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

PLANNING CYCLE 2024-2027

(FINAL)

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SECTION ONE: FOUNDATIONS, PURPOSE AND PRINCIPLES

From the Division of Mental Health and Addiction Services:

A. STATUTORY AND POLICY FOUNDATIONS

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

B. ADMINISTRATIVE FOUNDATIONS

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

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

C. PURPOSE AND PRINCIPLES

Purpose: The purpose of the CCP is to rationally relate existing county resources to the behavioral health needs of persons using legal drugs like alcohol and prescription medicines or illegal drugs like marijuana, heroin, cocaine and various hallucinogens. The DMHAS, in collaboration with the state's 21 Local Advisory Committees on Alcoholism and Drug Abuse as represented by the 21 county alcoholism and drug abuse directors, CADADs, recognizes that this purpose is best achieved by involving county residents and treatment providers, called "community stakeholders", in both identifying the strategic priorities of the plan and monitoring its successful implementation. Thus, the CCP is the product of a

community-based process that recommends to county authorities the best ways to ensure that county resources serve to: 1) protect county residents from the bio-psycho-social disease of substance abuse, 2) ensure access for county residents to client-centered detoxification and rehabilitative treatment, and 3) support the recovery of persons after treatment discharge.

Principles: County Comprehensive Planning is grounded in:

1) *Epidemiological community surveillance*. As a local public health authority, the county will both *observe* the changing prevalence of substance abuse and *monitor* the changing capacity of the local health care system to respond to it.
2) "*Gap analysis*." As the product of *surveillance*, the CCP will evaluate "gaps" both in coverage of total treatment demand and in the county's continuum of care. Because treatment need and demand always exceed treatment capacity, the CCP seeks to reduce disease incidence (prevention, early intervention, and recovery support services) and expand access to treatment services over the short, medium, and long terms.
3) *Resource allocation*. As the product of "gap analysis", the CCP will recommend "best uses" of AEREF and other state and county resources to meet *feasible* goals and objectives for the maintenance and continuous improvement of the county's substance abuse continuum of care.[1]

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

SECTION TWO: LOOKING BACK, ASSESSING THE NEEDS AND LOOKING FORWARD

LOOKING BACK AT THE OUTCOMES OF THE 2020-2023 CCP

INSTRUCTIONS: In one or two paragraphs of 5 to 7 sentences each, summarize your county's 2020-2023 plan for each domain of the continuum of care. What was the county trying to achieve, how many residents benefitted from the county's actions, and what were the measurable benefits for the community? For prevention and early intervention, be sure to describe your county's participation in its regional coalition.

A. PREVENTION

For the 2020-2023 prevention plan, Monmouth County offered evidence-based prevention programming throughout the county, focusing on youth and high-risk populations. The goal was to continue reducing early onset of drug and alcohol use and of antisocial behavior among Monmouth County youth. Monmouth County expanded where programming was offered to include the municipalities and school districts that were identified as high need and were not otherwise over served through other grants or prevention initiatives.

In 2020 and 2021, the goal was to increase the number of unduplicated individuals that receive prevention programming by providing Strengthening Families training to families identified as high risk throughout the county and by expanding Life Skills Training to additional high risk school districts in Monmouth County, including Asbury Park, Howell, Keansburg, Long Branch, Middletown, and Neptune. In 2022 and 2023, the goal was to provide a third and fourth year of prevention services by continuing to provide Strengthening Families and Life Skills Training. It was estimated that the number of unduplicated individuals receiving prevention education programming would increase by a minimum of 5% in 2020 and 2021 and that increase would be maintained throughout 2022 and 2023. The final reported number of people served reflected this projection. In 2020, there were 843 served. In 2021, there were 1,389. In 2022, it was estimated that a minimum of 1,144 would be served, but at the close of Q2, there were 1,156 already reported. Thus, despite the barriers faced through the COVID-19 pandemic with school closures and suspension of in-person activities, programming was still provided. Prevention staff delivered programs through a virtual platform and/or prerecorded lessons at a District's request. In person Strengthening Families occurred in the Fall and programming was held over summer through summer camps.

The foremost community benefit was an increase in youth knowledge of substance use/abuse, leading to a reduction in the number of youths who experience early onset of substance use. Preventing early onset use saves costs related to treatment, education expenses, and law enforcement. The National Institute on Drug Abuse estimates that every dollar spent on prevention can save up to $5 in treatment costs.[2]

In addition to expanding evidence-based prevention programming, Monmouth County has and will continue to increase substance use awareness and education activities through collaboration with the Municipal Alliance, Prevention Coalition, and other Community agencies. Indeed, our collaborative approach with the Municipal Alliance and Prevention Coalition of Monmouth County allowed for sharing of data, knowledge, and resources to establish and achieve our goal of reducing early onset of drug and alcohol use and of antisocial behavior among Monmouth County youth. Through activities of the Alliances, Prevention Coalition, and Prevention Services administered through this grant, we were able to maximize the impact of

[2] National Institute on Drug Abuse; National Institutes of Health; U.S. Department of Health and Human Services, *Monitoring the Future Survey*, (2021).

funding available by offering prevention services and education to a wider audience in various locations throughout Monmouth County. Through the GCADA grant, we were able to utilize county-wide training funds to provide the life skills training program to an additional high-risk student population that was not otherwise served. Many educational/awareness programs were provided throughout Monmouth County through our collaborative efforts as well.

B. EARLY INTERVENTION

Monmouth County's Early Intervention goal for the 2020-2023 planning cycle was to create an enhanced capacity, both in terms of level of service provided and broader access for screening, brief intervention, and referral (if necessary) of substance abusing at-risk youth residing in Monmouth County. Project Insight was selected to be continued at existing sites established in the 2016-2019 plan. Initially, Project Insight was developed as an enhanced early intervention/ assessment and referral program for adolescents with substance use related problems that were involved with the County Juvenile Justice System, but it quickly expanded to serve any at risk adolescent living in Monmouth County. The goal for 2020-2023 was to expand to serve additional areas of the County through school-based sites or office locations and increase youth participation by 10% (20 youths). Each youth served received five sessions, one psychosocial assessment with family involvement, three life skills psychoeducational life skills group sessions, two alcohol/drug screens, and an exit interview, including family involvement with findings/recommendations.

During the 2020-2023 planning cycle, focus groups identified the need to provide early intervention as a top priority for youth since families are not fully aware or educated and sometimes do not identify a substance use issue until the youth is in need of a higher level of care. As communities become educated on how to identify substance use early on and refer youth to early intervention programs, there is a decrease in treatment admissions long term. Having Project Insight available throughout the county increases the likelihood of intervention earlier on. It was estimated that 220 unduplicated youth would be served through Project Insight each year.

The trends in increased marijuana use and continued underage drinking, combined with the decrease in perception of harm, led Monmouth County to provide additional outreach to the community to educate them on the current trends. Through collaborations with Municipal Alliances and other community partners, information continues to be offered through community events, health and resource fairs, and community workshops geared towards educating parents. The community benefits include increased youth knowledge of substance use/abuse, reduction in the number of youths who continue to be involved with substance use/abuse, long term reduction in treatment admissions among youth, and reduction in drug & alcohol related juvenile offenses.

The participation of the County, the subcontracted agency providing Early Intervention program Project Insight, SACs, and school counselors/social workers at school-based sites aided in the execution of the strategy despite the barriers that COVID-19 presented. Still, participation in Early Intervention Programming continues to be low.

In 2020, the contracted provider expanded Project Insight to be offered at a satellite location in western Monmouth County, but the COVID-19 pandemic caused sudden closures to schools, which impacted the efficacy of providing this programming. However, the program was still able to take place in a more limited capacity due to COVID restrictions around in person services and school buildings being open. At year end, there were a total of 158 youth served. Still, as the pandemic continued to create barriers, there were limited referrals to Early Intervention programs, which presented a major obstacle. By year end of 2021, only 68 youth had been served despite aggressive marketing campaign, outreach to schools, and a return to in-person services, which lead to a slight increase in referral to the program as the school year began. As of Q2 of

2022, 25 youth were served. Originally, there was $50,000 allocated to Early Intervention for 2022. During Q2, the contracted agency reallocated $30,000 into Treatment, keeping only $20,000 in this domain. At the end of Q2, about 51% of funds have been spent. The goal for Early Intervention remained the same. However, as COVID-19 remained a hindrance and referrals to program were down, there is less participation in the Early Intervention program.

C. TREATMENT (Including Detoxification)

Monmouth County's Treatment goal for the 2020-2023 planning cycle was to increase treatment access across the continuum of care. Monmouth County planned to utilize the county comprehensive grant funding to increase admissions annually by 5% across all treatment levels. Funds supported the medically indigent population and purchased services to maintain access for these individuals as well as reduce barriers to treatment. As the need for funding residential services decreased due to other initiatives, other services in the continuum were enhanced to support sustained recovery. Capacity remained an issue throughout the County, and barriers posed by COVID-19 altered the way treatment services were delivered, limiting and even halting treatment access while in-person activities and services were suspended.

Individuals who are unable to access treatment are often at risk for illness, injury, hospitalization, job loss, incarceration, and death. These risks further stress the family unit and exhaust social, medical, and law enforcement resources. Every $1 spent on treatment saves $7 in crime/criminal justice costs, and when adding savings related to healthcare, savings increases to $12 per $1 spent on treatment.[3] Thus, Monmouth County sought to increase admissions by funding enhanced services throughout the continuum, reducing the risk of relapse and improving access for those in need.

In the 2020-2023 cycle, it was estimated that approximately $813,000.00 would be allocated to treatment annually. However, this fluctuated based on award amount, other state and federal treatment funding sources, and County fund utilization. The goal was to increase treatment admissions by 5%, resulting in 6,507 admissions for 2020; 6,817 admissions for 2021; 7,127 admissions for 2022; and 7,437 admissions in 2023. Monmouth County invested the following treatment funds combining outpatient, intensive outpatient, detoxification, short term residential and halfway house services:

Year	Treatment Allocation	Individuals Served	Planned Number
2020	$791,000	994	
2021	$751,000	625	438
2022	$773,500	227 *as of 4/28/22	399

[3] US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (SAMHSA), *Cost Offset of Treatment Services*, (2009).

The following chart shows Monmouth County treatment admissions information from NJSAMAS in the 2020-2023 cycle:

Year	**Monmouth County Total Admissions (All levels of care)**
2020	5799
2021	5974
2022 *as of 4/28/22	1976
Year	**Monmouth County Admissions (all funded levels of care)**
2020	4551
2021	4624
2022 *as of 4/28/22	1453

The following chart shows Monmouth County treatment admissions information from NJSAMS in the 2020-2023 cycle per level of care:

Year	**Monmouth County Admissions: Outpatient**	**Individuals served with AEREF funds**
2020	1278	484
2021	1196	299
2022 *as of 4/28/22	398	71 *as of Q2 (159 expected)

Year	**Monmouth County Admissions: Intensive Outpatient**	**Individuals served with AEREF funds**
2020	1330	Adults – 70 Adolescents – 79
2021	1365	Adults – 66 Adolescents - 2
2022 *as of 4/28/22	435	Adults – 15 *as of Q2 (40 expected) Adolescents – money reallocated as of Q2

Year	**Monmouth County Admissions: Short Term Residential**	**Individuals served with AEREF funds**
2020	854	Adults – 155 Adolescents – 2
2021	781	Adults – 82 Adolescents - 12
2022 *as of 4/28/22	227	Adults – 45 *as of Q2 (81 expected) Adolescents – 1 *as of Q2 (3 expected)

Year	Monmouth County Admissions: Halfway House	Individuals served with AEREF funds
2020	114	Men - 36 Women - 25
2021	114	Men - 22 Women - 21
2022 *as of 4/28/22	44	Men – 24 *as of Q2 (16 expected) Women – 11 *as of Q2 (15 expected)

Year	Monmouth County Admissions: Detox	Individuals served with AEREF funds
2020	975	143
2021	1168	121
2022 *as of 4/28/22	349	60 *as of Q2 (85 expected)

Even though COVID led to temporary disruptions in new admissions for all levels of treatment, agencies developed protocols to transition to telehealth. Adolescent treatment referrals remained low due to school and court disruptions. Through 2020, Residential treatment continued with COVID precautions. Adult Short-term Residential remained in demand. Outpatient providers moved toward telehealth models. Adolescent Intensive Outpatient (IOP) began a telehealth option towards the end of the year in preparation for a continued virtual environment in 2021, but it remained an underutilized service as youth did not commit to nor complete the full 9 hours weekly. In 2021, lack of adolescent treatment referrals continued to pose a barrier. As Fall approached, and schools reopened, outreach and marketing efforts were expanded. However, referrals did not increase as expected. Funds were reallocated to adult services where possible. Adult treatment services were highly utilized, particularly Short-term Residential. Funding to adolescent treatment programs was reduced for 2022. Before closing of Q2 in 2022, the remaining money that had been allocated for Adolescent IOP ($78,500) was reallocated to Outpatient services due to continued underutilization. However, the reallocation did not change the goals and objectives of the 2020-2023 planning cycle since treatment continued to be provided across the continuum of care.

