STATE OF NEW JERSEY

CUMBERLAND COUNTY COMPREHENSIVE PLAN

FOR THE ORGANIZATION AND DELIVERY OF ALCOHOL AND DRUG SERVICES
PLANNING CYCLE 2024-2027

Cumberland County Board of Commissioners

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Harold Johnson, County Administrator

Developed by
Cumberland County Department of Human Services
Division of Mental Health and Addiction
Melissa Niles LPC, LCADC, CCS, DRCC, Director

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

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SECTION ONE: FOUNDATIONS, PURPOSE, AND PRINCIPLES

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 use 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 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 misuse, 2) ensure access for county residents to client-centered withdrawal management 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 misuse 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?

A. PREVENTION

The 2020 – 2023 County Comprehensive Plan (CCP) focused prevention efforts on reducing the likelihood of adolescent onset of alcohol and substance use by providing Evidenced-Based Life Skills Programming through Student Assistance Coordinators (SAC) services to students K – 8 in Upper Deerfield, Seabrook, Hopewell, Fairfield, and Deerfield schools. SACS work with students in many New Jersey school districts to address substance misuse concerns, social and emotional issues, and behavioral problems. Generally, SAC's assist with:

1. In-service training of school staff concerning substance use/misuse related issues.
2. District programming to combat substance use and misuse.
3. Serving as an information resource to school districts for substance use/misuse prevention, curriculum development and instruction.
4. Revising and implementing substance use/misuse prevention programs and related policies and procedures in school districts.
5. Developing and administering substance use/misuse and related intervention services in the district
6. Providing counseling and referral services to students regarding substance use/misuse and related problems.
7. Cooperating with community service providers or other officials in the rendering of substance use/misuse and related treatment services.

Since Cumberland County Public Schools generally do not fund SAC's, the county desired to meet that need by providing funding for those services. The allocation for prevention services was approximately $28,000.00 per year, varying slightly year-to-year depending on the Division of Mental Health and Addiction Services (DMHAS) award determination each year.

These services have been awarded through the competitive contracting process since 2007 to Kids First...and Families, Too (KFFT) who provided SAC services in five rural K – 8 schools – Hopewell Township, Seabrook, Deerfield, Upper Deerfield, and Fairfield Townships. The SAC Counselor spent approximately one day per week in each school.

The program was contracted to provide the following per annum:

- Unit of Service – One(1) Student Assistance Coordinator (SAC) for six (6) hours/day @ $249.15/day
- 116 Days of Service (# of school days per year)
- 812 Total Hours of Service (696 Direct Service w/Student, Class, Family and/or Teachers and 116 for Program Administration/Supervision.

In 2021-22, KFFT serviced 727 youth in one-on-one sessions, and 114 youth in classroom/group activities (including the Evidenced-Based Botvin Life Skills Program), for a total of 841 individuals served over 116 school days and 812 hours of service.

TOTAL ALL SCHOOLS **PERIOD COVERED:** **2021-22**

STUDENT ASSISTANCE SERVICES	**GRADE**		
	K-5	**6-8**	**TOTAL**
TOTAL ALL STUDENT SESSIONS			
Male (Individual visits)	155	175	330
Female (Individual visits)	127	270	397
New Students Seen (Individual referrals)	20	41	61
Students Seen in Classroom Visits	104	10	114
PRESENTING PROBLEMS			
Alcohol	0	0	0
Drugs	0	7	7
COSA (Children of Substance Abusers)	83	109	192
Other (*Coping, Anxiety, Family Conflict, Sexuality/Gender*)	249	478	727
TYPES OF GROUPS CONDUCTED			
Art Expression	0	0	0
Violence Prevention/Dealing with Anger	0	0	0
Bullying	0	0	0
Conflict Resolution	4	6	10
Other (specify) Self-regulation, mindfulness	23	5	28
ATOD PREVENTION (CLASSROOMS)			
Drug/Alcohol	18	0	18
OTHER (CLASSROOMS)			
Healthy Decision Making/Social Emotional Learning	96	2	98
MISCELLANEOUS			
Administrative Meetings	12	33	44
Child Study Team/Guidance Counselors	73	83	154
Staff Contact	172	102	274
Teacher's In-Service/Staff Meetings	0	5	21
Parent/Family Contact *(includes phone contact)*	12	9	21
Other Support Services	8	4	12
REFERRALS (Outpatient, In-Patient, Partial Care)	2	16	18

B. EARLY INTERVENTION

2020 – 2023 Cumberland County CCP addressed the lack of community awareness and insufficient access to early intervention resources regarding Opiates and Opioids. Strategies included providing resource/information/education on:

1. Safe prescription drug storage and disposal through distribution of Deterra Drug Deactivation Bags
2. How to recognize the signs of an opiate/opioid overdose and administer Naloxone (Narcan), the opiate/opioid overdose anecdote through hosting Narcan Trainings

Additionally, the Senior Population continued to be offered support, education and resources through the Evidenced-Based Wellness Initiative for Senior Education (WISE) Program, a six-week evidence-based program to learn about the aging process, how to make healthy lifestyle choices, the benefits of aging, risk factors and behaviors to avoid, how alcohol and prescription medications affect older adults and to obtain simple tools to help feel more empowered about health and healthcare.

Due to limited funding, no Ch 51 dollars were allocated to provide these services. These efforts were realized through partnering with other agencies. For example, Cumberland County's Hospital System, Inspira, provided the Deterra Bags to the County who distributed them on-going at community events, and provided agencies and individuals per supply on demand. Urban Treatment provided the Narcan Trainings and Kits, while the County provided the space, managing the registration and follow-up schedule. Southwest Council provided the WISE Trainings and the County helped advertise the program by dissemination of flyers and brochures.

During the 2020-2023 cycle, there were thirty-six (36) Narcan Trainings and kits provided to 432 individuals, 1,500 Deterra Drug Deactivation Bags were distributed and there was at least one WISE Program rendered each year.

C. TREATMENT (Including Detoxification)

During the 2020-2023 cycle, treatment allocations were intended to provide the service "gap" for Cumberland County residents who did not have the means to pay. Prior to this planning cycle, the demand exceeded capacity and the funds would be expended by mid-year. Anticipating a reduction in need due to the phasing in of healthcare reform, the 2020-2023 allocations for each level of care was adjusted. Medicaid began reimbursing Withdrawal Management and Short-term residential and also allowed facilities to increase their bed capacity. These actions resulted in a profound reduction in the need for county funding in those levels of care. The county compensated for the decreased need for spending in the area of treatment through various strategies:

1. By raising the reimbursement by the county to providers equivalent to New Jersey Medicaid Rates (for Withdrawal Management and Short-term Residential)
2. Reimbursement for Enhancement services not covered by Medicaid
3. Raising Long-term treatment reimbursement rate to match Fee-For-Service rates

4. Increasing the allocation amount for Halfway House services so more Cumberland County residents would have access to those services.

Annual allocations for treatment services were as follows:

- Withdrawal Management $15,000.00
- Short-term Residential $15,000.00
- Long-term Residential $18,761.00
- Halfway House $25,000.00

Each year, all funding was spent for Withdrawal Management. However, there was a profound reduction in need for Short-term Residential Treatment reimbursements (that's where the enhancements began to be factored in). Halfway House services were also underutilized. The impact of COVID19 and Bail Reform/Criminal Justice reform are believed to be two significant factors in these changes.

Additionally, no providers responded to the bidding process to provide long-term treatment, even though it was issued twice per cycle in an effort to provide additional opportunities for solicitation. Therefore, those funds were not utilized in that category and were re-allocated elsewhere. All the funds were spent in the category of Halfway House except for 2022, where only $13,000.00 was expended. Here is 2022 snapshot:

<u>2022 Level of Service and Spending</u>

- Withdrawal Management @$428.00 per = 52 days per annum EXCEEDED
  (+$7,446.00 = $22,446.00 TOTAL SPENT)

- Short -term Residential @$230.00 per = 65 days per annum NOT MET
  (ADJUSTED)

0 days per annum served
101 units of various enhancements per

Physicians Visit	$74.00
Case Management	$12.60
LOCI	$25.00

Modification - Reduced award amount by $7,446.60 moved it into Withdrawal Management, thereby spending $7,553.40

- Halfway House @ $85.50 per day = 292 days per annum NOT MET
  (ADJUSTED)

140 days per annum served

Modification – Reduced award amount by $13,000 moved it into County Treatment and Recovery Support Services

The impact of Medicaid expansion resulted in a reduced need of funds to assist those without a funding source to pay for treatment. According to NJSAMS Substance Use Overviews, individuals admitted into treatment between January 1, 2020 – October 31, 2022 the following percentages had Medicaid: 80.7% of Withdrawal Management, 82.4% of Short-Term Residential, and 94.7% of Halfway House admissions (although Medicaid does not pay for halfway house services). Since Medicaid covered most Cumberland County individuals admitted into Withdrawal Management and Short-term Residential, Cumberland County re-assessed allocation amounts, pivoting to allow reimbursement for treatment enhancements that Medicaid does not cover. Interestingly, during 2022, all of the Withdrawal Management funds were spent for the contracted bed days, yet there were zero (0) paid contracted bed days for short-term residential (all submitted bills were for Enhancements . For example, physical examination and certain laboratory tests are not reimbursable through Medicaid). Unutilized short-term residential treatment dollars were moved into Withdrawal Management.

