New Jersey

UNIFORM APPLICATION
FY 2022/2023 Combined MHBG ApplicationBehavioral Health Assessment and Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 03/02/2022 - Expires 03/31/2025
(generated on 01/30/2024 3.29.00 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2023

End Year 2024

State SAPT DUNS Number

Number 806418257

Expiration Date

I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name Division of Mental Health and Addiction Services

Organizational Unit Office of Planning, Research, Evaluation, Prevention and Olmstead

Mailing Address 5 Commerce Way, PO Box 362

City Trenton

Zip Code 08625-0362

II. Contact Person for the SAPT Grantee of the Block Grant

First Name Valerie

Last Name Mielke

Agency Name Division of Mental Health and Addiction Services

Mailing Address 5 Commerce Way, PO Box 362

City Trenton

Zip Code 08625-0362

Telephone (609) 438-4352

Fax (609) 341-2302

Email Address Valerie.Mielke@dhs.nj.gov

State CMHS DUNS Number

Number 806418257

Expiration Date

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name New Jersey Division of Mental Health and Addiction Services

Organizational Unit Office of Planning, Research, Evaluation, Prevention and Olmstead

Mailing Address 5 Commerce Way, PO Box 362

City Trenton

Zip Code 08625-0362

II. Contact Person for the CMHS Grantee of the Block Grant

First Name Valerie

Last Name Mielke

Agency Name New Jersey Division of Mental Health and Addiction Services

Mailing Address	5 Commerce Way, PO Box 362
City	Trenton
Zip Code	08625-0362
Telephone	(609) 438-4352
Fax	609-341-2302
Email Address	Valerie.Mielke@dhs.nj.gov

III. Third Party Administrator of Mental Health Services

First Name	
Last Name	
Agency Name	
Mailing Address	
City	
Zip Code	
Telephone	
Fax	
Email Address	

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From	
To	

V. Date Submitted

Submission Date	9/1/2022 4:06:37 PM
Revision Date	10/26/2023 8:49:55 AM

VI. Contact Person Responsible for Application Submission

First Name	Valerie
Last Name	Mielke
Telephone	(609) 438-4352
Fax	(609) 341-2302
Email Address	Valerie.Mielke@dhs.nj.gov

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

Substance Abuse Block Grant Planner: Suzanne Borys, Ed.D., Suzanne.Borys@dhs.nj.gov

National Prevention Network Representative: Donald Hallcom, Ph.D., Donald.Hallcom@dhs.nj.gov

Mental Health Planner: Donna Migliorino, Donna.Migliorino@dhs.nj.gov

Children's Mental Health Planner: Nicholas Pecht, Nicholas.Pecht@dcf.nj.gov

SAMHSA
Office of Financial Resources, Division of Grants Management
Center for Substance Abuse Treatment, Division of States and Community Systems
Center for Substance Abuse Prevention, Division of Primary Prevention
Center for Mental Health Services, Division of State and Community Systems Development

Request for No Cost Extension (NCE) for COVID-19 Supplemental Funding

COVID-19 Award Issue Date: 3/11/21 **Approved Expenditure Period:** 3/15/21 through 3/14/23

Instructions: *Current MHBG and SABG grantees may request a No Cost Extension (NCE) for the FY 21 COVID-19 Supplemental Funding Award for an additional expenditure period of up to twelve (12) months, through March 14, 2024. Grantees are required to complete the information below for the proposed use of funds using the NCE, and agree to implement this NCE in accordance with:*

- *the March 11, 2021 Notice of Award (NoA) Terms and Conditions for the MHBG COVID-19 Supplemental Funding or the SABG COVID-19 Supplemental Funding;*
- *the March 11, 2021 COVID-19 Supplemental Funding Guidance Letter to the SSA Directors and the SMHCs from Tom Coderre, then Acting Assistant Secretary for Mental Health and Substance Use; and*
- *the grantee's SAMHSA currently approved MHBG COVID-19 Supplemental Funding Plan, or SABG COVID-19 Supplemental Funding Plan, as previously communicated to the grantee by the CMHS or CSAT State Project Officer.*

Grantees are requested to submit this **Request for No Cost Extension (NCE) for COVID-19 Supplemental Funding** *to their CMHS or CSAT State Project Officer by email as a Word document or PDF file, and to upload this NCE Request as an Attachment in WebBGAS in the FY 23 MHBG Plan, or in the FY 23 SABG Plan. Upon written notification of a grantee's intention to file a NCE Request, the CMHS or CSAT State Project Officer will be requested to create and send the grantee a Revision Request in the FY 23 MHBG Plan or FY 23 SABG Plan in WebBGAS, with instructions for uploading the NCE Request as an Attachment in the FY 23 MHBG Plan or the FY 23 SABG Plan. Separate NCE Requests are required for approval for either a MHBG NCE Request or a SABG NCE Request. Grantees are requested to complete and submit the NCE Request, as instructed above, no later than Friday, September 9, 2022, at 12:00 midnight EST. Further information about this process may be requested from your CMHS, CSAT, or CSAP State Project Officer. Thank you.*

Check One Only (✓): _✓__Request for NCE for FY 21 **MHBG** COVID-19 Supplemental Funding
_____Request for NCE for FY 21 **SABG** COVID-19 Supplemental Funding

A. Name of MHBG or SABG Grantee Organization	Department of Human Services, Division of Mental Health and Addiction Services		
B. Date of Submission of NCE Request	9/9/22 Revised 10/27/22	C. Length of Time Requested (in Months) for NCE (12 Mo. Max. through 3/14/24)	12 months (through 3/14/24)

D. Name and Title of Grantee Finance Official Approving This NCE Request	Morris Friedman, Chief Financial Officer, Division of Mental Health and Addiction Services		
E. Name and Title of Grantee Program Official Approving This NCE Request	Donna Migliorino, Deputy Assistant Division Director and State Mental Health Planner, Division of Mental Health and Addiction Services		
F. Name and Title of Other Grantee Official Approving This NCE Request	Valerie Mielke, Assistant Commissioner, Division of Mental Health and Addiction Services		
G. COVID-19 Award Total $ Amount Issued in NoA of 3/11/2021	$22,649,212	H. COVID-19 Award Total $ Amount Expended as of NCE Request Date Above	$801,698
I. COVID-19 Award Total $ Amount Planned to be Expended through 3/14/2023	$1,301,564	J. COVID-19 Award Total $ Amount Requested for NCE	$20,545,950

K. Please provide a brief listing of your grantee actual itemized expenditures for your COVID-19 Supplemental Funding approved projects, activities, and purchases, that have been completed with your current COVID -19 Supplemental Funding, through the date of your submission of your NCE Request.

Community Mental Health Law Project - Assistance Due to Covid/Housing Stability	$175,000
Mental Health First Aid (2)	$290,912
Administration	$335,786
Total:	$801,698

L. Please provide a brief listing of your grantee estimated itemized expenditures for your COVID-19 Supplemental Funding approved projects, activities, and purchases, that are planned to be completed with your current COVID -19 Supplemental Funding, from the date of this Request through the end of the current expenditure period of March 14, 2023.

The total is $1,301,564 with itemized expenditures as:

Community Mental Health Law Project - Assistance Due to Covid/Housing Stability	$175,000
Outreach/Navigation - Underserved populations/crisis response	$420,000
Mental Health First Aid (2)	$34,088
Peer Wellness Program Dr. Eilers to speak with Val	$66,667
CT-R	$83,333
TA (NIATx) (TA SRC)	$280,000
Administration: Staffing/Printing/Supplies	$242,476

M. Please provide a brief summary of the challenges that your program has experienced in fully expending the current COVID-19 Supplemental Funding by March 14, 2023, and what steps the

grantee will be implementing to ensure that approved NCE COVID-19 Supplemental Funding will be fully expended by the end of the NCE period of expenditure requested above.

Whole Health Peer Wellness and Recovery-Oriented Cognitive Therapy (CT-R): The state's required procurement process had delayed approval of the request for proposal (RFP) for both initiatives, which in turn has delayed the process for selecting bidders. This has produced a shortened timeframe for projects, which, given the required project deliverables, will interfere with the full implementation of the initiatives. Both initiatives involve the provision of training and follow up technical assistance with a large number of community providers that will be participating. Community providers that participate also will need to make an organizational commitment that will require a significant culture change for them, so their initial participation will likely require more time than usual.

Whole Health Peer Wellness Initiative: The process of the RFP requires that the awardee develop a training curriculum and tools used to promote the health and wellness of consumers attending the state's community wellness programs. The curriculum development will be a challenge and would take time to implement, as no standardized holistic health training program currently exists; while there are many useful tools and practices that could be incorporated into the training modules, these would also need to be geared to the needs of the members who attend the community wellness centers. The awardee would need to develop a needs assessment and receive input from participants during this phase. The awardee will provide both training and ongoing technical assistance to ensure that the practices are fully implemented and will be sustained.

CT-R: One of the main challenges for the successful bidder is reaching out to community agencies statewide and trying to promote their interest having staff attend training and implement the required practices, some of which are unfamiliar to them, such as use of incentivizing and other engagement practices. The successful RFP bidder will need to develop training modules and incentivizing procedures while they generate buy in on the part of community provider leadership for their participation. After they provide the training, the awardee will need to provide technical assistance over several months to assist with incentivizing and with the implementation and sustainability of CT-R practices.

Coordinated Specialty Care (CSC) and CSC Community Integration (CI): With the support of MHBG 10% set aside, COVID-19 Supplemental Funding and ARP funds, the New Jersey CSC program was able to plan a major expansion and serve a broader population in need. The SMHA has spent resources to research and plan the details of the expansion to ensure that the expansion of the program and the addition of a community integration or seamless step-down program did not change any of the fundamental elements of the CSC model. The New Jersey CSC program will be expanding its scope of services to include Affective Psychosis and other ESMI diagnoses that our current CSC programs are receiving referrals for but cannot serve under the admission criteria for CSC FEP. The SMHA has also added a CSC community integration component so that individuals ready for discharge from the CSC program can transition into the CSC CI program to continually receive seamless step-down services to address the needs of the individuals in CSC. The expansion also includes adding three additional CSC programs so that 6 instead of 3 providers will serve the ESMI population in New Jersey. Each provider will administer a CSC program and a CSC CI program. The CSC and CSC CI RFP has been drafted and the final budget is under review. Once the final budget is approved, the RFP will be issued. It is anticipated that the awards will be made in February/March 2023 and the services will start immediately after the award.

SRC Technical Assistance: This initiative has been challenging to implement to date due to the process of negotiating and locating a program with the right expertise in providing this assistance to the acute care community. This program has now been located and a contract is in effect as of August 22, 2022.

The Teen Mental Health First Aid program experienced underspending because the project is a collaborative effort with schools to train teens but the school year is September 2022 to June 2023. COVID shutdowns, trainer attrition, school closures and/or change of leadership within the school also led to challenges in implementation.

988: In awarding grant funds to the 988 Lifeline crisis centers, the Division had to comply with the state's extensive procurement process which included a Request for Letters of Intent (RLI). The initial RLI for capacity building funds was published March 31 with awards made in May. The Division intended to fund all five centers through this process; however, only three centers received awards. A second RLI was published in July which awarded funds to the other two centers. Those funds will begin to be disbursed in August/September. In addition to the procurement process taking unexpectedly long, funds have been awarded based on the centers' ability to recruit, hire, train and onboard new staff quickly. However, centers have shared their difficulties and delays in finding staff to fill new positions which has, in turn, delayed the allocation of these funds.

Crisis Receiving Stabilization Centers (CRSCs): Submission of the request for proposal (RFP) which would allow the process for selecting a bidder(s) to develop the CRSCs has been delayed as there is currently no licensing standard developed for this novel program. DMHAS is now developing a certification process in lieu of licensing. The time needed to complete the certification process, submission and approval of the RFP, and for providers to be awarded is anticipated to be around February which would mean a 3/2023 implementation date.

Diversion High End Utilizer: The scope of the project had been delayed due to the revision of the proposed model. DMHAS is currently in the process of issuing a Request for a Letter of Intent (RLI) to expand Intensive Outpatient Treatment and Supports Services (IOTSS) to provide enhanced case management services. The staff would work with hospitals to provide linkages with services and supports for behavioral health individuals presenting to the emergency rooms frequently. The services will focus on providing rapid access to individuals in need of mental health services. The services include a prescriber, individual and/or group therapy, and support. Programs will focus on decreasing inpatient visits and increasing community tenure. Program expansion is expected to begin in January 2023.

Outreach/Navigation: An RFP has recently been posted. The delay in implementation was due to the development and procurement process. It is now moving forward and it is anticipated that that the start date will be 1/1/23 for these programs.

N. Please provide a brief listing of your grantee planned itemized expenditures for your COVID-19 Supplemental Funding approved projects, activities, and purchases, that are requested to be supported with the No Cost Extension for the COVID-19 Supplemental Funding amount that is identified above, for the NCE expenditure period that is identified above. All planned expenditures that are requested to be supported in an approved NCE must be fully within the current scope of the grantee's SAMHSA currently approved MHBG COVID-19 Supplemental Funding Plan or currently approved SABG COVID-19 Supplemental Funding Plan.

ESMI set aside $580,000 per program-10% set aside (3)	2,264,921
ESMI additional dollars to fund full program from dollars left from above	405,079

Crisis set aside-5% set aside	1,132,461
ESMI Community Integration Programs (6) - $350,000	2,340,000
Crisis Receiving and Stabilization -$1,237,395 (3) - one per region	6,089,268
Diversion-High End Utilizers/Low Community Capacity - $366,000 (9)	4,541,000
Outreach/Navigation - Underserved populations/crisis response	1,380,000
Mental Health First Aid (2)	75,000
Peer Wellness Program	333,333
CT-R	416,667
988 Implementation	500,000
Systems Review Committee (SRC) Technical Assistance	520,000
Administration: Staffing/Printing/Supplies	548,221

CSC/CSC CI-funding will support staffing and start-up costs for teams. Staffing for the teams consist of a Team Leader (LCSW/LPC), APN, clinicians (LCSW/LPCs), Supported Employment/Education Specialists, and Peer Recovery Specialists.

CRSCs-Funding is being used to support a comprehensive crisis service team consisting of 24/7 APNs, masters level clinicians, and peer recovery specialists. Funding is being leveraged with the 5% set-aside in the MHBG and will be used for start-up costs as well as training of the staff.

Diversion High End Utilizer: DMHAS is currently in the process of issuing a Request for a Letter of Intent (RLI). Program staff would work with hospitals to provide enhanced case management services to individuals presenting to the emergency rooms frequently with the goal of decreasing emergency room visits and inpatient hospitalizations. Through enhanced case management services linkages with services and supports, including mental health and other co-occurring needs will be provided.

Outreach/Navigation: A Request for Proposal (RFP) has being posted. The delay in implementation was due to the development and procurement process. It is now moving forward and it is anticipated that that the start date will be 1/1/23 for these programs.

Peer Wellness Program – funds will be used to hire peer recovery specialist staff to develop a curriculum and implement a holistic health training program and educational materials and tools for peers at the wellness centers. A needs assessment and a follow up assessment will be done. Whole Health Peer Wellness program RFP has been posted. The awardee will develop a state-wide Whole Health Learning Collaborative (WHLC) that serves the NJ Wellness/Self-help Center Peer Workforce and member participants. The awardee will also develop a training curriculum and tools used to promote the health and wellness of consumers attending the state's community wellness programs.

Recovery Oriented Cognitive Therapy (CT-R) RFP has been posted. CT-R is an evidence-based treatment approach that engages, builds trust, motivates and empowers persons. The CT-R approach uses empirically-supported and innovative strategies to work with individuals in a strengths-based and hopeful manner, and is especially useful in working with individuals who have been non-responsive to traditional mental health and/or co-occurring treatment services. Through this initiative, agency staff will develop the expertise to improve the care that will result in meaningful outcomes for persons with serious mental health and other co-occurring challenges such as addiction and/or medical issues, especially those who have not yet been adequately served well by the system. Another important component to this initiative is the use of "incentives" or external rewards to use as reinforcement for individuals to either engage in positive behaviors or to stop harmful/hindering actions, routines habits or addictions. CT-R funds will be used to hire clinical staff to provide training and technical assistance on CT-R and incentivizing techniques.

988 – Implementation – funding will be utilized to staff the call centers, train staff, technology for staff (phones, computers, monitors, etc.), and office equipment (e.g. desks).

Systems Review Committee (SRC) Technical Assistance: The contract for this initiative was effective as of August 22, 2022. The agency has begun to work to hire staff that will provide technical assistance to County based mental health system review committees in examining wait times in emergency rooms for psychiatric services. Oversight and evaluation of a Performance Improvement Project implemented by the SRCs targeting improvements in this area. NJs emergency rooms play a vital role in providing care for those in psychiatric need. This program focuses on assisting the SRCs in developing performance improvement projects to create a structure for the SRCs to review and revise processes that lead to more expeditious outcomes for individuals requiring hospitalization. The SRC TA service will: review current data and propose other data to be collected; conduct resource mapping to identify all resources available in county; conduct needs assessment for the identified counties; produce report outlining each county's challenges and needs; support each SRC in design of a performance improvement project to address identified needs using the NIATx Plan, Do, Study, Act (PDSA) model; support each SRC in data collection, analysis, and in the implementation of the performance improvement project. This project is being implemented as of September 1, 2022 and will begin to focus on a small group of SRC committees initially.

