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 3 teams serving the counties of Essex, Morris and Passaic while based out of a satellite office in their corresponding county. Program staffing consists of 2 Program Directors, 3 Program Coordinators, 6 Senior Case Managers, 2 Case Manager-Co-Occurring, 20 Case Managers, and 4 administrative staff. This impressive group shares over 200 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 1.4 years. As of June 30, 2024, the ICMS ending caseload was 679 consumers.

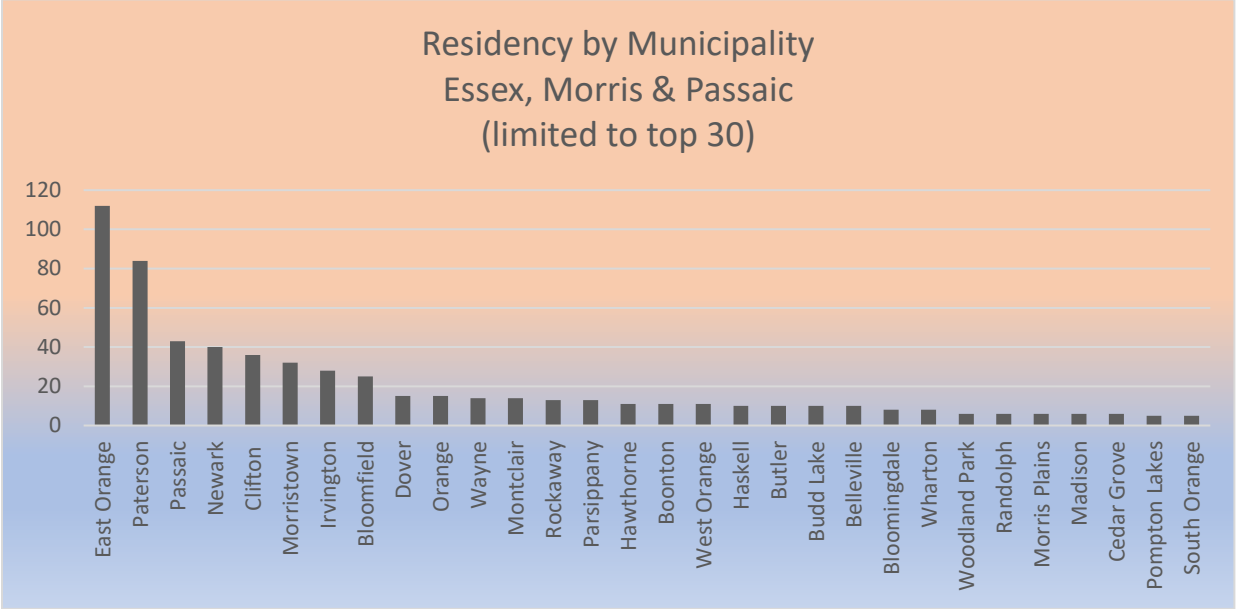
- Admissions/Referrals are received from a variety of sources including state and county hospitals, Short Term Care Facilities (STCF), voluntary psychiatric inpatient units, community treatment providers, families and consumers themselves. ICMS served 316 enrolled individuals in the community hospitals.

- 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 348 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 80,959 units, which is 20,240 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 85, the average age being 42. Gender identity was 66% female, 31% male and 3% transgender male. Self-reported races of consumers enrolled are as follows: White/Caucasian (48%), Black or African-American (33%); Black or African-American & White (7%); Asian (2%); American-Indian or Alaskan Native (1%); other (5%); 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 (88%); Spanish (10%); 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%	4%	4%
State/County Hospitalizations	2%	1%	<1%
Short Term Care Facility Hospitalizations (STCF)	2%	1%	<1%
Voluntary Hospitalizations	3%	2%	4%

- 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 FY2024, Passaic ICMS identified an average of 18% of the active caseload as employed, Essex ICMS identified 12%, and Morris ICMS identified 7%.

- 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%	99.6%	100%

Consumer Satisfaction Survey: In May 2024, 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). with an overall satisfaction score of 98.3%.

ICMS Highlights: MHA was able to purchase and provide over 75 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 2024, 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 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.