D. RECOVERY SUPPORT SERVICES

Monmouth County's goal for the 2020-2023 planning cycle was to continue to establish a *Recovery Capital* model of support services, focusing on the medically indigent residents. This objective aimed to increase their opportunities for sustained recovery and reduce risk of relapse. Residents in recovery, or seeking recovery, benefit from an array of recovery support services to increase their recovery capital and reduce risk of relapse. Monmouth County funded recovery support services for the first time in 2019 and continued funding an array of community-based recovery support services throughout 2020-2023.

SAMHSA has defined recovery support services as "non-clinical services that assist individuals and families to recover from alcohol or drug problems. They include social support, linkage to and coordination among allied service providers, and a full range of human services that facilitate recovery and wellness, contributing to an improved quality of life." Recovery support services identified include:

- Transportation to treatment, meetings, events, activities

- Self-help and support groups
- Employment and education services and job training
- Assistance in locating/obtaining sober housing
- Family education and referral to related community resources
- Peer-to-Peer Services, Mentoring, Coaching
- Life skills
- Parent education and child development
- Social activities for those in recovery to reduce isolation

Socioeconomically disadvantaged individuals, who are the county's primary responsibility, usually require the most fundamental support services to sustain their recovery, i.e. a safe/sober place to live, a job, and a supportive social network. Lack of recovery supports often results in relapse. Relapse results in potential readmission into the health, treatment, or judicial system, having a financial and social impact on the individual, the family, and the community. Relapse affects their ability to maintain employment, as well as their ability to be present and support family. Individuals may require public assistance for health, behavioral and/ or social issues, and law enforcement involvement. By providing an array of recovery support services, residents increase recovery capital and potentially reduce relapse. Thus, funding comprehensive recovery support services, which that allow the flexibility to "wrap around" the client, reduces barriers to recovery for each individual served, building a network of formal and informal supports.

Despite the challenges of COVID, recovery support services were able to quickly transition to virtual platforms where appropriate and continued without interruption in 2020. In 2021 and 2022, services continued to be delivered uninterrupted via virtual and in-person support and services. Monmouth County's goal for the 2020-2023 planning cycle was to increase funding of recovery support services by 10% each year, serving approximately 750 residents each year:

Year	**Projected Funding**
2020	$35,000
2021	$42,350
2022	$46,585
2023	$50,820

Community benefits include reduction in readmissions, which opens beds for individuals seeking treatment for the first time. In addition, there may be a reduction in costs for public assistance for health, behavioral and/ or social issues. The community may also benefit from individuals reentering the workforce.

ASSESSING THE NEEDS

Guideline: Using both quantitative and qualitative data that you have gathered and analyzed, identify those major issues or challenges the county will face during the 2024-2027 planning cycle in each dominium of care.

A. PREVENTION

Statewide, Monmouth County had the 5th most treatment admissions for all substances across all age groups in 2020 (5,799; 7%) and 2021 (5,974; 6.8%). Monmouth County comprised 6.3% of treatment admissions among youth 21 and under in 2020 and 7.8% of treatment admissions among youth 21 and under in 2021.[4] However, it is important to note that treatment admissions for ages 18-24 in Monmouth County have decreased from 2018-2022.[5] Thus, it is important to consider alternate points of intervention to provide services to these age groups.

Nationally, the number of United States students reporting past year illicit drug use in 2021 decreased significantly. The largest one-year drop since 1975:

	2019	**2020**	**2021**
8th grade	14.8%	15.6%	10.2%
10th grade	31%	30.4%	18.7%
12th grade	38%	36.8%	32%

Thus, from 2020-2021, there was a decrease of 5.4% reported in 8th graders, a 11.7% decrease reported from 9th graders, and a 4.8% decrease reported from 12th graders.[6]

However, substance use remains a concern. In 2018, there were 1,088 drug related hospital visits for those under 15, and 3,593 for those 15-24. Likewise, in 2019, there were 1,089 drug related hospital visits for those under 15, and 4,779 for those 15-24.[7] The chart below lists percentages of hospital visits for these age groups broken down by specifically identified illicit substances:

2018	**Benzo**	**Heroin**	**Opioids**	**Stimulants**
Under 15	N/A	N/A	3.6%	1.9%
15-24	7.68%	25.3%	33.9%	4.3%
2019	**Benzo**	**Heroin**	**Opioids**	**Stimulants**
Under 15	2.8%	N/A	4.13%	3%
15-24	7.4%	19.2%	27.3%	4%

According to NJ DHS, 8% of 7th and 8th graders reported polysubstance abuse. Furthermore, they reported that the most common source for alcohol was a family member or friend, and the most common source of marijuana was a friend, other person, or internet.

[4] New Jersey Substance Abuse Monitoring System (NJSAMS) (2018-2022). *Statewide Summary Report*
[5] New Jersey Substance Abuse Monitoring System (NJSAMS) (2018-2022). *Statewide Summary Report*
[6] National Institute on Drug Abuse; National Institutes of Health; U.S. Department of Health and Human Services, *Monitoring the Future Survey*, (2021).
[7] NJ Attorney General's Office for Addiction Response and Enforcement Strategy, *NJCARES*, (2018-2021).

Moreover, 51% reported feeling sad, empty, or depressed. Of those with Mental Health concerns, 24% reported using alcohol (10% of general population), 14% reported using "e-cigs" (7% of general population), and 5% reported using marijuana (3% of general population).[8]

According to Qualitative data collected through survey and focus groups with youth, youth serving agencies, SACs, and families, alcohol, marijuana, and vaping were named the top concern for youth substance abuse trends. Several key findings from the Monitoring the Future National Survey results on Drug Use Overview (2021) provide quantitative evidence to establish this concern as well. From 2017-2019, prevalence of vaping marijuana doubled or tripled in all three grades, specifically in 12th graders, rising from 4.9% in 2017 to 14% in 2019 (3.9% of 8th graders in 2019 and 12.6% of 10th graders). There was also an increase in vaping nicotine. For example, for 12th graders, 11% reported use in 2017, but 25.5% reported use in 2019.

In 2020, annual marijuana prevalence was 11.4% for 8th graders, 28% for 10th graders, and 35.2% for 12th graders. Daily rates were 1.1%, 4.4%, and 6.9% respectively. The report stated, "Alcohol remains the substance most widely used by today's teenagers;" there has also been a "gradual increase in the prevalence of binge drinking over the past two years in all grades." The report goes on to state, "By the end of high school, nearly 2 out of 3 students in 2020 (61.5%) consumed alcohol at some point in their lives, and a quarter (26%) had done so by 8th grade." In 2020, alcohol use for all 3 grades combined increased significantly in lifetime, annual, 30 day, and current use. Drinking alcoholic beverages in 30 days prior was reported by 10% of 8th graders, 20% of 10th graders, and 34% of 12th graders. Binge drinking (5+ drinks in a row, 1+ times in prior two weeks) was identified by 5% of 8th graders, 10% of 10th graders, and 17% of 12th graders.[9]

According to the Department of Children and Family Services (2021), there are 129,478 children under 18 in Monmouth County. Middletown and Howell have the highest number of children. 17% of children reside in a single parent household. 5% of families with children under 18 are living in poverty. Furthermore, 27% of families with children under 18 in Neptune City are living in poverty, 37.8% in Keansburg and 37% in Asbury Park. 3.9% of youth 16-19 are disconnected (not enrolled in school or work), which has increased since 2017. In 2019, there were 275 substance offenses in schools reported. Monmouth County is #4 in HIB cases in NJ with 348 offenses.[10]

According to the April 2022 CIACC report, there were 425 Unique Youth "call activity", 37.9% were for ages 14-17; 26.8% were for ages 5-10, and 23.5% were for ages 11-13. 127 of the calls involved youth with substance abuse indicators (7% of state population). 77.2% of those were for ages 14-17. 52% reported current cannabis use, 13/3% reported current alcohol use, and 12% reported current tobacco use.[11]

There is still a great need in Monmouth County for Prevention education and services. According to Human Services Advisory Council (HSAC, 2021), Monmouth County was 1 of 10 counties that identified SUD and prevention services as a priority need area. Indeed, it was identified that a key issue was lack of prevention education for SUD, specifically in schools. Participants recommended increasing education about services and treatment options, as well as increasing prevention through school-based programming for youth.[12]

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[8] National Institute on Drug Abuse; National Institutes of Health; U.S. Department of Health and Human Services, *Monitoring the Future Survey*, (2021).

[9] National Institute on Drug Abuse; National Institutes of Health; U.S. Department of Health and Human Services, *Monitoring the Future Survey*, (2021).

[10] DCF Family and Community Indictors for Monmouth County (2021).

[11] CIACC Summary – NJ Children SOC (April 2022).

[12] Human Services Advisory Council Needs Assessment Synthesis Report for 21 counties (2019-2020) – Institute of Families at Rutgers school of social work June 2021

Similarly, recommendations from the Rutgers Needs Assessment (2019-2020) included "increasing education/training, which specifically stated to increase in-school, in-community prevention education."[13] More specifically, focus groups drew attention to the need for more father-oriented parenting programs.[14]

The Prevention Coalition of Monmouth County will utilize SAMHSA's Strategic Prevention Framework to address five identified priority areas including underage drinking, marijuana use, the use of electronic nicotine delivery systems, and opioid use across the lifespan, and new and emerging drugs. The priorities identified by the Regional Coalition align with the priorities identified through the Monmouth County comprehensive planning process and data analysis. In addition, the Monmouth County Municipal Alliance plan has identified the same priorities. The Monmouth County Alcohol and Drug Director, County Municipal Alliance Coordinator, and Monmouth County Regional Coalition have cross representation at prevention-based meetings and work collaboratively to assess prevention needs and strategize methods of delivering prevention education and activities to maximize services available throughout Monmouth County.

B. EARLY INTERVENTION

Due to the COVID-19 pandemic, amongst other factors, referral to and utilization of early intervention services are down. This is further affected by the legalization of marijuana and the shift in perception of harm of its use. Focus groups held with individuals in recovery, youth service providers, school professionals, and treatment providers identified less need to provide early intervention. Instead, a recommendation was put forth to increase funding in Prevention and Recovery Supports.

According to NJSAMS data, utilization of Early Intervention services in Monmouth County are severely underutilized. [15] This information was corroborated from treatment providers who stated that there is very little engagement:

	2018	**2019**	**2020**	**2021**
Total Tx Admissions	6947 (7.74% of NJ)	7,254 (7.34% of NJ)	5,799 (7.04% of NJ)	5,974 (6.79% of NJ)
Admissions in E.I (.5 LOC)	31 (.4%)	66 (.9%)	27 (.5%)	23 (.4%)
Under 18	81 (1.2%)	110 (1.5%)	55 (.9%)	34 (.6%)
18-21	283 (4.1%)	253 (3.5%)	174 (3%)	196 (3.3%)

Project Insight is underutilized and was not able to spend funding that was allocated during the 2020-2023 planning cycle. In 2020, $65,000 was allocated to Early Intervention. 34.3% of these funds ($22,315.64) were left unspent. Likewise, in 2021, $50,000 was allocated to Early Intervention. 52% of these funds ($26,119) were left unspent. As of 2022 Q2, $20,000 has been allocated to Early Intervention with less than 50% of that being utilized.

Monmouth County Municipal Alliance Plan utilizes county wide training funds to deliver prevention education opportunities to areas or sectors that may not otherwise be served, providing training activities for prevention stakeholders, and to bring additional prevention resources to targeted groups when a specific need is identified. These County wide training fund activities create community awareness, increasing the likelihood that families will be able to identify substance use concerns earlier on and refer to the appropriate resource when necessary.

[13] Rutgers HSAC (DCF) Needs Assessment (2019-2020)
[14] Monmouth County – Needs Assessment 2020 – MAAC (NJ DCF)
[15] New Jersey Substance Abuse Monitoring System (NJSAMS) (2018-2022). *Statewide Summary Report*.

C. TREATMENT (Including Detoxification)

"Monmouth County is resource rich with a number of community-based non-profits, grassroots organizations, and government agencies dedicated to meeting the needs to residents." Monmouth County houses two inpatient treatment centers, 22 community outpatient treatment programs, three halfway houses, and numerous sober living homes and Harm reduction centers.[16] However, there is still an unmet need and continued need for treatment services across the continuum of care.