Teen Mental Health First Aid: The Teen Mental Health First Aid Program anticipates utilizing 80% of their allocated funding prior to 3/14/23 and would like to continue with their current collaborative efforts with schools training teens in MHFA.

O. Please provide any other relevant information about the current use of this COVID-19 Supplemental Funding, with actual itemized expenditures, and/or the proposed use of this COVID-19 Supplemental Funding, with estimated itemized expenditures, through a SAMHSA approved NCE for projects, activities, and purchases approved for expenditure under this funding.

End of NCE Request. Thank you.

New Jersey Division of Mental Health and Addiction Services
Mental Health Block Grant Supplemental Funding
Bipartisan Safer Communities Act (BSCA) Narrative and Budget
Budget Period 10/17/2022-10/16/2024

Resubmitted January 20, 2023
Revision and Resubmission on August 2, 2023

New Jersey's Department of Human Services (NJ DHS) houses the Division of Mental Health and Addiction Services (DMHAS). Located within DMHAS is a specialized behavioral health focused unit referred to as the Disaster and Terrorism Branch (DTB), is responsible for activating the State's behavioral health disaster response plan in coordination with the NJ Office of Emergency Management and the NJ Emergency Social Services Coordinators, during declared disasters. Each county (21 in total) in the State also maintains a county-specific all hazards behavioral health disaster plan. During times of disaster, the county's plan may also be activated by the County Mental Health Administrator and County Alcoholism and Drug Abuse Directors in coordination with the County Office of Emergency Management and in collaboration with State partners. The DMHAS partners with over 120 contracted community behavioral health provider agencies to provide services to New Jersey residents. Over the past several years and especially since September 11th, training for these behavioral health providers as well as private practitioners, has been consistently provided through federal grant programs. In the past year more than 1,000 people received training through DMHAS sponsored training programs. The DTB consists of a multi-disciplinary Training and Technical Assistance Group (TTAG), which has the capacity to provide on-demand training for behavioral health professionals in the wake of disaster to further increase the State's capacity to address the psychosocial needs of the community.

According to the CDC, more than 1.4 million adults in New Jersey have a disability; this is roughly 1 in 5, or 21% of the State's population. The disabilities and access and functional needs (DAFN) population is very diverse; disabilities can be physical, cognitive or behavior-health-related; as well as temporary or permanent. Individuals with disabilities and access and functional needs are often the most vulnerable residents during emergencies, being the most difficult to reach through public information and community outreach, and are more likely to result in medical emergencies and/or necessitate transitional housing, home modification and mental health services and counseling.

The DTB sits on the Disability, Access and Functional Needs Shelter Taskforce Committee (STF). The task force focuses on the needs of those with disabilities, access and functional needs before, during and after disasters. DTB will use the BSCA for educational opportunities for our DRCCs as well as to promote working with those in DAFN community and individuals with SMI/SED in emergency management planning and exercises, and to promote participation of those with SMI/SED in exercises.

The services available through the Disaster and Terrorism Branch include but are not limited to:

› Individual crisis counseling
› Psychological First Aid
› Disaster-specific psycho-educational information
› Group crisis counseling
› Consultation and training
› Information and referral services
› Toll-free warm line services

The DTB will use the Bipartisan Safer Communities Act (BSCA) funding to expand its existing behavioral health services continuum in the aftermath of traumatic events that impact the psychological health of New Jersey residents. DTB will focus on specific vulnerable populations who are more often victims of violence such as those with such as SMI/SED and of low socio-economic communities. Outlined below are multiple initiatives that help support this work.

Disaster Response Crisis Counselor

In 2007, DTB began the Disaster Response Crisis Counselor (DRCC) Certification Program. DRCC's are trained and background-checked volunteers who are deployed in a county or Statewide in the immediate aftermath of a community crisis. With the help of BSCA funding, DTB will increase the numbers and scope of the DRCC program in order to have a more specialized crisis taskforce for specific response types such as mass casualty events, impacting target populations of SMI and SED including those served in rural communities and the deaf and hard of hearing community. In order to best communicate with individuals who, have access and functional needs, the support of technology is vital and is an included budget line item. The development of such unique task force teams to deploy to incidents of mass casualties will require coordination with law enforcement, medical examiner offices and healthcare systems. The preparation of DRCC teams to respond to more complex anticipated and no-notice events is a vital part of response efforts.

Disaster response is always local and the DTB has cultivated successful working partnerships with the County Mental Health Administrators and the County Alcoholism and Drug Abuse Directors; they are responsible for the planning of behavioral health services in their counties. A stipend will be given to each county to fund recruitment, completion of exercise drills, training activities as well as engagement efforts for Disaster Response Crisis Counselors; each county will be awarded up to $15,000 per year based on need and or county population. Each county will be encouraged to include providers that serve that SMI/SED population in the planning and drills.

The DTB will promote the DRCC program throughout New Jersey through dissemination of printed materials, electronic newsletter, and podcast or recorded informational pieces of current responses, lessons learned and emerging trends in the field.

Learning Management System

With BSCA funds, DTB would like to secure a robust learning management system (LMS) in order to ensure consistency and quality of training and messaging. The learning management system would consist of informative video clips, interactive quizzes, pre and post knowledge test that engage and enhance the learning of participants. The target audiences for the LMS are Disaster Response Crisis Counselors, first responders, behavioral health providers, county behavioral health coordinators, emergency managers, non-profit organizations, and the disability, access and functional needs community.

Critical Incident Stress Management

Critical Incident Stress Management (CISM) is a comprehensive, integrative, multicomponent crisis intervention system. CISM is considered comprehensive because it consists of multiple crisis intervention components, which functionally span the entire temporal spectrum of a crisis. CISM interventions range from the pre-crisis phase through the acute crisis phase, and into the post-crisis phase. CISM is also considered comprehensive in that it consists of interventions which may be applied to individuals, small functional groups, large groups, families, organizations, and even communities. CISM teams have been an important part of the behavioral response for first responders in New Jersey for the past two decades, but attrition has led the teams to fold or be chronically understaffed. DTB proposes coordinating with the remaining CISM teams in New Jersey to increase training for law enforcement, fire, dispatchers, and EMS to rebuild the CISM Infrastructure.

Traumatic Loss Coalition

The DTB deploys DRCC's to work with all residents of New Jersey. However, when there is an incident primarily impacting youth and young adults, DTB works closely with New Jersey's Traumatic Loss Coalition (TLC). DTB proposes strengthening this partnership through cross-training. For this effort, the plan is to train 250 lead responders in the "Managing Sudden Traumatic Loss" (MSTL) response model. Specifically, the goal is to:

- Build Statewide capacity to respond to incidents involving SED youth and SMI young adults such as significant incidents of school violence, with 10-15 responders per county
- Offer 5-6 trainings with an audience of 40-50 people
- Conduct staff training with two co-facilitators/trainers for each offering
- Provide in person or virtual or hybrid trainings
- Provide manuals to participants

Approximately $5,000 per training (Trainer's fee, manuals, and fees for venue when required; cost range $25,000 to $30,000 per year). Sustainability would be possible as teams will be located in each county; and can cross-train as DRCC's to also work with the adult population. Volunteers have no ongoing costs for deployment.

BTAM Team Initiative

The NJ BTAM (Behavioral Threat Assessment and Management) Team is a centralized resource focused on the sharing of information and knowledge, and leveraging support of law enforcement and behavioral health professionals for the purpose of threat management. When law enforcement identifies a community threat, the team convenes to provide consultation in reviewing individuals at risk for engaging in violence or other harmful activities, and recommending intervention strategies to manage the risk of harm for individuals who pose a potential safety risk. Interventions and strategies will include and prioritize the SMI/SED population. The team includes representatives from several agencies and organizations including law enforcement, intelligence, education and behavioral health sectors. Each member of the team has advanced training in behavioral threat assessment, and works collaboratively to prevent targeted acts of violence through early identification, consultation, and management of individuals displaying concerning or threatening behavioral indicators. The team's goal is to reduce the number of incidents that occur by creating diversion pathways for at-risk individuals into programs for behavioral health or other services. DTB will play an integral role in the BTAM, a DTB staff person will lead DTB efforts and engagement with the team. The DTB Trainer will engage with the New Jersey Behavioral Health Provider network for a series of trainings to recognize the signs of radicalization, pathways to violence, and how to engage with law enforcement to prevent future episodes of mass violence.

Vulnerable Populations

New Jersey has incredible diversity and DTB will prioritize individuals with SMI/SED as well as connect with faith-based, LGBTQ+, and other cultural and racially vulnerable populations. DTB will partner with organizations to prepare for incidents of mass violence. Areas of training will be recognizing the pathways to violence, responding to active shooters, and Stop the Bleed training.

FAC's and Reunification Exercises

The DTB works in coordination with the NJ Department of Human Services' Office of Emergency Management (OEM) in planning for the aftermath of a mass casualty event. We propose using this grant to conduct regional exercises for Reunification and Family Assistance Centers. The increase in mass fatality incidents in the past decade – natural, man-made, and intentional – underscores the need for communities to be able to provide specialized behavioral health support to the families directly affected by these tragic incidents. In the aftermath of a mass casualty event, a Family Reunification Center (FRC) will be operational to facilitate the reunification of those affected by the event with their family members. Reunification is the process of reuniting friends and family members who have been physically separated as the result of an incident. After a crisis event, such as active shooter, the FRC is the gathering place where family reunification can occur.

The FRC may run in concert with Family Assistance Centers (FAC). The FAC is established to provide an array of support services to those impacted by the event. There are many services provided at a FAC. Some require or benefit from behavioral health support. Here is a list of some services provided at a FAC:

- Family Briefings
- Antemortem Data Collection (to assist in identifying victims)
- Death Notifications
- Call Center/Hotline
- Reception and Information Desk
- Spiritual Care Services
- Behavioral Health Services
- Medical/First Aid Services
- Translation/Interpreter Services
- Child Care

DRCC's and DTB specialized behavioral health crisis response teams are an integral part of assisting the families at these centers to aid survivors and their families with their immediate crisis mental health needs while they are at the FAC. By conducting disaster behavioral health exercises, DTB will prepare members of the DRCC's and other specialized crisis teams for their role in Reunification and Family Assistance Center operations. At the completion of the Reunification and FAC Training Exercise, DRCC's and other specialized disaster behavioral health teams will be prepared to assist with Reunification and FAC's, provide behavioral health support to individuals affected by a mass casualty incident. DTB will enlist the SMI/ED community to participate in drills to ensure responders learn how to best serve this population in a crisis.

County and State Emergency Partners Workshops

The facilitation of local, county, and State workshops with all emergency management partners will ensure coordination and collaboration ahead of a community crisis or mass causality incident. The goal is to break down existing silos to prevent duplication of services and to educate partners about the importance of and improved behavioral health outcomes when behavioral health issues are addressed in the immediate aftermath of a community crisis. Continuity of services for individuals with SMI/SED including minimizing disruptions to medication management and treatment require involvement of the whole of the emergency management workforce (law enforcement, offices of emergency management) as well as behavioral healthcare providers. The workshops will include education and planning for all partners on specific needs of individuals with serious mental illness and those living with substance use disorders, specifically those in need of medication assisted treatment. Behavioral health providers as well as County Alcoholism and Drug Abuse Directors and Mental Health Administrators are a vital part of increasing communication and planning to ensure better behavioral health outcomes for NJ residents after an event.

Set Aside Funds (ESMI and Crisis Services)

The 10% ESMI/FEP set aside will be utilized to help expand the continuum of services for individuals with early psychosis. NJ first implemented Coordinated Specialty Care (CSC) services, an evidence-based practices for serving the individuals with First Episode Psychosis in 2016. DMHAS is in the process of expanding access to CSC services to include individuals with affective psychosis as well. NJ is looking to have a total of six CSC programs. Additionally, each CSC program will have a CSC Community Integration (CI) program which will allow for

individuals to be able to step down to CSC CI or go back up to CSC if more intense services are needed. The transition between levels of care will be virtually seamless to the individual as the treatment team will remain the same for continuity of services.

The 5% Crisis Services set aside will be used for the implementation of the six new Crisis Receiving Stabilization Centers, including one time funds such as furniture, computers, medication carts, medication refrigerators and other equipment that might be needed to serve the patients at the centers as the current budgeted funds will not be enough to cover these expenses.

The BSCA Budget is outlined in the table below:

BSCA Budget Proposal	
Performance Period 10/17/2022-10/16/2024	
Set Aside Funds	**Cost**
ESMI/FEP10% Set Aside	$ 183,588
Crisis Services 5% Set Aside	$ 91,794
Subtotal	**$ 275,382**
DRCC	**Cost**
Statewide/Regional Meetings	$ 24,000
Update Printed Materials	$ 40,000
Deployment Shirts	$ 15,000
Deployment Kits	$ 65,000
Podcast/Electronic Communications	$ 15,000
Inclusive Language Services	$ 22,000
Technology for Language Services	$ 52,000
Database/Website Improvements, ID Equipment	$ 100,000
Continuing Education Credits	$ 12,000
Specialized Trainings for DTB State Coordinators/DRCC	$ 56,000
DRCC Engagement Activities (30k each, 21 Counties total)	$ 630,000
Subtotal	**$ 1,031,000**
Learning Management System	**Cost**
Start Up Cost	$ 119,000
Maintenance Cost	$ 10,000
Subtotal	**$ 129,000**
CISM	**Cost**
Regional Trainings x6 (3 per yr.)	$ 60,000
Part-time CISM Coordinator	$ 40,000
Subtotal	**$ 100,000.00**

TLC	Cost
TLC Trainings	$ 60,000
Subtotal	**$ 60,000**
FAC	**Cost**
Regional Exercises	$ 9,000
Space/Venue	$ 4,000
After Action	$ 4,000
Medical Examiner Office Exercises	$ 10,000
Subtotal	**$ 27,000**
BTAM	**Cost**
Staff Time	$ 61,794
Training	$ 43,709
Subtotal	**$ 105,503**
Vulnerable Populations	**Cost**
VP Special Initiatives	$ 60,000
Subtotal	**$ 60,000**
Emergency Partners Workshops	**Cost**
Staff Time	$ 30,000
Travel	$ 10,000
Printed Materials	$ 8,000
Subtotal	**$ 48,000**
GRAND TOTAL	**$ 1,835,885**

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2023

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
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as required by
Substance Abuse Prevention and Treatment Block Grant Program
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1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
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7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
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10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: _____

Name of Chief Executive Officer (CEO) or Designee: Valerie L. Mielke, MSW

Signature of CEO or Designee[1]: _____

Title: Assistant Commissioner

Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

State Information

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to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals.

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: New Jersey

Name of Chief Executive Officer (CEO) or Designee: Valerie L. Mielke, MSW

Signature of CEO or Designee[1]: Valerie Mielke

Title: Assistant Commissioner

Date Signed: 8/1/22

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

State of New Jersey
OFFICE OF THE GOVERNOR
P.O. BOX 001
TRENTON, NJ 08625-0001

PHILIP D. MURPHY
Governor

December 19, 2018

Elinore F. McCance-Katz, M.D., Ph.D.
Assistant Secretary for Mental Health and Substance Use
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, Suite 18E41
Rockville, MD 20857

Dear Dr. McCance-Katz:

As the Governor of the State of New Jersey, for the duration of my tenure, I delegate signatory authority to the Assistant Commissioner for the Division of Mental Health and Addiction Services (DMHAS) within the New Jersey Department of Human Services (DHS), for all the transactions required to administer the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment (SAPT) Block Grant, Mental Health Block Grant (MHBG) and Projects for Assistance in Transition from Homelessness (PATH) grant.

Sincerely,

Philip D. Murphy
Governor

c: Deepa Avula, SAMHSA
Carole Johnson, Commissioner, DHS
Valerie Mielke, Assistant Commissioner, DMHAS

Department of Human Services
Division of Mental Health and Addiction Services
Substance Use Prevention, Treatment and Recovery Services (SUPTRS) Block Grant
COVID-19 Supplement No-Cost Extension
Budget Revision Request
November 3, 2023

The Department of Human Services (DHS), Division of Mental Health and Addiction Services (DMHAS) requests a budget revision of its SUPTRS COVID-19 Supplemental no-cost extension to reallocate $11,200,000 in funding. In addition, DMHAS proposes to refocus its public awareness campaign to the benefits of Naloxone.

Reallocation of Funding

DMHAS proposes to relocate $11,200,000 funding to:

- Fund each of NJ's 21 Early Intervention Support Services (EISS) programs for a SUD Peer Recovery Support Specialist at $200,000 each for a total of $4,200,000
- Implement a public awareness prevention campaign for anti-stigma at $4,000,000
- Fund the Governor's Council for Alcoholism and Drug Abuse for its Municipal Alliance SUD Prevention Program at $2,000,000
- Develop a transportation program for clients to access services at $1,000,000

A total of $11,200,000 in funding will be reallocated from the following initiatives:

- SUD Crisis Receiving Stabilization Centers at $5,700,000
- Peer Recovery Support Specialists in Residential Treatment at $2,925,000
- Naloxone for DMHAS portal at $1,500,000
- Recovery care support or care coordination at $700,000
- College Recovery Support Services at $375,000

Early Intervention Support Services (EISS) Programs

Early Intervention Support Services (EISS) provide immediate mental health care to adults in crisis, offering an alternative to emergency room visits. EISS focuses on crisis intervention and stabilization through both on-site and outreach services. The program aims to quickly connect individuals with appropriate mental health resources, thereby reducing unnecessary ER visits and hospitalizations. Services include medication management, therapy, and recovery support, with care episodes ranging from a single consultation to up to six weeks of crisis stabilization.