- ***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, 2024, there were 39 active cases. During FY 2024, 55 referrals were enrolled into the AOT program; 87% of the referrals were made through Short Term Care Facilities (STCF) and/or private hospitals via conversion or amended hearings; 13% were made through conversion hearings at long-term care facilities, i.e., Essex County Hospital Center (ECHC) and/or state hospitals. There were no referrals enrolled through the designated screening centers.

Sussex

As of June 30, 2024 there were 14 active cases. During FY2024, 20 referrals were enrolled into the AOT program; 45% of the enrollee referrals were made through STCF via conversion hearings; 45% were made through conversion hearings at other hospitals; 5% were state hospital referrals and 5% of the referrals were made through the designated screening facility.

Morris

As of June 30, 2024, there were 17 active cases. During FY2024, 25 referrals were enrolled into the AOT program; 8% of the enrolled referrals were made through STCF via conversion hearings; 52% were made through conversion hearings at other hospitals, and 32% were state hospital referrals; 8% of the enrolled referrals were made through cross-county transfer. There were no referrals made through the designated screening centers.

Demographics: MHA 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 self-reported gender for individuals served in AOT Essex was 45% female, 51% male, and 4% transgender; the self-reported gender for individuals served in Sussex was 50% male and 50% female; and the self-reported gender for individuals served in Morris was 35% female and 65% male.

- ***Ethnicity:*** During Fiscal Year 2024, AOT Essex provided services to individuals who self-reported the following races and ethnicities: 52% African-Americans, 9% Hispanics, 22% Caucasians, 13%-unknown and 4% individuals who identified as multiracial. AOT Sussex provided services to individuals who self-reported the following races and ethnicities: 77% Caucasian, 6% African-American, 5% unknown, 3% Asian, 3% American Indian or Alaskan Native, 3% Hispanic, 3% other-identifying individuals. AOT Morris provided services to individuals who self-reported the following races and ethnicities: 64% Caucasian, 13% Hispanic, 10% African-American, 5% multiracial, 3% Asian individuals, with the remaining 5% identifying with other or unknown ethnicity.

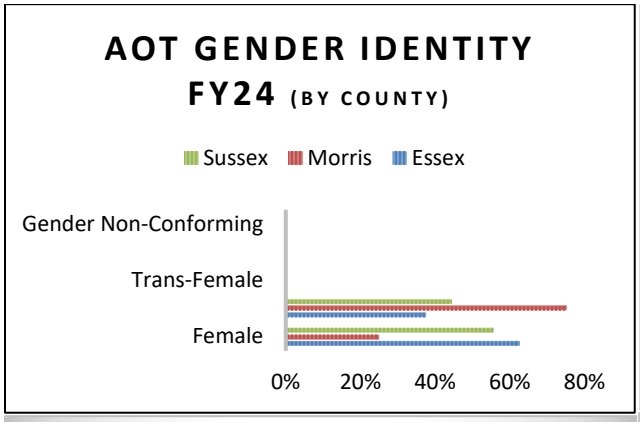
- ***Age:*** AOT Essex provided services to 33% of individuals between the ages of 18-29, 23% between the ages of 30-39, 17% between the ages of 40-49, 12% between the ages of 50-59, and 15% above the age of 60. AOT Sussex provided services to 19% of individuals ages 20-29, 32% between the ages of 30-39, 16% between the ages of 40-49, 23% between the ages of 50-59, and 10% aged 60 or older. AOT Morris provided services to 28% of individuals ages 20-29, 26% between the ages of 30-39, 10% between the ages of 40-49, 18% between the ages of 50-59, and 18% aged 60 or older.

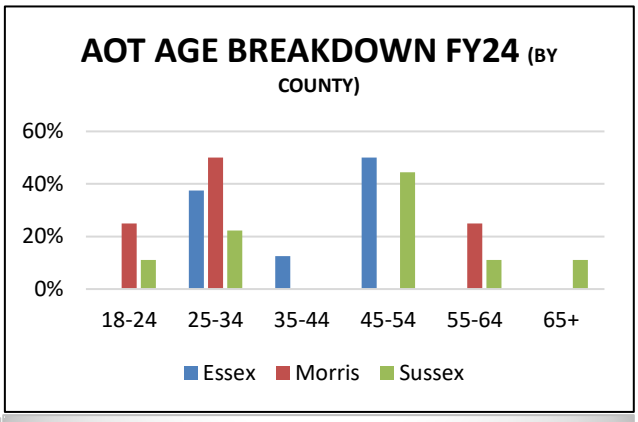
Performance Outcomes: All AOT consumers are identified as high risk for decompensation and have a history of frequent inpatient hospitalizations, emergency room visits, arrests and incarcerations. AOT closely monitored these indicators and established baselines to help measure the access, efficiency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