Cumberland County also provides direct services for residents aged 12 and up regardless of ability to pay. The amount awarded per annum during 2020-2023 varied slightly based on the amount allocated each year by the state. In 2022, $309,617.00 were budgeted to help run the facility. There were 721 unduplicated individuals served in either Outpatient or Intensive Outpatient during the 2020-2023 cycle.

D. RECOVERY SUPPORT SERVICES

Desiring to provide opportunities for individuals to increase their "recovery capital" – the internal and external resources an individual has that helps reduce risk of relapse in increase likelihood of remission of substance use problems, Cumberland County forged full speed ahead. Recovery Support Services took firm rooting during the 2020-2023 planning cycle. The following programs were continued, expanded, or initiated:

(Unfunded by Ch 51) Cumberland C.A.R.E.S. (Compassionate Addiction Recovery Equals Success) 24/7 Hotline – Trained recovery coaches are available 24/7 to provide support, information, and referral. **Between September 30, 2021 – September 29, 2022, the coaches answered 230 calls, with 163 being unique callers, totaling 908.7 total minutes.**

(Unfunded by Ch 51) partially funded through Cumberland County Government and New Jersey Attorney General's Operation Helping Hands Initiative (OHH), **Recovery on Wheels, (ROW)** Cumberland County's mobile unit had its maiden voyage in 2018 and continued throughout the planning cycle. It is a bus outfitted to provide access to substance use disorder and recovery support services on the spot in real time. Numerous services are available through ROW as it continues to navigate to scheduled locations throughout the county. Services include peer recovery coaches, direct linkage to treatment in real time, temporary ID for the purpose of accessing treatment, information and referral to various social services, needle disposal, Hepatitis A vaccinations, health screenings and other health services, disposal of prescription drugs and distribution of drug-deactivation Deterra Pouches and Narcan Education (in 2021, also began distributing kits). **Between September 30, 2021 – September 29, 2022, 95 ROW outings were completed, where coaches interacted with 549 individuals, 72 of whom completed an intake and provided on**

the spot treatment navigation and/or recovery support services. Temporary ID was provided to 41 individuals.

(Unfunded by Ch 51) Knock and Talk utilizing data collected via High Intensity Drug Trafficking Area's (HIDTA)'s Overdose (OD) Mapping system, an outreach team goes door to door to attempt contact with those who have received naloxone reversal. **Between September 30, 2021 – September 29, 2022, 827 contact attempts were made to the records on file, many of them repeatedly, either in person or telephonically. Out of the 827 attempts, 296 were successful with 130 being in-person contact. The team made contact with approximately 137 unduplicated individuals who received some sort of recovery support, ranging from treatment navigation, housing assistance, and/or employment assistance. 28 were intake and navigated into treatment.** In 2023, the program expanded to include Bridgeton Emergency Medical Services (EMS).

(Partially Funded by Ch 51) Located in the heart of our community, **Capital Recovery Center is our community peer recovery center.** DMHAS State Opioid Response (SOR) and Cumberland County Government also partially fund this program. Capital Recovery Center mottos are, "How can we help you with your recovery today?" and "What does recovery mean for you? "The Center provides a sanctuary for those seeking or sustaining recovery and their family/loved ones. Recovery housing, rent, mortgage and utility assistance and emergency food are provided through Emergency Food and Shelter Program (EFSP), SOR and Ch 51. **Between September 30, 2021 – September 29, 2022, 351 unduplicated participants were served. Out of those, 149 received recovery housing assistance (DMHAS Innovative Funds), 351 received Recovery Coaching, and 26 were provided Employment Support. Five hybrid support groups are offered weekly – Coffee and Conversation, Men In Training (M.I.T.), GratiTuesday, All Recovery Meeting and Family and Friends Support Group. There were 143 hybrid support meetings, 279 individual meetings in person, 1,213 successful phone contacts, over 300 texts/emails, 118 community activities, 325 referrals to various services and over 100 mailings.**

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.

Community Profile (Complied by Walter Rand Institute, End-of- Year Cumberland County Overdose Fatality Review Report, 2022, pgs. 5-12)

Located in the south-central part of New Jersey, Cumberland County is approximately 45 minutes from Philadelphia and Atlantic City, and two hours from New York City and Baltimore. With a land area of 483.7 square miles, Cumberland County is the 5th largest county in the state and ranked 16th in population (New Jersey Counties by Population, 2020). The County was originally formed in 1798 from parts of Salem County and named after Prince William, Duke of Cumberland from England. The geography of Cumberland County is low lying and sits near the Delaware Bay. Cumberland County is one of the most rural counties in the State of New Jersey. The population

per square mile is 324.4 while the state rate is 1,195.5 per square mile (U.S. Census, 2010). Nearly 25% of its population (representing roughly 23,000 residents) live in a rural area and nearly 90% of its land area is considered rural (U.S. Census, 2017). Cumberland County has approximately 70,000 acres of farmland, accounting for about 20% of the agricultural land in the State of New Jersey. Nineteen of its thirty-five census tracts (54%) qualify as rural according to federal standards and approximately 20% of all housing units available in the county are in rural areas (U.S. Census, 2010). It consists of a total of 14 municipalities: 3 cities, 10 townships, and 1 borough. The county seat is Bridgeton, also the site of a county's administration and courts. From 2010 to 2020, the county's population decreased 1.75%, from 156,898 to 154,152 (U.S. Census, 2020). A range of various metrics indicate Cumberland County has the highest percentage/rate of residents who are currently experiencing poverty out of the state's 21 counties.

According to the official website of Cumberland County, the economy historically in Cumberland County was built around industries of glassmaking, food processing, textiles, and maritime trade. Today, the county's economy consists of a large agricultural base and is also developing four key industry sectors: Health Care, Construction, Hospitality/Tourism, and Advanced Manufacturing.

The largest employer in the county is the Hospital System, Inspira Health, which employs 3,600 people, more than double the number of employees of the next leading employer, F&S Produce/ Pipco Transportation, which employs 1,208 people (Top Employers in Cumberland County, 2021). The largest industry sectors are Education and Health Care and Social Assistance, which account for 25.7% of employment for those 16 and over. In Cumberland County, the preliminary unemployment rate in May 2019 was 4.3%, higher than the state's rate of 3.0% (Senator Walter Rand Institute for Public Affairs, 2021). Estimates indicate that from 2014 to 2019, the unemployment rate in Cumberland County dropped from 9.9% to 5.3%, a 46.46% decrease, while the state's estimated rate dropped from 6.7% to 3.4%, an approximate 49% decrease (U.S Department of Labor, 2021). As highlighted, the county's unemployment rate has continued to decrease over the course of the past two years, but it remains higher than New Jersey's rate; there are several municipalities in Cumberland County that continue to have high unemployment rates, including Bridgeton (8.8%), Millville (7.4%), and Vineland (7.2%).

Projected employment changes from 2014 to 2024 anticipates large employment increases in the sectors of Arts, Entertainment, and Recreation (23%), Construction (21%), Management of Companies and Enterprises (19%), and Administration and Waste Services (17%). Sectors expected to decrease in employment include Information (-20.1%), Government (-11.5%), Manufacturing (-6.6%), and Education Services (-5.1%).

According to the 2019 American Community Survey, Cumberland County is significantly behind the state's average in educational attainment. Statewide, 91% of the population possesses a high school diploma or higher, and 39% of the population have earned a bachelor's degree or higher. In contrast, only 81% of Cumberland County's population have a high school diploma or higher, and only 16% have earned a bachelor's degree or higher.

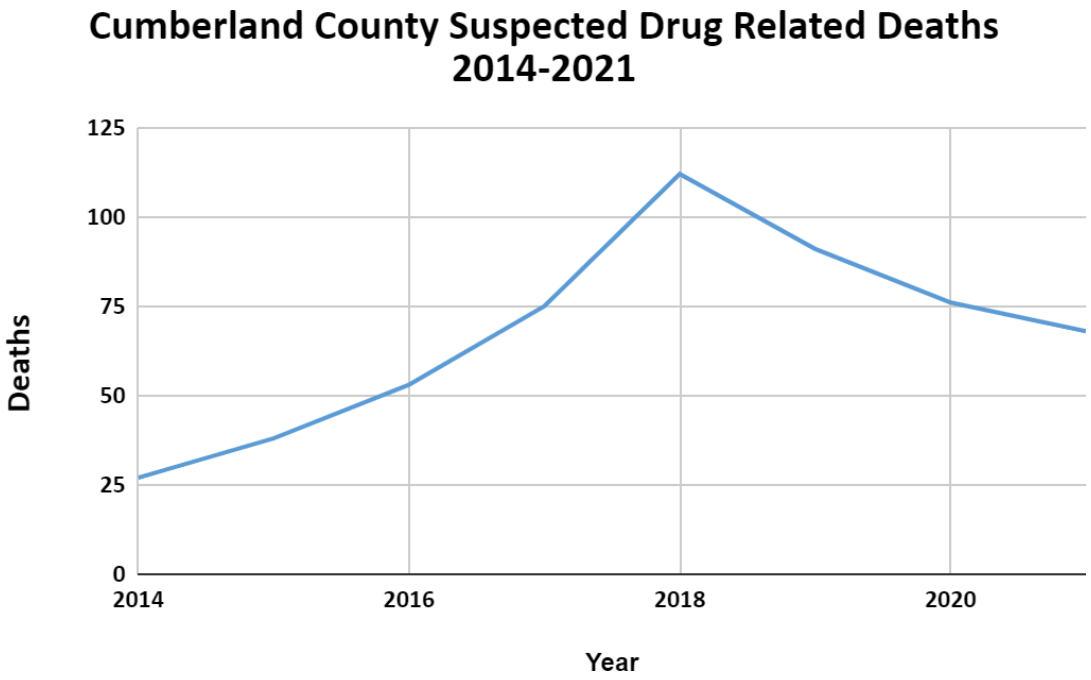
There are only 1.7 municipal police officers per 1,000 citizens in Cumberland County as compared to the state rate of 2.2 officers. Yet, Cumberland County is home to one federal, three state correctional facilities: Bayside State Prison, South Woods State Prison, and Southern State Prison.

