaged individuals onsite and provided weekly case management to link individuals to

medical services, mental health treatment, financial resources, and additional case management needs.

- PATH Director participated in weekly development meetings with The City of Newark at the newest shelter, Miller Street Pathways to Housing Center. PATH Outreach staff engaged individuals onsite and provided weekly case management to link individuals to medical services, mental health treatment, financial resources, and additional case management needs.
- PATH Director organized four events with New Jersey Motor Vehicle Commission for their mobile van to come out to the Mental Health Association and provided 65 individuals with NJMVC services, such as driver's licenses and non-driver state IDs, to community locations.
- PATH Director continued the collaboration with Newark YMCA to obtain three emergency housing rooms to be utilized by PATH consumers as an alternative to shelter placement.
- Homeward Bound continued operations at The Newark International Airport. Homeward Bound is a 24 hour, 7 day a week program contracted by The Port Authority of New York & New Jersey to provide homeless outreach to individuals residing at The Newark International Airport. One hundred and twenty-two individuals were outreached throughout the year.
- The Shelter Diversion Program, through the NJ Department of Community Affairs (DCA), was extended an additional year. Additional funding was obtained to provide housing problem-solving techniques to quickly establish stable housing options and to reduce the length of time and trauma associated with housing instability or homelessness. Shelter Diversion successfully diverted over 140 households from shelters and homelessness.

Morris

- PATH was able to house at least 22 clients in Morris, Essex, Sussex, and Warren Counties.
- PATH established relations with the Department of Consumer Affairs, Morris County Housing Authority, Dover County Housing Authority, Homeless Solutions, and Morris County COC to reduce the homeless need and to house individuals in the PATH Program.
- PATH participated in the GRIT YMCA Mountain Lakes ski program were one targeted family with children was able to learn how to ski.
- PATH completed the Annual Point-in-time on January 26th. PATH partnered with Hope Hub and volunteers in Morris County for outreach in various homeless hot spots in Morris County in hopes of capturing a true number of homeless as well as provide hygiene and warm items for the day.
- PATH ended collaboration with the Safe Haven program February 25, 2023 due to funding loss with Homeless Solutions.
- PATH participated in the Annual Community Day in Morris County and was able to collaborate with a number of vendors and community supports in the Morristown service area.

Advocacy

Essex

- PATH Director is first Vice Chair for the Essex County Continuum of Care (CoC)/Comprehensive Emergency Assistance System (CEAS).
- Voting member for the Essex County CoC/CEAS.
- Member of the Outreach Committee for the Essex County CoC/CEAS. Through this committee, PATH Outreach staff participated in organized outreaches with 10+ agencies to provide regular outreach and develop a list of the county's chronically homeless to assure they are prioritized for housing.
- Member of the CoC/CEAS's Coordinate Entry Committee - this is a subcommittee of the CoC/CEAS and is used to develop a HUD mandated Coordinated Entry (No Wrong Door) into the homeless service system.
- Member of the CoC/CEAS's Housing and Homeless Prevention Committee - this is a subcommittee of the CoC/CEAS and is used to develop strategies to house and maintain housing for individuals.
- DMHAS Systems Review Committee (SRC) - PATH actively participates in monthly meetings. The purpose of the committee is to identify countywide gaps in service delivery. Within this committee, PATH Director was selected to chair the High Recidivism Committee to advocate and plan for improved treatment for the high utilizers of the acute mental health system.
- Quarterly DMHAS's PATH Coordinators' Meeting.
- PATH Director participates in Newark's Street Outreach Collaborative to create policies and procedures for Street Outreach and Engagement in The City of Newark which include topics of data collection, case conferencing, and service coordination.
- PATH Director participates in Fourth Ward Councilor, David Cummings' collaborative meeting to end homelessness in Montclair.

Morris

- PATH Director participates in multiple committees within Morris County Continuum of Care (CoC).
- PATH collaborates monthly with other providers as part of Community Assistance Services (CAS).
- PATH Director was the Co-chair for Everyday Connect.
- *The goal of the program is to enroll individuals in services, link them to entitlements, treatment, and permanent housing. Self-sufficiency is promoted through job training and employment assistance, education and courses (free and non-credit courses including: Language Barriers Addressed, Social Security Benefits, Updated Resource Guide). At their graduation from PATH, individuals would have increased their earned income by 20% and moved into housing.*

Edna's Haven Resource Center (Morris)

The mission of Edna's Haven is to offer temporary relief from the pressures of homelessness and poverty and to provide companionship and constant inspiration. We will use positive encouragement, our time, talents and existing community resources to provide a safe and welcoming daytime refuge for all, foster self-sufficiency, renew hope, give comfort and enrich lives.