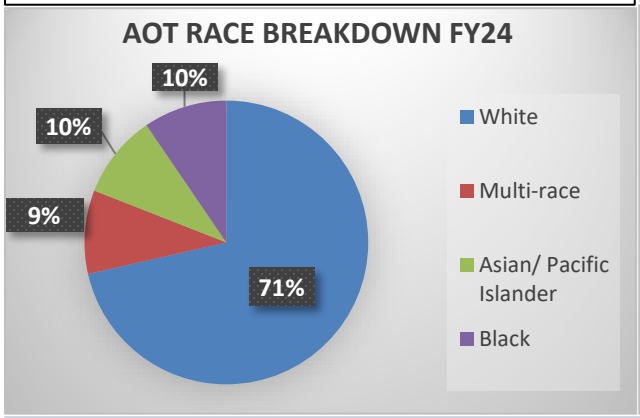
AOT ensures easy access and availability for referral via screening, Short Term Care Facility (STCF) and/or Long-Term Care (LTC) in order to assess consumers for appropriateness to AOT services. AOT staff is available 24 hours a day 7 days a week via on-call if a referral needs to be seen on off hours. This year, AOT collectively received 1 referral from local screening centers, 59 STCF referrals and 16 LTC referrals.
The use of the AWARDS clinical database allows for efficient and orderly clinical record keeping. With multiple report modules, we are able to better track staff interventions and crises.
in FY24, AOT was 100% in compliance with chart auditing.
Lastly, AOT measures the recidivism rates to ensure quality of services and outcomes via court ordered treatment on a monthly basis and prove effectiveness; these statistics are then calculated yearly. Recidivism is defined as any instance of hospitalization visits including ER (screening) visits, psychiatric admissions including involuntary, voluntary, long-term care, and arrests, incarceration, and homelessness. The individual county benchmarks are as follows:
Essex: < 6 ER Admissions; < 3 Voluntary Admissions; < 2 Involuntary Admissions; < 3 LTC Admissions; < 3 Arrested; < 3 Incarcerated; < 3 Homeless ♦ **Morris**: ≤ 4 ER Admissions;≤ 2 Voluntary Admissions; ≤ 2 Involuntary Admissions; ≤ 2 LTC Admissions; ≤ 2 Arrested; ≤ 2 Incarcerated; ≤ 2 Homeless ♦ **Sussex**: ≤ 3 ER Admissions;≤ 1Voluntary Admissions; ≤ 1Involuntary Admissions; ≤ 2 LTC Admissions; ≤ 1 Arrested; ≤ 1 Incarcerated; ≤ 1 Homeless. AOT met all benchmark expectations in all counties.

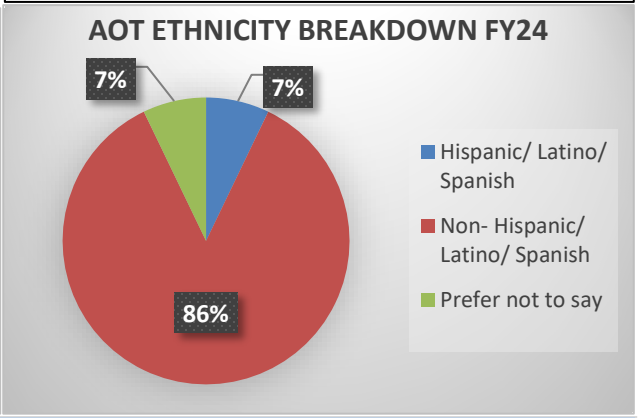
Consumer Satisfaction Survey: MHA is continuously refining services based on consumer input. This is received through various methods, including the annual Consumer Satisfaction Survey. Consumers completed the survey via web link, QR code, or hard copy. The results were analyzed by the Director of Quality Assurance and provided to the program director for review.