The violent crime rate in Cumberland County is 548.4 per 100,000 (Crime in NJ, 2016). New Jersey's violent crime rate is 229.0 per 100,000 (Crime in the US, 2017). Cumberland County's violent crime rate is 50% higher than the state's.

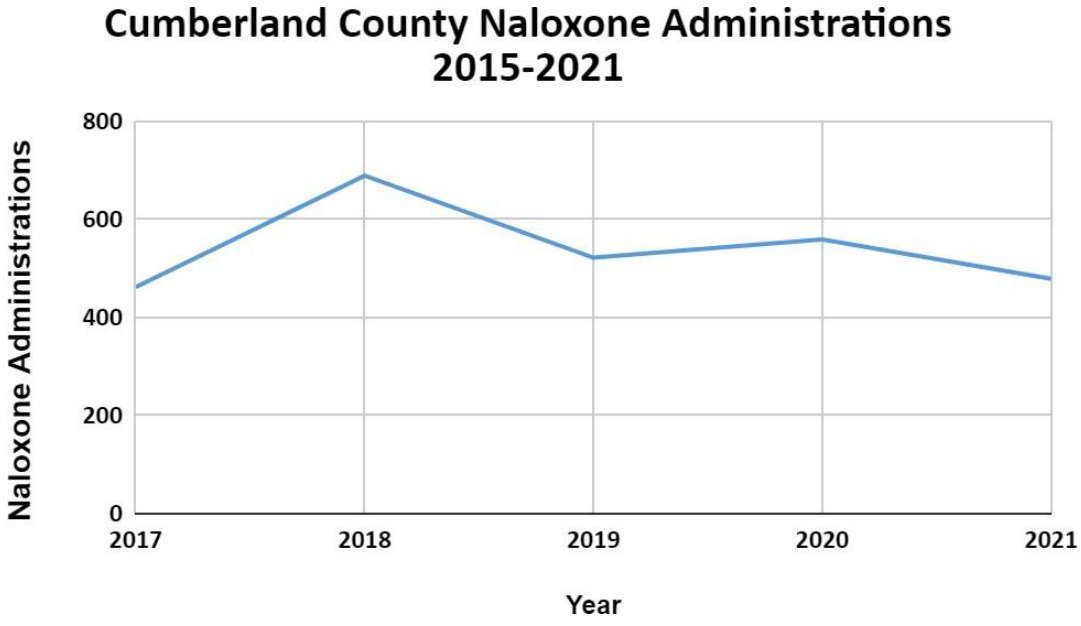
Grocery stores in Cumberland County are nearly double the federal average distance at five miles (Senator Walter Institute for Public Affairs, 2019). Thirteen of Cumberland's thirty-five census tracts (37%) qualify as food deserts (areas where there is very little or no access to healthy foods and supermarkets) and 63% (22) are considered low access (e.g., supermarkets are half mile away for urban areas or 10 miles for rural areas) (U.S. Department of Agriculture, 2015). At 7.5 (out of 10) Cumberland County has the lowest Food Environment Index in the state, compared to the state's 9.3 score. This Index measure demonstrates the difficulty of residents to afford and gain access to healthy foods.

In Cumberland County, 79% of individuals have access to exercise opportunities, compared to 95% of New Jersey citizens and 91% nationally who have access to exercise opportunities.

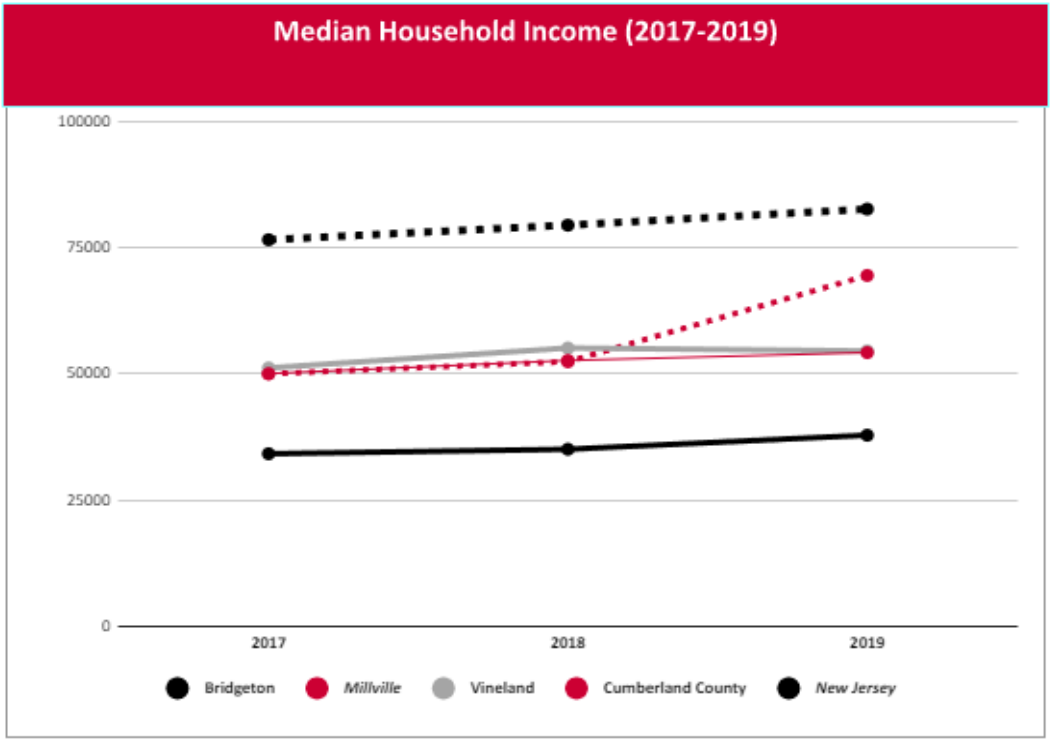
Cumberland County has experienced a rise in suspected drug-related deaths from 2014 to 2021. In the past three years, Cumberland County has had 91, 76, and 68 suspected drug-related deaths in 2019, 2020, and 2021 respectively2; conversely, the number of suspected drug-related deaths statewide has remained relatively constant over the past three years, with New Jersey reporting 2,914 deaths in 2019, 3,046 deaths in 2020, and 3,081 deaths in 2021 (New Jersey Office of the Chief Medical Examiner, 2022b).



While Cumberland County has experienced an increase in the number Naloxone deployments between 2014 to 2021, there has been a decrease in reported deployments from the County's high-water mark in 2018 (688 deployments), with the County reporting 521 deployments in 2019, 558 deployments in 2020, and 478 deployments in 2021.[3] This trend was also observed in the statewide data; New Jersey reported its highest number of deployments in 2018 (16,082 deployments) and reported a subsequently decreasing number of deployments, with 15,189 deployments in 2019, 14,437 deployments in 2020, and 13,187 deployments in 2021 (New Jersey Office of the Chief Medical Examiner, 2022c).