Monmouth County was ranked 5th of 21 counties in number of treatment admissions by county residents. Between January 2019 and June 2021, Monmouth County reported a total of 1,722 Narcan related incidents (overdose) with over 75% transported to local hospitals.[17] Monmouth County was able to utilize Department of Human Services statistics to assess the need for continued treatment access across the levels of care based on Monmouth County statistics for the percentage of unmet need for Substance Use Disorder concerns: [18]

2018	2,660	38%
2019	2,649	39%
2020	14,708	82%

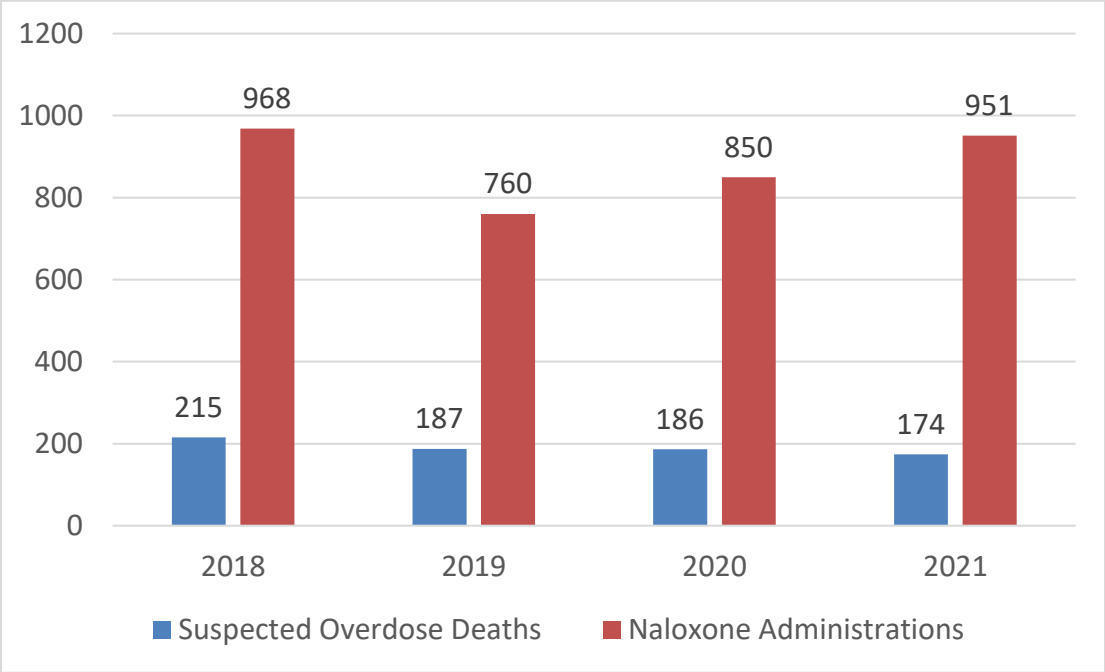
According to the Office of Drug Monitoring (2022), "The opioid epidemic in NJ continues to affect every municipality, in every county, every day, during every season, and involved every demographic." 95% of suspected heroin submissions to forensic labs contained fentanyl or fentanyl class compounds, 58% did not contain any heroin, and 30% contained xylazine. From 2020-2021, there was a 53% increase of cases involving cocaine. There was an average of 35 naloxone administrations daily. There were 2,009 submissions of suspected heroin in the state; 148 were from Monmouth County (7.3%). Only 5% of those had only heroin in them. In fact, "more bags containing xylazine were analyzed in 2021 (239,866) then the previous six years combined; 9% in Monmouth County for the first Quarter of 2022." From 2015-2021, Fentanyl related submissions increased by 982%. 10 municipalities accounted for 44% of all fentanyl related submissions. Neptune was amongst these with 4%. 98% of heroin submissions from Monmouth County contained fentanyl. Five counties accounted for 51% of naloxone administrations (EMS/LE) in New Jersey: Camden, Essex, Hudson, Middlesex, and Monmouth. Monmouth had 184 of the 3,162 (6%). Furthermore, five counties accounted for 49% of all drug related arrests: Camden, Essex, Mercer, Monmouth, and Passaic. Monmouth had 385 of 5,312 (7%). Drug use remains a pivotal concern for Monmouth county, and the need for treatment remains high, especially in regard to the increased lethality of substances being abused as evidenced by these findings. [19]

In addition, NJCARES data shows Monmouth County has experienced a continuous high rate of naloxone administration as well as fatal overdoses. In 2021, Monmouth County had 174 suspected overdoses and 951 naloxone administration.[20]

Indeed, Naloxone Administrations steadily increased from 2015-2018 (7,218 to 16,082) statewide but then decreased in 2019 (15,104). This same trend was reflected in Monmouth County: 2015 had 448 administrations, 2016 had 708, 2017 had 659, 2018 had 968, and 2019 had 760. Monmouth County's administrations are still down from 2018 but have increased since 2019. In 2020, there were 850 administrations (366 from EMS and 484 from Law Enforcement); these made up 5.88% of New Jersey's

[16] Janus Solutions: Monmouth County Needs Assessment (2020) MAAC, NJ DCF
[17] New Jersey Division of Mental Health and Addiction Services (2018-2020). *Annual Substance Abuse Overview*
[18] Department of Human Services (2022). ReachNJ.
[19] NJ Office of Drug Monitoring and analysis quarterly report Jan 1 2022-March 31, 2022
[20] NJ Attorney General's Office for Addiction Response and Enforcement Strategy, *NJCARES*, (2018-2021)

total reported administrations (14,437). In 2021, there were 951 administrations (465 from EMS and 486 from Law Enforcement); these made up 6.61% of the total administrations reported in New Jersey.[21]



It is important to note that administration to black residents has been increasing since 2015, as well as to those who are 55+ in age. There has been a decrease in administrations to three age groups: 18-21, 22-24, and 25-29.[22] As of September 30, 2021, 29% of all naloxone administration were to black residents, 47% white, and 8% Hispanic. This data is disproportionate to the overall 2020 Census data of Monmouth County, which reflected 71.6% white, 6.1% black, 12.5% Hispanic, and 9.8% other. Furthermore, Monmouth County had a reported 1,743 Naloxone incidents from 2020-2022, comprising 5.7% of the State incidents.[23] The same five municipalities had the highest Naloxone incidents reported each year from 2018-2021: Asbury Park (361), Long Branch (268), Keansburg (228), Middletown (164), and Freehold (159).[24]

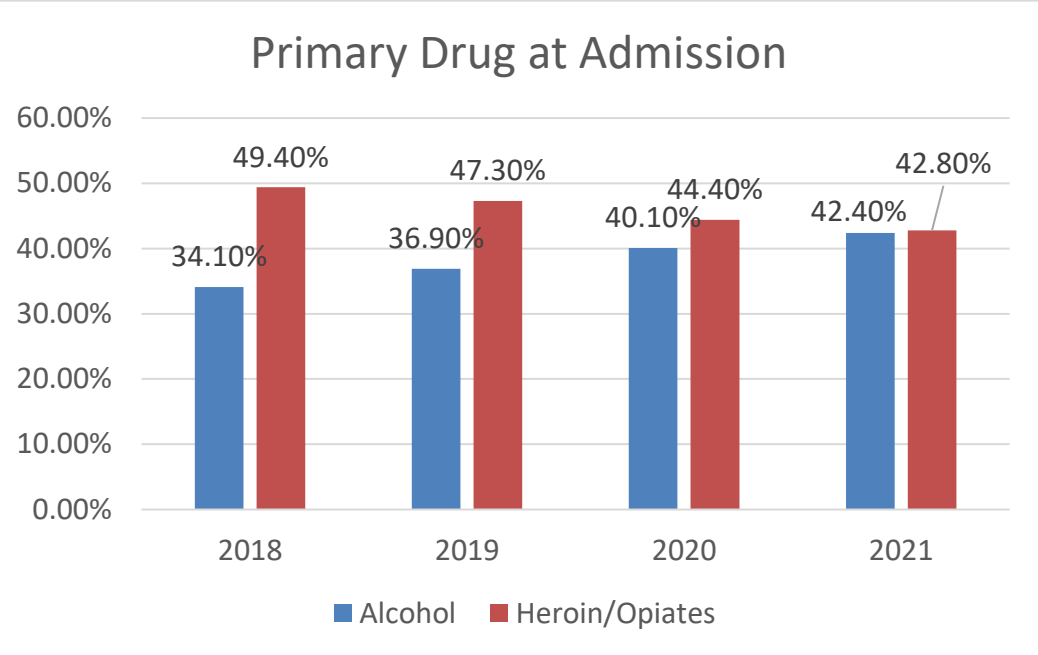
According to the Medical Examiner reports accessed through the Opioid Dashboard (2022), there was a decrease in drug related deaths in Monmouth County from 2018 to 2019. In 2018, there were 215 drug related deaths in the County, the majority of these involved Fentanyl (166), Heroin (102), or other opiate/opioids (89). There were no reported cases involving alcohol (ETS). In 2019, there were 185 drug related deaths in the County, 133 had Fentanyl involved. There were 76 that involved Heroin and 75 involving other opiate/opioids, including fentanyl analogs, methadone, morphine, and oxycodone. 2019 also had 31 deaths involving alcohol (ETS). The data reflects that the percentage of drug related deaths is increasing for black residents. In 2015, 13% were black residents, but that rose to 25% in 2021. There is also an increase in deaths for those 55+ and a decrease in deaths for those 22-29 years old.[25]

According to the NJ office of Chief State Medical Examiner, Drug and/or Alcohol related deaths made up more than half of recorded accidents in the state, 272 cases were in Monmouth county. In 2019, there were 2,914 certified deaths being related to drugs/alcohol statewide: 2,805 were accidents (96%), 83 were suicides (3%), and 22 were undetermined (11%). Of the total deaths, 79% (2,314) were drug related and 21% (600)

[21] New Jersey Department of Health (2022). Opioid Dashboard.
[22] New Jersey Department of Health (2022). Opioid Dashboard.
[23] United States Census Bureau, *US census population estimate*, (2020).
[24] New Jersey Department of Health (2022). Naloxone Dashboard
[25] New Jersey Department of Health (2022). Opioid Dashboard.

were alcohol and drug related. Monmouth County had 185 drug related deaths. Drugs identified in the total 2019 deaths included: Methamphetamines (147), Methadone (116), Benzodiazepines (457), Cocaine (963), Fentanyl (2,248), Fentanyl Analogs (438), and Heroin (1,076).[26]

Heroin and alcohol continue to make up the highest percentage of primary drugs reported at time of treatment admission. However, it is important to note that in 2021, alcohol as primary drug is almost even with that of heroin/other opiates for the first time (data reviewed dating back to 2018). The following charts were created to further illustrate a reflection on admission trends seen in the County.[27]



(NJSAMS)	2018	2019	2020	2021
Alcohol	2371 (34.1%)	2674 (36.9%)	2323 (40.1%)	2534 (42.4%)
Heroin/Opiates	3431 (49.4%)	3429 (47.3%)	2577 (44.4%)	2554 (42.8)
Marijuana	617 (8.9%)	539 (7.4%)	323 (5.6%)	279 (4.7%)

	Total Admissions	Unduplicated		Total Admissions	Unduplicated
2018	6947	4368	2020	5799	3324
2019	7254	4114	2021	5974	3386

In 2018 and 2019, more municipalities had admissions for heroin then alcohol. However, this shifted in 2020 and more municipalities reported admissions were for alcohol:[28]

	Alcohol	Heroin
2018	2371	3004
2019	2663	3034
2020	2308	2232

[26] NJ office of the Chief State Medical Examiner Annual Report (2019)
[27] New Jersey Substance Abuse Monitoring System (NJSAMS) (2018-2022). *Statewide Summary Report*.
[28] New Jersey Substance Abuse Monitoring System (NJSAMS) (2018-2022). *Statewide Summary Report*.

In 2018, the municipalities with highest number of treatment admissions included Middletown (624), Neptune Township (608 – Neptune City had 127), and Asbury Park (578). However, there was a shift in 2019. Asbury Park was highest (614), followed by Neptune Township (608 – Neptune City had 134), and Middletown (581). In 2020, Asbury Park remained highest (482), Long Branch City followed with 471 (biggest jump from #4 to #2 from 2018 to 2020), and Middletown was third (415).[29]

Information collected through focus groups and key informant interviews during the planning process reiterated the community's concerns over continued difficulty with access to treatment across the continuum of care. Lack of transportation to/from treatment was named as a frequent barrier, as well as long wait times, lack of awareness of services available, limited housing opportunities, child-care concerns, and increasing mental health challenges (28% of treatment admissions in 2019 involved co-occurring concerns). Gaps identified included lack of bilingual services and case management dedicated to follow up and continuum of care issues.