Edna's Haven Resource Center was founded in January 2012 and is open from 1:00pm to 5:00pm, Monday through Friday, at the Trinity Lutheran Church in Dover, NJ. Homeless individuals come to the resource center for relief from the pressures of homelessness. The center offers refreshments, public restrooms, computer and Wi-Fi access, movies and a variety of enrichment activities. From the moment they walk in the door, regardless of how much information they are willing to share, they can begin receiving assistance immediately with no formal intake process. The center is equipped with resource materials from various community service providers for linkage and referral based on the individuals need. Services provided include but are not limited to, skills groups, presentations by third party service providers, health screenings, job searching/resume writing, transportation resources including bus passes, assistance with locating temporary shelter, food and clothing. Edna's Haven also serves as a mailing address for homeless individuals to ensure they receive important mail pertaining to benefits, health care and other entitlements.

When a person enters the center, Edna's Haven Coordinator is there to greet them, offer refreshments and sign them in. A small profile of the individual is created in an electronic health record, which may consist of any amount of information they are willing to share. Once further trust is developed and they begin to share more information, the Coordinator can determine if the individual is eligible for PATH or other case management services. Edna's Haven staff use a progressive engagement model to link each individual to any service they might need based on their situation.

Edna's Haven Resource Center has been an access point for the Morris County Coordinated Entry System since its launch in 2019. This project was developed in response to the U.S. Department of Housing and Urban Development (HUD) Continuum of Care priority to create a systemic response to homelessness that strategically allocates resources and uses a Housing First approach to gaining access to shelter and housing. A Resource Navigator is stationed at Edna's Haven specifically to assist individuals in need of shelter and housing to bring them through the process of Coordinated Entry. The Resource Navigator serves as a point of contact to individuals on the county shelter and housing wait list and directs each individual to any other needed resources.

Caseload

Edna's Haven uses a drop-in center model and does not hold a formal caseload. A log of visitors is kept to determine how many individuals are served each year. Contact information is collected so follow-up is possible, when necessary.

Demographic

Due to the structure of the resource center and informal intake process, specific demographic information is not required. Although all are welcome, the population served generally come from Dover, Rockaway, and Roxbury Townships because the center is easily accessible to them on foot or through public transportation.

Personnel

The PATH Morris Director - Master's Level, one part-time Coordinator – Bachelor's Level, one Resource Navigator – Bachelor's Level, dedicated to Coordinated Entry and two volunteers oversee Edna's Haven services. The MHA staff are culturally diverse and represent the consumers served. One Spanish speaking case manager is available on an as-needed basis to assist the resource center staff with communicating with the Spanish speaking population. In the event the case manager is unavailable, the resource center staff utilize a Language Line, which is capable of translating 200 languages.

Performance Outcomes

Edna's Haven participates in the agency-wide Quality Assurance Committee (QA), which conducts monthly meetings and collects data on the utilization and quality of services provided by each MHA program. During this fiscal year, Edna's Haven provided 466 linkages to services and resources to individuals who visited.

Consumer Satisfaction Survey

MHA is continuously refining services based on consumer input. This is received through various methods, including the Annual Consumer Satisfaction Survey. In response to the COVID-19 pandemic, MHA has steadily followed all CDC recommendations resulting in modifications to some of our services. The 2023 Consumer Satisfaction Surveys were distributed and all highlights were noted of outcomes.

Edna's Haven Highlights

- Edna's Haven implemented a new flyer and went live on the MHA website for Edna's Haven weekly schedule of events.
- Director attended a Luncheon in Dover, NJ with the Dover Rotary Club, Hispanic Affairs, Family Success Center, and the Mayor of Dover to discuss Edna's Haven and ways to collaborate to service the homeless individuals in Dover.
- Edna's Haven hosted quarterly HIV and Hep clinics with the Atlantic Health Care Group.
- Edna's Haven hosted Veteran groups weekly on Mondays.
- Edna's Haven hosted CARES substance and support group on Fridays.
- Edna's Haven hosted pizza Tuesdays.