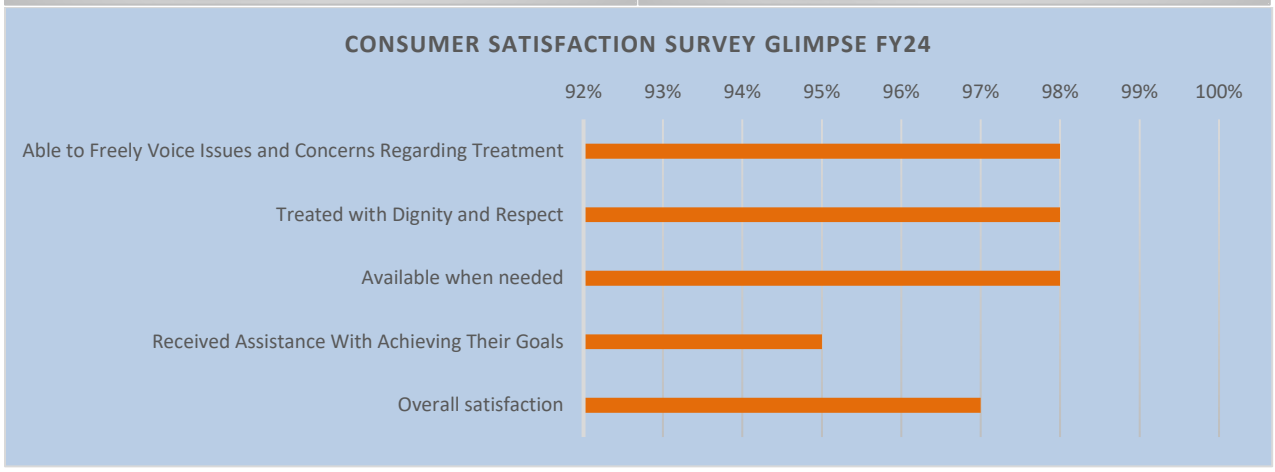
Approximately 63 surveys were delivered to consumers in Essex, Sussex and Morris counties. This accounts for a response rate of 23%, 69% and 40% respectively. Refer to graphs for overview of results:











AOT Highlights:

Essex

- During the past fiscal year, 21 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 successfully worked with the courts and public defenders to reinstate in person court hearings quickly, post pandemic.
- 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

- During the past fiscal year, 7 consumers from Morris County, and 7 consumers from Sussex County were able to successfully accomplish their goals and graduate from the program.
- AOT strengthened its professional relationship with Newton Medical Center's Short Term Care Facility and Screening Center.
- Sussex County AOT was able to reach its target of serving an active caseload of 20 consumers concurrently.
- AOT met with the Morristown Medical Center Department of Psychiatry and educated psychiatrists and nurse practitioners on the program.
- AOT collaborated with Intensive Family Support Services to provide a training to the Social Work Department at Ramapo Ridge Behavioral Health.
- AOT consumers, along with all other MHA adult programs, attended several holiday parties and 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. 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.

- **System Review Committee** is a monthly meeting convened by Rutgers UBHC. The purpose of these meetings is to identify countywide gaps in services and gaps 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.

Morris

- **Acute Care Systems Review Committee** is a monthly meeting convened by the Director of Inpatient Behavioral Health and Psychiatric Emergency Services at Saint Clare's Health. The purpose of these meetings is to identify countywide gaps in services and gaps 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

- **Systems Review Committee** is a monthly meeting convened by the Director of the Screening Center at Newton Medical Center. The purpose of these meetings is to identify countywide gaps in services and gaps 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.

- **Behavioral Health Providers Meeting, formerly Professional Advisory Committee (PAC),** is a bimonthly meeting convened by the County Mental Health Administrator. The purpose of these meetings is to identify and address the current mental health service needs, trends and priorities of the County.

<u>Upcoming Year Recommendations:</u>

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 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 to increase the community's knowledge of the program.

Co-Response Initiative

Co-Response delivers crisis response in collaboration with local police departments, ensuring that individuals in a mental health-related crisis feel safe and receive the support they need in order to stabilize. Co-Response is an interactive approach to emergency response and crisis intervention that involves both law enforcement officers and mental health professionals working together to address situations involving individuals experiencing mental health crises or emotional distress. This model recognizes that traditional law enforcement responses may not always be the most appropriate or effective way to handle such situations, especially when mental health issues are involved.