Crisis Receiving and Stabilization Centers (CRSCs) were proposed utilizing SUPTRS Supplemental funding. The program will provide services to those in need of immediate in-person crisis intervention and stabilization for a behavioral health crisis. The decision was made to combine both mental health (MH) and substance use disorder (SUD). CRSC offers a no-wrong-door access to crisis stabilization, operating much like a hospital emergency department (ED) that accepts all walk-ins, and law enforcement and fire-department drop-offs. The individuals served in the program will receive community-based treatment and supportive services 24 hours a day, 7 days a week, 365 days per year, with the goal of mitigating the need to use the ED to access

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community-based services and preventing unnecessary or inappropriate hospitalization and provide short-term (less than 24 hour) community-based services to individuals experiencing a suicidal, mental health or substance use crisis. Individuals will be available to walk-in for immediate crisis response services. The program will also result in cost savings through the reduction in avoidable ED visits, inpatient admissions, police engagement, arrests, incarcerations and 911 calls. In 2021 there were 49,219 visits to EDs related to alcohol use disorder (AUD) with about 55 in 10,000 individuals visiting EDs for AUD. There were 110,386 visits for drug related issues with about 124 individuals per 10,000 using the ED for a drug issue. Currently, there is no alternative to EDs for individuals who are in crisis due to a SUD.

These facilities will be staffed by health and behavioral health professionals, including professionals with prescribing authority and trained peer professionals. Once a crisis is de-escalated, individuals will be linked to aftercare services and offered follow-up support.

In light of the fact that plans for Crisis Receiving and Stabilization Centers (CRSCs) have been delayed, DMHAS plans to add funding to the existing EISS programs to provide crisis/urgent care services for individuals with a substance use disorder as an interim measure, until CRSCs are operational in NJ. The EISS programs will receive funding so they can hire CADCs or LCADCs and SUD Peer Recovery Specialists to serve the SUD population.

Anti-Stigma Public Awareness Campaign

DMHAS plans to develop an anti-stigma campaign that produces and disseminates media messaging on a simple theme with a catchy slogan, along with educational webinars for the general public. The main theme or message is that bias and negative attitudes about people with addiction can be lethal, as it prevents these individuals from asking for help and others from providing the help.

There are multiple forms of stigma, including ‘public stigma,’ when the general population supports discriminatory stereotypes against a group of people; ‘self-stigma,’ when that group internalizes the stereotypical messages they receive; and ‘structural stigma’ where the policies, rules and practices of social institutions arbitrarily restrict the rights and opportunities of people with an addiction.

Addiction is a complex disease, similar to heart disease, cancer, and other chronic illnesses. Unfortunately, many people believe the myth that addiction is purely a choice. The truth is that addiction is caused by many factors that are often outside a person's control, things like genetics and family history, living with mental illness, and having a history of trauma and abuse.

Addiction stigma experienced by people with SUDs leads to tens of thousands of preventable deaths each year. Stigma prevents many from seeking treatment, creates social isolation, and prevents the use of life-saving medications.

The campaign will appear on broadcast television, streaming services, radio, outdoor advertising, and digital and social media. While the main focus is on opioid use disorder, all forms of addiction

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should be addressed, including use of alcohol. A 'words matter' component should promote first-person language and the avoidance of stigmatizing language (e.g., addict, dirty urine, etc.).

A component of the campaign will address structural stigma, which speaks to social determinants of health, and the discrimination and marginalization of people with substance use, and their effects on care and individuals' ability to recover. The public campaign will also address self-stigma, which describes how individuals with a substance use disorder who experience stigma will internalize this, lowering their self-esteem, and decreasing their interest in seeking help, leading to a worsening of their symptoms

Transportation for Clients to Access Services

This is a new initiative and will eliminate the barrier of access to treatment and other services for individuals who do not have access to transportation to get to the desired service. NJ's 2018 Household Survey of Drug Use and Health indicated that of the clients surveyed who indicated they wanted treatment, transportation was a barrier for 39% of the participants.

One of the determinants frequently reported across all healthcare domains, including behavioral health, is transportation (Locatelli et al., 2017; Syed et al., 2013). According to Bellamy et al. (2016), unreliable access to transportation was the most frequently documented and reported non-medical barrier to clients seeking substance abuse and mental health outpatient services. Transportation barriers manifest themselves in several ways: a lack of independent car ownership, high cost of public transportation, travel distance, travel time, parking fees, a lack of public transportation, distance from agency to a bus stop, and cost of ride-sharing services (Locatelli et al., 2017). Other factors include not having a valid driver's license; not having a working vehicle available in the household; or having a physical, cognitive, mental, or developmental limitation. Without adequate and affordable transportation options, clients are unable to begin vital treatment nor consistently attend and complete treatment or attend recovery support programs.

The primary purpose is to get clients to SUD prevention, treatment, and recovery support services. Eligible entities are existing non-profit DMHAS contracted and fee-for service SUD prevention, treatment and recovery support providers. Providers will be able to utilize UberHealth and other private transport companies in addition to bus and train tickets/passes.

Governor's Council for Alcoholism and Drug Abuse for its Municipal Alliance SUD Prevention Program

Block grant funding provided by the Department of Human Services- Division of Mental Health and Addiction Service (DMHAS) to the Governor's Council on Alcoholism and Drug Abuse (GCADA) will provide funding until March 14, 2024. This is a partnership opportunity for state government agencies to work collaboratively to service communities across New Jersey, particularly DMHAS and GCADA, the two leading providers of prevention programming and education in the state. The following information outlines the scope of service and provides an itemized budget.

GCADA's Municipal Alliance Program:

The recipients of the block grant funding will be the 21 counties in New Jersey who will then distribute the funding to the Municipal Alliances in their respective counties. The Municipal Alliances are comprised of local volunteers engaged in addressing substance misuse through prevention programming in their communities. In Fiscal Year 2021, there were 320 Municipal Alliances in 425 municipalities across all 21 counties. Prevention programming was planned for approximately 1,700,000 participants statewide - over 400,000 youth, 30,000 older Americans, and 1,200,000 community-wide event participants, reaching millions of New Jerseyans. The Municipal Alliance Program is an inextricable part of communities across the state, engaging all parts of the community: families who have lost loved ones, those trying to save them, educators, students, parents, seniors, coaches, athletes, clergy and communities of faith, veterans, law enforcement, chambers of commerce, county officials, and community members.

Program Parameters:

Evidence based programs will be required for implementation where higher funding levels allow; however, all programs, regardless of funding amount, must follow an evidence-based process of identifying the community need through county and municipal-level data, as well as outcome data to track and prove effectiveness. Cultural fluency as well as sustainability will be key factors in addressing equity and efficacy as part of the needs assessment and evaluation process through a public health approach.

GCADA develops comprehensive programmatic and fiscal guidelines for all funding. While more details are provided in the guidelines, here are some program content examples by which Municipal Alliances may apply the funding:

- Cannabis education for youth, parents, and community
- Youth Mental Health First Aid or other youth-based mental health programs
- Resiliency and leadership development programs for youth (No alternative programs)
- ACES/trauma-informed/harm reduction education programs for youth and parents
- Peer leadership programs
- Vaping education programs
- Community-building and other strengths-based youth programs
- Fentanyl overdose prevention education

GCADA applies an existing best practice model for community problem solving. This model—the Strategic Prevention Framework established by SAMHSA—has been utilized for the last 20 years of the Alliance program. All programs must align with the needs of the community as determined through previously administered needs assessments conducted by each Municipal Alliance Committee that focuses on risk factors associated with substance misuse, provide a plan for implementation along with demographics of the population being addressed, and include an evaluation component to assess effectiveness. Program evaluations are submitted and will include process evaluations to determine whether the program was run as intended and reached the anticipated population and participants. We will also measure program impact via short term outcomes, which will include indicators on specific program parameters. Each Alliance is required to submit exactly what and how they will evaluate their programs/activities, including timeline and parameters to be measured, as part of their grant information. Program modifications are permitted but must follow County and GCADA approval processes.

Project Budget: $2 million

Training Budget: $300,000

New Jersey has the unique opportunity to be the pioneer in addressing prevention efforts under the new landscape of legalization and decriminalization efforts while incorporating a public health approach in keeping with our shared goals. A comprehensive training series would be developed to offer the current science of prevention to prime the Alliance network in the use of the latest research to support community-driven outcomes. The focus of the trainings will include, but certainly not limited to, the implications and application of underage deterrence with regards to risk and protective factors that impact our youth, restorative prevention efforts that utilize our robust community relationships, learning how to repair the harm done to communities as a result of draconian drug laws and the impact of that system on racial oppression, understanding the social determinants of health and importance of equity through a trauma-informed perspective as well as the overview of the law as it relates to recreational use of marijuana. The trainings will inform and bring greater acceptance to mental health and harm reduction practices through a public health and trauma-informed lens.

MAGS Development Budget: $500,000

GCADA has developed an online grant management system which collects all the data for our grant process. The grants are all submitted, approved, and reported online. System upgrades will need to be developed to capture the grant requirements and allow for us to collect data for reporting to our funding partners. Reporting requirements will be tailored to the needs of state government along with measures consistent with data-driven prevention indicators.

Special Project Funding: $700,000

Special project funds will allow us to allocate funding to comprehensive programs within our Alliance network that incorporate the previously outlined principles without having to wait to align with our current grant cycle. This will allow us to offer programs in communities of need through a grant process. A special project funding application with a strategic action plan, identified outcomes and evaluation measures would need to be submitted by prospective grantees. All applications will be reviewed and approved by a designated GCADA review team. No funding may be spent until approved by GCADA. Considering the shortened timeline for spending, an expedited process will be established.

Fentanyl Overdose Prevention Campaign: $500,000

Song for Charlie is a fentanyl overdose prevention education campaign established in California. The organization uses a two-prong approach designed to reach teens/young adults and families. The comprehensive campaign provides education, tools, and resources to help educate on the dangers of fentanyl and fake pills. The teen/young adult portion of the campaign educates young people on the dangers of consuming fentanyl pills, healthy ways to cope with stress, and resources for help. The family portion of the campaign focuses on fentanyl education, how to have conversation with young people about substance misuse and resources if their child needs help. GCADA would like to bring this effort to NJ to provide statewide public awareness and education resources for youth and families.

Refocus of Public Awareness Campaign

Public Awareness Campaign

SAMHSA has approved DMHAS to expend $4,027,980 for a media campaign to bring awareness of the effectiveness of medication to treat addiction and suggestions for individuals to call their physician or 1-844-ReachNJ (NJ's SUD 24/7 Helpline) for more information. DMHAS media campaign for this initiative is currently funded by the State Opioid Response (SOR) grant. DMHAS proposes to refocus its media campaign funded by its SUPTRS COVID-19 Supplemental grant to a campaign focused on the benefits of Naloxone, so it is more secondary prevention focused.

According to the CDC, nearly 50,000 people died from an opioid-involved overdose in 2019. One study found that bystanders were present in more than one in three overdoses involving opioids. With the right tools, bystanders can act to prevent overdose deaths. Anyone can carry naloxone, give it to someone experiencing an overdose, and potentially save a life. In nearly 40% of overdose deaths, someone else was present. Having naloxone available allows bystanders to help a fatal overdose and save lives.

The campaign would focus on points raised by the CDC:

- If someone is at increased risk for opioid overdose, especially those struggling with **opioid use disorder (OUD)**, you should carry naloxone and keep it at home.
- People who are taking high-dose opioid medications (greater or equal to 50 morphine milligram equivalents per day) prescribed by a doctor, people who use opioids and benzodiazepines together, and people who use illicit opioids like heroin should all carry naloxone.
- Because you can't use naloxone on yourself, let others know you have it in case you experience an opioid overdose.

Carrying naloxone is no different than carrying an epinephrine auto-injector (commonly known by the brand name EpiPen) for someone with allergies. It simply provides an extra layer of protection for those at a higher risk for overdose.

The public in general needs more awareness of the value of naloxone.

NJ SUPTRS Block Grant COVID-19 Supplement NCE 11-3-23	3/15/2023 - 3/14/2024				
Initiative	**Cost Per Program**	**# Programs**	**Total Cost**		
			$ 45,050,958	$ 2,252,547.90	Admin Limit
Prevention (Primary)				$ 9,010,191.60	Prevention set-aside Min
Screening with EB tools (Universal ACE's, Social Determinants of	$ 30,000	21	$ 630,000		
Preventure	$ 2,000	21	$ 42,000		
Risk Messaging (adolescents/young adults)/Social Media	$ 250,000	1	$ 250,000		
Risk Messaging (parents)Social Media	$ 250,000	1	$ 250,000		
Strenghtening Families for Criminal Justice (14 week)	$ 21,000	21	$ 441,000		
Crisis or warm lines by prevention providers	$ 16,666	21	$ 349,986		
Puchase of Technical Assistance	$ 300,000	1	$ 300,000		
COVID-19 Awareness for persons w SUD	$ 5,000	21	$ 105,000		
Transportation to access prevention and vaccines	$ 5,000	21	$ 105,000		
Creation of Prevention Hub Infrastructure	$ 50,000	21	$ 1,050,000		
Prevention for Tribal Groups	$ 75,000	3	$ 225,000		
Youth Peer Leadership and Education	$ 1,000,000	1	$ 1,000,000		
Over the Counter (OTC) Prevention	$ 25,000	21	$ 525,000		
Marijuana Prevention	$ 75,000	21	$ 1,575,000		
Military/Veteran Enhance services	$ 49,000	1	$ 49,000		
College Recovery-4 yr	$ 375,000	4	$ 1,125,000	Reduced by $375,000	
College Recovery-2 yr	$ 250,000	3	$ 750,000		
Survey of 18-25 year olds	$ 250,000	1	$ 250,000		
Municipal Alliance	$ 2,000,000	1	$ 2,000,000	GCADA MOA - New	
Anti-Stigma Campaign	$ 4,000,000	1	$ 4,000,000	Marketsmith - Prevention Media Campaign - New	

Subtotal			**$ 15,021,986**		
Intervention					
Screening (SBIRT)	$ 1,650,000	1	$ 1,650,000		
Screening (SBIRT) in Eds	$ 1,000,000	1	$ 1,000,000		
Infrastructure/evaluation for SBIRT Provider	$ 250,000	1	$ 250,000		
988 Implementation	$ 500,000	1	$ 500,000		
Advertising Campaign	$ 4,027,980	1	$ 4,027,980	Refocus on Naloxone Benefits	
Naloxone for Portal	$ 1,500,000	1	$ -	Reallocated	
Naloxone & Training	$ 1,000,000	1	$ 1,000,000		
EISS SUD Peer Recovery Support Specialist	$ 200,000	21	$ 4,200,000	21 EISS Programs - New	
Subtotal			**$ 12,627,980**		
Treatment					
Underserved Populations	$ 150,000	10	$ 1,500,000		
SUD Crisis Services	$ 1,100,000	1	$ 1,100,000	Reduced by $5.7M	
SUD Crisis Services start-up	$ 900,000	1	$ 900,000		
Recovery Care Support (Care Coordination)	$ 1,300,000	1	$ 1,300,000	Reduced by $700k	
Peers in Residential Tx Programs	$ 75,000	26	$ 1,950,000	Reduced by $2.925M	
Subtotal			**$ 6,750,000**		
Recovery Support					
Pregnant and new moms (other substances)	$ 150,000	7	$ 1,050,000		
Resource Directory	$ 250,000	1	$ 250,000		
Peer Roster	$ 25,000	1	$ 25,000		
Recovery Data Platform	$ 25,000	1	$ 25,000		
Simulation Training	$ 250,000	1	$ 250,000		
Peer recovery Specialist Training	$ 1,000,000	1	$ 1,000,000		
Subtotal			**$ 2,600,000**		
Infrastructure					

PPE Equipment	$ 300,000	1	$ 300,000		
Outreach Workers for check-in of SUD individuals	$ 500,000	3	$ 1,500,000		
Increased connectivity, Wi-fi, equipment to improve service delivery	$ 20,000	100	$ 2,000,000		
Transportation Pool (TRIP)	$ 1,000,000	1	$ 1,000,000	Reimbursment Program - New	
Subtotal			**$ 4,800,000**		
Workforce Support					
Workforce Support	$ 1,000,000	1	$ 1,000,000		
Subtotal			**$ 1,000,000**		
Administration					
OPREPO Evaluator (Health Data Specialist 1)					
Crisis programs	$ 195,580	1	$ 195,580		
Prevention/Intervention/Outreach	$ 195,580	1	$ 195,580		
Treatment	$ 195,580	1	$ 195,580		
Evaluation Support (Health Data Specialist)	$ 156,464	1	$ 156,464		
OPREPO Program Managers (Program Manager)					
Supplemental Funds SABG Program Manager	$ 187,757	1	$ 187,757		
Prevention Hubs (and new target groups)	$ 183,845	2	$ 367,690		
Treatment and Recovery Supports	$ 181,756	1	$ 181,756		
OPREPO Asst Administrative Analyst					
RFPs	$ 136,906	1	$ 136,906		
Monitoring Unit SABG Supplemental Monitors					
Monitoring the new programs	$ 176,022	1	$ 176,022		
Fiscal Contract Analyst (Fiscal Analyst)					
Contract Analysts	$ 136,906	2	$ 273,812		

Treatment and Recovery Program Manager:					
Crisis Services/ Pregnant Women	$ 183,845	1	$ 183,845		
Subtotal			**$ 2,250,992**		
Total			**$ 45,050,958**	$0	

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2023

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
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As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
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7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Valerie L. Mielke, MSW

Signature of CEO or Designee[1]: _____

Title: Assistant Commissioner

Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2023

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8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Valerie L. Mielke, MSW

Signature of CEO or Designee[1]: Valerie Mielke

Title: Assistant Commissioner

Date Signed: 8/1/22

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

State of New Jersey
OFFICE OF THE GOVERNOR
P.O. BOX 001
TRENTON, NJ 08625-0001

PHILIP D. MURPHY
Governor

December 19, 2018

Elinore F. McCance-Katz, M.D., Ph.D.
Assistant Secretary for Mental Health and Substance Use
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, Suite 18E41
Rockville, MD 20857

Dear Dr. McCance-Katz:

As the Governor of the State of New Jersey, for the duration of my tenure, I delegate signatory authority to the Assistant Commissioner for the Division of Mental Health and Addiction Services (DMHAS) within the New Jersey Department of Human Services (DHS), for all the transactions required to administer the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment (SAPT) Block Grant, Mental Health Block Grant (MHBG) and Projects for Assistance in Transition from Homelessness (PATH) grant.