D. RECOVERY SUPPORT SERVICES

Out of total treatment admissions from 2018 to 2021, according to NJSAMS data, an average of 57.4% were readmissions (14,919 out of 25,978). 2,475 out of a total 5,799 admissions were duplicated in 2020 (42.7%). In 2021, 2,588 out of 5,974 were duplicated (43.3%).[30]

Socioeconomically disadvantaged individuals, who are the county's primary responsibility, usually require the most fundamental support services to sustain their recovery, i.e. a safe/sober place to live, a job, and a supportive social network. With an average relapse rate of 42%, evidenced by readmissions data, Monmouth County residents would benefit from the availability of recovery support services.[31] By providing an array of recovery support services, residents will increase recovery capital and potentially reduce relapse. Lack of recovery supports throughout the continuum often results in the need for costly assistance in health, behavioral and/ or social issues, and law enforcement involvement. In 2021, 30% of Monmouth County residents admitted for treatment had legal issues, 17.3% were unemployed, 9.5% had received a DUI, 7.2% were homeless, and 14.1% lacked health insurance.[32]

Relapse results in potential readmission into the health, treatment, or judicial system, having a financial and social impact on the individual, the family, and the community. Relapse affects their ability to maintain employment as well as their ability to be present and support family. Out of total treatment admissions from 2018 to 2021, according to NJSAMS data, an average of 57% were readmissions. In 2021, 58.3% of clients discharged met their employment goal, 54.3% met their family situation goal, 62.3% met their physical health goal, 55.3% met their alcohol or drug problem goal, and 54% met their legal goal.[33]

Participants during the planning process named Recovery Support Services as one of the major gaps within our local system. There is concern that lack of housing, transportation, employment, education, support, life skills, and social activities increases the likelihood of relapse, particularly for individuals with limited resources living under the federal poverty level. Information collected through focus groups and key informant interviews during the planning process reiterated that sober living remains the number one barrier. Indeed, 60% of survey respondents reported that housing assistance was a needed recovery support while 37% specifically said sober living. 40% responded sober living activities and peer support. 33% reported employment services, and 50% reported transportation.

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[29] New Jersey Division of Mental Health and Addiction Services (2018-2020). *Annual Substance Abuse Overview*.
[30] New Jersey Substance Abuse Monitoring System (NJSAMS) (2018-2022). *Statewide Summary Report*.
[31] New Jersey Substance Abuse Monitoring System (NJSAMS) (2018-2022). *Statewide Summary Report*.
[32] New Jersey Substance Abuse Monitoring System (NJSAMS) (2021). *Statewide Summary Report*.
[33] New Jersey Substance Abuse Monitoring System (NJSAMS) (2021). *Statewide Summary Report*.

LOOKING FORWARD: THE 2024 TO 2027 CCP PLAN

Guideline: Describe the county's 2024-2027 plan for each level of care below. Highlight the issues or major challenges identified in the needs assessment facing the county over the next four years. Describe the actions the county will take to address these needs.

A. PREVENTION

For the 2024-2027 prevention plan, Monmouth County will offer evidence-based prevention programming throughout the county, focusing on youth and high-risk populations. The goal will be to continue reducing early onset of drug and alcohol use and of antisocial behavior among Monmouth County youth. Monmouth County will expand where programming is offered to include the municipalities and school districts that are identified as high need and are not otherwise over served through other grants or prevention initiatives. Some programming will focus on special high-risk populations, such as children of substance abusers. In 2024 and 2025, Monmouth County will increase the number of unduplicated individuals that receive prevention programming by expanding evidence-based programming including Strengthening Families, Keys to Innervisions, and programming that teaches Life Skills, such as Als Pals, Botvins, Safe Dates, and Footprints. In 2026 and 2027, Monmouth County will maintain the number of individuals receiving prevention services by continuing to provide evidence-based prevention programming.

Focus groups and surveys with youth, youth serving agencies, SACs, and families named marijuana, vaping, and alcohol use, the top concern for youth substance abuse trends.

The 2021 Overview of the Monitoring the Future Survey found that the prevalence of vaping marijuana doubled or tripled in all three grades, specifically in 12th graders, increasing from 4.9% in 2017 to 14% in 2019 (3.9% of 8th graders in 2019 and 12.6% of 10th graders in 2019). There was also an increase in vaping nicotine. For example, for 12th graders in 2019, 11% reported use in 2017, but 25.5% reported use in 2019.[34] Nicotine products and marijuana oil are both used in vape products, leaving parents and professionals concerned that vaping is a new "gateway drug", putting youth at risk for use of other substances.

Additionally, the perception of harm related to marijuana use has decreased among youth. When perception of harm goes down, use goes up. This trend has been witnessed and reported by schools and youth serving agencies. The Monitoring the Future Survey Overview (2021) also reported, 71% of High School seniors do not view regular marijuana smoking as being very harmful, which coincides with the information received locally through focus groups. The survey reported that annual marijuana prevalence was 11.4% for 8th graders, 28% for 10th graders, and 35.2% for 12th graders.[35]

In addition to expanding evidence-based prevention programming, Monmouth County Division of Behavioral Health has and will continue to increase substance use awareness and education activities through collaboration with the Municipal Alliance, Prevention Coalition, and other Community agencies.

[34] National Institute on Drug Abuse; National Institutes of Health; U.S. Department of Health and Human Services, *Monitoring the Future Survey*, (2021).
[35] National Institute on Drug Abuse; National Institutes of Health; U.S. Department of Health and Human Services, *Monitoring the Future Survey*, (2021).

B. EARLY INTERVENTION

Monmouth County does not have an Early Intervention goal for the 2024-2027 planning cycle. Project Insight is underutilized and was not able to spend funding that was allocated during the 2020-2023 planning cycle. In 2020, $65,000 was allocated to Early Intervention. 34.3% of these funds ($22,315.64) were left unspent. Likewise, in 2021, $50,000 was allocated to Early Intervention. 52% of these funds ($26,119) were left unspent. As of 2022 Q2, only $20,000 had been allocated to Early Intervention with less than 50% of that being utilized.

Due to the COVID-19 pandemic, amongst other factors, referral to and utilization of this service is down. This is further affected by the legalization or marijuana and the shift in perception of harm. Focus groups identified less need to provide early intervention, and instead, recommended increasing funding for Prevention and Recovery Supports. Survey results show that 40.7% of respondents believe funding is most needed for Prevention and Recovery Supports, 17.7% say services are needed, and 16.8% say treatment is needed. A very small percentage sited Early Intervention as needed, but results do not show Early Intervention to be a priority above the other domains. Thus, money will not be allocated to this domain for the 2024-2027 planning cycle. Funds that would otherwise be utilized for Early Intervention services will instead be added to the funding made available for other prioritized domains, such as Recovery Supports.

C. TREATMENT (Including Detoxification)

Monmouth County's treatment goal for the 2024-2027 planning cycle is to increase treatment access across the continuum of care. Monmouth County will utilize the county comprehensive grant funding to increase admissions annually across all treatment levels. Funds will continue to support the medically indigent population and purchased services will maintain access for these individuals as well as reduce barriers to treatment. If the need for funding specific services decreases, other services in the continuum will be enhanced to support sustained recovery and increase the availability of residential services for new residents accessing treatment.

Capacity remains an issue in Monmouth County and throughout the state as the number of residents accessing treatment continues to increase. Monmouth County has had the 5th highest treatment admissions throughout the state each year during the current cycle (NJSAMS).[36] As the anticipated need for treatment continues to grow for Monmouth County residents annually, it is imperative that efforts are made locally to enhance the treatment continuum, reducing the risk of relapse and improving access for those in need.

D. RECOVERY SUPPORT SERVICES

Monmouth County's goal for the 2024-2027 planning cycle is to continue the Recovery Capital model of support services established in previous planning years, initially focusing on the medically indigent residents, to increase their opportunities for sustained recovery and reduce risk of relapse. Recovery support services continue to be a gap in the Monmouth County continuum of care. Residents in recovery or seeking recovery would benefit from an array of recovery support services to increase their recovery capital and reduce risk of relapse. Monmouth County first funded recovery support services in 2019 and will continue funding an array of community-based recovery support services.

[36] New Jersey Substance Abuse Monitoring System (NJSAMS) (2018-2022). *Statewide Summary Report*.

Recovery support services identified include:

- Transportation to treatment, meetings, events, activities
- Self-help and support groups
- Employment and education services and job training
- Assistance in locating/obtaining sober housing
- Family education and referral to related community resources
- Peer-to-Peer Services, Mentoring, Coaching
- Life skills
- Parent education and child development
- Social activities for those in recovery to reduce isolation

Funding comprehensive recovery support services, which allow the flexibility to "wrap around" the client, reduces barriers to recovery for each individual served and builds a network of formal and informal supports, reducing risk of relapse and overdose deaths. Additionally, reducing risk of relapse will lead to a reduction in readmissions, which will open beds for individuals seeking treatment for the first time. There may also be a reduction in costs for public assistance for health, behavioral and/ or social issues, and the community will benefit from individuals reentering the workforce.

SECTION THREE: THE 2024-2027 COUNTY COMPREHENSIVE PLAN

A. VISION

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

B. PLANNING PROCESS

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

1. Indicate the source and kind of the data that was used in conducting the county needs assessment. (Please **CIRCLE** or **HIGHLIGHT** your answers)

SOURCE	QUANTITATIVE		QUALITATIVE	
1. NEW JERSEY DMHAS	YES	NO	YES	NO
2. GCADA	YES	NO	YES	NO
3. MOBILIZING ACTION THROUGH PLANNING AND PARTNERSHIPS, MAPP (CDC/NJDOH SPONSORED)	YES	NO	YES	NO
4. REGIONAL PREVENTION COALITIONS	YES	NO	YES	NO
5. COUNTY PLANNING BODIES	YES	NO	YES	NO
6. HOSPITAL COMMUNITY HEALTH PLAN	YES	NO	YES	NO
7. MUNICIPAL ALLIANCES	YES	NO	YES	NO
8. TREATMENT PROVIDERS	YES	NO	YES	NO
9. FOUNDATIONS	YES	NO	YES	NO
10. FAITH-BASED ORGANIZATIONS	YES	NO	YES	NO
11. ADVOCACY ORGANIZATIONS	YES	NO	YES	NO

12. OTHER CIVIC ASSOCIATIONS	YES	NO	YES	NO
13. RECOVERY COMMUNITY	YES	NO	YES	NO

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

In 2022, the Monmouth County Division of Behavioral Health began to recruit stakeholders to participate in the upcoming 2024-2027 CCP planning process. Volunteers were recruited from the following: Board of Addiction Services (LACADA), Mental Health Board, Professional Advisory Committee (PACADA), Prevention Steering Committee (CASS), Municipal Alliance Coordinators, IDRC Committee, Monmouth County Opioid Fatality Review Team, Monmouth Acts Behavioral Health Hub, Regional Prevention Coalition, Faith Based Organizations, Children System of Care Representatives, Student Assistance Counselors, Human Services Advisory Council, Social Services, the recovery community, and county residents.

Monmouth County utilized e-mail distribution lists, social media, and press releases to disseminate information about a county wide stakeholder meeting geared towards educating attendees on the planning process and gathering community input. A county wide community survey via google forms was also used to gather information anonymously.

A county wide meeting was held virtually via zoom. The meeting was open to the public. Results of the widely shared survey were shared, and a presentation took place to provide an understanding of the CCP and the planning process. Data was distributed to all attendees. Attendees utilized breakout sessions (zoom feature) to discuss one of the four target domains (prevention, early intervention, treatment, and recovery supports). Each break out room was geared toward one domain and was utilized to further discuss needs and gaps as well as provide recommendations for the services needed for each of the domains respectively.

Multiple focus groups and key informant interviews were held representing special populations or specialized topics. These were conducted virtually via zoom and WebEx. Some groups, such as the focus group for those in recovery and workforce were held through already existing organizations or groups to increase participation, such as RWJ's established All Recovery Meeting.

3. Which of the following participated directly in the development of the CCP? (Please **CIRCLE** or **HIGHLIGHT** your answers)

1. Members of the County Board of Freeholder	YES	NO
2. County Executive (If not applicable leave blank)	YES	NO
3. County Department Heads	YES	NO
4. County Department Representatives or Staffs	YES	NO

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

4. Briefly evaluate your community outreach experience over the last three years of preparing your 2024-2027 CCP. What role did the LACADA play in the community participation campaign? What approaches worked well, less than well, or not at all to generate community participation and a balance of "interests" among the participants?

Monmouth County's Division of Behavioral Health has a tradition of continuous evaluation and planning fully supported by the Board of Addiction Services and the Professional Advisory Committee (LACADA and PACADA).