In a co-response model, specially trained mental health professionals called clinical co-responders are paired with law enforcement officers to jointly respond to calls involving individuals in crisis. The clinical co-responders provide expertise in de-escalation techniques, crisis intervention, and assessment of mental health needs, while law enforcement officers ensure the safety and security of the situation. Overall, co-response represents a proactive and compassionate approach to addressing mental health crises, emphasizing collaboration, empathy, and the prioritization of individual well-being.

Morris

The ARRIVE (Alternative Responses to Reduce Instances of Violence & Escalation) Together program, initially introduced by the New Jersey State Police, recognizes the importance of addressing mental health concerns with compassion, understanding, and specialized expertise.

Beginning in March 2024, a partnership with the Mental Health Association of Essex & Morris County; the police departments (Madison, Morristown, Morris Township, Morris Plains, Roxbury, Montville, Denville, Parsippany) deploy the Close in Time/Follow-up response program. With this delivery system, a Crisis Intervention Team (CIT) trained law enforcement officer (when available) and a mental health specialist respond to emergency service calls and/or follow-up visits that relate to a behavioral health crisis in separate vehicles. This response may be simultaneous or there may be a short delay in the mental health specialist's arrival, but generally within 30 minutes of the law enforcement encounter. The mental health specialist's response may also require staging before arrival at the scene with law enforcement. The mental health specialist provides social and mental health services as appropriate and arranges for follow-up services as deemed appropriate. The program operates Monday through Friday, 7 AM to 11 PM. The mental health specialist is stationed at each of the police departments on a daily rotating basis.

Morris 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 well as follow up support. 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. Since March 2024, Morris co-response provided follow up support and co-response to 342 incidents in all eight (8) police departments. As a result of these efforts, the following outcomes were measured:

- 156 of 342 co-response incidents/follow ups were transported to the hospital.
- 40 involuntary hospital transports

- 116 voluntary hospital transports
- 58 linkages (i.e., mental health services, substance services, community resources) were made in the community as a result of follow-up.

Essex

West Orange: 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. In FY2021, WOPD was awarded the Connect and Protect grant through the Bureau of Justice Assistance (BJA) to allow MHA to provide full-time Co-Response, Monday through Friday from 7 AM to 11 PM. The Co-Responders are stationed at the WOPD Community Services Unit (CSU) substation, where they work very closely with the CSU WOPD officers.

In FY2024, MHA was able to provide 24 trainings to WOPD 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, law enforcement and suicide awareness, co-occurring disorders and substance use and abuse, mental health and racism/cultural awareness, and family perspective on mental health.

Throughout the course of FY2024, MHA and WOPD worked together to review body camera video footage bi-monthly. 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 77 incidents throughout the fiscal year. Assessment of videos determined the following outcomes: six recommendations were made for performance improvement purposes, while 77 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 FY2024, MHA co-responded to 148 incidents in West Orange. As a result of these efforts, the following outcomes were measured:

- 24 trainings were provided to WOPD
- 82 of 148 Co-Responses required transport to the hospital.
- 25 involuntary hospital transports
- 57 voluntary hospital transports
- 63 Co-Responses were resolved at scene
- 59 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.

South Orange: In June of FY2024, MHA started a Co-Response Program with South Orange Police Department. The program consists of 1 FT Clinical Co-Responder to provide co-response from Monday to Friday, 10 AM to 6 PM. Although the program has only recently started, in the month of June, MHA co-responded to four incidents in South Orange. Of these, two individuals were transported voluntarily to the hospital, two incidents were resolved at the scene, and two individuals accepted linkages.

Middlesex

MHA implemented Co-Response in partnership with Perth Amboy Police Department (PAPD) through the Connect and Protect grant through the 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 consists of two staff coverage Monday through Friday 7 AM to 11 PM. During FY2024, MHA co-responded to 184 incidents in Perth Amboy. As a result of these efforts, the following outcomes were measured:

- 9 trainings were provided to PAPD
- 83 of 184 Co-Responses required transport to the hospital.
- 8 involuntary hospital transports
- 75 voluntary hospital transports
- 94 were resolved at scene
- 51 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. The program aims 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 their 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.