Sincerely,

Philip D. Murphy
Governor

c: Deepa Avula, SAMHSA
Carole Johnson, Commissioner, DHS
Valerie Mielke, Assistant Commissioner, DMHAS

New Jersey Division of Mental Health and Addiction Services

MH ARPA Funding Plan 2021 Proposal

Revised on May 31, 2022 for Implementing Teens Mental Health First Aid

Revised again on June 15, 2022 for removing Outpatient Expansion Project

Funding Modification for Outreach/Navigation and Outpatient Expansion Programs Revised September 28, 2022

Funding Modification for Diversion-High End Utilizers Program Revised January 19, 2023

Overview

New Jersey has methodically determined plans and strategies to enhance its mental health services. After review of the recommended funding priorities, the SMHA has developed a plan that will enhance diversionary efforts, crisis stabilization, and community integration efforts with a goal of reducing visits to emergency departments and screening centers as well as reducing inpatient admissions. The SMHA will also enhance outreach and treatment activities with the goal of increasing access to community services. The SMHA is requesting the full allocation of $39,121,366.

1. Identify the needs and gaps of your state's mental health services continuum including prevention, intervention, access to crisis services, treatment, and recovery support services.

   The SMHA has identified needs and gaps in the New Jersey mental health services continuum in the aspects of prevention and early intervention, access to crisis services, treatment services, and recovery support services. Some of the needs and gaps are:

   - **Early Intervention:**
     - FEP/ESMI Community Integration. The SMHA will continue to expand and support the Early Serious Mental Illness (ESMI) services, enhance coverage across the state and increase access for youth and young adults in remote and underserved areas. The SMHA has also identified a need for ESMI Community Integration. DMHAS currently does not have any community integration programs and has been experiencing a continued increase in the volume of individuals served in its current programs. Consumers that need less intensive services will be able to move to the transitional program where services will be titrated in accordance with the individuals assessed needs.

   - **Access to Crisis Services:**
     - Crisis Receiving and Stabilization Services. The SMHA will develop a new crisis receiving and stabilization home which will advance the development of crisis services based on the National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit. This will meet the need to decrease the utilization

of local hospital emergency services, designated screening centers, and in-patient psychiatric hospitalization.

- High Utilization/Low Capacity. The SMHA will continue to fund programs to divert individuals that frequently utilize crisis services including emergency rooms and designated screening centers. In addition, the SMHA has identified a need to fund services for individuals for navigating mental health crisis system, providing linkages and coordination of care in communities and counties where service capacities are low.

- Electronic Referral Systems. The SMHA currently does not have the capacity to fully track housing and service inventories and referrals. Part of the referral process is tracked manually. The SMHA needs to enhance the communication process for referral tracking via a Web-based Electronic Referral System. Additionally, the SMHA has identified a need for a crisis module to track crisis calls and response as well as disposition and linkages with services and housing supports.

- Crisis Diversion Programs. The SMHA has identified gaps in its system of care that are attributable to an increase in inpatient admissions and extended emergency room stays. As such, the SMHA will be looking to bridge the gap between homelessness and permanent housing by developing community-based housing that is staffed 24/7. This is a transitional program providing services are provided until the client is stabilized and community supports, services and permanent housing have been arranged. This will provide the client the opportunity to remain in the community with needed supports. Services provided by this program are on a temporary basis and will mostly receive referrals from crisis receiving and stabilization facilities or from emergency rooms that have individuals that need to be connected with additional services that will take longer than 23 hours to put the services or supports in place, including individuals that may need additional WRAP around services.

- **Treatment Services:**
  - Co-occurring SMI/DD initiative. Current statistics demonstrate that there are many individuals with Serious Mental Illness (SMI) and co-occurring Intellectual and/or Developmental Disabilities (ID/DD) who are frequent users of the acute care system. They present repeatedly at hospital Emergency Departments (EDs) and are often re-hospitalized as they require inpatient services. In order to decrease the frequency, there is a need to develop a Community Support Program to target the population of individuals who are dually diagnosed with a primary SMI diagnosis and a co-occurring ID/DD diagnosis and who frequently seek help from the acute care system.

- Community Support Program will serve the target population of individuals who are dually diagnosed with a SMI (primary) and ID/DD, and who frequently seek help from the acute care system.

- **Recovery Supports:**

  - Law Enforcement Crisis Diversion Pilot Collaborative. The SMHA has identified a need for continued diversionary activities and is looking to engage in a collaborative relationship with law enforcement to serve individuals in the field and connect them with clinicians who will work with the individual to provide clinical intervention, support and linkages with a goal of averting an emergency room and inpatient admission.

  - Older Adult Services. The SMHA will be implementing two older adult evidence-based practices that address the needs of the aging SMI population in New Jersey. Both initiatives take a collaborative team approach to address depression in older adults.

  - Children's System of Care (CSOC) Acute Care Services Capacity Improvement Program. A gap in the system of care has been identified to increase the capacity of psychiatric screening centers and CCIS (Children's Crisis Intervention Services) units to enhance knowledge and use of best practices when working with SED youth and SED youth with co-occurring disorders. The goal is to increase ability to link youth and families to appropriate community-based services promoting youth and family wellness and reducing unnecessary use of the acute care system.

  - 9-8-8 Implementation. With the roll out of 9-8-8 to become the new 3 digit dialing code for mental health crisis to replace the current National Suicide Prevention Lifeline number by July 2022, funding is pivotal to support the expected increase in incoming calls, growth in capacity for local Lifeline Center staff, and to ensure the Centers are able to provide required follow-up services to callers, texters, and chatters.

2. Identify the needs and gaps of your state's mental health services related to developing a comprehensive crisis continuum. Focus on access to your states services through crisis call centers with local knowledge of available services, availability of mobile crisis response teams and crisis receiving and stabilization services.

   The network of call center and hotlines programs for New Jersey residents is robust as evidenced by the 284,893 calls received by designated screening and affiliated emergency services plus 57,059 calls in 2020 and 27,522 calls through May, 2021 were received by the New Jersey Suicide Prevention Hopeline; these programs will be sustained through other funding sources. With the roll out of 9-8-8 to become the new 3 digit dialing code for mental health crisis to replace the current National Suicide Prevention Lifeline number by July 2022,

funding is pivotal to support the expected increase in incoming calls, growth in capacity for local Lifeline Center staff, and to ensure the Centers are able to provide required follow-up services to callers, texters, and chatters. The psychiatric emergency service program also includes mobile outreach capacity, providing approximately 30,000 episodes of mobile outreach per year, with approximately 12,000 of these episodes to community settings. Approximately half of the mobile outreaches to community settings result in diversions from hospital emergency departments. These will continue to be maintained with other funding sources.

However, less than 25% of people in the state have access to the current respite beds and community-based crisis diversion beds. In order to better meet this need and increase access to services, the DMHAS is targeting the development of more community-based crisis and diversionary services.

Accordingly, DMHAS proposes to continue further development of an alternative to traditional crisis mental health services by diverting consumers from going to the emergency room and inpatient treatment when community-based alternatives would better meet their needs. Funding will be continued for the four crisis receiving and stabilization centers that will be developed in the northern, central and southern regions of the state with the Covid Supplemental dollars. These programs will address the needs of high risk SMI consumers, including those diagnosed with a co-occurring mental illness and developmental disability or a history of forensic involvement. In order to better meet this need and increase access to crisis services in the community, the DMHAS will develop one more crisis stabilization and receiving program, which will result in statewide access through the services provided in these five region-based programs.

Diversionary efforts will also focus on individuals who are high utilizers of acute care services. A successfully piloted program in the state demonstrated decreased emergency room admissions for this cohort of individuals. Funding for this initiative will also focus on individuals residing in areas where there is a reduced capacity for services. Wrap-around funding has been budgeted for individuals served by the high-utilizer programs and by the crisis receiving and stabilization programs. These funds will be available until they have been expended for purposes of providing additional community supports to individuals when needed.

These resources will also be used to support legal needs of consumers that have arisen because of the COVID-19 pandemic, e.g., evictions. New Jersey and the federal government have eviction moratoriums in place related to COVID. Once the eviction moratoriums are lifted, landlords will be able to commence eviction proceedings. Housing stability is an important component of recovery. The DMHAS will use funds to support housing stability to avert homelessness through eviction. The resources will be used to enter into a contract with an agency that is staffed to provide landlord/tenant legal services to individuals facing eviction.

3. Describe your state's spending plan proposal, including a budget that addresses the needs and gaps related to crisis and services continuum.

An itemized spending plan is included in the table below:

MHBG ARP Budget 06/25/21		
Initiative	**Estimated Cost**	**# Programs**
ESMI set aside $580,000 per program-10% set aside	**3,912,136.60**	3.00
ESMI Community Integration Programs (6) - $350,000	3,150,000.00	6.00
Crisis set aside-5% set aside - (1)	**1,956,068.30**	0.53
Crisis Receiving and Stabilization - additional funding to make up the difference in set aside shortfall for one program as stated above	538,721.70	0.47 + start up
Crisis Receiving and Stabilization	7,473,729.00	4.00
Crisis Receiving and Stabilization add-on	400,000.00	
Diversion-High End Utilizers - $366,000	4,541,000.00	35.00
Web-based Electronic Referral System	1,865,000.00	
Web-based Electronic Referral System - Crisis Management Module	1,200,000.00	
Crisis Diversion Programs	4,000,000.00	2.00
Community Mental Health Law Project - Assistance Due to Covid/Housing Stability	150,000.00	
Outreach/Navigation - Underserved populations/crisis response	1,700,000.00	
Teen Mental Health First Aid	400,000.00	
WRAP dollars	200,000.00	
Co-occurring SMI/ID/DD initiative	1,418,330.70	1.00
Children's System of Care (CSOC) Acute Care Services Capacity Improvement Program	1,677,563.00	1.00
Performance Improvement	1,400,000.00	1.00
Improving Mood, Promoting access to Collaborative Treatment (IMPACT)	320,719.20	1.00
Program to Encourage Active, Rewarding Lives for Seniors (PEARL)	320,719.20	1.00
Law Enforcement Crisis Diversion Pilot Collaborative	41,310.00	1
988 Implementation	500,000.00	
Subtotal of Initiatives	**37,165,297.70**	
Subtotal Administrative Dollars - 5%	**1,956,068.30**	**FTE**
ARF OPREPO Block Grant Manager	249,900.00	1.00
Diversion - OPREPO Health Data Specialist Evaluation (Crisis Receiving Stabilization/High Utilization)	168,000.00	1.00

ESMI - OPREPO Program Manager	168,000.00	1.00
Outreach/Navigation and other initiatives - OPREPO Health Data Specialist Evaluation	168,000.00	1.00
Diversion Olmstead Program Manager (Crisis Receiving Stabilization/High Utilization)	173,355.00	1.00
Diversion Olmstead Staffing and On-Call 24/7	213,637.00	1.40
Electronic Referral Tracking/Data Analysis OPREPO	273,000.00	1.00
Grant Report Writer OPREPO	118,301.30	0.40
Fiscal Staff-Outreach/Navigation and other	63,000.00	0.50
Fiscal Staff-ESMI/Electronic Vacancy Tracking	63,000.00	0.50
Fiscal Staff-Diversion (Crisis/High Utilizer/Crisis Diversion Beds	63,000.00	0.50
Fiscal Staff-Compliance	63,000.00	0.50
Compliance Officer	171,875.00	0.50
Total ARPA Funding	**39,121,366.00**	

The $200,000 initially allocated to expand outpatient services is no longer requested for that service. After further analysis it was determined that significant additional funding would be needed in order to implement that service. DMHAS requests the re-allocation of those funds towards Outreach/Navigation services for Special Populations as funds are needed for start-up. The $200,000 will allow the anticipated 12 awarded grants to apply for one time needs including mileage reimbursement, mobile devices for staff, technology needs such as laptops that will assist staff while they are outreaching the population to be served in the community.

Outreach/Navigation: A Request for Proposal (RFP) has being posted. The delay in implementation was due to the development and procurement process. It is now moving forward and it is anticipated that that the start date will be 1/1/23 for these programs.

This is an update of the High End Utilizers program on January 19, 2023. The funding amount decreased by $400,000 to a total of $4,541,000. The $400,000 was moved to Crisis Receiving and Stabilization program, named Crisis Receiving and Stabilization add-on in the Table above:

Diversion-High End Utilizers: DMHAS proposes to allocate this funding to our contracted Psychiatric Designated Screening Center providers and Affiliated Emergency Services providers in each County. Providers will submit to DMHAS a plan to prioritize the hiring of peer staff to work with individuals presenting to psychiatric screening services via the emergency room or via mobile outreach by screening staff, multiple times throughout the course of the year. Non-peer staff can be hired if the organization is unable to hire peer staff. Staff would work with hospitals and systems partners to provide follow up services to high utilizers of the psychiatric screening services including to provide follow up calls, linkages to needed services, in person visits as needed, collateral contact and information services to family members and enhanced case management services to individuals presenting to the emergency rooms frequently utilizing psychiatric screening services, with the goal of decreasing emergency room visits and inpatient hospitalizations. Some medication services through the use of a prescriber may be provided as part of this initiative for follow up services. Through enhanced case management services linkages

with services and supports, including mental health and other co-occurring needs will be provided. The updated funding for this initiative is $4,541,000.

4. Describe how the state will advance the development of crisis and other needed prevention, intervention, treatment and recovery support services so that your state's system is responsive to the needs of your residents with SMI and SED. Refer to the guidebook on crisis services.

   ESMI Program. Since its inception in November 2016, NJ Coordinated Specialty Care (CSC) programs have gone through a rapid expansion. This initiative, which is covered statewide by three providers, was designed to serve 105 clients annually. The CSC initiative now serves over 210 clients annually with some clients receiving service after two years in the program. The programs have doubled in size since inception and have reached their capacity. Each agency currently covers 7 counties. This presents a challenge for providers in covering the vast territory as well as for the individuals receiving services because of the time spent traveling to the provider agency. DMHAS will be expanding Early Serious Mental Illness (ESMI) services by three new programs to enhance coverage across the state and increase access for youth and young adults in remote and underserved areas.

   ESMI Community Integration. The DMHAS has identified a need for ESMI Community Integration since Coordinated Specialty Care (CSC) originally opened in the state. There has been a rapid expansion of services in the first few years due to demand for services; however, most outpatient programs do not specifically fit the programmatic needs of an individual discharged from a CSC program. Service needs should be flexible and comprehensive to meet the client's needs. The need for a community integration program comes with the increasing number of FEP consumers in need of a transitional support program post-CSC intensive treatment. Consumers that need less intensive services will be able to move to the transitional program and titrate services according to their need. Treatment and supports will be geared toward reintegration of the client into the community, return to school/work, symptom stabilization, diversion from inpatient services and a reduction of screening center utilization. It will maintain a supportive environment where the client can access an array of services and remain connected in the community, thus reducing hospital recidivism, integration of health and behavioral health via continuity of care between the CSC APN and the client's primary care practitioner, reduction in duration of untreated illness, increase in medication adherence, and increase in functioning.