The LACADA and PACADA have played an integral role in the planning process, assisting in sharing information about various meetings and surveys, reviewing data, and offering feedback where appropriate. The training activities, work groups, and focus groups, as well as the redistribution of emails, surveys, and informational materials constituted the foundation of the process.

In Spring 2022, the 2020-2023 CCP was reviewed with the LACADA to determine if the priorities set at that time remained a concern. A Survey Monkey went out in the Summer of 2022 looking for input on trends, needs, and gaps as it relates to substance use in Monmouth County.

In July of 2022, a County wide community stakeholder meeting was held where members of the public were encouraged to attend along with providers representing non-profit substance abuse and mental health agencies, nurses, Social Services, Department of Human Services, Department of Health, youth serving agencies, hospitals, prevention, school personnel, and the Prosecutor's Office, and many more. Following the presentation reviewing the 2020-2023 CCP, planning process, and survey results, as well as the findings of other data collected, attendees selected a break out room to join in order to participate in a work group for each domain, allowing individuals the opportunity to not only share their perspective on the needs, but to

provide feedback on recommendations regarding the gaps identified in relation to one of the four domains (prevention, early intervention, treatment, and recovery supports). There were approximately 48 participants in the meeting and an even distribution of representation in each of the four break-out sessions.

Over the course of 2022, several focus groups and key informant interviews were conducted to cover the special populations identified in Chapter 51. In order to ensure attendance and participation, focus groups were held virtually or in conjunction with already existing groups in the community. Furthermore, focus groups/key informant interviews were conducted to discuss special topics, including homelessness, housing, prevention, and harm reduction. These topics were discussed in relation to each of the special populations identified in Chapter 51, as well as in relation to the four overall domains (prevention, early intervention, treatment, and recovery supports).

It was observed throughout this planning process that providing virtual options for meetings via platforms like zoom or by phone helped overcome barriers, such as schedule conflicts, COVID concerns, and transportation. Moreover, utilizing groups and meetings already established in the community to meet people where they are yielded better participation and willingness to provide input.

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

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

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

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

Stakeholders and providers are often overwhelmed by the number of meetings they attend on a regular basis. The use of surveys and already established meetings allowed participants to offer their feedback without the time commitment of multiple meetings and allowed for the use of meeting agendas to disseminate the information about the CCP planning process. In addition, surveys allowed individuals in the community to provide input anonymously, as well provided an opportunity for input for those who may not be able to attend a meeting. The community survey was offered in both English and Spanish to help address the language barrier, which was identified several times throughout the planning process as a concern. Focus groups conducted through already existing groups proved successful as well. Not only does it ensure attendance, but it was observed that participants were more inclined to engage and provide honest feedback.

A different approach that could be beneficial when preparing for the next CCP would be to schedule the county wide stakeholder meeting during the school year instead of Summer, so that more participation from school related entities could be generated.

7. How were the needs of the Ch.51 subpopulations identified and evaluated in the planning process?

a. Offenders - Key informant interviews were held with the Supervisor of Substance Abuse Services at Monmouth County Correctional Institution, as well as with social workers at Long Branch Library and Re-entry who work with this population
b. Intoxicated Drivers - The Intoxicated Driver Resource Center (IDRC) is located within the Monmouth County Office of Addiction Services. Monthly activity and trends of the IDRC are reported to the County Alcohol and Drug Director.
c. Women - A focus group was held with individuals in recovery, which included women. In addition, key informant interviews were held with staff at the Women's Halfway House in Long Branch and Asbury Park. Furthermore, 67% of participants in the stakeholder meeting that identified as being in recovery were women.
d. Youth - Youth input was obtained through the online community survey. In addition, several of the respondents identified as school professionals. A focus group was held with Children's System of Care Representatives and another was held with Spanish speaking parents through the Prevention Coalition. A key informant interview was conducted with the Director of Operations for the Boys & Girls Clubs of Monmouth County. The stakeholder meeting consisted of several entities that work and represent youth, including CIACC and SACs.
e. Disabled - Monmouth County Division of Behavioral Health has received input on the needs of this population from the Division on Aging, Disabilities, and Veteran's Services through collective participation in a Monmouth County Human Services initiative, Monmouth ACTS. A focus group was held with ADRC staff as well.
f. Workforce - Focus groups held with individuals in recovery encompassed individuals currently in the workforce. A Key informant interview was conducted with Workforce Development staff. Furthermore, 91% of the survey participants identified as being in the workforce.
g. Seniors - In addition to input received from the Division on Aging, Disabilities, and Veteran's Services, information regarding seniors was obtained through alliance and prevention coalition initiatives and director of Senior Centers. A focus group was held with ADRC staff and with Monmouth Acts Aging Hub. A key informant interview was conducted with the Chair of the Hub

who is also the Director of the Neptune Senior Center. Furthermore, 18% of survey participants identified as 65+ seniors.
h. Co-occurring - The co-occurring population has been represented through the PACADA, as many providers have co-occurring treatment programs. In addition, input was gathered during an All Recovery meeting, in which most participants reported having co-occurring diagnoses.

The needs of the C51 subpopulations were identified through a combination of surveys, focus groups, and key informant interviews. In addition to receiving survey responses from individuals representing each special population, focus groups and/or key informant interviews took place to evaluate each population specifically. Focus groups were held targeting individuals in recovery or family members of individuals with substance use disorders. These focus groups encompassed many of the subpopulations identified. In addition to these, focus groups specific to youth, women, and seniors/disabled were held. Key informant interviews took place with Monmouth County Correctional Institution, IDRC, Women's Halfway House staff, youth serving agencies, and the Division on Aging, Disabilities, and Veteran's Services. Other key informant interviews addressed topic specific concerns related to affordable housing, homelessness, harm reduction and workforce development. Agency and organization participant stakeholders provided additional information and insights. Focus groups took place virtually and with already existing groups, enhancing attendance and participation.

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

Monmouth County has a history of strong collaboration amongst mental health and addiction service providers. Through the planning process, there was an increase in inter-governmental communication and information sharing. While each governmental division has its unique role and tasks, the planning process has allowed us to build collaborative working relationships that have led to resource sharing, easier referrals, professional networking, and improved case management. This has been further realized through Monmouth ACTS and the Hubs, which provided essential information and collaboration to the planning process.

C. PREVENTION AND EARLY INTERVENTION

INSTRUCTIONS: In a few short paragraphs of 5 to 7 sentences each, describe your county's plan for the use of its AEREF prevention set-aside in each of the four years from 2024 to 2027. Indicate that you will spend your required set-aside to purchase and implement an evidence-based prevention education program such as Mental Health First Aid, Parenting Wisely, Strengthening Families or SBIRT, or another evidence-based program including a link to the list of EBPs where the program may be found. Additionally, describe the prevention plans of your county's regional prevention coalition and county alliance steering subcommittee. Request help from both groups to describe the plans they are implementing in 2024-2027.

1. SUMMARY OF THE [NAME] COUNTY REGIONAL PREVENTION COALITION IMPLEMENTATION PLAN

A summary of the Prevention Coalition of Monmouth County's (PCMC) strategic plan for 2022-2025, created by the coalition, is laid out below distinguishing priorities per task force. The purpose of PCMC is to improve substance use/misuse prevention strategies through awareness, education, and advocacy to effect community-level change. To achieve its mission, vision, and purpose, PCMC utilizes five (5) task forces, Underage Drinking/Marijuana Use and Misuse, Tobacco and Electronic Nicotine Delivery System (ENDS), Opioid Use and Misuse, New and Emerging Drugs, Sustainability, and Youth Time to Shine/Youth Tobacco Action Group. Recently, a comprehensive assessment was completed by compiling research and statistics from multiple data sources including assessments created by PCMC.

The **Underage Drinking/Marijuana Use and Misuse** task force will continue its efforts, including providing educational materials and collaborating with the community for events and trainings as requested. Community interest and the task force involvement in implemented programs will be documented. Information such as infographics and the Underage Drinking and Marijuana Substance Use Referral and Education (SURE) Hotline will be shared with community members. In addition, **Training for Intervention Procedures (TIPS) University** and **TIPS for On Premise**, a training for servers at establishments where alcohol is consumed, will continue to be an effort supported by the coalition. PCMC staff will be trained across several programs including, PreVenture and Mental Health First Aide. This will allow PCMC staff to facilitate and/or be better equipped to share the benefits of prevention programming with other community organizations.

The **Tobacco and Electronic Nicotine Delivery Systems (ENDS)** task force will continuously provide information/education, create avenues for trainings on multiple levels and allot opportunities to change/modify policies. To aide our community in making changes, PCMC is offering a sample Town Smoking Ordinance to any municipality seeking help to create one. Currently, PCMC is assisting with efforts to make Preferred Behavioral Health Group, its lead organization, a smoke free workplace by sharing resources and collaborating with community partners.

Opioid Use and Misuse task force will utilize its resources towards community outreach as a priority focus. Events and trainings will be at the forefront of this task force to educate community members, create a space of inclusion and support, and deliver resources. The safe storage/drop box disposal of medications campaign is an inclusive effort that gives the community information and options to safely store medications and dispose of expired, unwanted, and unused medications. Other initiatives include the Purple Flag Initiative and Proclamation in support of International Overdose Awareness Day. Purple flags will be displayed in participating towns, at local businesses, municipal buildings, individual homes, etc. to represent the number of lives lost to an overdose in Monmouth County. The Opioid Task Force will collaborate with Monmouth County's Division of Behavioral Health to outreach and provide resources at overdose hot spot locations throughout Monmouth County.

The **New and Emerging Drugs** task force has a data focus. The taskforce connects with community members to identify problem areas within Monmouth County and provide the coalition and community members with up-to-date new and emerging drugs and trends. Efforts will be made to work collaboratively with the different sectors throughout Monmouth County to examine the needs of the community and provide opportunities for education and awareness. Surveys have been created and will continuously be distributed to better gauge the needs and gaps that exist in the community. Individuals can participate in the community surveys several different ways, paper surveys and QR codes will be available at various community events/programs. The survey can also be located on the PCMC website www.PCofMC.org. Understanding that language can be a barrier we have create the surveys in multiple languages.

The **Sustainability** task force responsibilities include an annual review and update of the coalition's progress. The taskforce will evaluate efforts such as recruitment and fundraising, along with material essential to the structure of the coalition such as the strategic plan, by-laws, and logic models. It is important for the future of the coalition that this task force have access to the most up to date information and clear goals. Documents such as the strategic plan need to be reviewed, evaluated, and updated annually to assess the success of each task force and redirect its focus, if necessary. Also, an important focus of this group is to explore avenues to help support the rapid growth of the coalition. Recruitment and fundraising are efforts that will be made through community outreach and events that will aide in the ability to reach even more people/sectors within the community.

Youth Time to Shine (Youth Tobacco Action Group) is a sub-committee of the coalition and consists of middle and high school aged youth in Monmouth County. The groups priorities include distributing education material and signage, participating in peer-to-peer education, participate in trainings relevant to the groups mission, and reviewing policies to improve effectiveness. As requested, "Don't Get Vaped In" and "Over the Counter Medicine Safety Training" will be provided to enhance education, awareness, and involvement within the group and with community partners. Other projects this group leads include "Let's Clear the Air" which are multiple recorded modules that youth will utilize to discuss marijuana, vaping, and alcohol. This miniseries will be distributed to schools and organizations to utilize as a peer-to-peer education tool.

Evaluation of each task force includes centralizing data and information to a master excel sheet. This sheet will track programming, materials, resources, contacts, etc. to give PCMC measurable information to continuously evaluate programs, events, and trainings. Documentation and surveys will be distributed through all events PCMC is involved in and beyond to gather as much relevant data to the communities served as possible.

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

Monmouth County currently has 12 Municipal Alliances representing 16 of the county's 53 municipalities. The Governors' Council on Alcoholism and Drug Abuse awarded $ 282,216.00 to Monmouth County with $ 209,479.20 going directly to local municipal alliances for prevention services and $ 2,736.80 for county wide training activities.

Participating Municipal Alliances currently select a priority area deemed a significant community problem based on a local needs assessment and then develop logic models to plan prevention strategies based on that priority. Priority areas, per GCADA, include alcohol abuse, use of illegal substances, medication misuse, tobacco and nicotine misuse and new or emerging drugs of abuse. Additionally, local alliances work to build community capacity, engaging stakeholders as well as residents to deliver education and awareness as well as build supports and protective factors in their communities that reduce the risk of substance use.

County wide activity funds are used to enhance and support the prevention priority messages from a county wide perspective, delivering prevention education opportunities to areas or sectors that may not otherwise be served, providing training activities for prevention stakeholders, and to bring additional prevention resources to targeted groups when a specific need is identified.