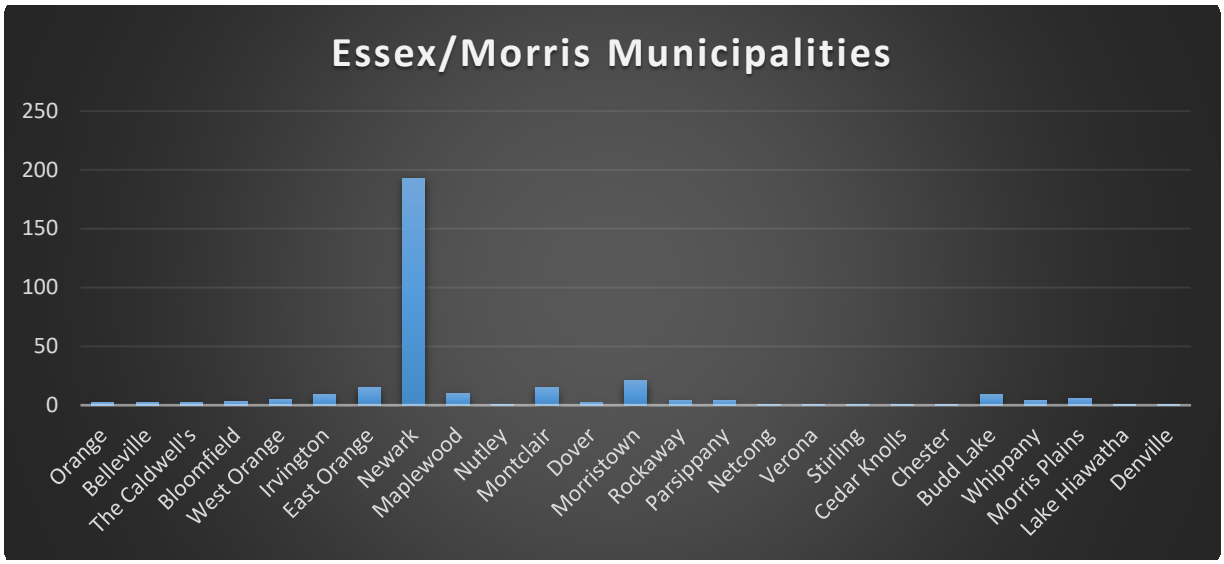
Caseload: Since July 1, 2023, PATH outreached 771 homeless individuals and those at imminent risk of homelessness across both counties. Of those outreaches, 358 consumers received case management services through the PATH Program. PATH conducts weekly outreaches in the community covering all townships 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 New Jersey Community Research Initiative (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 individuals) as well as other social service providers. Referrals are also obtained through the Coordinated Entry waitlist.

Demographics: As of June 30, 2024, Essex and Morris PATH serviced 358 individuals. Of the individuals serviced, there were 194 males (54%), 162 females (45%), and 2 transgender (1%). The self-reported ethnicities of the consumers were as follows: 31 Hispanic/Latino (9%) and 327 Non- Hispanic/Latino (91%). The self- reported races of the enrolled consumers with PATH are as follows: 5 Multiple Race (2%), 94 Caucasian (26%), 242 African-American (68%), 3 Asian (1%), 1 Native Hawaiian or Other Pacific Islander (1%), 4 American-Indian or Alaska Native (1%), and 1 Middle Eastern (1%).

PATH makes every effort to provide services to homeless consumers throughout Essex and Morris Counties, with the understanding that homelessness does not only affect 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:

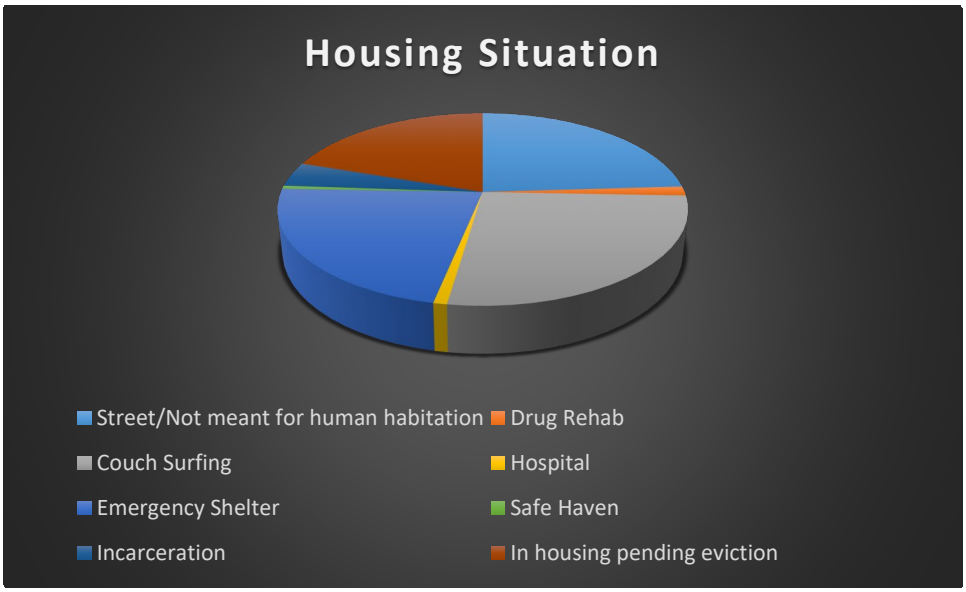
Belleville	2	Morristown	21
Bloomfield	3	Netcong	1
Rockaway	4	Newark	193
Budd Lake	9	Nutley	1
Stirling	1	Orange	2
Califon	1	Parsippany	4
Denville	1	Pine Brook	1
Dover	2	Cedar Knolls	1
East Orange	15	Chester	1
Irvington	9	The Caldwell's	2
Lake Hiawatha	1	Verona	1
Maplewood	10	West Orange	5
Montclair	15	Whippany	4
Morris Plains	6		



Consumers outreached by the PATH Program reported sleeping in the following locations the night before engagement. Street or place not meant for human habitation (186) (24%), Emergency Shelter including motel paid with emergency assistance (173) (22%), Safe Haven (4) (.5%), Drug

Rehab (12) (1.5%), couch surfing (207) (27%), inpatient hospital (7) (1%), incarceration (32) (4%) and housing pending eviction (153) (20%). Others serviced did not wish to provide this information.

Of enrolled consumers, 161 (45%) 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: Essex PATH services are provided by 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. Staff are culturally diverse and represent the consumers served. PATH has one staff member fluent in Spanish.

Morris PATH services are provided by one Master's Level Director, one Master's Level PATH Intake Coordinator, one full-time PATH Outreach Case Manager, one full-time Outreach Case Manager (County), one part-time Outreach Case Worker and one part-time Housing 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 771 (individuals or 133% of the contract commitment and serviced 358 individuals or 126% of the contract met. During the past fiscal year, PATH successfully linked to the following services: 197 to Community Mental Health, 30 to substance abuse treatment, 133 to financial benefits, 96 to temporary housing, 88 to permanent housing, 56 to medical/dental, and 45 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 medication education and support, at least quarterly or at medication change.

Consumer Satisfaction Survey: Approximately 59 satisfaction surveys were completed by consumers enrolled in the PATH Program. Many more surveys were offered but were declined. Consumers surveyed reported an overall 99% satisfaction with services provided by the PATH Program.

Survey Demographics: Of the 59, 45% were female, 53% were male, and 2% Gender Non-Conforming. The average age of respondents was 48 years old; 47% were African-American, 41% were Caucasian, 3% were other mixed race, 5% were Hispanic, and 4% did not wish to provide this information.

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 significant accomplishment is sixty-five (65) 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 meetings with The City of Newark of the Newark Hope Village II, 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 organized five events with New Jersey Motor Vehicle Commission for their mobile van to come out to the Mental Health Association and provided 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 seventy individuals were outreached throughout the year.
- The Homelessness Diversion Program, through the NJ Department of Community Affairs (DCA), was awarded for 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. Homelessness Diversion successfully diverted over 210 households from shelters and homelessness.

Morris

- PATH Director organized and led the Morris County Project Homeless Connect for the first time after a 4 year break due to the Covid outbreak. The organization consisted of PATH Director recruiting 40 other agencies with numerous departments, services and resources. PATH Director met with the organizations biweekly and together gathered 33 volunteers to help run the event. During Project Homeless Connect 102 attendees signed in and received a wraparound service under one roof from over 35 agencies. During the event 25 Narcan Trainings and Kits were distributed, 50 people were HIV tested and 30 Blood Pressure Screenings and 6 Foot Screenings were provided. Additionally, 60 Blessing Bags were distributed by the Morris County Sheriff's Hope One Initiative and countless donations were received and distributed to consumers in need.
- PATH Director became a HUD mandated Point-In-Time Count Coordinator for Morris County and led the Point-In-Time organization and implementation of the Point-In-Time Count for the entire County of Morris. PATH Outreach staff conducted the count and provided hygiene/food/warm packets for the homeless. The Point in Time Coordinator Committee has now grown into a year around committee that is dedicated to ensuring a correct count by educating and engaging the community with the goal of ending homelessness.