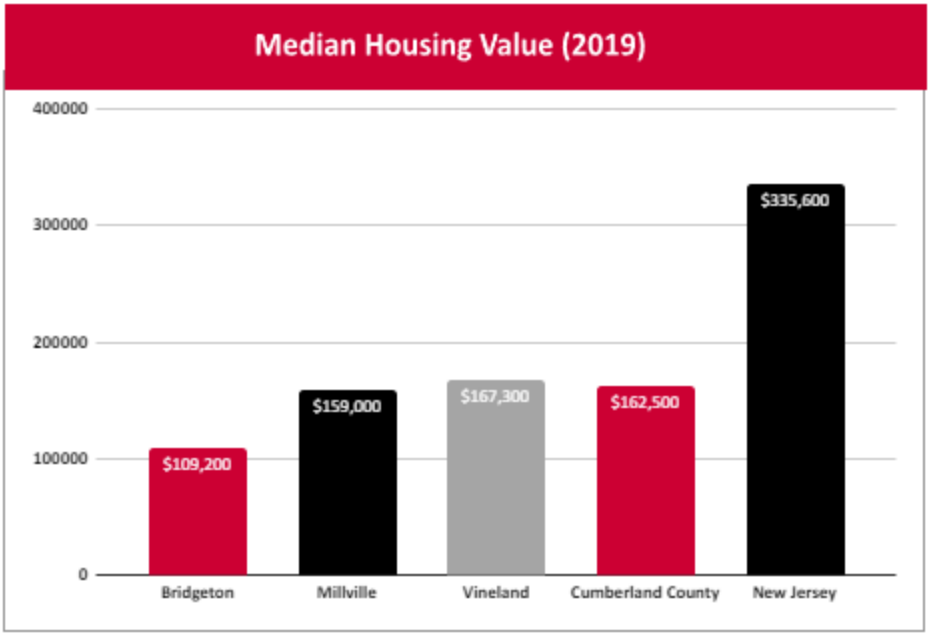


Community Profile: Additional Data



Source: *United States Census*

Median Household Income			
	2017	**2018**	**2019**
Bridgeton	$34,135	$35,023	$37,804
Millville	$49,950	$52,352	$69,411
Vineland	$51,113	$55,054	$54,476
Cumberland County	$50,000	$52,593	$54,149
New Jersey	$76,475	$79,363	$82,545



Source: *United States Census*

The median household income (MHI) in Cumberland County is approximately 42% lower than the stat of New Jersey. While the state saw an increase in household incomes from 2017 to 2019, Cumberland County experienced a slight increase too. Note that with the exception of Bridgeton, two municipalities (Millville and Vineland) are higher than the County's MHI. However, all three highlighted municipalities are lower than the State's MHI. From 2017 to 2019, Bridgeton's MHI remained significantly lower than the other two neighboring municipalities, with an estimated $37,804 MHI in 2019 compared with the County's $54,149 estimated MHI (U.S. Census, 2020).

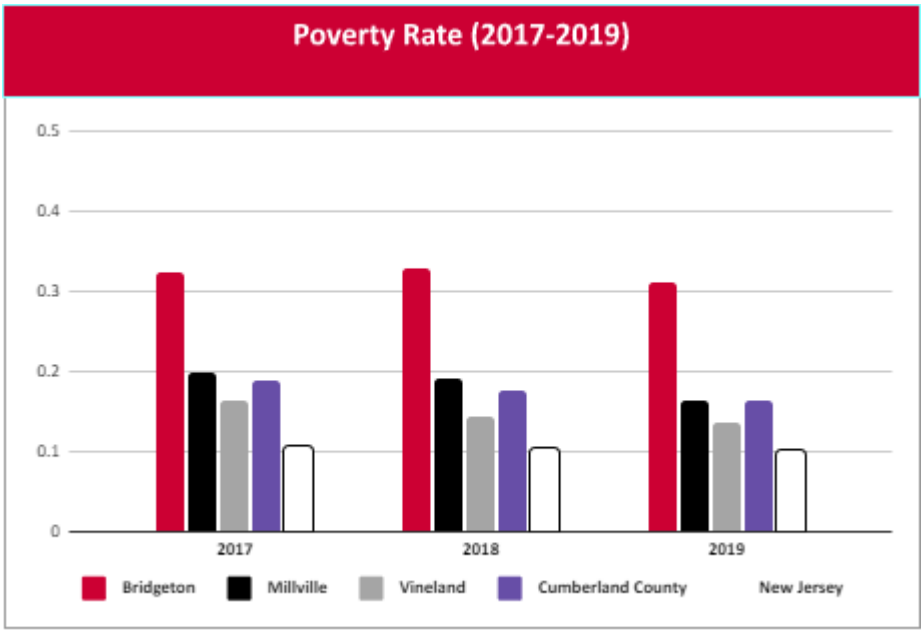
Median Housing Value (2019)	
Bridgeton	$109,200
Millville	$159,000
Vineland	$167,300
Cumberland County	$162,500
New Jersey	$335,600

In 2019, the median value of owner-occupied housing units in Cumberland County was $162,500. This is nearly 70% lower than New Jersey's median value of owner-occupied housing units, which is $335,600.

Composition of Population (2019)						
	White	Black	Asian	Other	Two or More Races	Hispanic and Latino
Bridgeton	53.3%	33.2%	0.6%	9.9%	0.0%	49.4%
Millville	76.3%	16.1%	2.7%	1.6%	3.0%	18.3%
Vineland	70.9%	14.2%	1.3%	7.9%	5.3%	40.9%
Cumberland County	68.1%	19.5%	1.4%	6.1%	4.1%	30.7%
New Jersey	67.8%	13.5%	9.5%	6.3%	2.7%	20.2%

Source: *United States Census*

Bridgeton is 1 of the 76 municipalities in the state with a majority-minority population.



Source: *United States Census*

Poverty Rate (2017-2019)

	2017	2018	2019
Bridgeton	32.3%	33.0 %	31.2 %
Millville	19.8%	19.2 %	16.5 %
Vineland	16.5%	14.4 %	13.7 %

Bridgeton's poverty rate increased from 2017 to 2018 but decreased from 2018 to 2019. However, it remains close to three times New Jersey's rate and close to double of the County's rate. Millville's poverty rate was on an upward trend from 2017 to 2018 but decreased in 2019. Vineland's poverty rate has decreased every year since 2017 (U.S. Census, 2020).

Overall, Cumberland County's unemployment rate has been trending downward since 2016, but remains higher than the State's rate. The unemployment rate of Bridgeton and Millville municipalities have been trending downward since 2016. Vineland's unemployment rate was on a similar decline until its increase in 2019. Millville exhibits the highest unemployment rate among municipalities (8.9%) (U.S.Census, 2020).

Occupancy Rates (2019)			
	Owner-Occupied	Renter-Occupied	Vacant
Bridgeton	38.1%	61.9%	12.6%
Millville	65.0%	35.0%	12.2%
Vineland	65.9%	34.1%	6.6%
Cumberland County	65.2%	34.8%	10.1%
New Jersey	63.9%	36.1%	10.6%

Source: *United States Census*

Cumberland County follows a similar trend in occupancy rates as those of the state, with about 65% being owner-occupied. Among the highlighted municipalities, Bridgeton is the only exception, with almost 62% of housing being renter-occupied instead. Bridgeton and Millville also have about twice the rate of vacant housing than Vineland (U.S. Census, 2020).

A. PREVENTION

According to the **2022 Kids Count Survey**: 17% of children in Cumberland County are living below the poverty level compared to 14% for the State and 54% of families spend 30% or more on rent, compared to the state average of 50%; there were 1,998 calls to Perform Care in 2020 and 584 Crisis Mobile Response calls in 2020, compared to 908 calls in 2019. COVID 19 had an impact on the level of mobile responses because of the requirement of social distancing, quarantining and significant exodus of in-home provider availability during that time. During

2017-18, Cumberland County 11th grade State Exams met or exceeded expectations only 20%, compared to the state average of 39%. Perhaps the most striking of this data is that Cumberland County also had the highest percentage of 16–19-year-olds not working or in school (16% - double the next highest of 8% in Cape May. All the rest of the state was not even close to Cumberland's ranking in that category. Key informant interviews yielded concerns about the legalization of marijuana in New Jersey and how it might increase access for youth.

The Monitoring the Future survey is conducted each year by researchers at the University of Michigan, Ann Arbor, and funded by the National Institute on Drug Abuse (NIDA), part of the National Institutes of Health and is considered one of the best and most timely tools available to monitor and understand changes in substance use among young people over time. (Volkow, NIDA Director). The survey is given annually to students in eighth, 10th, and 12th grades who self-report their substance use behaviors over various time periods, such as past 30 days, past 12 months, and lifetime. The survey also documents students' perception of harm, disapproval of use, and perceived availability of drugs. Notably, the survey results are released the same year the data are collected.

31,438 surveys from students enrolled across 308 public and private schools in the United States were collected data For 2022 results indicated 11% of eighth graders, 21.5% of 10th graders, and 32.6% of 12th graders reported **any illicit drug use in the past** year. Specifically, 12% of eighth graders, 20.5% of 10th graders, and 27.3% of 12th graders report **vaping nicotine**, c**annabis use** was reported at 8.3% of eighth graders, 19.5% of 10th graders, and 30.7% of 12th graders. Of note, 6.0% of eighth graders, 15.0% of 10th graders, and 20.6% of 12th graders reported **vaping cannabis**. 51.9% of 12th graders reported alcohol use. **Any illicit drug use other than marijuana** was 4.9% of eighth graders, 5.7% of 10th graders, and 8.0% of 12th – including past-year use of cocaine, heroin, amphetamines, and nonmedical use of prescription drugs, generally. 2.1% of seniors reported **Use of narcotics other than heroin (**including **Vicodin, OxyContin, Percocet, etc.**)

Perceived harmfulness of occasionally taking specific prescription medications (such as OxyContin and Vicodin), or the risk of "narcotics other than heroin" overall, the percentage of students who reported perceiving a "great risk" ranged from 22.9% among eighth graders to 52.9% among 12th graders. The percentage of respondents who reported perceiving a "great risk" associated with taking Adderall occasionally ranged from 28.1% among eighth graders to 39.6% among 12th graders (www.nida.gov).