Name of Municipality	Amount of Funding
Colts Neck	$ 9,730.00
Eatontown	$ 11,955.00
Freehold Twp./Boro **	$ 32,600.00
Hazlet	$ 14,690.00
Highlands/Atl. Highlands **	$ 14,954.20
Holmdel	$ 12,710.00
Keyport	$ 8,740.00
Shore Alliance*	$ 21,360.00
Middletown	$ 34,470.00
Millstone	$ 9,990.00
Neptune Township	$ 21,290.00
Wall	$ 16,990.00
SUB-TOTAL	$ 209,479.20
County Coordination	$ 70,000.00
Countywide Activities	$ 2,736.80
TOTAL	$ 282,216.00

*Shore Alliance includes the following Municipalities: Spring Lake Heights, Sea Girt, and Manasquan
** Consortium of 2 Municipalities

D. LOGIC MODEL NARRATIVES

NARRATIVE INSTRUCTIONS: There will be FOUR logic models. These sections are the following: **Prevention**, **Early Intervention**, **Clinical Treatment with Detoxification** and **Recovery Support Services**. Each logic model must have a narrative. Answer the following questions within each narrative. Please keep each narrative to no more than five pages. FOR EACH GOAL, another logic model and narrative is required. Label multiple goals in their order of importance: "FIRST", "SECOND", etc. The Logic Models are to be placed in Appendix 4.

PREVENTION LOGIC MODEL NARRATIVES

1. Describe a treatment need-capacity "gap" in the substance abuse treatment system of care that impedes county residents' access to appropriate and effective treatment on demand? Please describe its strategic significance to the overall success of the 2024-2027 CCP.

The "gap" in the county's prevention system of care is that the availability of funding for evidence-based prevention programming does not meet the need when compared to the number of youths in Monmouth County. Monmouth County has 53 municipalities with approximately 129,478 youth under the age of 18.[37] It is important that every youth has access to effective prevention education to decrease early onset drug and alcohol use.

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

Lack of evidence-based prevention programming may result in an increase of early onset drug and alcohol use among youth. 90% of adults with substance use disorder starting using before the age of 18 (Drugfree.org, Alcohol and Drug Problem Overview).

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

Statewide, Monmouth County had the 5th most treatment admissions for all substances across all age groups in 2020 (5,799; 7%) and 2021 (5,974; 6.8%).[38] Monmouth County comprised 6.3% of treatment admissions among youth 21 and under in 2020, and 7.8% of treatment admissions among youth 21 and under in 2021 (NJSAMS).[39] In 2019, there were 275 substance offenses in schools reported. Monmouth County is #4 in HIB cases in NJ with 348 offenses. Through local surveys and focus groups, youth were identified as the most effected by substance use and underserved subpopulation (74%).[40]

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[37] United States Census Bureau, *US census population estimate*, (2020).
[38] New Jersey Substance Abuse Monitoring System (NJSAMS) (2018-2022). *Statewide Summary Report*.
[39] New Jersey Substance Abuse Monitoring System (NJSAMS) (2018-2022). *Statewide Summary Report*.
[40] DCF Family and Community Indictors for Monmouth County (2021).

4. Please restate this "gap" and related community problem as a treatment goal to be achieved during the 2024-2027 CCP.

The goal is to reduce early onset of drug and alcohol use and of antisocial behavior among Monmouth County youth.

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

2024 – To increase the number of unduplicated individuals that receives prevention education programming
2025 – To increase the number of unduplicated individuals that receives prevention education programming
2026 – To maintain the number of individuals that receives prevention education programming
2027 – To maintain the number of individuals that receives prevention education programming

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

2024: To expand evidence-based programming that teaches life skills to high risk schools in Monmouth County & provide Strengthening Families training to families identified as high risk throughout the County.
2025: To provide a second year of evidence-based programming that teaches life skills to elementary and middle school age children & continue Strengthening Families training to families identified as high risk.
2026: To provide a third year of evidence-based programming that teaches life skills training to middle school and elementary school children & provide Strengthening Families training to families identified as high risk throughout the County.
2027: To provide a fourth year of evidence-based programming that teaches life skills to middle school and elementary school children & provide Strengthening Families training to families identified as high risk throughout the County.

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

It will cost approximately $250,000.00 annually to meet the objectives, for a total of $1,000,000.00 allotted to prevention services across the four-year planning cycle. (Approximately 22.73% of the total grant award annually)

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

It is estimated that the number of unduplicated individuals receiving prevention education programming will increase by a minimum of 5% in 2024 and 2025, and the increase in recipients will be maintained throughout 2026 and 2027.

9. What will be the annual outcomes, or community benefits, of the strategy? Please estimate the social cost-offsets for the community.

The community benefits will be an increase in youth knowledge of substance use/abuse, leading to a reduction in the number of youths who experience early onset of substance use. Preventing early onset use will save costs related to treatment, education expenses, and law enforcement. The National Institute on Drug Abuse estimates that every dollar spent on prevention can save up to $5 in treatment costs.[41]

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

The participation of the County, subcontracted Prevention agencies, Schools, Community, and Municipal Alliances will allow for successful execution of the strategy to achieve the goal.

Treatment Logic Model Narratives

1. Describe a treatment need-capacity "gap" in the substance abuse treatment system of care that impedes county residents' access to appropriate and effective treatment on demand? Please describe its strategic significance to the overall success of the 2024-2027 CCP.

Access to specific treatment modalities remains a need-capacity gap, not only for Monmouth County, but throughout New Jersey. Monmouth County has had the 5th highest treatment admissions throughout 2020 and 2021 (NJSAMS).[42] As the anticipated need for treatment continues to grow for Monmouth County residents annually, the county looks to continue to support an annual increase in treatment admissions across the continuum. While Monmouth County does not have the infrastructure to support a mass increase in capacity, we will look to increase admissions by funding enhanced services throughout the continuum, reducing the risk of relapse and improving access for those in need. If the need for funding specific services decreases, other services in the continuum will be enhanced to support sustained recovery and increase the availability of residential services for new residents accessing treatment. According to the 2009 Household Survey on Drug Use and Health, 12.4% of Monmouth County residents surveyed met criteria for substance use disorder in the past year, yet only .3% of those individuals received formal treatment.[43]

[41] National Institute on Drug Abuse; National Institutes of Health; U.S. Department of Health and Human Services, *Monitoring the Future Survey*, (2021).
[42] New Jersey Substance Abuse Monitoring System (NJSAMS) (2018-2022). *Statewide Summary Report*
[43] US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (SAMHSA), *Cost Offset of Treatment Services*, (2009).

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

Individuals who are unable to access treatment are often at risk for illness, injury, hospitalization, job loss, incarceration, and death. These risks further stress the family unit and exhaust social, medical, and law enforcement resources. Every $1 spent on treatment saves $7 in crime/criminal justice costs and when adding savings related to healthcare, savings increases to $12 per $1 spent on treatment.[44]

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

Monmouth County treatment admissions, overdoses, and naloxone administrations have increased in proportion with the growing lethality of the substances being abused. Monmouth County had 174 suspected overdoses in 2021. In 2020, there were 850 naloxone administrations (366 from EMS and 484 from Law Enforcement); these made up 5.88% of New Jersey's total reported administrations. In 2021, there were 951 administrations (465 from EMS and 486 from Law Enforcement); these made up 6.61% of the total administrations reported in New Jersey.[45] Anecdotal reports received through focus groups and key informant interviews reiterate concerns over continued difficulty with access to treatment across the continuum of care and the risks associated.

4. Please restate this "gap" and related community problem as a treatment goal to be achieved during the 2024-2027 CCP.

Monmouth County's treatment goal for the 2024-2027 planning cycle is to increase treatment access across the continuum of care

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

Objective Year 1: To increase the number of residents that access the treatment continuum within the calendar year by 5%, using 2021 admissions of 5,974 as a baseline. In 2024, an additional 298 residents will enter into treatment.
Objective Year 2: To increase the number of residents that access the treatment continuum within the calendar year by an additional 5%, for a total of 6,585 admissions.
Objective Year 3: To increase the number of residents that access the treatment continuum within the calendar year by another 5%, for a total of 6,914 admissions.
Objective Year 4: To increase the number of residents that access the treatment continuum within the calendar year by 5%, for a total of 7,259 admissions

[44] US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (SAMHSA), *Cost Offset of Treatment Services*, (2009).
[45] New Jersey Department of Health (2022). Opioid Dashboard.

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

County comprehensive funding will be monitored annually in addition to quarterly monitoring on utilization of funds to ensure access to a continuum of care. IME information will be shared to ensure access to NJ State Fee for Service network and residents will continue to be encouraged to enroll in Medicaid.

Annual investments will be determined based off the annual grant award, utilization monitoring, and the status of other funding sources at that time.

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

Based on 2021 and 2022 grant awards, investments, and utilization monitoring, it is estimated that approximately $690,000.00 will be allocated to treatment annually (approximately 62.73% of the total grant award annually). However, this may change based on award amount, other state and federal treatment funding sources, and County fund utilization.

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

2024: 6,272 treatment admissions
2025: 6,585 treatment admissions
2026: 6,914 treatment admissions
2027: 7,259 treatment admissions

9. What will be the annual outcomes, or community benefits, of the strategy? Please estimate the social cost-offsets for the community.

The associated outcomes will be increased admissions into substance use treatment and increased participation/engagement throughout the continuum of care, resulting in additional recovery time and a decrease in risk of relapse

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

The participation of the County, the subcontracted treatment providers, Monmouth County stakeholders, IME, and NJ Division of Mental Health and Addiction Services

Recovery Supports Logic Model Narratives

1. Describe a treatment need-capacity "gap" in the substance abuse treatment system of care that impedes county residents' access to appropriate and effective treatment on demand? Please describe its strategic significance to the overall success of the 2024-2027 CCP.

Participants during the planning process named Recovery Support Services as one of the major gaps within our local system. There is concern that lack of housing, transportation, employment, education, support, life skills, and social activities increases the likelihood of relapse, particularly for individuals with limited resources living under the federal poverty level. Information collected through focus groups and key informant interviews during the planning process reiterated that sober living remains the number one barrier.

Socioeconomically disadvantaged individuals, who are the county's primary responsibility, usually require the most fundamental support services to sustain their recovery, i.e. a safe/sober place to live, a job, and a supportive social network. With an average relapse rate of 42%, evidenced by readmissions data, Monmouth County residents would benefit by the availability of recovery support services.[46] By providing an array of recovery support services, residents will increase recovery capital and potentially reduce relapse. Lack of recovery supports throughout the continuum often results in the need for costly assistance in health, behavioral and/ or social issues, and law enforcement involvement. In 2021, 30% of Monmouth County residents admitted for treatment had legal issues, 17.3% were unemployed, 9.5% had received a DUI, 7.2% were homeless, and 14.1% lacked health insurance.[47]

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

Relapse results in potential readmission into the health, treatment, or judicial system, having a financial and social impact on the individual, the family, and the community. It affects their ability to maintain employment as well as their ability to be present and support family. Individuals may require public assistance for health, behavioral and/ or social issues, and law enforcement involvement.

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

Out of total treatment admissions from 2018 to 2021, according to NJSAMS data, an average of 57.4% are readmissions (14,919 out of 25,978). 2,475 out of a total 5,799 admissions were duplicated in 2020 (42.7%). In 2021, 2,588 out of 5,974 were duplicated (43.3%). In 2021, 58.3% of clients discharged met their employment goal, 54.3% met their family situation goal, 62.3% met their physical health goal, 55.3% met their alcohol or drug problem goal, and 54% met their legal goal.[48]

[46] New Jersey Substance Abuse Monitoring System (NJSAMS) (2018-2022). *Statewide Summary Report*.
[47] New Jersey Substance Abuse Monitoring System (NJSAMS) (2021). *Statewide Summary Report*.
[48] New Jersey Substance Abuse Monitoring System (NJSAMS) (2018-2022). *Statewide Summary Report*.

Participants during the planning process, which included individuals in recovery, family members of individuals with substance use disorders, and treatment providers, named Recovery Support Services as one of the major gaps within our local system. There is concern that lack of housing, transportation, employment, education, support, life skills, and social activities increases the likelihood of relapse. Information collected through focus groups and key informant interviews during the planning process reiterated that sober living remains the number one barrier. Indeed, 60% of survey respondents reported that housing assistance was a needed recovery support while 37% specifically said sober living. 40% responded sober living activities and peer support. 33% reported employment services, and 50% reported transportation.

4. Please restate this "gap" and related community problem as a treatment goal to be achieved during the 2024-2027 CCP.

Monmouth County's goal for the 2024-2027 planning cycle is to continue the *Recovery Capital* model of support services established in previous planning years, initially focusing on the medically indigent residents, to increase their opportunities for sustained recovery and reduce risk of relapse.