   Crisis Receiving and Stabilization. NJ DMHAS will develop a new crisis receiving and stabilization home which will advance the development of crisis services based on the National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit. The target population is individuals 18 years of age and older with a primary SMI who are experiencing acute psychiatric symptoms that could interfere with community tenure. DMHAS will be using the "no wrong door" concept and partnering with community crisis responders. The goal is to develop an appropriate alternative to the use of local hospital emergency services and in-patient psychiatric hospitalization, by providing crisis services and placement support for those in need of permanent housing. Referring entities, including first responders and law enforcement, can make referrals 24/7 by contacting the crisis receiving and stabilization home to ensure there is

bed availability. If beds are not available, staff will provide resources for alternative crisis stabilization. At a minimum, services will include 24/7 access to trained staff who can provide intensive supports, including engagement, psycho-education, identification of strengths, collaborative problem solving, and individualized recovery planning. Services will be offered in a safe, clean, home-like environment conducive to the recovery process. Medication management, administration, and education will also be offered. Clinical staff in the program will strive to stabilize individuals and address mental health needs. The program will offer continuity of care promoting continued stability and ensuring linkages are arranged that meet the needs of the individual. Overall, the aim of this program is to decrease the utilization of local hospital emergency services and in-patient psychiatric hospitalization, while maintaining crisis stabilization treatment.

Diversion - High End Utilization. Diversionary efforts will be developed to target individuals who frequently use acute care / crisis services. DMHAS will be looking at a similar model piloted by the Camden Coalition with promising outcomes. The goal of this initiative is to reduce emergency room admissions. Interdisciplinary care coordination teams will serve SMI adults 18 years and older in the community who require care coordination services, linkages and/or follow up to services such as primary care and specialist care, mental health services, and peer supports. Service recipients will be assisted with navigating the mental health network and linking to treatment and appropriate supports and services. Treatment will be provided by licensed providers who will expand services to reach underserved populations in their service areas.

Many of these consumers have co-occurring mental health issues, including co-existing medical conditions, co-occurring substance use disorders, co-occurring ID/DD issues, complex service needs and/or housing-related needs. Consumers are expected to be full partners in planning their own treatment and will identify and direct the types of activities that would help them maximize opportunities for successful community living. Staff support shall be provided through a flexible schedule, which must be adjusted as consumers' needs or interests change.

Web-based Electronic Referral System. Funding will enable DMHAS to procure a web-based data system that provides a registry for behavioral health beds and services to facilitate access for persons with SMI. The data system will maintain information and communications on community and hospital referrals and provides the information needed to monitor referrals and intervene to facilitate placement and linkages to services. The ability to manage behavioral health bed vacancies and ongoing referral communications in one system allows for timely response and efficiently managing diversionary efforts. The electronic registry will assist in diverting admissions from emergency rooms and inpatient settings including state hospitals. The electronic registry is necessary to enhance movement along the continuum. The data system will foster a continuum of community-based care that meets the needs of the individual where they live. The registry will contain a public facing portal to identify vacant beds that can assist with next day appointments since the system captures service availability. Funding will be provided for annual costs for 10/1/21 through 9/30/25 as well as one-time start-up costs in year one.

Web-based Electronic Referral System - Crisis Management Module. The crisis management module expedites access to assessment and treatment for those in crisis, tracks their journey from call to treatment, and coordinates all stakeholders' information within a crisis management system. The module, combined with the vacancy treatment and referral system, supports collaboration between the state, law enforcement organizations, local community organizations, faith-based organizations, and other behavioral health stakeholders in their efforts to ensure the integrated delivery of culturally competent, evidence-based, and family-centered services. The system provides a real-time connection between crisis call center professionals, crisis response teams, and treatment providers. The Service Availability dashboard displays the availability and location of mobile crisis teams, along with the directory and availability of behavioral health providers at two distinct dashboard tabs. The Crisis Management professional at the call center can document their intake interview and perform a validated assessment, toggle between the Crisis Provider and Behavioral Health Provider dashboards, and select which pathway is necessary for the client. The dual dashboard expands and collapses as needed, bringing into focus the necessary services to quickly serve the consumer. Crisis teams are dispatched using GPS-enabled technology and can view the caller's information, accept the dispatch, and document their assessment and plan at the scene. The crisis teams can, in turn, use the Service Availability dashboard to find available crisis beds or refer to outpatient assessment or treatment. The module's framework is based on SAMHSA's crisis management best practices and core elements of 1. No "Wrong Door" Access; 2. Regional Crisis Call Centers; 3. Mobile Crisis Team Response; and 4. Crisis Receiving and Stabilization Facilities. The technology provides real-time situational awareness and connection to all crisis stakeholders so that crisis professionals can connect consumers to care more quickly. Funding is requested from 10/1/21-9/30/25.

Crisis Diversion Programs. In order to bridge the gap between homelessness and permanent housing, DMHAS will be developing two crisis diversion homes with 5-10 beds each which are staffed 24/7. At a minimum, staffing will include clinical staff, peer support, nursing coverage, a housing specialist, an employment specialist, a co-occurring specialist, and prescriber services and/or coordination of services. Although the crisis diversion housing is not permanent, individuals experiencing a recent psychiatric hospitalization or relapse will receive the support they need from professionally trained and dedicated staff to continue their recovery in the community in a home like environment. The services and supports will be prioritized for individuals who have received crisis intervention services in an emergency room setting (inclusive of designated screening centers and affiliated emergency services) or in a crisis stabilization and receiving facility. Additional referrals may come from community inpatient programs as a step-down from short-term acute inpatient services providing the opportunity to further stabilize the client and connect the client with services and supports. The Crisis Diversion programs will include linkages to peer supports, clinical services, and housing with a goal of community re-integration to permanent or long-term housing for the consumer. DMHAS will not be using these funds for capital expenditures.

The length of stay of this program is dependent upon client need and is anticipated to be up to 30 days. This is a transitional program where services are provided until the client is stabilized and community supports, services and permanent housing have been arranged. This program provides the client the opportunity to remain in the community with supports with the goal of

reducing the need for emergency room or inpatient services. Services provided by this program are transitional and thus are provided on a temporary basis. Referrals will mostly be received from crisis receiving and stabilization facilities or from emergency rooms that have individuals that need to be connected with additional services that will take longer than 23 hours to implement the services or supports. By providing this additional level of care to the service continuum, the goal is to decrease the number of individuals in emergency screening longer than 23 hours while providing a mechanism for referral for crisis receiving and stabilization facilities for individuals with complex behavioral health needs that require significant services and supports to return to the community. This program will provide community-based stabilization in a home-like setting and is not long term or permanent housing.

Outreach/Navigation of Underserved Populations/Crisis Response. DMHAS will continue to fund outreach, treatment, and services from the previous award cycle. This initiative is planned to provide opportunities for local or county stakeholder groups to suggest innovative solutions and promising practices to address health disparities of underserved SMI populations at the grassroots level. Some of the groups that may be considered include individuals with SMI/SED from the following underserved populations: LGBTQ, Faith-based communities, Muslim, Haitian, African American, Indigenous populations, as well as colleges, high schools, and middle schools. Please note that this list is not comprehensive, and stakeholders will be asked to present proposals demonstrating needs or gaps in services for the proposed underserved SMI/SED populations. Programs will assess the need for services to the SMI population and ensure that services are delivered in a culturally competent manner.

Co-occurring SMI/DD initiative. The SMI/ID/DD Community Support Program will serve the target population of individuals who are dually diagnosed with a SMI (primary) and ID/DD, and who frequently seek help from the acute care system. The Program will offer services in the community to these individuals with the goal of providing a "stepdown" plan for individuals in EDs or on inpatient units (including state psychiatric hospitals, Trinitas 2D and Short Term Care Facilities (STCFs)). Services will include: Assessment of SMI/ID/DD, medication and situational needs (in person as needed); Behavioral Plan; Prescriptions and medication management; Education regarding disabilities and symptom management; Psychological support; and Coordination of community-based services. The Community Support Program team will include: a prescriber, a therapist, a peer family member, a behavioral analyst and a consulting medical professional. The program will serve individuals statewide and include a mobile outreach component that can meet potential Program consumers at their ED or hospital location. The Program is expected to serve 100 unduplicated individuals per year.

Law Enforcement Crisis Diversion Pilot Collaborative. A pilot program to be implemented between a DMHAS crisis diversion funded program such as Early Intervention Supportive Services (EISS) program or Crisis Receiving and Stabilization program, and a local police department where individuals in crisis will be able to communicate with a clinician on the EISS or Crisis Receiving and Stabilization team via an IPAD for assistance and potentially avoid an emergency room admission or an inpatient psychiatric admission through this intervention.

The use of electronic platforms such as Doxy.me is free for the minimum service. The budget includes a cost of 90 IPADs equipped with Wi-Fi + cellular connectivity. The requested funding for this initiative is from 10/1/22-9/30/24.

IMPACT (Improving Mood, Promoting Access to Collaborative Treatment). IMPACT is a Collaborative and Integrated Mental and Physical Health model designed to assist primary care practitioners recognize and treat depression in older adults. Primary care practitioners, social workers and a team psychiatrist provide the services in the IMPACT care model. The funding requested will be for 2 years (10/1/22-9/30/24). This model is a proven model that has been replicated in other states and is published in SAMHSA's evidence-based toolkit for treating depression in older adults.

PEARLS (Program to Encourage Active, Rewarding Lives for Seniors). PEARLS is a home-based setting via an outreach program. The program utilizes a social worker to provide eight sessions of problem-solving treatment (PST) over a 19-week period combined with increased participation in activities that the individual finds enjoyable. The staffing for the PEARLS program includes a consulting psychiatrist, LCSW or LPC, a vehicle, and phones. The psychiatrist provides recommendations to the older adults' primary care physician with regards to the use of antidepressants and other psychotropic medications. The funding requested is for 2 years (10/1/2022 to 9/30/24). This model is published in SAMHSA's evidence-based toolkit for treating depression in older adults and has been replicated in other states.

Children's System of Care (CSOC) Acute Care Services Capacity Improvement Program.
Psychiatric screenings centers and CCIS units may benefit from additional training with youth with co-occurring disorders including youth with mental health and intellectual or developmental disabilities or youth with mental health and substance use challenges. In addition, these agencies/programs do not always have a method for maintaining a resource directory and guidance for families regarding services available through the Children's System of Care and/or understand the process for linking youth and families to the sub-acute providers. As a result, youth are sometimes discharged without being linked to an appropriate provider. The goal is to increase the capacity of psychiatric screening centers and CCIS units to utilize best practices in working with youth with mental health including youth with co-occurring disorders and to enhance their ability to link youth and families to appropriate community-based services that promote youth and family wellness and may reduce unnecessary use of the acute care system.

The proposed project is to create a statewide consultation and technical assistance center (Center) dedicated to psychiatric screening centers and CCIS units that will assume a systems and direct practice approach to improving the quality of care for youth with acute behavioral health needs. The Center will be charged with conducting a multi-systemic needs assessment of each agency to distill training and consultation needs from "door to discharge" that will serve in enhancing the work force and the delivery of quality care for youth with co-occurring disorders. Equally important, the needs assessment will identify system barriers that impede the delivery of services. Information gathered through the assessment will be used to develop an agency specific and statewide training and consultation curriculum. Similarly, information gathered related to system barriers will be utilized to inform the evolution of state-driven

policies and contractual requirements. Following the review of the needs assessment data, the Center will design and offer agency specific and statewide training and technical assistance that will be complemented by subject matter experts in areas such as best practices in supporting and treating youth with IDD challenges with acute psychiatric needs and their family. In addition to providing training and consultation, the Center will concurrently develop structured forums for screening centers and CCIS units to consistently communicate with New Jersey Department of Health (DOH), DMHAS and Department of Children and Family (DCF) with an agenda that elicits acute care service system strengths and challenges and nurtures collaboration. In addition, a best practice forum will be created amongst agency medical directors and led by the DCF Medical Director. Best practice forums will serve in unifying medical directors across the state and provide an opportunity to highlight and discuss optimal treatment strategies in acute care settings. Progress towards curriculum and forum goals will be monitored quarterly and will include gathering and reviewing data related to workforce confidence and consumer satisfaction. The work plan will be revised as needed through an iterative process. The work of the Center will serve in complementing an initiative funded through the Garret L Smith grant aimed at supporting emergency departments in linking youth who present as suicidal and their families to targeted services and supports. The project will be implemented over a three-year period.

9-8-8 Implementation. The network of call center and hotlines programs for New Jersey residents is robust as evidenced by the 284,893 calls received by designated screening and affiliated emergency services; these programs will be sustained through other funding sources. With the roll out of 9-8-8 to become the new 3 digit dialing code for mental health crisis to replace the current National Suicide Prevention Lifeline number by July 2022, funding is pivotal to support the expected increase in incoming calls, growth in capacity for local Lifeline Center staff, and to ensure the Centers are able to provide required follow-up services to callers, texters, and chatters. The SMHA also provides an additional 12,000 mobile outreach episodes on average per year which are accessible to about 50% of the people in the state. These will continue to be maintained with other funding sources.

5. Explain how your state plans to collaborate with other departments or agencies to address crisis, treatment, and recovery support services.

The SMHA will collaborate with a number of state agencies, mental health service providers, community agencies, and other entities to address the needs of the SMI population. The state agencies comprise New Jersey Department of Health (DOH), Division of Developmental Disabilities (DDD), Children System of Care (CSOC), Division of Medical and Health Services (DMAHS)/Medicaid, and the Department of Community Affairs (DCA). The mental health service providers include emergency departments, Short Term Care Facilities (STCF), Designated Screening Centers (DSC), State Psychiatric Hospitals, County Psychiatric Hospitals, and Wellness Centers. The community partners consist of community-funded programs, faith-based organizations, and tribes. Other entities include secondary schools and colleges, law enforcement, and first responders. The SMHA has existing relationships with

almost all of these entities and has ongoing meetings and calls with them. This will continue for the initiatives in this proposal.

6. Describe how the state plans to spend the ten percent set aside for first-episode psychosis/early SMI and, if applicable, the five percent set aside for crisis services.

   The state will continue to address ESMI in fiscal year 2022 through the Coordinated Specialty Care (CSC) program. The three CSC providers have doubled their service capacity to 70 clients at each site. Each site serves 7 counties which presents a barrier to services for individuals because of transportation and distance. The current ESMI programs often exceed their existing caseload. Therefore, DMHAS is looking to expand the ESMI initiative by three additional agencies. In addition, DMHAS will be developing 6 ESMI Community Integration Programs which will be able to provide treatment and supports to individuals after they complete the ESMI program. The COVID Supplement funds will be used to build the 3 ESMI programs and the 6 ESMI Community Integration Programs from September 2021 to March 2023. After March 15, 2023, the APRA funds will continue to support the 3 ESMI programs and the 6 ESMI Community Integration Programs until September 2024.

   NJ DMHAS will continue implementation of four crisis receiving and stabilization centers in addition to the new center which will advance the development of crisis services based on the National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit. The target population is individuals over age 18 with a primary SMI diagnosis, experiencing acute psychiatric symptoms that could disrupt community tenure. Referring entities, including first responders and law enforcement, can make referrals 24/7 by contacting the crisis receiving and stabilization centers to ensure there is bed availability. If beds are not available, staff will provide resources for alternatives. At a minimum, services will include 24/7 access to trained staff who can provide intensive supports, including engagement, education, identification of strengths, collaborative problem solving, and individualized recovery planning. Medication prescription, administration and education will also be offered. Clinical staff in the program will strive to stabilize individuals and address psychiatric needs as well as provide assistance with assessing level of care and facilitating placement as needed. The program will offer continuity of care in an effort to promote continued stability by ensuring the linkages put in place are suitable for the individuals' needs. Overall, this program would decrease the utilization of local hospital emergency services and in-patient psychiatric hospitalization, while maintaining crisis stabilization treatment.

7. Describe other state priorities or activities that the state plans to fund during the performance period using ARPA funds, with consideration given to disproportionately high rates of MH/SUD in certain communities and disparities in COVID-19 BH-related outcomes by race, ethnicity, and other factors.

   WRAP dollars. Realignment of the service system to be proactive and responsive requires mobilization of resources to meet the needs of the individuals we serve in the community. Wrap dollars may be used to support an individual's community integration and housing needs by providing temporary financial support. Wrap dollars may be used for services, additional

staffing, specialized medical or clinical services not covered by consumer benefits or insurance, specialized clinical services, interpreter services, or court mandated services. Funding is requested from 10/1/21-9/30/25 or until funds are available.

Community Mental Health Law Project - Legal Assistance due to Covid/Housing Stability. These resources will also be used to support legal needs of SMI consumers that have arisen as a result of COVID, e.g., evictions. New Jersey and the federal government have eviction moratoriums in place related to COVID. Once the eviction moratorium is lifted, landlords will be able to commence eviction proceedings. Housing stability is an important component of recovery. The DMHAS will use funds to support housing stability to avert homelessness through eviction. DMHAS will use the MHBG COVID Supplement to enter into a contract with an agency that is staffed to provide landlord/tenant legal services to individuals facing eviction. Services will be provided statewide. DMHAS will use ARPA grant to continue to fund the Community Mental Health Law Project for 1.5 years. The funding will not be used for rent.

Teen Mental Health First Aid. The NJ Mental Health Awareness Training project will provide mental health first aid training by a team consisting of experienced, certified full-time and part-time trainers from DMHAS. They will train personnel in the evidence-based Mental Health First Aid (MHFA) model. The funding was originally allocated for providing Mental Health First Aid curriculum for the adult population (3/16/23-9/15/24).