- PATH Director became a Code Blue Provider Participant with the Office of Temporary Assistance and The Office of Emergency Management in Morris County.
- PATH Director became a part of the initiative "S.E.R Solutions" (Serving Everyone Regardless) a collaborative program with local nonprofit organizations established by the Mayor James P. Dodd and Councilman Sergio Rodriguez of the Town Of Dover . This initiative aims to enhance the quality of life in our community by providing crucial assistance, resources, and follow-up to those in need especially the homeless population in Dover.
- PATH Director re-established a working relationship with Homeless Solutions which includes monthly case conferencing meetings to ensure case collaboration for temporary homeless consumers with the goal to expedite permanent housing.
- PATH Director continued to strengthen relations with the Department of Consumer Affairs, Morris County Housing Authority, and Morris County COC to reduce the homeless need and to house individuals in the PATH Program.

- PATH Director established active attendance with the COC Morris County Permanent Supportive Housing Case Conferencing, Shelter Workgroup and Diversion and Prevention case conferencing meetings monthly with a goal to obtain Permanent Housing Vouchers for PATH Consumers.
- PATH Morris continued to implement the part time Coordinated Entry Housing Navigator position funded by NJ 211.
- PATH Morris continued to implement the Homeless Outreach Case Management and Step off the Street outreach positions funded by the Morris County Human Service Department. Through these positions PATH Morris was able to outreach additional 126 people and providing over 910 additional units of service during the fiscal year.

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 advocated to become a Coordinated Entry "hub" for the county to ensure individuals experiencing homelessness could have immediate, easy access to the permanent supportive housing waitlist.
- PATH Director participates in Fourth Ward Councilor, David Cummings' collaborative meeting to end homelessness in Montclair.

Morris

- PATH collaborates monthly with other providers as part of Community Assistance Services (CAS) and attends CAS quarterly.
- PATH Director actively participates in multiple committees within Morris County Continuum of Care (CoC). Some of these include Morris County Permanent Supportive Housing Case Conferencing, Shelter Workgroup and Diversion and Prevention case

conferencing meetings monthly to advocate and achieve better housing outcomes for PATH Consumers.

- PATH Director attended the Statewide Public Housing Authorities-COC Partnership Conference to End Homelessness which highlighted ways to advocate for collaboration and voucher flexibility advocacy.

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 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, provide comfort, and enrich lives.

Edna's Haven Resource Center was founded in January 2012 and is open from 1:00 PM to 5:00 PM, 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 individual's needs. 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 staff 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 staff 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 guide 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 to allow follow-up 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 staff at Edna's Haven includes the PATH Morris Director (Master's Level), one part-time staff (Bachelor's Level), one Resource Navigator (Bachelor's Level) dedicated to Coordinated Entry and volunteers who help provide 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 served 141 individuals, providing them with numerous resources, linkages and services.

Consumer Satisfaction Survey: MHA is continuously refining services based on consumer input, which is received through various methods, including the Annual Consumer Satisfaction Survey. This fiscal year, Edna's Haven has returned to full in-person functioning after last year's modifications to some of our services due to the COVID-19 pandemic. 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 became a part of the initiative "S.E.R. Solutions" (Serving Everyone Regardless) a collaborative program with local nonprofit organizations established by the Mayor James P. Dodd and Councilman Sergio Rodriguez of the Town Of Dover. This initiative aims to enhance the quality of life in our community by providing crucial assistance, resources, and follow-up to those in need, especially the homeless population in Dover. This initiative utilizes Edna's Haven as a resource towards its goal.
- Edna's Haven hosted quarterly HIV and Hep C testing with the Atlantic Health Care Group.
- Edna's Haven re-established relationships with local organizations such as Zufall and Hope House who are attending Edna's Haven quarterly to bring in resources and education for individuals on site.
- Edna's Haven hosted CARES substance and support group on Fridays.
- Edna's Haven hosted pizza Tuesdays.