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

Objective Year 1: Increase funding of recovery support services by 25%, using 2022 funding of $80,000.00 as a baseline, for a total of $100,000.00
Objective Year 2: Increase funding of recovery support services by 10%, for a total of $110,000.00.
Objective Year 3: Increase funding of recovery support services by 10%, for a total of $121,000.00.
Objective Year 4: Increase funding of recovery support services by 10%, for a total of $133,100.00.

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

Assuming there is not a significant decrease in county comprehensive funding during the 2024-2027 cycle, savings realized from treatment funding initiatives will support the funding increase of recovery support services. County comprehensive funding will be monitored annually in addition to quarterly monitoring on utilization of funds and client outcomes by the contracted agency

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

2024: $100,000.00
2025: $110,000.00
2026: $121,000.00
2027: $133,100.00

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

750 residents will be served each year

9. What will be the annual outcomes, or community benefits, of the strategy? Please estimate the social cost-offsets for the community.

Community benefits include reduction in readmissions, which will open beds for individuals seeking treatment for the first time. In addition, there may be a reduction in costs for public assistance for health, behavioral and/ or social issues. The community may also benefit from individuals reentering the workforce.

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

The participation of the County, the subcontracted providers, Monmouth County stakeholders, and other community agencies

E. 2024-2027 Evidence-Based Programs

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

Name: **Life Skills Training Program (Evidence based programming that teaches Life Skills, including Als Pals, Botvins, etc)**

Description: Evidence based prevention education program for elementary and middle school aged students. Activities are designed to increase social competency, self-management, and resistance skills as well as enhance protective factors in the critical domains of family-peer-community, so as to decrease the early onset of substance use and antisocial behavior.

Objectives: Students develop skills that enhance self-esteem, develop problem-solving skills, and build social skills to enhance relationships and avoid conflict as well as build defenses against pressures to use substances.

Location or Setting for its Delivery: Elementary and/or Middle Schools

Expected Number of People to Be Served: At minimum, 300 individuals per year over four years, for a total of 1,200 individuals in the 2024-2027 planning cycle.

Cost of Program: $57,000 per program, per year.

Evaluation Plan: Quarterly reports on progress, including pre/posts tests collected by subcontracted Prevention agency.

Name: **Strengthening Families Program**

Description: Evidence based, 14-week prevention education program for families identified as at-risk. Activities are predicated on five protective factors; resilience, social connection, concrete support in times of need, knowledge of parenting and child development, and social and emotional competency.

Objectives: Families develop parenting skills, social skills, and family life skills that aid in reducing substance abuse, family dysfunction and delinquency risk factors.

Location or Setting for its Delivery: Schools, places of worship, recovery community centers, prevention agencies, municipal community centers, halfway houses.

Expected Number of People to Be Served: 54-120 individuals per year

Cost of Program: $50,000 per program, per year.

Evaluation Plan: Quarterly reports on progress, including pre/posts tests collected by subcontracted Prevention agency.

Name: **Funding treatment across the continuum of care**

Description: Monmouth County comprehensive funding will fund the American Society of Addiction Medicine (ASAM) following levels of care for treatment:
Level III.7d Sub-Acute Detoxification
Level III.7 Short Term Residential
Level III.I Halfway House for Male and Female
Level II.5 Co-Occurring
Level II. I Intensive Outpatient
Level I Outpatient
Level .5 Early Intervention

Objectives: Increase treatment admissions annually by funding the treatment continuum for access by indigent residents

Location or Setting for its Delivery: Treatment agencies/facilities

Expected Number of People to Be Served: Estimated 481 per year, for a total of 1,924 people served with county comprehensive plan funding

Cost of Program: Estimated $690,000.00 annually based on current information available

Evaluation Plan: Quarterly reports, PRAG monitoring, annual site visits

Name: **Community based recovery support services**

Description: Provision of an array of community-based recovery support services available to county residents that may include transportation, self-help and support groups, employment and education services, assistance with housing, family education, peer to peer services, life skills, and recovery based social activities.

Objectives: To help residents build recovery capital by providing an array of recovery support services.

Location or Setting for its Delivery: Community based services to be determined by sub-contract

Expected Number of People to Be Served: 750 Monmouth County residents per year

Cost of Program: Based on current funding levels:
2024: $100,000.00
2025: $110,000.00
2026: $121,000.00
2027: $133,100.00

Evaluation Plan: Quarterly monitoring reports, client outcome reports, annual site visit

APPENDIX 1: DEFINITIONS OF PLANNING CONCEPTS

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

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

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

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

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

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

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

Gap Analysis describes needs that are not being met because of a shortfall in resources available to meet them. By comparing the number and characteristics of residents who are likely to present for care, Demand, with the number and characteristics of care providers available to treat them, a "gap" in services may be identified. In the first instance, a "gap" is the arithmetic difference between a projected service need and the existing capacity

of providers to meet the need. But a "gap" may also arise because of access issues called "barriers," such as a lack of insurance, transportation or child care.

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

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

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

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

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

APPENDIX 2: REFERENCES

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Appendix 3: List of Participants in the Planning Process

No.	NAME	AFFILIATION	CONTACT INFO.
1	Pamela Capaci	Hope Sheds Light - Community	
2	Deidre Lonza	New Hope - Community	
3	Lynn Seaward	County	
4	Kait McCarthy	Prevention First, Prevention Coalition (PCMC)	
5	Dr. Zeeshan Khan	New Hope IBHC, VNA CHC - LACADA	
6	Irene Hoylie-Ristaino	MC Board of Addictions	
7	Alysa Fornarotto-Regenye	Chair of MC Brd of Addictions / Wall Twp. HS School Student Assistance Counselor	
8	Stephanie Ruane	Supervisor of Substance Abuse Services and Social Services for Monmouth County Correctional Institution (MC Sheriff's Office)	
9	Ken Pecoraro	CPC - Community	
10	Jeanna RIBON	MC Board of Addictions, Howell Alliance Co-Chair, & Howell Township Public Schools District SAC	
11	Detective Srgt. Matthew Chesek	Highlands Police Department	
12	Nikki Tierney	Coalition member, MC Board of Addictions, Recovery Community	
13	William Horbatt	MC Alliance Coordinator, Recovery Community	
14	Diane Aifer	Vice Chair MC Board of Addictions, Prosecutor's Office	
15	Marcy McMullen	MC Board of Addictions,	
16	Selma Morris	Sheriff's Office, MC Board of Addictions,	
17	Phil O'Hara	MC Board of Addictions,	
18	Dr. Lester Richens	Dept. of Education, MC Board of Addictions,	
19	Jeffry Nielsen	MC Board of Addictions,	

Stakeholder Meeting

No.	NAME	AFFILIATION	CONTACT INFO.
1	Dawn Doherty	Society for the Prevention of Teen Suicide	
2	Christa Riddle	Howell Alliance Coordinator	
3	Lynn Seaward	RWJBH-IFPR	
4	Darcy Dobens	Bayshore Family Success Center	
5	Sarah Skrocki	Central Jersey Family Health Consortium	
6	Bil Rosen	EMS Chief, Neptune NJ and Deputy Ems COORDINATOR mcso oem/ems	
7	Kristin Meyler	Wall Alliance and Shore Alliance	
8	Heather Ogden	CDC Foundation on behalf of OAG/NJCARES	
9	Scott Wolman	CSPNJ	
10	Nikki Tierney	Person in sustained remission from opioid use disorder, Hazlet Alliance	
11	John Bates	Community Outreach Coordinator Seabrook	
12	Rebecca Green	JSAS Healthcare	
13	Jacki Gerchman	Director of Business Development - Northeast Family Services	
14	Heather Church-Soto	YMCA	
15	Shelley Feingold	Monmouth County Div of Behavioral Health	
16	Nicki Francis	Wellspring Center for Prevention- Coordinator of Monmouth County	
17	Kait McCarthy	Assistant Director at Prevention First, a division of Preferred Behavioral Health Grouo and Regional Coordinator for the Prevention Coalition of Monmouth County	
18	Ken Pecoraro	CPC Behavioral Healthcare	
19	Billy Horbatt	Monmouth County Alliance Coordinator	
20	Julia Barugel	Chair, Monmouth County Mental Health Board	
21	Pamela Major	CIACC coordinator, Monmouth County	

22	Samantha Paulsen	Prevention First & the Prevention Coalition of Monmouth County	
23	Sally Hanna	program director Involuntary outpatient Commitment Middlesex & Monmouth counties	
24	Rachel Mamrosh	Prevention First and the Prevention Coalition of Monmouth County	
25	GiAnna Rossano	Community Development Specialist at Prevention First, a division of Preferred Behavioral Health Group and the Prevention Coalition of Monmouth County	
26	Letizia Duncan	HMH Riverview Medical Center and Jersey Shore University Medical Center	
27	Samantha Schleifer	Community Prevention Manager, RWJBarnabas Health Institute for Prevention & Recovery	
28	Sara Arias	SW Asbury Park Social Services	
29	Jessica Reyes	Director of Adult Protective Services Monmouth County	
30	Cole Zaccaro	MAT program manager at the Community Health Center of Asbury Park - VNA	
31	Lauren Sacs	Student Assistance Counselor, Raritan High School	
32	Desiree Whyte	Assistant Director of Operations MC Dept. of Human Services	
33	Nicole Cyr	Assistant Director of Planning MC Dept. of Human Services	
34	Jeanna RIBON	MC Board of Addictions, Howell Alliance Co-Chair, & Howell Township Public Schools District SAC	
35	DSG. Matthew Chesek	Highlands PD	
36	Tricia Bambach	Monmouth Cares CMO – Care Engagement Network	
37	Tyler B	MonmouthCares CMO, Clergy Association	
38	Chad Majczan	Monmouth Cares	
39	Diane Villari	JSAS	
40	Jamie Hentschel	Middletown Medical	
41	LeeAnn Wagner	YMCA	
42	Mary Pat Angelini	Preferred Behavioral Health	

43	Michael Moore	RWJ – Institute prevention recovery, Peer Recovery Specialist, Recovery Community	
44	Stephanie Ruane	Supervisor of Substance Abuse Services and Social Services for Monmouth County Correctional Institution (MC Sheriff's Office)	
45	Stephanie Cervino	HABcore	
46	Carly Dawson	Affiliated Emergency Services (AES) - Affiliated with Primary Screening Service - Riverview	
47	Diana Dandeo	Resident/community, not affiliation reported	
48	Heather Simms	CSPNJ (supportive housing)	

Key Informant Interviews/Focus Group Participants

No.	NAME	AFFILIATION	CONTACT INFO.
1	Peter Boynton	Affordable Housing	Topical focus group on housing/homelessness
2	Yolanda Taylor	Workforce Development	KII on Workforce, Topical FG on employment
3	Stephanie Ruane	Monmouth County Correctional Institution	KII on Offenders
4	Belen	Resident/Community/Parent	Spanish Parent FG
5	Guadencia	Resident/Community/Parent	Spanish Parent FG
6	Aristedes	Resident/Community/Parent	Spanish Parent FG
7	Sabrina	Resident/Community/Parent	Spanish Parent FG
8	Bricia	Resident/Community/Parent	Spanish Parent FG
9	Inhyoung Chae	ADRC Coordinator	FG on Disabled and Seniors
10	Chris M	ADRC	FG on Disabled and Seniors
11	Colleen Smith	ADRC	FG on Disabled and Seniors
12	Joan Vawter	ADRC	FG on Disabled and Seniors
13	Salinda	ADRC	FG on Disabled and Seniors
14	Joseph Corcione	ADRC	FG on Disabled and Seniors
15	Katie Allen	counselor in HWH Asbury – New Hope	FG Women, Workforce, Topical FG Mother's in Recovery
16	Electra Willis	Counselor in HWH Long Branch – New Hope	FG Women, Workforce, Topical FG Mother's in Recovery