On May 25, 2022, the New Jersey Division of Mental Health and Addiction Services submitted a waiver request to use the $400,000 in the Mental Health Block Grant (MHBG) ARPA to fund the Teen Mental Health First Aid (MHFA) curriculum from the National Council on Mental Wellbeing. Using the MHBG Covid Supplemental, the Division has begun a Teen MHFA Pilot which has been successfully launched and has several additional schools interested in participating. The ARPA funding will allow 9 additional school to begin a Teen MHFA project in their school, which includes training school staff as instructors for sustainability.

The Teen Mental Health First Aid curriculum can mitigate the need for hospitalizations and higher levels of care for the SED population by identifying those at high risk and creating safe interventions. The curriculum will also address the stigmatization that this vulnerable population can feel as they navigate the high school environment. By teaching teen peers to identify signs and symptoms of significant mental health disorders such as anxiety, depression, substance abuse, and psychosis to create a safety plan including a trusting adult, students with developing or current severe emotional disturbances can receive assistance before a crisis develops.

Performance Improvement. DMHAS will contract for performance improvement activities, including an evaluation of the impact of these county and project specific initiatives supported by the ARPA grant on the acute care system in New Jersey. The vendor will be tasked with completing a needs assessment that examines outcome measures of each initiative. The vendor will identify potential best practices that may be further implemented throughout the state and

areas of strength as well as potential weakness in the acute care system that can be further improved upon. Funding for this initiative is requested from 10/01/22 through 09/30/25.

8. Describe how the state will use, or consider, health IT standards if using funds for health IT infrastructure or advancement. This includes a description of standards and, as applicable, conformance to Office of the National Coordinator certification criteria in health IT products used or that will be used to support behavioral health clinical priorities and interoperable data exchange. States must use standards identified by the Office of the National Coordinator for Health IT in 45 C.F.R. 170 where applicable and also should consider standards identified in the Interoperability Standards Advisory (https://www.healthit.gov/isa/), including but not limited to those standards described in the, the "Allows for the Exchange of State Prescription Drug Monitoring Program (PDMP) Data" section and the "Social Determinants of Health" section.

   DMHAS will not be using funds to implement an electronic health record or exchange of state prescription drug monitoring program (PDMP), but will be requesting funding for implementation of an electronic bed registry, including a treatment locator for available services and a public facing portal. The web-based application will be in real-time and will be responsive to a crisis management system.

New Jersey Division of Mental Health and Addiction Services

MHBG COVID-19 Supplemental Funding Plan Proposal

Revised December 7, 2021 for Implementing Teens Mental Health First Aid

Revised September 29, 2022 for Reallocation of Funds in High End Utilizers and Acute Care System Review Committee TA Programs

Revised January 19, 2023 for an updated description of High End Utilizers Program

Overview

New Jersey has methodically determined plans and strategies to enhance its mental health services. After review of the recommended funding priorities, the SMHA has developed plans to enhance diversionary efforts, crisis stabilization, and community integration efforts with a goal of reducing visits to emergency departments and screening centers as well as reducing inpatient admissions. The SMHA is also planning to enhance outreach and treatment activities which should increase access to community services. The SMHA is requesting the full allocation of $22,649,212.

1. Identify the needs and gaps of your state's mental health services in the context of COVID-19.

The network of call center and hotlines programs for New Jersey residents is robust as evidenced by the 284,893 calls received by designated screening and affiliated emergency services; these programs will be sustained through other funding sources. With the roll out of 9-8-8 to become the new 3 digit dialing code for mental health crisis to replace the current National Suicide Prevention Lifeline number by July 2022, funding is pivotal to support the expected increase in incoming calls, growth in capacity for local Lifeline Center staff, and to ensure the Centers are able to provide required follow-up services to callers, texters, and chatters. The SMHA also provides an additional 12,000 mobile outreach episodes on average per year which are accessible to about 50% of the people in the state. These will continue to be maintained with other funding sources.

However, less than 25% of people in the state have access to the current respite beds and community-based crisis diversion beds. In order to better meet this need and increase access to services, the DMHAS is targeting the development of more community-based crisis and diversionary services.

Individuals with acute mental health needs are at times unwilling or reluctant to utilize traditional mental health services, concerned they may lead to the use of more restrictive settings including involuntary admissions. As such, DMHAS proposes to further develop an alternative to the traditional crisis mental health system by diverting consumers from potentially unnecessary hospitalizations. Crisis receiving and stabilization centers will be developed in the northern, central and southern regions of the state and will address the needs of high risk SMI consumers, including those diagnosed with a co-occurring mental illness and developmental disability or a history of forensic involvement.

Diversionary efforts will also focus on individuals who are frequent users of acute care services. A successfully piloted program in the state demonstrated decreased emergency room admissions for this cohort of individuals. Outreach and treatment services will also be developed targeting counties that have fewer services available for individuals who present for emergency services and in need of community services that are not readily available.

Since its inception in November 2016, NJ Coordinated Specialty Care (CSC) programs have gone through a rapid expansion. This initiative, which is covered statewide by three providers, was designed to serve 105 clients annually. The CSC initiative now serves over 210 clients annually with some clients receiving service after two years in the program. The programs have doubled in size since inception and have reached their capacity. Each agency currently covers 7 counties. This presents a challenge for providers in covering the vast territory as well as for the individuals receiving services because of the time spent traveling to the provider agency. DMHAS will be expanding Early Serious Mental Illness (ESMI) services by three new programs. In addition, DMHAS will be developing six ESMI Community Integration Programs which will be able to provide treatment and supports to individuals after they complete the ESMI program.

These resources will also be used to support legal needs of consumers that have arisen as a result of COVID, e.g., evictions. New Jersey and the federal government have eviction moratoriums in place related to COVID. Once the eviction moratorium is lifted, landlords will be able to commence eviction proceedings. Housing stability is an important component of recovery. The DMHAS will use funds to support housing stability to avert homelessness through eviction. The resources will be used to enter into a contract with an agency that is staffed to provide landlord/tenant legal services to individuals facing eviction.

Funding will also be used to provide training and technical assistance to peer staff in 30 community Wellness Centers, which will develop programs to address health and wellness in a culturally sensitive and trauma-informed manner. These peer-run centers provide support and recovery services to a diverse population of consumers around the state whose recovery was seriously impacted by COVID. DMHAS oversight of the peer-run centers found a gap in their capability to provide empirically proven recovery and support interventions.

The NJ Mental Health Awareness Training project will provide mental health first aid training by a team consisting of experienced, certified full-time and part-time trainers from DMHAS. They will train personnel in the evidence-based Mental Health First Aid (MHFA) model. On December 2, 2021, the DMHAS sent a waiver request to use the $400,000 in the Mental Health Block Grant Covid Supplemental to fund the Teen Mental Health First Aid curriculum from the National Council on Mental Wellbeing. The funding was originally allocated for providing Mental Health First Aid curriculum for the adult population.

2. Describe how your state's spending plan proposal addresses the needs and gaps.

The state will continue to address ESMI in fiscal year 2021 through the Coordinated Specialty Care (CSC) program. The three CSC providers have doubled their service capacity to 70 clients at each site. Each site serves 7 counties which presents a barrier to services for individuals because of transportation and distance. Therefore, DMHAS is looking to expand the ESMI initiative by

three additional agencies. Additionally, the current ESMI programs often exceed their existing caseload.

The DMHAS has identified a need for ESMI Community Integration since Coordinated Specialty Care (CSC) originally opened in the state. There has been a rapid expansion of services in the first few years due to demand for services; however, most outpatient programs do not specifically fit the programmatic needs of an individual discharged from a CSC program. Service needs should be flexible and comprehensive to meet the client's needs. The need for a community integration program comes with the increasing number of FEP consumers in need of a transitional support program post-CSC intensive treatment. Consumers that need less intensive services will be able to move to the transitional program and titrate services according to their need. Treatment and supports will be geared toward reintegration of the client into the community, return to school/work, symptom stabilization, diversion from inpatient services and a reduction of screening center utilization. It will maintain a supportive environment where the client can access an array of services and remain connected in the community, thus reducing hospital recidivism, integration of health and behavioral health via continuity of care between the CSC APN and the client's primary care practitioner, reduction in duration of untreated illness, increase in medication adherence, and increase in functioning.

DMHAS will be allocating 5% of the funds to the crisis set aside. As a result, DMHAS will be creating four Crisis Receiving and Stabilization programs in the community to provide for 24/7 community access to crisis diversion, stabilization, and linkages to services and housing supports. Individuals who are medically stable can receive services in a home-like setting with staff trained to provide crisis intervention services, medication management, counseling, and transitional services. The Olmstead staff will be on call to assist with providing education and training to the programs regarding services available in the community, as well as assist in the community re-integration process as needed These programs will serve to divert admissions from emergency departments and screening centers, as well as inpatient facilities.

Funding has been allocated for the creation of programs to serve individuals with behavioral health needs who frequent the emergency department. Service recipients, who will have a SMI, will be assisted with navigating the mental health network and linking to treatment and appropriate supports and services. in order to prevent readmissions to the Emergency Departments, Screening Centers and Inpatient Units. Treatment will be provided by licensed providers who will expand services to reach the underserved populations in their service areas.

DMHAS plans to increase its outreach, treatment and services to underserved populations such as LGBTQ individuals and faith-based communities. Programs will assess the need for services to the SMI population and ensure that services are delivered in a culturally competent manner. In addition, outreach will be extended to address the needs of the acute care service system and enhance mobile outreach services.

DMHAS plans to fund a Wellness program which is intended to improve consumers' self-esteem and practicing positive self-care using empirically proven interventions. The peer-run centers that provide support and recovery services to a diverse population of consumers around the state will

receive training and supervision on Recovery-Oriented Cognitive Therapy (CT-R) along with Peer Wellness Coaching.

The DMHAS is looking to expand our efforts with regard to Mental Health Awareness Training to provide teen mental health first aid. The Teen Mental Health First Aid curriculum can mitigate the need for hospitalizations and higher levels of care for the SED population by identifying those at high risk and creating safe interventions. The curriculum will also address the stigmatization that this vulnerable population can feel as they navigate the high school environment. By teaching teen peers to identify signs and symptoms of significant mental health disorders such as anxiety, depression, substance abuse, and psychosis to create a safety plan including a trusting adult, students with developing or current severe emotional disturbances can receive assistance before a crisis develops.

DMHAS will use funds to offer Recovery-Oriented Cognitive Therapy (CT-R) training to providers. Guided by Dr. Aaron T. Beck's cognitive model, CT-R is an evidence-based practice that provides concrete, actionable steps to promote recovery and resiliency. Originally developed to empower individuals given a diagnosis of schizophrenia, CT-R applies broadly to individuals experiencing extensive behavioral, social, and physical health challenges. CT-R is highly collaborative, person-centered, and strength-based, and tailored to those who have a history of feeling disconnected from and distrustful of mental health professionals.

An itemized spending plan is included in the table below:

MHBG Supplemental Budget		
Initiative	**Estimated Cost**	**# of Programs**
ESMI set aside $580,000 per program-10% set aside	2,670,000.20	3
ESMI Community Integration Programs	2,340,000.00	6
Crisis set aside-5% set aside	1,132,460.60	
Crisis Receiving and Stabilization	6,089,268.00	4
Diversion-High End Utilizers/Low Community Capacity	4,541,000.00	35
Community Mental Health Law Project - Legal Assistance with Evictions and Housing due to Covid/Housing Stability	350,000.00	
Outreach/Navigation - Underserved populations/crisis response	1,800,000.00	
Teen Mental Health First Aid	400,000.00	2
Peer Wellness Program	400,000.00	
Recovery-Oriented Cognitive Therapy (CT-R) training	500,000.00	
988 Implementation	500,000.00	
Acute Care Systems Review Committee (SRC) Technical Assistance	800,000.00	
Initiative Subtotal	21,522,728.80	

Administration	Estimated Cost	FTE
Supplemental Grant Manager OPREPO	83,600.00	0.5
Diversion - OPREPO Health Data Specialist Evaluation	156,464.00	1.0
ESMI - OPREPO Health Data Specialist Evaluation	156,464.00	1.0
Outreach/Treatment - OPREPO Health Data Specialist Evaluation	78,232.00	0.5
Diversion Olmstead Program Manager	195,580.00	1.0
Diversion Olmstead Staffing and On-Call 24/7	235,000.00	1.4
ESMI Fiscal Staff	55,440.00	0.4
Outreach/Treatment Fiscal Staff	55,440.00	0.4
Diversion Fiscal Staff	97,020.00	0.7
Printing/Supplies	13,243.20	
Administration Subtotal	1,126,483.20	
Total	22,649,212.00	

A funding modification was requested for two programs on September 29, 2022:

Diversion-High End Utilizers: DMHAS is currently in the process of issuing a Request for a Letter of Intent (RLI). Intensive Outpatient Treatment Services and Support (IOTSS) program staff would work with hospitals to provide psychiatric evaluations, medication management, counseling services, and enhanced case management services to individuals presenting to the emergency rooms frequently with the goal of decreasing emergency room visits and inpatient hospitalizations. Through enhanced case management services linkages with services and supports, including mental health and other co-occurring needs will be provided. The original funding was $4,941,000 and will decrease to $4,541,000. The decreased funds of $400,000 will be moved to fund the Acute Care Systems Review Committee (SRC) Technical Assistance.

Acute Care Systems Review Committee (SRC) Technical Assistance: The contract for this initiative was effective as of August 22, 2022. The agency has begun to work to hire staff that will provide technical assistance to County based mental health system review committees in examining wait times in emergency rooms for psychiatric services. This program focuses on assisting the SRCs in developing performance improvement projects to create a structure for the SRCs to review and revise processes that lead to more expeditious outcomes for individuals requiring hospitalization. The SRC TA service will: review current data and propose other data to be collected; conduct resource mapping to identify all resources available in county; conduct needs assessment for the identified counties; produce report outlining each county's challenges and needs; support each SRC in design of a performance improvement project to address identified needs using the Plan, Do, Study, Act (PDSA) model; support each SRC in data collection, analysis, and in the implementation of the performance improvement project. This project is being implemented as of September 1, 2022 and will begin to focus on a small group of SRC committees initially. After moving $400,000 from Diversion-High End Utilizers program, the funding for the Acute Care TA program is increased to $800,000.

This is an update of the High End Utilizers program on January 19, 2023. The funding amount did not change:

Diversion-High End Utilizers: DMHAS proposes to allocate this funding to our contracted Psychiatric Designated Screening Center providers and Affiliated Emergency Services providers in each County. Providers will submit to DMHAS a plan to prioritize the hiring of peer staff to work with individuals presenting to utilize psychiatric screening services via the emergency room or via mobile outreach by screening staff, multiple times throughout the course of the year. Non-peer staff can be hired if the organization is unable to hire peer staff. Staff would work with hospitals and systems partners to provide follow up services to high utilizers of the psychiatric screening services including to provide follow up calls, linkages to needed services, in person visits as needed, collateral contact and information services to family members and enhanced case management services to individuals presenting to the emergency rooms frequently utilizing psychiatric screening services, with the goal of decreasing emergency room visits and inpatient hospitalizations. Some medication services through the use of a prescriber may be provided as part of this initiative for follow up services. Through enhanced case management services linkages with services and supports, including mental health and other co-occurring needs will be provided. The funding amount for this initiative is $4,541,000.

3. Describe how the state will advance the development of crisis services based on the National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit. The five percent crisis services set-aside applies to these funds.

NJ DMHAS will develop four new crisis receiving and stabilization centers in addition to the current planned center which will advance the development of crisis services based on the National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit. The target population is individuals over age 18 with a primary SMI diagnosis, experiencing acute psychiatric symptoms that could disrupt community tenure. Referring entities, including first responders and law enforcement, can make referrals 24/7 by contacting the crisis receiving and stabilization centers to ensure there is bed availability. If beds are not available, staff will provide resources for alternatives. At a minimum, services will include 24/7 access to trained staff who can provide intensive supports, including engagement, education, identification of strengths, collaborative problem solving, and individualized recovery planning. Medication prescription, administration and education will also be offered. Clinical staff in the program will strive to stabilize individuals and address psychiatric needs while the DMHAS Olmstead staff will provide assistance with assessing level of care and facilitating placement as needed. The program will offer continuity of care in an effort to promote continued stability by ensuring the linkages put in place are suitable for the individuals' needs. Overall, this program would decrease the utilization of local hospital emergency services and in-patient psychiatric hospitalization, while maintaining crisis stabilization treatment.

4. Explain how your state plans to collaborate with other departments or agencies to address the identified needs.

The SMHA will collaborate with a number of state agencies, mental health service providers, community agencies, and other entities to address the needs of the SMI population. The state agencies comprise New Jersey Department of Health (DOH), Division of Developmental

Disabilities (DDD), Children System of Care (CSOC), Division of Medical and Health Services (DMAHS)/Medicaid, and the Department of Community Affairs (DCA). The mental health service providers include emergency departments, Short Term Care Facilities (STCF), Designated Screening Centers (DSC), State Psychiatric Hospitals, County Psychiatric Hospitals, and Wellness Centers. The community partners consist of community-funded programs, faith-based organizations, and tribes. Other entities include secondary schools and colleges, law enforcement, and first responders. The SMHA has existing relationships with almost all of these entities and has ongoing meetings and calls with them. This will continue for the initiatives in this proposal.