Though the data have indicated stable or declining use of illicit drugs among young people over many years, other research has reported a recent dramatic rise in overdose deaths among young people ages 14-18. This increase is largely attributed to illicit fentanyl, a potent synthetic drug, contaminating the supply of counterfeit pills made to resemble prescription medications like benzodiazepines, ADHD medications, and opioids.

"The proliferation of fentanyl in the drug supply is of enormous concern. Though the data indicate that drug use is not becoming more common among young people than it has been in the past, the

tragic increase in overdose deaths among this population suggest that drug use is becoming more dangerous than ever before," said Dr. Volkow. "It is absolutely crucial to educate young people that pills purchased via social media, given to someone by a friend, or obtained from an unknown source may contain deadly fentanyl" (Jama Research Letter, April 2022). Trends in Drug Overdose Deaths Among US Adolescents, January 2010 to June 2021 | Emergency Medicine | JAMA | JAMA Network

The results were gathered from a nationally representative sample, and the data were statistically weighted to provide national numbers. This year, 11% of the 12th grade students who took the survey identified as African American, 22% as Hispanic, 5% as Asian, 1% as American Indian or Alaska Native, 47% as white, 1% as Middle Eastern, and 14% as more than one of the preceding categories. The survey also asks respondents to identify as male, female, other, or prefer not to answer. For the 2022 survey, 48% of 12th grade students identified as male, 47% identified as female, 1% identified as other, and 4% selected the "prefer not to answer" option.

B. EARLY INTERVENTION

According to www.ocsme.nj.gov in 2020, Cumberland County had 71 confirmed overdose deaths. 7 heroin, 55 Fentanyl, 4 Fentanyl Analog, 0 morphine, 2 oxycodone, 3 methadone, 30 cocaine, 10 methamphetamine, 5 benzodiazepine and 14 alcohol. **Cumberland was 5th in deaths per capita (47.3)**. Atlantic had the highest (71.4) and Hunterdon had the lowest (9.6). It is important to note that most of the highest per capita deaths occurred in the southern counties, with the exception of Essex (43.4), Warren (35.0), and Passaic (33.6). It is important to note Fentanyl by far was the leading cause of death and cocaine was second and methamphetamine third. This suggests the continual increased presence of fentanyl being added to other substances, making it extremely dangerous for users who possibly unbeknownst to them, take an accidental overdose of a substance they did not know or intend to consume.

In 2021, there were a total of 15,407 Naloxone deployments. **The City of Vineland in Cumberland had the highest percentage of Naloxone administrations in the State** (1.86%). New Brunswick was second (1.56%) and then the City of Millville, also in Cumberland, had the third highest (1.26%) https://www.nj.gov/health/populationhealth/opioid_naloxone).

Driving under the influence continues to be a public health and safety issue. Although convictions in New Jersey went down during COVID19, the numbers have steadily trended upwards. In 2020, there were 10,956 convictions, 2021 had 12,663, 2022 had 15,241 and 2023 projected conviction is 17,513. There have been an estimated 7,000 more driving under the influence convictions in 2023 compared to just three years ago.
("These data were provided by the State of New Jersey Department of Human Services, Division of Mental Health and Addiction Services, Intoxicated Driving Program. The Department specifically disclaims responsibility for any analyses, interpretations, or conclusions"). Despite strong opposition from various professionals and community members, recreational use of cannabis was made legal in in 2021. Although the law states it is illegal to operate a vehicle while under the influence of marijuana, current substance field and laboratory testing is limited to

detecting presence and a level of tetrahydrocannabinol (THC). This means law enforcement is not able to differentiate whether someone is actively under the influence, or if their THC level indicates last use a week ago. Community Awareness efforts are currently underway through prevention agencies across the state. It is too soon to measure the impact of cannabis legalization in New Jersey. This will be monitored throughout the 2024-2027 County Comprehensive Plan.

Southwest Council is the designated Intoxicated Driver Resource Center (IDRC) for Cumberland County. The agency tracks offenders progress and also provides the twelve (12) hour Early Intervention classes. The program is funded by fines assessed to the offender. No Chapter 51 funds are used to operate the IDRC.

C. TREATMENT (Including Detoxification)

According to the 2021 NJSAMS Substance Abuse Overview, in Cumberland County, 39% of treatment admissions were for heroin, 34% alcohol, and 9% cocaine, similar to the overall state, where the top three treatment admissions were heroin (42.5%) alcohol (30%) and marijuana (12%). In Cumberland County, admissions for withdrawal management were 47% heroin, followed by 42.6% alcohol; short-term were 40.4% alcohol and 38.7% heroin, long-term were 34.9% alcohol and 25.8% heroin, **halfway house were 52.6% heroin and 16.5% alcohol (the only level of care where the substance use percentages were different),** outpatient were 44% alcohol, and 14% heroin and Intensive Outpatient were alcohol 37.5% and heroin 24.4%.

As demonstrated in the 2020-2023 review section, the expansion of Medicaid has reduced the need for Ch 51 dollars for Withdrawal Management and Short-term residential. Lack of provider and provider interest in responding to requests for proposals for long-term treatment for the entire prior cycle and now also, unfortunately, includes halfway house in 2023 (no providers responded to the bid that was issued twice due to no responses). The impact of COVID and criminal justice/bail reform have decreased treatment demand. It is not certain if this is how the trend will continue.

D. ASSESSING NEED : RECOVERY SUPPORT SERVICES

NJSAMS admission data between 2019 – 2021 indicate a relapse rate ranging from 49-52%. 100 community members completed surveys at the Capital Recovery Center, First Step Clinic and Recovery on Wheels. There were ten key informant interviews conducted. 75% of those surveyed indicated the need for affordable housing for individuals. Key informant interviews stated housing programs for families is a current non-existent but needed resource in our community. 78% indicated community and recreational activities as integral to the on-going recovery process. 90% said that having recovery support services available has increased their own recovery capital in one way or another, including, but not limited to being reunited with family, stabilizing substance use challenges through treatment, medication assisted treatment, engaging in support groups, volunteering at the recovery center or other community service, etc.

The following data is taken directly from the Capital Recovery Center 2023 Midyear Report:

- Unduplicated Individual Recovery Support Services from 9/30/22 – 3/30/22: 234

Within a six-month time period, unduplicated clients received:

- Recovery Housing (includes Oxford Housing, Sober Living, and Residential Housing: 58
- Recovery Coaching or Peer Coaching: 226
- Employment Support: 32
- Multiple Recovery Support Services: 158
- Transportation: 23
- Treatment Navigation: 120
- Temporary Identification for Treatment Purposes: 19

Description of major accomplishments for CPRC. Include outcomes data 9/30/2022 – 3/30/2023:

• ***Knock and Talk*** **-** Knock and Talk team outreach going door to door to attempt contact with those who have received naloxone reversal from the data collected with HIDTA's OD Mapping. • Total 527 total attempts

• 222 were in-person visits

• 305 were telephone calls

• 160 successful attempts of which 86 were in-person

- ***Recovery on Wheels Outings*** o We have completed 37 ROW outings as of end of March. During those outings, we interacted with 488 individuals, 32 of whom completed an intake and was provided on the spot treatment navigation and/or recovery support services. We also provided temporary identification for treatment purposes to 15 of those individuals.

- **Cumberland CARES 24/7 Hotline** – CRC answered 91 total calls during this time frame with 68 being unique callers for a total of 301.4 total minutes.

- **Recovery Housing, Utility Assistance & Emergency Food –** CRC secured EFSP, federal funding, to provide past due or first month's rent/mortgage assistance, utility assistance and food for recoverees who qualify. To date we have been able to provide recovery housing payment assistance, rent/mortgage assistance, utility assistance and/or emergency food to over 41 individuals through funds from EFSP & Chapter 51 Innovative Funds.

- **Hybrid Support Groups** – CRC hosts five hybrid support groups, including GratiTuesday, Coffee and Conversation, Family Support Meeting, All Recovery, M.I.T. (Men In Training). Meetings are hosted in person and through Microsoft Teams and streamed live on Facebook. All recorded meetings are posted on CRC's You Tube channel. https://www.youtube.com/channel/UC6Cb0OF2XJb4HPMVK0caalA

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

As indicated in the prior section, the need for evidenced based programs in schools for youth continue. Cumberland County will seek to meet that need by providing funding for before or after-school or summer camp programming that focus on character building, resiliency, and healthy choices. The county will continue to seek qualified providers who are trained in the Evidenced-based Botvin Life Skills program.

The dangers of using substances and alcohol and drug overdose have never been higher. It is crucial that residents of Cumberland County are continually aware of the risks in the local community in real time and that protective resources are also made available in tandem. Guided by the Cumberland County Overdose Fatality Review Team (CCOFRT), the county is planning to launch an awareness campaign program in the latter part of 2023 through various mediums, including Paid Advertisements on social media, newspaper, billboards and fliers.