17	Sylvia James	Director of Women's HWH – New Hope	FG Women, Workforce, Topical FG Mother's in Recovery
18	David Perez	Long branch library social worker; Fresh Start	KII Offenders, Topical FG Homelessness
19	Danny Rivera	Boys and Girls Club	KII Youth
20	Gena Haranis	VP Janus solutions; Aging Hub Monmouth Acts	KII Aging and Disabled
21	Randy Bishop	Aging Hub chair (Monmouth Acts), Director of Neptune Senior Center	KII Aging and Disabled
22	Robert Lowry	Harm Reduction - VNA	Topical FG Harm reduction, LGBTQIA+
23	SGG Christopher Petrizzo	Counter Drug Task Force	Topical FG Prevention
24	SSG Williams – north jersey	Counter Drug Task Force	Topical FG Prevention
25	Javier Serra	Counter Drug Task Force	Topical FG Prevention
26	Deirdra Lonza	New Hope	CSOC – FG Youth
27	Cinaida Anthony	family based services	CSOC – FG Youth
28	Chad Majczan	Monmouth cares	CSOC – FG Youth
29	Danielle Gasperini	CPC – Mobile Response	CSOC – FG Youth
30	Kristina Bloodgood	New Hope	CSOC – FG Youth
31	Joan Sciorta	RWJ – Recovery Community - Peer Specialist	All Recovery Meeting
32	Steve	RWJ – Recovery Community - Peer Specialist	All Recovery Meeting
33	Michael Moore	RWJ – Recovery Community – Peer Specialist	All Recovery Meeting
34	Steph	Resident/Recovery Community	All Recovery Meeting
35	Alfonso	Resident/Recovery Community	All Recovery Meeting
36	Althea	Resident/Recovery Community	All Recovery Meeting
37	Dan	Resident/Recovery Community	All Recovery Meeting
38	Dwayne K	Resident/Recovery Community	All Recovery Meeting
39	Mike C	Resident/Recovery Community	All Recovery Meeting
40	Jess	Resident/Recovery Community	All Recovery Meeting
41	Graham	Resident/Recovery Community	All Recovery Meeting
42	Jarrod	Resident/Recovery Community	All Recovery Meeting
43	Terri	Resident/Recovery Community	All Recovery Meeting
44	Jennifer H	Resident/Recovery Community	All Recovery Meeting
45	Eileen	Resident/Recovery Community	All Recovery Meeting
46	Carlos	Resident/Recovery Community	All Recovery Meeting
47	Roceter C	Resident/Recovery Community	All Recovery Meeting
48	Kimberly R	Resident/Recovery Community	All Recovery Meeting
49	Dennis K	Resident/Recovery Community	All Recovery Meeting
50	Rich C	Resident/Recovery Community	All Recovery Meeting
51	Freddie	Resident/Recovery Community	All Recovery Meeting
52	Don A	Resident/Recovery Community	All Recovery Meeting
53	Greg T	Resident/Recovery Community	All Recovery Meeting

54	Juan B	Resident/Recovery Community	All Recovery Meeting
55	Nedrah	Resident/Recovery Community	All Recovery Meeting
56	Nicolette	Resident/Recovery Community	All Recovery Meeting
57	Ritchie	Resident/Recovery Community	All Recovery Meeting
58	Eric M	Resident/Recovery Community	All Recovery Meeting
59	Willie R	Resident/Recovery Community	All Recovery Meeting
	Online survey-121 anonymous respondents	Community/Residents/Workforce/Recovery, etc	

APPENDIX 4: LOGIC MODELS

LOGIC MODEL: PREVENTION

Need-capacity **gap and** associated community **problem (A)**	**Evidence** of problem **and** its **significance** for the county (B)	**Goal** For 2024-2027 (C)	**Objectives** Targets Per Annum (D)	**Strategy** To Achieve Objective (E)	**Inputs** Financial or Other Resources (F)	**Outputs** Expected product (G)	**Outcomes** Expected Community Benefits (H)	**Agency** Responsible (I)
Need-capacity Gap: The availability of funding for evidence based prevention programming does not meet the need compared to the number of youths in Monmouth County.	MC had the 5th most treatment admissions for all substances across all age groups in 2020 and 2021. 90% of adults with substance use disorder started using before the age of 18. In 2019, there were 275 substance offenses in schools reported. Surveys and focus groups identified youth as the most effected by substance use and underserved subpopulation (74%). Marijuana, vaping, and alcohol top concerns for youth substance abuse trends.	**To:** Reduce early onset of drug and alcohol use and of antisocial behavior among Monmouth County youth	2024: To increase the number of unduplicated individuals that receives prevention education programming	2024: Expand evidence-based programming that teaches life skills & Strengthening Families to additional high-risk areas in MC	**County: $00:00 AEREF/State: $250,000.00 Total: $250,000.00**	Number of unduplicated residents receiving prevention programming a minimum of 390	Short Term: schools and targeted populations, not previously served, will receive prevention programming	Subcontracted Prevention agency, Schools, Community, Municipal Alliances
			2025: To increase the number of unduplicated individuals that receives prevention education programming	2025: Provide a 2nd yr. of evidence-based programming that teaches life skills & Strengthening Families (SF)	**County: $00:00 AEREF/State: $250,000.00 Total: $250,000.00**	Number of unduplicated residents receiving prevention programming a minimum of 410	Middle Term: Increase in number of unduplicated residents that have received prevention programming	Subcontracted Prevention agency, Schools, Community, Municipal Alliances
Associated Community Problem: Lack of evidence-based prevention programming may result in an increase in early onset drug and alcohol use among youth.			2026: To maintain the number of individuals that receives prevention education programming	2026: Provide a 3rd yr. of evidence-based programming that teaches life skills & SF	**County: $00:00 AEREF/State: $250,000.00 Total: $250,000.00**	Number of unduplicated residents receiving prevention programming a minimum of 410	Middle Term: Increase youth knowledge of substance use	Subcontracted Prevention agency, Schools, Community, Municipal Alliances
			2027: To maintain the number of individuals that receives prevention education programming	2027: Provide a 4th yr. of evidence-based programming that teaches life skills & SF	**County: $00:00 AEREF/State: $250,000.00 Total: $250,000.00**	Number of unduplicated residents receiving prevention programming a minimum of 410	Long Term: Reduction in number of youth who experience early onset substance use	Subcontracted Prevention agency, Schools, Community, Municipal Alliances

LOGIC MODEL: CLINICAL TREATMENT WITH DETOXIFICATION

Need-capacity **gap and** associated community **problem (A)**	**Evidence** of problem **and** its **significance** for the county (B)	**Goal** For 2024-2027 (C)	**Objectives** Targets Per Annum (D)	**Strategy** To Achieve Objective (E)	**Inputs** Financial or Other Resources (F)	**Outputs** Expected product (G)	**Outcomes** Expected Community Benefits (H)	**Agency** Responsible (I)
Need-capacity Gap: Access to specific treatment modalities remains a need-capacity gap, resulting in long wait lists for certain modalities	MC had 174 suspected overdoses in 2021. In 2020, there were 850 naloxone administrations. In 2021, there were 951 administrations. Focus groups and key informant interviews reiterate concerns over continued difficulty with access to treatment across the continuum of care and the risks associated.	**To:** Increase treatment access across the continuum of care	2024: **To** Increase number of residents that access treatment continuum by 5%	2024: Monitor utilization of funds & collaborate with system partners to ensure access to continuum of care	**County: $00:00 AEREF/State: $690,000.00 Total: $690,000:00**	Number of Monmouth County resident treatment admissions 6,272	Short Term: Increased treatment admissions across continuum of care for Monmouth County residents	Subcontracted treatment providers, IME, NJ DMHAS
			2025: **To** Increase number of residents that access treatment continuum by 5%	2025: Monitor utilization of funds & collaborate with system partners to ensure access to continuum of care	**County: $00:00 AEREF/State: $690,000.00 Total: $690,000.00**	Number of Monmouth County resident treatment admissions 6,585	Middle Term: Increase sobriety time by movement through the treatment continuum, reducing risk of relapse	Subcontracted treatment providers, IME, NJ DMHAS
Associated Community Problem: Individuals who are unable to access treatment are at risk for illness, injury, job loss, incarceration, and death			2026: **To** Increase number of residents that access treatment continuum by 5%	2026: Monitor utilization of funds & collaborate with system partners to ensure access to continuum of care	**County: $00:00 AEREF/State: $690,000.00 Total: $690,000.00**	Number of Monmouth County resident treatment admissions 6,914	Middle Term: Increase sobriety time by movement through the treatment continuum, reducing risk of relapse	Subcontracted treatment providers, IME, NJ DMHAS
			2027: **To** Increase number of residents that access treatment continuum by 5%	2027: Monitor utilization of funds & collaborate with system partners to ensure access to continuum of care	**County: $00:00 AEREF/State: $690,000.00 Total: $690,000.00**	Number of Monmouth County resident treatment admissions 7,259	Long Term: MC residents have increased access to treatment, reducing relapse and increasing capacity for unduplicated admissions	Subcontracted treatment providers, IME, NJ DMHAS

LOGIC MODEL: RECOVERY SUPPORT SERVICES

Need-capacity **gap and** associated community **problem (A)**	**Evidence** of problem **and** its **significance** for the county (B)	**Goal** For 2024-2027 (C)	**Objectives** Targets Per Annum (D)	**Strategy** To Achieve Objective (E)	**Inputs** Financial or Other Resources (F)	**Outputs** Expected product (G)	**Outcomes** Expected Community Benefits (H)	**Agency** Responsible (I)
Need-capacity Gap: Recovery Support Services as one of the major gaps within our local system. There is concern that lack of housing, transportation, employment, education, support, life skills, and social activities increases the likelihood of relapse. Socioeconomically disadvantaged residents often require the most support to sustain their recovery	From 2018 to 2021, according to NJSAMS data, an average of 57.4% are readmissions. 42.7% were duplicated in 2020 and 43.3% in 2021. In 2021, 30% of Monmouth County residents admitted for treatment had legal issues, 17.3% were unemployed, 9.5% had received a DUI, 7.2% were homeless, and 14.1% lacked health insurance.	**To:** continue the *Recovery Capital* model of support services established in previous planning years, initially focusing on the medically indigent residents, to increase their opportunities for sustained recovery and reduce risk of relapse	2024: **To** increase funding of recovery support services by 25%	2024: Monitor funding utilization and residents served	**County: $00:00 AEREF/State: $100,000.00 Total: $100,000.00**	Number of residents receiving recovery support services: 750	Short Term: MC residents will have access to recovery support services not previously available	Subcontracted agency, community agencies, and treatment providers
			2025: **To** increase funding of recovery support services by an additional 10%	2025: Monitor funding utilization and residents served	**County: $00:00 AEREF/State: $110,000.00 Total: $110,000.00**	Number of residents receiving recovery support services: 750	Middle Term: MC residents receiving recovery support services will increase recovery capital	Subcontracted agency, community agencies, and treatment providers
Associated Community Problem: Relapse may result in readmission into the health, treatment, or judicial system having a financial and social impact on the individual, family, and community			2026: **To** increase funding of recovery support services by an additional 10%	2026: Monitor funding utilization and residents served	**County: $00:00 AEREF/State: $121,000.00 Total: $121,000.00**	Number of residents receiving recovery support services: 750	Middle Term: MC residents receiving recovery support services will increase recovery capital	Subcontracted agency, community agencies, and treatment providers
			2027: **To** increase funding of recovery support services by an additional 10%	2027: Monitor funding utilization and residents served	**County: $00:00 AEREF/State: $133,100.00 Total: $133,100.00**	Number of residents receiving recovery support services: 750	Long Term: MC residents receiving recovery support services will see a reduction in relapse rates	Subcontracted agency, community agencies, and treatment providers

FINANCIAL PLAN, 2024-2027: AN OVERVIEW

	***All percentages are based on current funding levels, subject to change based on annual award amounts and previous year utilization**
PROGRAM DOMAIN	**PERCENT OF AVAILABLE RESOURCES**
PREVENTION	22.73% Minimum
EARLY INTERVENTION	N/A
TREATMENT ACCESS	62.73% (Dependent on previous year utilization)
RECOVERY SUPPORT SERVICES	14.54% Minimum
Treatment – Level of Care funding allocations	
Level of Care	**PERCENT OF AVAILABLE RESOURCES**
OUTPATIENT	14.49% Minimum (Dependent on utilization)
INTENSIVE OUTPATIENT	2.17% Minimum (Dependent on utilization)
HALFWAY HOUSE	18.12% Minimum (Dependent on utilization)
DETOXIFICATION	24.64% Minimum (Dependent on utilization)
SHORT-TERM REHABILITATION	40.58% Minimum (Dependent on utilization)

**Based on 1,100,000 estimated grant reward	***All percentages are based on current funding levels, subject to change based on annual award amounts and previous year utilization**
PROGRAM DOMAIN	**PERCENT OF AVAILABLE RESOURCES (listed above)**
PREVENTION	$250,000
EARLY INTERVENTION	N/A
TREATMENT ACCESS	$690,000
RECOVERY SUPPORT SERVICES	$160,000
Treatment – Level of Care funding allocations	
Level of Care	**PERCENT OF AVAILABLE RESOURCES (listed above)**
OUTPATIENT	$100,000 (Dependent on utilization)
INTENSIVE OUTPATIENT	$15,000 (Dependent on utilization)
HALFWAY HOUSE	$125,000 (Dependent on utilization)
DETOXIFICATION	$170,000 (Dependent on utilization)
SHORT-TERM REHABILITATION	$280,000 (Dependent on utilization)