5. If your state plans to utilize any of the waiver provisions or the recommendations listed in this guidance, please explain how your state will implement them with these funds. (These waivers are only applicable to these COVID-19 Relief supplemental funds and not to the regular or FY 2021 MHBG funds. States will be required to provide documentation ensuring these funds are tracked separately.)

NJ does not intend to utilize waiver provisions.

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Name

Title

Organization

Signature: Date:

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Footnotes:

This form is not applicable to the NJ Division of Mental Health and Addiction Services.

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Table 2 addresses funds to be expended during the 24-month period of July 1, 2021 through June 30, 2023. Table 2 now includes columns to capture state expenditures for COVID-19 Relief Supplemental, ARP funds, and BSCA funds. Please use these columns to capture how much the state plans to expend over a 24-month period (7/1/21-6/30/23). Please document the use of COVID-19 Relief Supplemental, ARP and BSCA funds in the footnotes.

MHBG: Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 7/1/2022 Planning Period End Date: 6/30/2023

Activity (See instructions for using Row 1.)	Source of Funds										
	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID Relief Funds (SABG)	J. ARP Funds (MHBG)[b]	K. BSCA Funds (MHBG)[c]
1. Substance Abuse Prevention and Treatment											
a. Pregnant Women and Women with Dependent Children											
b. All Other											
2. Primary Prevention											
a. Substance Abuse Primary Prevention											
b. Mental Health Primary Prevention[d]											
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[e]		$2,659,541.00						$2,264,921.00			$91,794.00
4. Tuberculosis Services											
5. Early Intervention Services for HIV											
6. State Hospital											
7. Other 24-Hour Care		$6,646,831.00	$366,829,803.00		$40,271,996.00		$400,000.00			$1,263,347.00	$734,354.00
8. Ambulatory/Community Non-24 Hour Care		$14,629,494.00	$568,759,604.00	$2,071,389.00	$349,499,239.00			$18,119,370.00			
9. Administration (excluding program/provider level)[f] MHBG and SABG must be reported separately		$1,329,770.00	$1,315,000.00	$211,308.00	$17,003,319.00			$1,132,461.00			$45,897.00
10. Crisis Services (5 percent set-aside)[g]		$1,329,770.00		$1,260,846.00	$72,332,899.00			$1,132,461.00			$45,897.00
11. Total	**$0.00**	**$26,595,406.00**	**$936,904,407.00**	**$3,543,543.00**	**$479,107,453.00**	**$0.00**	**$400,000.00**	**$22,649,213.00**	**$0.00**	**$1,263,347.00**	**$917,942.00**

[a]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard SABG expenditures are for the state planned expenditure period of July 1, 2022 – June 30, 2023, for most states.

[b]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A-G are for the state planned expenditure period of July 1, 2022 - June 30, 2023, for most states

[c]The expenditure period for the Bipartisan Safer Communities Act (BSCA) supplemental funding is **October 17, 2022 - October 16, 2024**, which is different from the normal block grant expenditure period. Column K should reflect the spending for the state reporting period. The total may reflect the BSCA allotment portion used during the state reporting period.

[d]While a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

[e]Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside.

[f]Per statute, Administrative expenditures cannot exceed 5 percent of the fiscal year award

[g]Row 10 should include Crisis Services programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

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Footnotes:

For this interim reporting of ARP expenses, the expenses reported do not meet the set aside requirements, due to the timing of project initiatives. However, the set aside requirements will be met by the end of the award period.

Reported in the column K. BSCA Funds in this table is our SFY23 total expense of $917,943. The remainder of the $1,835,885 will be spent by the award end date.

Planning Tables

Table 4 SABG Planned Expenditures

States must project how they will use SABG funds to provide authorized services as required by the SABG regulations, including the supplemental COVID-19 and ARP funds. Plan Table 4 must be completed for the FFY 2022 and FFY 2023 SABG awards. The totals for each Fiscal Year should match the President's Budget Allotment for the state.

Planning Period Start Date: 10/1/2022 Planning Period End Date: 9/30/2023

	FFY 2022			FFY 2023		
Expenditure Category	**FFY 2022 SA Block Grant Award**	**COVID-19 Award[1]**	**ARP Award[2]**	**FFY 2023 SA Block Grant Award**	**COVID-19 Award[1]**	**ARP Award[2]**
1 . Substance Use Disorder Prevention and Treatment[5]	$34,566,031.00	$34,159,435.00	$14,842,174.00	$38,542,435.00	$781,250.00	$1,599,997.00
2 . Primary Substance Use Disorder Prevention	$11,799,689.00	$10,117,027.00	$4,198,012.00	$11,655,876.00	$1,622,331.00	
3 . Tuberculosis Services		$0.00	$0.00			
4 . Early Intervention Services for HIV[6]		$0.00	$0.00			
5 . Administration (SSA Level Only)	$2,104,717.00	$774,497.00	$413,637.00	$1,835,102.00	$381,193.00	
6. Total	**$48,470,437.00**	**$45,050,959.00**	**$19,453,823.00**	**$52,033,413.00**	**$2,784,774.00**	**$1,599,997.00**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2022 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures reflecting the President's FY 2022 enacted budget for the FFY 2022 SABG Award year that is October 1, 2021 - September 30, 2022. For purposes of this table, all planned COVID-19 Relief Supplemental

expenditures between October 1, 2021 and September 30, 2022 should be entered in this column.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2022 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures reflecting the President's FY 2022 enacted budget for the FFY 2022 SABG Award year that is October 1, 2021 - September 30, 2022. For purposes of this table, all planned ARP expenditures between October 1, 2021 and September 30, 2022 should be entered in this column.

[3]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President's FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

[4]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President's FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022- September 30, 2023. For purposes of this table, all planned ARP expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

[5]Prevention other than Primary Prevention

[6]For the purpose of determining which states and jurisdictions are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant (SABG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state's AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

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Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2022 Planning Period End Date: 9/30/2023

A		B			B		
Strategy	IOM Target	FFY 2022			FFY 2023		
		SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]	SA Block Grant Award	COVID-19 Award[4]	ARP Award[5]
1. Information Dissemination	Universal						
	Selected						
	Indicated						
	Unspecified						
	Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
2. Education	Universal						
	Selected						
	Indicated						
	Unspecified						
	Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
3. Alternatives	Universal						
	Selected						
	Indicated						
	Unspecified						
	Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
4. Problem Identification and Referral	Universal						
	Selected						
	Indicated						
	Unspecified						
	Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
	Universal						

5. Community-Based Processes	Selected						
	Indicated						
	Unspecified						
	Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
6. Environmental	Universal						
	Selected						
	Indicated						
	Unspecified						
	Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
7. Section 1926 Tobacco	Universal	$0	$0	$0	$0	$0	$0
	Selected				$0	$0	$0
	Indicated	$0	$0	$0	$0	$0	$0
	Unspecified	$0	$0	$0	$0	$0	$0
	Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
8. Other	Universal						
	Selected						
	Indicated						
	Unspecified						
	Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Prevention Expenditures					**$0**	**$0**	**$0**
Total SABG Award[3]		**$48,470,437**	**$45,050,959**	**$19,453,823**	**$52,033,413**	**$2,784,774**	**$1,599,997**
Planned Primary Prevention Percentage		**0.00 %**	**0.00 %**	**0.00 %**	**0.00 %**	**0.00 %**	**0.00 %**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2022 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures reflecting the President's FY 2022 enacted budget for the FFY 2022 SABG Award year that is October 1, 2021 - September 30, 2022. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 and September 30, 2022 should be entered in this column.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2022 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures reflecting the President's FY 2022 enacted budget for the FFY 2022 SABG Award year that is October 1, 2021 - September 30, 2022. For purposes of this table, all planned ARP expenditures between October 1, 2021 and September 30, 2022 should be entered in this column.

[3]Total SABG Award is populated from Table 4 - SABG Planned Expenditures

[4]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President's FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

[5]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President's FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned ARP expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

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Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2022 Planning Period End Date: 9/30/2023

Activity	FFY 2022 SA Block Grant Award	FFY 2022 COVID-19 Award[1]	FFY 2022 ARP Award[2]	FFY 2023 SA Block Grant Award	FFY 2023 COVID-19 Award[3]	FFY 2023 ARP Award[4]
Universal Direct	$1,988,771	$3,380,000	$1,250,000	$2,517,510		$639,867
Universal Indirect	$2,901,982	$350,000	$437,500	$3,673,509		
Selected						$432,464
Indicated	$2,699,046	$2,292,000	$150,000	$3,416,620		$550,000
Column Total	**$7,589,798**	**$6,022,000**	**$1,837,500**	**$9,607,639**	**$0**	**$1,622,331**
Total SABG Award[5]	**$48,470,437**	**$45,050,959**	**$19,453,823**	**$52,033,413**	**$2,784,774**	**$1,599,997**
Planned Primary Prevention Percentage	**15.66 %**	**13.37 %**	**9.45 %**	**18.46 %**	**0.00 %**	**101.40 %**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2022 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures reflecting the President's FY 2022 enacted budget for the FFY 2022 SABG Award year that is October 1, 2021 - September 30, 2022. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 and September 30, 2022 should be entered in this column.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2022 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures reflecting the President's FY 2022 enacted budget for the FFY 2022 SABG Award year that is October 1, 2021 - September 30, 2022. For purposes of this table, all planned ARP expenditures between October 1, 2021 and September 30, 2022 should be entered in this column.

[3]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President's FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

[4]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President's FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned ARP expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

[5]Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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Footnotes:

New Jersey chooses to use a portion ($2,048,237) of the primary prevention set-aside to fund Non-Direct Services/System Development activities.

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities - Required

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2022 and FFY 2023 SABG awards.

Planning Period Start Date: 10/1/2022 Planning Period End Date: 9/30/2023

	SABG Award	COVID-19 Award[1]	ARP Award[2]
Targeted Substances			
Alcohol	☑	☑	☑
Tobacco	☑	☑	☑
Marijuana	☑	☑	☑
Prescription Drugs	☑	☑	☑
Cocaine	☑	☑	☑
Heroin	☑	☑	☑
Inhalants	☑	☑	☑
Methamphetamine	☑	☑	☑
Targeted Populations			
Students in College	☑	☑	☑
Military Families	☑	☑	☑
LGBTQ+	☑	☑	☑
American Indians/Alaska Natives	☑	☑	☑
African American	☑	☑	☑
Hispanic	☑	☑	☑

Homeless	☑	☑	☑
Native Hawaiian/Other Pacific Islanders	☐	☐	☐
Asian	☑	☑	☑
Rural	☐	☐	☐
Underserved Racial and Ethnic Minorities	☑	☑	☑

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President's FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President's FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned ARP expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

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Footnotes:

Planning Tables

Table 6 Non-Direct-Services/System Development [SA]

Please enter the total amount of the SABG, COVID-19, or ARP funds expended for each activity.

Planning Period Start Date: 10/1/2022 Planning Period End Date: 9/30/2023

Expenditure Category	FFY 2022					FFY 2023				
	A. SABG Treatment	B. SABG Prevention	C. SABG Integrated[1]	D. COVID-19[2]	E. ARP[3]	A. SABG Treatment	B. SABG Prevention	C. SABG Integrated[1]	D. COVID-19[4]	E. ARP[5]
1. Information Systems	$1,712,490.00	$10,556.00				$1,720,172.00	$12,411.00		$0.00	$0.00
2. Infrastructure Support				$3,550,000.00	$1,949,250.00	$226,200.00	$0.00		$0.00	$0.00
3. Partnerships, community outreach, and needs assessment	$215,849.00			$1,476,496.00	$558,453.00	$215,849.00	$0.00		$0.00	$0.00
4. Planning Council Activities (MHBG required, SABG optional)						$0.00	$0.00		$0.00	$0.00
5. Quality Assurance and Improvement	$6,300.00					$6,300.00	$0.00		$0.00	$0.00
6. Research and Evaluation	$2,699,720.00	$1,642,343.00		$250,000.00		$3,241,318.00	$2,035,826.00		$0.00	$0.00
7. Training and Education	$254,010.00			$1,300,000.00	$1,000,000.00	$408,004.00	$0.00		$0.00	$0.00
8. Total	**$4,888,369.00**	**$1,652,899.00**	**$0.00**	**$6,576,496.00**	**$3,507,703.00**	**$5,817,843.00**	**$2,048,237.00**	**$0.00**	**$0.00**	**$0.00**

[1]Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2022 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures reflecting the President's FY 2022 enacted budget for the FFY 2022 SABG Award year that is October 1, 2021 - September 30, 2022. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 and September 30, 2022 should be entered in this column.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2022 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures reflecting the President's FY 2022 enacted budget for the FFY 2022 SABG Award year that is October 1, 2021 - September 30, 2022. For purposes of this table, all planned ARP expenditures between October 1, 2021 and September 30, 2022 should be entered in this column.

[4]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President's FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

[5]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President's FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned ARP expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

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Footnotes:

Amount of SABG Primary Prevention funds (from Table 4, Row 2) used for SABG Prevention Resource Development Activities for SABG Prevention, Column C, and/or SABG Combined, Column D = $2,045,642.

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Amount of SABG Administration funds (from Table 4, Row 5) used for SABG Prevention Resource Development Activities Activities for SABG Prevention, Column C, and/or SABG Combined, Column D = $0.

Planning Tables

Table 6 Non-Direct-Services/System Development [MH]

Please enter the total amount of the MHBG, COVID-19, ARP or BSCA funds expended for each activity.

MHBG Planning Period Start Date: 07/01/2022 MHBG Planning Period End Date: 06/30/2023

Activity	FFY 2022 Block Grant	FFY 2022[1] COVID Funds	FFY 2022[2] ARP Funds	FFY 2023 Block Grant	FFY 2023[1] COVID Funds	FFY 2023[2] ARP Funds	FFY 2023[3] BSCA Funds
1. Information Systems	$1,200,000.00			$600,000.00		$3,065,000.00	$205,000.00
2. Infrastructure Support							$85,000.00
3. Partnerships, community outreach, and needs assessment							$30,000.00
4. Planning Council Activities (MHBG required, SABG optional)	$47,480.00			$23,740.00			
5. Quality Assurance and Improvement						$1,400,000.00	
6. Research and Evaluation							
7. Training and Education					$1,200,000.00	$1,677,563.00	$66,252.00
8. Total	**$1,247,480.00**	**$0.00**	**$0.00**	**$623,740.00**	**$1,200,000.00**	**$6,142,563.00**	**$386,252.00**

[1] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

[3] The expenditure period for the Bipartisan Safer Communities Act (BSCA) supplemental funding is **October 17, 2022 - October 16, 2024**, which is different from the normal block grant expenditure period. Column K should reflect the spending for the state reporting period. The total may reflect the BSCA allotment portion used during the state reporting period.

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Footnotes:

There is no change to Table 6 due to the increase of the allotment.

Environmental Factors and Plan

15. Crisis Services - Required MHBG, Requested SABG

Narrative Question

SAMHSA is directed by Congress through the Consolidated Appropriations Act, 2021 and the Coronavirus Response and Relief Supplement Appropriations Act, 2021 [P.L. 116-260], to set aside 5 percent of the MHBG allocation for each state to support evidence-based crisis systems. The appropriation bill includes the following budget language that outlines the new 5 percent set- aside:

> *Furthermore, the Committee directs a new five percent set- aside of the total for evidence-based crisis care programs addressing the needs of individuals with serious mental illnesses and children with serious mental and emotional disturbances. The Committee directs SAMHSA to use the set-aside to fund, at the discretion of eligible States and Territories, some or all of a set of core crisis care elements including: centrally deployed 24/7 mobile crisis units, short-term residential crisis stabilization beds, evidence-based protocols for delivering services to individuals with suicide risk, and regional or State-wide crisis call centers coordinating in real time.*

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources.

SAMHSA recently developed **Crisis Services: Meeting Needs, Saving Lives**, which includes "**National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit**" as well as other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with SMI or children with SED. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

Please refer to the **https://www.samhsa.gov/sites/default/files/grants/fy22-23-block-grant-application.pdf [samhsa.gov]** for additional information.

1. Briefly narrate your state's crisis system. Include a description of access to the crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crsis receiving and stabilization centers.