B. EARLY INTERVENTION

Unfortunately, Cumberland County continues to be impacted by the overdose epidemic. Although not funded through Ch 51, Cumberland County plans on continuing to provide Naloxone training and kits, and also have added Fentanyl Test Strips and Deterra Drug Deactivation Bags to distribute. Harm Reduction initiatives are increasing, and Cumberland County intends to follow the data and trends and seek funding and/or partnership opportunities in order to increase the number of individuals who are still using substances but are interested in being educated in and provided access to safe use practices, with the hope of being able to keep them alive. Harm reduction meets the person where they are (usually pre-contemplative or contemplative in Prochaska and DiClemente's Stages of Change) providing support and tools along the journey that will hopefully result in the person engaging and sustaining a recovery lifestyle that they define and enjoy.

C. TREATMENT (Including Detoxification)

Since 1975, Cumberland County intends to continue to serve its community through providing direct Outpatient and Intensive Outpatient services through First Step Clinic that is partially funded by Chapter 51.

The lack of residential and halfway house provider interest in contracting with the county is alarming and concerning. Cumberland County will continue to advocate for providers to either expand existing facilities or perhaps open facilities in order to serve our community. A possible strategy is seeking permission from DMHAS to solicit bids instead of the cumbersome and

laborious competitive bidding process. This approach may increase the likelihood of a bidder's interest. The competitive bidding process is very involved, technical, and time-consuming, which can often be a deterrent for vendors to apply. Allocation award amounts for withdrawal management, short-term, long-term, and halfway house amounts are expected to be below the State of New Jersey's purchasing law requirements.

D. RECOVERY SUPPORT SERVICES

Funding for Recovery Support Services is anticipated to be a significant investment of allocated funds for Cumberland County during 2024- 2027, including supporting the operations of Capital Recovery Center and its initiatives.

As the data indicated in the prior section, continuing to fund recovery support services during the 2024-2027 County Comprehensive Plan interval is justifiable. Trends and needs will be continually monitored. Initiatives will be added or amended based on need and availability of resources.

SECTION THREE: THE 2024-2027 COUNTY COMPREHENSIVE PLAN

A. VISION

Cumberland County envisions a future for all residents facing chronic substance use concerns 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 use challenges 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

2. The data that was collected from the above listed groups consisted of quantitative data such as NJSAMS (2019-2021), IDRC reports (2020-2021), Community Health Needs Assessment provided by the local hospital, Recovery Court survey 2022, and others. This data is embedded in the different sections of this plan.

Cumberland County reached out to various groups of providers, advisory boards, clients, and other involved entities on a regular basis through the period 2019 through 2022. Substance use concerns affect all the groups. Input from the groups identified below involved representation from law enforcement, drug court, government officials, the Prosecutors office, private non-profits, the local hospital, parents, faith-based communities, education professionals and a small area foundation. Many of the same representatives sit on the various boards and committees so the cross over and sharing of information was critical in the planning process.

In addition, the Professional Advisory Committee on Alcoholism and Drug Abuse (PACADA), the County Alliance Steering Committee (CASS) , the Youth Services Advisory Commission (YSAC), the County Interagency Children's Council the PRIDE Committee and the newly formed Overdose Fatality Review Team discussed emerging needs and barriers to services for adults, youth, and families.

2. 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 Co. Commissioners	**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

3. 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?

In Cumberland County, the Local Advisory Council on Alcohol and Drug Abuse (LACADA) and the Mental Health Board (MHAB) merged in 2012. It acts as a clearinghouse of all the activities related to substance use and mental health services in the county. Representatives from the private sector, education, families, consumers, the Prosecutor's office, as well as active agencies, attend each meeting and review plans for outreach and inclusion in this planning process. Many of the people on MHAB sit on other County planning bodies or sectors and share information and data about issues without formal systems. COVID impacted the ability of focus groups etc. to meet face to face; however, virtual meetings were able to produce valuable information to the process.

The advent of Recovery Support Services, Certified Peer Recovery Specialists and Recovery Coaches have joined the efforts. Survey responses to key questions about recovery and treatment help guide the planning process. Also, the information generated by the OORP program, and the New Jersey Attorney General Operation Helping Hand (OHH) were integral in providing relevant

data. Key Informant interviews were also valuable to reach those not directly involved in the substance abuse system.

4. 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

Countywide Town Hall Meeting	YES	**NO**	1	2	3	4	5
Within-County Regional Town Hall Meeting	YES	**NO**	1	2	3	4	5
Key Informant Interviews	YES	**NO**	1	2	3	**4**	5
Topical Focus Groups	YES	NO	1	2	3	**4**	5
Special Population Focus Groups	**YES**	NO	1	2	3	**4**	5
Social Media Blogs or Chat Rooms	YES	**NO**	1	2	3	4	5
Web-based Surveys	YES	**NO**	1	2	3	4	5
Planning Committee with Sub-Committees	**YES**	NO	1	2	3	4	5
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.

N/A

4. 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?

Beneficial information came from the community. Also, Key Informant Surveys/Interviews and were helpful as many of the participants had first-hand experience and knowledge. a neutral platform.

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

a. Offenders. Drug/Recovery Court clients, parolees, and those under various supervision programs were surveyed.
b. Intoxicated Drivers. Data from IDP was reviewed and informal discussions with IDRC staff were conducted.
c. Women - Agencies who serve women were surveyed. Women have always been and continue to be disproportionately underrepresented.
d. Youth – Key information interviews of community members and youth enrolled in First Step Clinic
e. Disabled – Cumberland County Office on Aging and Disabled could assist with better identifying the extent of substance use and concomitant needs of this population.

f. Workforce According to NCADD, 70% of the Workforce use illicit substances. Perhaps they have private insurance and/or go through their Employee Assistance Program (EAP) so government entities do not have access to that data. Drug-Free Workplaces require those that are under reasonable suspicion must go through a return-to-duty process and get referred for services.
g. Seniors - Key informant focus groups have been completed at some Senior Centers.
h. Co-occurring – Interested parties who attend the Mental Health and Addictions Board meeting, community surveys and key informant data.

6. **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.**

The planning processed helped to build and strengthen collaborative relationships among the county by increasing direct communication, sharing knowledge, experience, programs, and resources.

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.

Cumberland County's plan for the use of the AEREF prevention funds during 2024-2027 will have the objective of delaying the onset of alcohol and substance use among youth by promoting general development of student's self-esteem, interpersonal relationships, problem-solving, coping skills and issues of bullying by providing education and connecting them to services which would improve overall well-being. The strategy used will be to have a program in schools or summer camps that do not have that service. The evidenced based Botvin Life Skills Training Program will be used as a framework
https://www.lifeskillstraining.com/?gclid=EAlalQobChMlzsmGooGb4AlVw0GGCh1k4wU2EAAYASAAEgLX0_BwE#
There will continue to be alcohol and drug specific education and prevention referral services for participating schools. Currently, there are policies in place that outline how a teacher may refer a youth and family to those services. Opportunities to participate will be advertised through the county website, social media, Children's Interagency Coordinating Council (CIACC), Youth Services Advisory Council (YSAC) and others.

The County will also endeavor to launch a community awareness media campaign delivering prevention and early intervention messaging. Billboards, social media, paid advertisements on the internet, television and newspapers will be implemented on an experimental basis. Effectiveness and breadth of audience reach will be analyzed through the year to monitor which mediums are more effective than others. The goal is to reduce potential harm and increase protective factors for Cumberland County residents.

SUMMARY OF THE CUMBERLAND COUNTY REGIONAL PREVENTION COALITION IMPLEMENTATION PLAN

Salem-Cumberland Regional Action Toward Community Health (SCRATCH) is a regional coalition dedicated to eliminating substance abuse in Salem and Cumberland Counties. It is an initiative of The Southwest Council, a substance abuse prevention agency which has been providing substance abuse education and prevention services in Salem and Cumberland Counties for more than 21 years.

The coalition employs environmental strategies to change community norms which might be favorable to substance abuse. For instance, the coalition will work to change the belief that underage drinking is a normal part of growing up by conducting Sticker Shock Campaigns designed to inform adults of the legal consequences of providing alcohol to underage drinkers.

SCRATCH initiatives address three main issues:

1. Underage Drinking
2. Prescription Drug Abuse across the lifespan
3. Illegal Substances with a special emphasis on marijuana use

The coalition is 60 members strong and enjoys good representation at our monthly meetings. The coalition membership is diverse and includes both professionals and volunteers from Salem and Cumberland Counties who are interested in reducing substance abuse in their communities. Members consist of health professionals, school officials, municipal alliance coordinators, religious leaders, parents, and youth, to name a few. All are welcome to join the coalition. Coalition members look forward to working to reduce substance abuse in the Salem-Cumberland region for years to come.

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

Cumberland County has 7 Municipal Alliances funded through the Drug Enforcement and Demand Reduction (DEDR) fund: ASAP – a consortium consisting of Deerfield, Fairfield, Greenwich, Hopewell, Shiloh, Stow Creek, and Upper Deerfield, Bridgeton, Commercial Township, Lawrence/Downe Township – a consortium, Maurice River Township, Millville, and Vineland. These 7 Alliances make up all 14 municipalities/townships in Cumberland County. Unfortunately, the ASAP Coordinator has retired and none of the consortia were willing to take on oversight. This County intends to supplement this loss by providing community programs in

those townships. The remaining 7 Alliances and the County strategic plans seek to address the Governor's Council on Alcoholism and Drug Addiction's (GCADA) State Priorities, which focus on the consequences of the following: alcohol/underage drinking, marijuana, prescription drugs and tobacco.

The below gives a profile of the strategies that each Alliance employs to effectively prevent negative consequences resulting from one or more of the State's prevention priorities.

Community Awareness Programs	Provide information to the community regarding: misuse of prescription drugs and proper prescription drug disposal/monitoring including drop box information; consequences of underage drinking and the monitoring of alcohol in the home; consequences of marijuana use; consequences of vaping.
Youth Prevention & Awareness	Develop and/or support drug-alcohol free activities for community and youth to alter perception that alcohol/drugs are necessary ingredient for a good time and distribute information to youth about the consequences of using/misusing alcohol, tobacco products, and illicit/prescription drugs.
School-Based Prevention Programs	Provide information to the students, parents, and the community at large, regarding the misuse, access, dangers, and consequences of use of prescription drugs, marijuana, and vaping; wellness/healthy living strategies, proper prescription drug disposal/monitoring. Deliver evidenced based prevention programs such as Life Skills Training, Ripple Effects, Leader in Me, Mental Health First Aid, etc.

The programmatic components of each strategy serve as a compliment to the prevention component of this comprehensive alcohol and drug plan by providing direct preventive supports to all the municipalities within the County.

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 are required. Label multiple goals in their order of importance: "FIRST", "SECOND", etc. The Logic Models are to be placed in Appendix 4.

LOGIC MODEL NARRATIVE: PREVENTION

1. **Describe a prevention need-capacity "gap" in the county's prevention system of care and the strategic importance of addressing this "gap" for reducing the county's treatment need in the 2024-2026 planning cycle.**

First, Demand for access to evidenced based prevention program and services for youth and families exceeds capacity

Second, lack of community awareness puts residents at risk to the dangers of substance use and unhealthy choices.

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

Youth lack healthy coping skills that can increase risk of alcohol and substance misuse.

Substance users are at an increased risk of overdosing due to fentanyl being in the drug supply. The community lacks prevention and harm reduction awareness.

1. **What quantitative and qualitative evidence did you find that helped you to identify this gap and evaluate its significance?**
   According to 2020 Kids Count data, 54% of Cumberland County youth live in poverty, and only 20% of youth met or exceeded the 11th grade ELA Exam. According to a community survey issued by Cumberland County, 62% of youth surveyed indicated marijuana is not a "gateway" drug.
   The 2022 end of year Cumberland County Opioid Overdose Fatality Review Team Report indicated out of all of the decedents studied, the medical examiner reported only two toxicology reports that had the presence of opioids. All the rest were fentanyl, fentanyl/methamphetamine, and fentanyl/cocaine.

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

   Reduce substance misuse in the underage population by increasing the knowledge about its school-based and family focused life skills/family management programs.

   Increase community awareness regarding the dangers of fentanyl and any other subsequent illicit substance that will emerge during the planning cycle and provide resources to reduce the risk of overdose.

3. **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.**

   The accomplishments for the county-funded programs throughout the 2024-2027 planning period is to provide services to K to 8th grades that will increase youth's coping and refusal skills.

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

   2023: Issue a Request for Proposal for the program (if required); solicit bids for advertising media
   2024-2026: Monitor the program effectiveness
   2026-2027: Redirect funds if programs failure to meet goals

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

   $35,000 Evidenced-based youth prevention programs
   $15,000 Community Awareness media campaign.

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

   At least 100 students will learn and apply evidenced-based life skills. At least 50,000 county residents will be engaged through the community awareness media campaign.

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

   The community benefits of this program is that youth will be provided with skills to help regulate impulse and emotion, thereby delaying the onset of alcohol and drug use among youth. The community at large will benefit by increasing awareness of risks of substance use and protective resources, reducing overdose risk and increasing access to harm reduction resources.

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

   The County will solicit bids through a competitive process and obtain quotes when appropriate. The awardee will be responsible to carry out its specifications.

2024-2027: PREVENTION Evidence-Based Programs

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

Name: Botvin Life Skills

Description: In these evidenced-based programs, youth learn and practice a set of general life skills that aim to enhance overall confidence and reduce internal motivation to engage in substance abuse, while also teaching them problem-solving skills and techniques to resist social pressure from friends or family to use substances.

Objectives: 80+% of the students will demonstrate increased knowledge of the dangers of drug and alcohol misuse through pre and post testing.

Location or Setting for its Delivery: K-8 Schools in Deerfield, Upper Deerfield, Seabrook, Fairfield and Stow Creek.

Expected Number of People to Be Served: 300 annually

Cost of Program: $50,000 annually

Evaluation Plan: Pre and post-test scores demonstrating 20% increase in knowledge of dangers of drug and alcohol through pre and post-tests, on-going monitoring of program efficacy by the county alcohol and drug director and required participation of the provider to attend at least 75% of Professional Advisory Council on Alcohol and Drug Abuse (PACADA) meetings.

LOGIC MODEL NARRATIVE: EARLY INTERVENTION

1. **Describe an early intervention need-capacity "gap" in the county's substance abuse system of care which could be reduced by the county investments in treatment. Please describe the strategic importance of addressing this "gap" for increasing residents' access to treatment on demand in the 2024-2027 planning cycle.** Cumberland County has a lack of community awareness on how to respond to an overdose, lacks access to Naloxone and has insufficient access to early intervention services.

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

3. **What quantitative and qualitative evidence did you find that helped you to identify this gap and evaluate its significance?** Participation in the County Overdose Fatality Review Team (OFRT) end of the year 2021 report, OD Mapping, Knock and Talk data

4. **Please restate this "gap" and related community problem or problems as a goal to be pursued during the 2020-2023 CCP.** Cumberland county residents will be provided Naloxone kits and overdose prevention education with the goal of reducing overdoses, both fatal and non-fatal. The community will have access to early intervention services.

5. **What annual accomplishments has your county set for itself in pursuit of this goal over the next four years?** All Cumberland County residents will be able to access Naloxone on demand. 10,000 community members will be informed and made aware of early intervention programs.

6. **How much will it cost each year to meet the annual objectives?** This initiative will be realized through partnerships and agencies providing Naloxone and early intervention programming.

LOGIC MODEL NARRATIVE: TREATMENT

1. **Describe a treatment need-capacity "gap" in the county's substance abuse system of care which could be reduced by the county investments in treatment. Please describe the strategic importance of addressing this "gap" for increasing residents' access to treatment on demand in the 2020-2023 planning cycle.** Although Medicaid funds a majoring of Cumberland County treatment admissions, a small gap will still need to be covered. The county needs to continue to operate First Step Clinic to meet the demand of drug and alcohol evaluation, referral, Outpatient, and Intensive Outpatient Services.

2. **What annual accomplishments has your county set for itself in pursuit of this goal over the next four years? State these as investment objectives for each level of care involved in meeting the objective in each year of the planning cycle.** The county seeks to keep the doors of its outpatient facility open, providing co-occurring substance use services for individuals and families, regardless of ability to pay. We aim to have one hundred clients on the roster at any given time throughout each year.

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

   The county provides a cash match to the Chapter 51 funds. It will continue to employ and utilize the expertise of an alcohol and drug coordinator to plan, monitor and oversee needs and services.

4. **How much will it cost each year to meet each individual objective in each year?**

Withdrawal Management:	$15,000.00
Short Term Residential:	$15,000.00
Halfway House:	$15,000.00

   Direct Services – Operation of First Step Clinic - $380,000 annually

5. **Once the strategy is implemented, how many residents do you anticipate will be treated? That is, what will be the annual "outputs" of the strategy?**

   Withdrawal management: 35 people per year and/or 500 units of Enhancement Services
   Short Term Residential: 17 people and/or 100 units or Enhancement Services
   Halfway House: At least 100 bed days
   First Step Clinic: Serve at least 500 clients per year

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

   Access to care will reduce the number of deaths, crimes, and the use of the Emergency Room. Overall community health and wellness will improve.

7. **Whose participation beyond the county's initiative will be needed to execute the strategy or any of its parts?** Participation will be needed by the providers for Withdrawal Management, Short-term Residential and Halfway House.

LOGIC MODEL NARRATIVE: RECOVERY SUPPORT

1. **Describe a prevention need-capacity "gap" in the county's recovery support system of care and the strategic importance of addressing this "gap" for reducing the county's treatment need in the 2024-2027 planning cycle.** On-going recovery support services are needed to help prevent relapse.

2. **What social costs or community problem(s) does this "gap" impose on your county?** Individuals and families will continue to relapse and cost more in treatment funds.

3. **What quantitative and qualitative evidence did you find that helped you to identify this gap and evaluate its significance?** According to 2021 Substance Use Overviews, 34% of Cumberland County admissions were duplicated, meaning those individuals had relapsed.

4. **Please restate this "gap" and related community problem as a treatment goal to be achieved during the 2024-2027 CCP.** The goal will be to enhance recovery capital opportunities for individuals seeking to reduce or eliminate substance misuse in their lives by providing recovery support services through the operation of Capital Recovery Center and its various initiatives.

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.** To continue to offer and expand opportunities to the recovering community to maintain sobriety through customized recovery plans and services provided through Capital Recovery Center, Recovery On Wheels (ROW) and Cumberland C.A.R.E.S. 24-hour hotline.

6. **What strategy will the county employ to achieve each annual objective?** The County will operate Capital Recovery Center and provide an array of recovery support services.

7. **How much will it cost each year to meet the annual objectives?** $90,000.00 of Chapter 51 funds will be put towards the operating costs and programs.

8. **If successful, what do you think will be the annual outputs of the strategy?** At least 300 unduplicated individuals and families will be served.

9. **What will be the annual outcomes, or community benefits, of the strategy? Please estimate the social cost-offsets for the community.** Increased periods of sustained recovery for individuals and families.

10. **Who is taking responsibility to execute the strategy or any of its parts?** The County of Cumberland Department of Human Services.

APPENDIX 1: DEFINITIONS OF PLANNING CONCEPTS

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

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

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

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

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

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

Demand Assessments seek to convert an assessed need into an estimate of the number of persons who can be expected to seek the planned care. The purpose of demand assessment is to anticipate how many persons with the need will actually use the care if it is offered. Treatment need may or may not convert to treatment demand. That portion that seeks and obtains treatment is called "Met demand" and that portion which does not is called "Unmet demand" when any individuals in this

group indicate a desire to obtain treatment. The remainder are persons in need with no indicated demand for care.

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

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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Disclaimer: "These data were provided by the State of New Jersey Department of Human Services, Division of Mental Health and Addiction Services, Intoxicated Driving Program. The Department specifically disclaims responsibility for any analyses, interpretations or conclusions".

APPENDIX 3: LIST OF PARTICIPANTS IN THE PLANNING PROCESS

No.	NAME	AFFILIATION	CONTACT INFO.
1	Connie Cossaboom	CASS	conniesc@comcast.net
2	Rabbi Abby Michaleski	LACADA	Rabbiabby18@verizon.net
3	Angelica Mercado	LACADA	angelicam@southwestcouncil.org
4	Toni Primas	LACADA	tprimas@famcareinc.org
5	Tiliya Reid	Department of Corrections	tiliyare@CumberlandCountyNJ.gov
6	Matthew Rudd	Prosecutor's Office	matthewru@CumberlandCountyNJ.gov
7	Miguel Torres	Mental Health and Addictions Board	Migueltorres2057@gmail.com
8	Jo Valenti	Mental Health and Addictions Board	Jvalenti49@hotmail.com
9	Gwen Piccioni	Mental Health and Addictions Board	vgpiccioni@comcast.net
10	Susan Shapiro	Department of Health	sshapiro@ccdoh.org
11	Dr. Josephine White	Mental Health and Addictions Board	Josiewhite40@aol.com
12	Joseph Sileo	County Commissioner	josephsi@CumberlandCountyNJ.gov
13	Donna Pearson	County Commissioner	donnape@CumberlandCountyNJ.gov

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: Demand for access to evidenced-based prevention programs for youth and family exceeds capacity. Lack of Community Awareness	2020 Kids Count NJ Profile indicate 5% of youth misuse alcohol or drugs Cumberland County ranks the 5th highest overdose rate per capita	**To**: Provide evidenced based programming provided by a qualified Student Assistance Coordinator (SAC). Increase Community Awareness	2024: Solicit qualified providers Secure a media company	2024: Implement the Botvin Life Skills		100 students served 50,000 residents reached through media	Short Term: Decrease behavioral incidents in school and decrease alcohol and substance use among youth; increase community awareness	A&D Director and funded agency
			2025: Provide x units of services, serve at least 100 students Media Campaign Continued	2025: To review performance and outcomes	County: $00:00 AEREF/State: $35,000 Total: $15,000	Number of Same as above	Middle Term: Decrease behavioral incidents in school and decrease alcohol and substance use among youth, increase in relationship effectiveness; increase community awareness	A&D Director and funded agency
			Provide x units of service, serve 100 students,	2026: to determine if programs	County: $00:00 AEREF/State:	Number of Same as above	Long Term: Decrease behavioral incidents	A&D Director and

Associated Community Problem: Youth will continue to underestimate the dangers of substance misuse			reach 50,000 community members through media	should be continued	$35,000 $15,000 Total: $50,000		in school decrease alcohol and substance use among youth, increase relationship effectiveness; Increase community awareness	funded agency
			2027: Provide x units of service, serve 100 students, reach 50,000 community members through media Provide	2027: To redirect funds if needed	County: $ AEREF/State: $35,000 $15,000 Total: $50,000	Number of Same as above unless funds are redirected		A&D Director and funded agency

LOGIC MODEL: EARLY INTERVENTION

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: Lack of community awareness and insufficient access to early intervention resources and information	Drug Death per 100,000 in Cumberland County is the 5th highest in the State.	**To:** Maximize access to early intervention tools for all community members.	2024: **To** Increase access to early intervention programs and resources	2024: Partner with community resources to distribute Narcan and promote programs	**County: $00:00 AEREF/State: $00:00 Total: $00:00**	All residents will have access to Naloxone and early intervention programs	Short Term: More residents will be informed and prepared to respond to an alcohol or substance use concern	Various Community Partners, State of NJ, Participating Pharmacies, Harm Reduction Coalition of NJ, Southwest Council
			2025: **To** Increase access to early intervention programs and resources	2025: Partner with community resources to distribute Narcan and promote programs	**County: $00:00 AEREF/State: $00:00 Total: $00:00**	All residents will have access to Naloxone and early intervention programs	Middle Term: Continued increase in informed and prepared residents	Same as above
Associated Community Problem: Overdoses			2026: **To** Increase access to early intervention programs and resources	2026: Partner with community resources to distribute Narcan and	**County: $00:00 AEREF/State: $00:00 Total: $00:00**	All residents will have access to Naloxone and early intervention programs	Middle Term: Continued increase in informed and prepared residents	Same as above

				promote programs				
			2027: **To** Increase access to early intervention programs and resources	2027: Partner with community resources to distribute Narcan and promote programs	**County: $00:00** **AEREF/State: $00:00** **Total: $00:00**	All residents will have access to Naloxone and early intervention programs	Long Term Middle Term: Continued increase in informed and prepared residents	Same as above

LOGIC MODEL: TREATMENT

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: Cumberland County residents are in need to access to treatment services	Residents accessing recovery support services through the mobile unit, hotline or recovery center indicate a need for treatment	**To:** Maximize the number of county residents who have a need access treatment on demand	**2024:** All Cumberland County residents who need substance use treatment will have access and funding.	**2024:** Contract with agencies to provide services and also provide direct Outpatient and Intensive Outpatient Services	**County: $61,434.00** **AEREF/State: $263,209.00** **Total: $324,643.00**	Number of clients served: See logic model narrative	More residents will be able to access treatment.	Various treatment providers to be identified through request for quotes or proposals (depending on award amount) and First Step Clinic
			2025: Same as above	**2025**: Same as above.	Same as above.	Same as above.	Middle Term: Continued access to treatment	
Associated Community Problem: Associated Community Problem: Residents who want treatment and cannot access appropriate services are in jeopardy of			2026: To Same as above	2026: Same as above	Same as above.	Same as above.	Middle Term: Continued access to treatment	Various treatment providers to be identified through request for quotes or proposals (depending on award amount) and

impaired health, incarceration, or death.								First Step Clinic
			2027: To Same as above	2027: Same as above	Same as above.	Same as above.	Long Term Continued access to treatment	Various treatment providers to be identified through request for quotes or proposals (depending on award amount) and First Step Clinic

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: On-going recovery support services are needed to help prevent relapse.	Community Survey and Key Informant Interviews clearly indicate a need for recovery support services	**To:** Continue to provide recovery support services through the operation of Capital Recovery Center	2024: **To** Provide at least 300 individuals per year with assistance to increase recovery capital through options in the program.	2024: Access to community support services	**County: $00:00 AEREF/State: $107,761.00 Total: $107,761.00**	Number of individuals to be served: 300 per year	Short Term: Increase incidents in residents achieving longer periods of recovery	Cumberland County Department of Human Services
			2025: **To** Same as above	2025: Increase access and opportunity	**County: $00:00 AEREF/State: $107,761.00 Total: $65,920**	Number of Same as above	Middle Term: Expand number of residents achieving longer periods of recovery	Same as above
Associated Community Problem: High rates of continued use and relapse, lack of recovery capital.			2026: **To** Same as above	2026: Same as above.	**Same as above.**	Same as above	Middle Term: Same as above	Same as above
			2027: **To** Same as above	2027: Same as above.	**Same as above.**	Same as above	Long Term: Stigma will decrease and recovery will be celebrated	Same as above