The Division of Mental Health and Addiction Services (DMHAS) is the State Mental Health Authority (SMHA) in New Jersey (NJ)¬. The state's Crisis Response system includes a network of 35 contracted Psychiatric and Affiliated Emergency Screening Services (Screening) staffed by trained mental health professionals to assess for involuntary commitment. In addition, DMHAS funds the NJ Suicide Prevention Hopeline, which also serves as one of the 988 Suicide & Crisis Lifeline Network call centers in NJ. This crisis call line is also staffed 24/7 by trained mental health professionals and facilitates "warm transfers" (when needed) to local Screening. The Screening program also includes mobile outreach capacity, providing approximately 30,000 outreach episodes per year. Approximately 12,000 of these occur in community settings and approximately half the community interventions result in diversion of individuals in crisis from hospital emergency departments. DMHAS funds 11 Psychiatric Early Intervention Support Service (EISS) programs. These clinics are similar to urgent care centers. They accept "walk-ins' and allow NJ residents rapid access to crisis intervention services without reliance on hospital emergency departments. These programs provide 12,000 to 15,000 episodes of care per year. DMHAS has recently procured and executed contracts to develop 10 new EISS programs which will establish one clinic per county. Crisis Residential Services offer short-term residential care as an alternative to hospitalization. These programs, funded by DMHAS, provide 34 beds in seven locations with a variety of models including peer-staff respite. All have 24/7 staffing in a therapeutic setting. The length of stay is seven to 21 days depending on the model. In addition, NJ has Certified Community Behavioral Health Clinics (CCBHCs) across the state. These comprehensive behavioral health services offer a wide range of programs for individuals dealing with mental health, substance use and co-occurring disorders. They also collaborate with medical service providers to ensure integrated health care services. NJ has five crisis call/contact centers that are part of the 988 Suicide and Crisis Lifeline network. Each of these centers has been awarded funds to build their response capacity and will have formal contracts with DMHAS. "Warm transfers" between 911/PSAPs (Public Safety Answering Points), state agencies, and other elements of the crisis response system are in development. One center operates 24/7 and all counties have primary coverage for 988. Additional funding from the FY23 State budget will be procured to add further capacity with the goal of 24/7 statewide back up coverage as well. Mobile Crisis Response (MCR) services and Crisis Receiving and Stabilization Centers (CRSC) are both funded for the FY23 fiscal year. These programs are currently in development; procurement for these services will begin as soon as possible. MCR will provide teams of trained staff to meet with individuals in crisis, in the community, when it is safe to do so. These teams will be dispatched by the 988 system and offer 24/7 statewide coverage. At CRSCs located throughout the state, professional staff and trained peer counselors will provide services designed to meet the

immediate needs of people experiencing a mental health or substance use crisis. CRSC will offer short-term community-based response on a 24/7 "walk-in" basis and will also provide referrals to other community programs.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

a) The Exploration stage: is the stage when states identify their communities's needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.
b) The Installation stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. this includes coordination, training and community outreach and education activities.
c) Initial Implementation stage: occurs when the state has the three-core crisis services in place and agencies begin to put into practice the SAMHSA guidelines.
d) Full Implementation stage: occurs once staffing is complete, services are provided, and funding streams are in place.
e) Program Sustainability stage: occurs when full implementation has been achived, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.

1. Someone to talk to: Crisis Call Capacity
- *a. Number of locally based crisis call Centers in state*
  - *i. In the Suicide lifeline network*
  - *ii. Not in the suicide lifeline network*
- *b. Number of Crisis Call Centers with follow up protocols in place*
- *c. Percent of 911 calls that are coded as MH related*

2. Someone to respond: Number of communities that have mobile behavioral health crisis capacity
- *a. Independent of first responder structures (police, paramedic, fire)*
- *b. Integrated with first responder structures (police, paramedic, fire)*
- *c. Number that employ peers*

3. Place to go
- *a. Number of Emergency Departments*
- *b. Number of Emergency Departments that operate a specialized behavior health component*
- *c. Number of Crisis Receiving and Stabilization Centers (short term, 23 hour units that can diagnose and stabilize individuals in crisis)*

a. Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Available to less than 25% of people in state	Middle Implementation Available to about 50% of people in state	Majority Implementation Available to at least 75% of people in state	Program Sustainment
Someone to talk to	☐	☐	☐	☐	☑	☐
Someone to respond	☑	☐	☐	☐	☐	☐
Place to go	☑	☐	☐	☐	☐	☐

b. Briefly explain your stages of implementation selections here.

New Jersey has five locally based crisis call centers that are part of the 988 Suicide and Crisis Lifeline network and all were a part of the National Suicide Prevention Lifeline network prior to the transition to the 988. Through these centers, primary coverage is available to all 21 counties in the state. Backup coverage is currently available to many counties and additional capacity building will allow full coverage statewide. Each center has its own procedures for follow-up services consistent with requirements made by the Lifeline administrator, Vibrant Emotional Health. A variety of other crisis call centers in NJ are not part of the Lifeline network including (but not limited to): NJ Mental Health Cares (mental health information and referrals); ReachNJ (substance use information and treatment options); CONTACT of Ocean and Monmouth Counties; and NJ 211 (social services). In recent months, $3.7 million has been procured to build capacity within the existing National Suicide Prevention Lifeline member centers. These funds have been allocated from the MH and SA COVID Supplemental grants, the MH ARPA funds and a SAMHSA 988 Lifeline Center Capacity Building grant. All five centers were provided the opportunity to receive funding from this procurement and will be contracted with NJ DMHAS. Another $12.8 million from the State FY23 budget will be procured soon to expand the response to crisis calls, chats and texts, and create a more robust 988 Suicide and Crisis Lifeline system throughout NJ. NJ DMHAS does not yet have data regarding the percentage of 911 calls coded as mental health related. The structure of individual 911/PSAPs in the state is complex which impacts the standardization and availability of this data. The NJ Legislature recently allocated $16 million in the FY23 budget for Mobile Crisis Response. The MCR system is in development now and will include 24/7, statewide coverage by two-person teams that can be dispatched to meet with individuals in crisis within the community. The goal is for a mental health professional and (whenever possible) a trained peer counselor to be available for in-person outreach; a master's level clinical professional will be available at all times for consultation. NJ plans to establish MCR to function independently of first responder structures whenever it is safe to do so. At this time, the Office of the Attorney General has established a few pilot projects in which mental health professionals "ride along" with Law Enforcement. The current mobile response service available in New Jersey is Mobile Screening which goes into the community to assess for involuntary commitment. Law Enforcement is routinely dispatched along with Mobile Screening. This service will

continue to be available, as needed, once Mobile Crisis Response is in place. New Jersey is developing Crisis Receiving and Stabilization Centers CRSCs) which will be located throughout the state. CRSCs will serve individuals with primary SMI, SUD or co-occurring disorders. Approximately $11.57M has been allocated from the MH and SA COVID Supplemental grants plus funds from the MHBG Crisis Set Aside for the implementation of Crisis Receiving and Stabilization Centers in NJ for 2023. New Jersey has 23 designated Screening Centers that respond to urgent mental health situations. Of these, 19 are located within a hospital setting which allows for quick access to medical treatment and/or commitment if necessary. Additionally, there are seven Crisis Residential Service programs which offer short-term residential care as an alternative to hospitalization. These programs offer 24/7 staffing (professional/peer depending on the program) and goal-focused programming support for individuals to manage stressful periods and avoid more serious crises. Individuals can also access the 11 Early Intervention Support Services locations in the state. These clinics offer crisis intervention and stabilization services in a setting that provides diversion from hospital-based emergency room treatment. EISS programs operate seven days a week and work with individuals for approximately 30 days to connect then with more traditional treatment and services. Funding for an additional 10 EISS programs has been awarded which will establish this service in every NJ county. Emergency Departments of local hospitals serve as a last resort for managing mental health crises.

3. Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.

As The Division of Mental Health and Addiction Services (DMHAS) continues to develop its crisis system, the core elements of a crisis system (regional crisis call center, mobile crisis teams, and 23-hour crisis receiving and stabilization centers) as outlined in SAMHSA's National Guidelines for Behavioral Health Crisis Care are integrated into the planning and design of the services. In order to further align with the SAMHSA's National Guidelines for Behavioral Health Crisis Care, DMHAS aims to ensure that the minimum expectations of each core crisis component are met and strives to incorporate noted best practices. New Jersey's five crisis call centers are part of the 988 Suicide Crisis Lifeline network and provide crisis intervention coverage to all 21 counties. The centers are staffed 24 hours per day, 7 days a week, 365 days of the year by clinicians overseeing clinical triage and other trained team members who respond to all calls received. Calls that are unable to be unanswered are routed to national Lifeline backup centers in order to coordinate overflow coverage. Call center services are in alignment with National Suicide Prevention Lifeline (NSPL) standards for risk assessment of suicide and danger to others within each call. Individuals are connected to facility-based care through warm hand-offs and transportation as needed. While crisis mobile teams in NJ are in the development phase, crisis call centers do coordinate with Mobile Screening, operated by Psychiatric Emergency Screening Services, when appropriate. As DMHAS continues to build capacity within the existing NSPL member centers, discussion is ongoing regarding strategies to align with best practices to operating a regional crisis call center as outlined in the evidence-based practice toolkit. The NJ Legislature recently allocated $16 million in the FY23 budget for Mobile Crisis Response (MCR). DMHAS' plans for MCR encompass each of the elements outlined in the toolkit in order to meet the minimum expectations to operate mobile crisis response. The MCR system is in development now and will include 24/7, statewide coverage by two-person teams that can be dispatched to meet with individuals in crisis within the community. The goal is for a mental health professional and (whenever possible) a trained peer counselor to be available for in-person outreach; a master's level clinical professional will be available at all times for consultation. Continuity of care will be established by connecting individuals to facility-based care as needed through warm hand-offs and coordinating transportation when and only if situations warrant transition to other locations. DMHAS plans to incorporate peers within the mobile crisis team and establish MCR to function independently of first responder structures whenever it is safe to do so. As planning continues, DMHAS endeavors to incorporate additional best practices to operate mobile crisis teams. All of the minimum expectations to operate a crisis receiving and stabilization program have been incorporated into the planning of DMHAS' 23-hour Crisis Receiving Stabilization Centers. CRSC will accept all referrals of individuals with mental health and/or substance use crisis issues and not require medical clearance prior to admission. Individuals will be assessed for medical stability and provided support for most minor physical health challenges with an identified pathway in order to transfer the individual to more medically staffed services if needed. CRSCs will be staffed 24 hours per day, 7 days a week, 365 days per year by a multidisciplinary team including a prescriber, clinicians able to complete assessments and peers. Licensed clinicians will screen for suicide risk and more comprehensive violence risk assessments when clinically indicated. CRSCs will offer a no-wrong door access to crisis stabilization, accepting all walk-ins and first responder drops with capacity to accept all referrals at least 90% of the time. DMHAS' plans include several of the best practices noted in the toolkit. The CRSC will support flow for individuals who may need additional support, CRSCs may refer to DMHAS funded crisis diversion homes. Continuity of care will be achieved by linking individuals to aftercare services and providing follow up contacts at a minimum of 48 hours, 2 weeks, and 30 days from initial contact to ensure that individuals engage in recommended aftercare or identify if there is another service that would best meet their needs.

4. Briefly describe the proposed/planned activities utilizing the 5 percent set aside.

The New Jersey Department Human Services, Division of Mental Health and Addiction Services (DMHAS) plans to create a new evidence-based service for "somewhere to go", otherwise referred to as crisis receiving stabilization centers (CRSCs). The CRSCs are one of the three core components of the behavioral health crisis continuum. The proposed program provides services to those in need of immediate in-person crisis intervention and stabilization for a behavioral health crisis. The proposed program will assess individuals 18 years of age and older with a primary serious mental illness, primary substance use disorder, or other individuals with co-occurring disorders. CRSCs offers a no-wrong-door access to crisis stabilization, operating much like a hospital emergency department that accepts all walk-ins, law enforcement drop offs, and fire department drop offs for individuals experiencing acute psychiatric symptoms. The individuals served in the proposed program will receive community-based treatment and supportive services in an effective and timely manner 24 hours a day, 7 days a week, 365 days per year, with the goal of mitigating the need to use the ED to access community-based services and preventing unnecessary or inappropriate hospitalization. The proposed program will result in positive individual outcomes and an improved individual experience. The proposed program will also result in cost savings through the reduction in avoidable ED visits, psychiatric inpatient admissions, police engagement, arrests, incarcerations, 911 calls, and 988 calls. The proposed program will serve as a community-based alternative to psychiatric emergency screening for individuals who require crisis stabilization but do not need inpatient treatment. In order to increase access to services, DMHAS is targeting the development of more community-based crisis and diversionary services. DMHAS proposes to develop an alternative to traditional crisis services by diverting individuals from going to the emergency room and inpatient treatment when community-based alternatives would better meet their needs. This program would provide services to those in need of immediate in-person crisis intervention and stabilization for a MH or SUD crisis. The targeted population for the program is: individuals in crisis due to SMI; individuals in crisis due to SUD; individuals who walk in or voluntarily agree to

transport to the program by the identified partners; and individuals who meet medical criteria for safe transport to the program. The intent is that meeting this group where they are currently accessing care and providing immediate, safe, communitybased, trauma-informed care, peer recovery support, complementary and alternative therapies, and direct linkages to ongoing care will be a better way to make meaningful and lasting connections that will lead to improved treatment outcomes.

Footnotes:

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[69]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[69] **https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf**

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

The SMHA actively keeps the public, vis-a-vis the NJ Behavioral Health Planning Council, updated on developments on both the on both the CMHSBG and the SAPTBG. The Planning Council/public receives regular briefings on said information (substance misuse prevention, SUD treatment & recovery, mental health services, etc.) directly from SMHA staff, including the State Mental Health Planner, and the Chief Financial Officer of the SMHA.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? ( ) Yes (●) No

3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The NJ Behavioral Health Planning Council (BHPC) is a key partner of the SMHA in both the development of the CMHSBG / SAPTBG as well as in the overall direction of the publicly funded behavioral health services in New Jersey. The BHPC is given open access to the Block Grants via webBgas, as well as through regular updates from key members of the SMHA, including the Mental Health State Planner, the Chief Financial Officer and the Assistant Commissioner.

Please indicate areas of technical assistance needed related to this section.

The SMHA / BHPC struggles to recruit currently under-represented populations for membership and participation on the Council.

Additionally, please complete the Advisory Council Members and Advisory Council Composition by Member Type forms.[70]

[70] There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

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Footnotes:

EW JERSEY BEHAVIORAL HEALTH PLANNING COUNCIL
Minutes
July 14, 2021, 10:00 am

This meeting was conducted exclusively through MS Teams video teleconference & conference call

Participants:

Phil Lubitz (Chair)	Darlema Bey(ViceChair)	John Tkacz	Patricia Matthews
Lisa Negron	Joe Gutstein	Julia Barugel	
Barb Johnston	Connie Greene	Suzanne Smith	
Donna Migliorino	Damian Petino	Heather Simms	
Francis Walker	Connie Greene	Tracy Maksel	
Suzanne Borys	Michelle Madiou	Thomas Pyle	
Robin Weiss			

DMHAS, CSOC. DDD, DMAHS & DoH Staff:

Yunqing Li	Jonathan Sabin	Nicholas Pecht	Mark Kruszczynski
Helen Staton	Morris Friedman		

Guests:

Nina Smukuluvasky	Kurt Baker	Wendy Rodgers
Anne Smullen-Thieling	Marta Hess	William Cole

Minutes:

I. Administrative Issues/Correspondence/ Review of Previous Meeting Minutes Phil Lubitz

A. Role call: 19 members attended, quorum reached (48% attendance)

B. Minutes of June 2021 meeting will be voted on at August meeting

II. Certified Community Behavioral Health Centers (CCBHCs) Charlotte Sadashige

A. See PowerPoint

B. Q&A

Q1. How many Patient Experience of Care and Youth and Family Services Surveys questionnaires were distributed and how many were returned?

A1. Exact number of surveys distributed is not known. CCBHCs did not obtain the sufficient sample size of 300 completed adult or youth/family surveys per CCBHC in DY3.

Q2. What is the estimated size (number of consumers) of the potential NJ CCBHC service population? What is the enrollment target for FYE 6/30/22?

A2. We do not have data on the number of potential CCBHC clients in New Jersey. NJ has seven CMS CCBHC Demonstration providers, and many NJ providers have received CCBHC grants

awarded by SAMSHA. NJ DMHAS does not manage or receive data from the SAMHSA CCBHC grantees. In Year 3 the CMS Demonstration, CCBHCs served 20,396 clients and we anticipate that number will grow. We do not know the numbers of individuals anticipated or served in the SAMHSA CCBHC grantees. More information on SAMHSA CCBHC grants and grantees can be found at: https://www.samhsa.gov/grants-awards-by-state/NJ/discretionary/2021/details

Q3. What is the target for "Depression Remission at 12 months"? When or at what CCBHC service population enrollment is it expected that this statistic will be reported?

A3. New Jersey does not anticipate reporting the statistic for the Depression Remission at 12 month measure.

Q4. How does DMHAS determine the impact of CCBHC services on Morbidity and mortality for the CCBHC service population?

A4: The impact on morbidity and mortality are not reported outcomes for the CCBHC.

Q5. What effect, if any, does a consumer's CCBHC enrollment have on the capitation paid to his/her MMCO?

A5. CCBHCs services are not managed or paid by the NJ Medicaid MCOs.

III. DMHAS 2022 Budget Morris Friedman

A. See PowerPoint Presentation: https://www.state.nj.us/humanservices/dmhas/information/provider/Provider_Meetings/2021/DMHAS%20FY22%20Approp%20Act%20Highlights.pdf

B. Q&A

1. Q: EISS Programs and funding increases. A. No changes in existing contracts.
2. Q: State Voucher increase; will Fair Market Rate (FMR) match small area FMRs? A: We are increasing them to more current FMRS, but whether they get to specific small areas FMRs we will have to confer with Housing staff before we answer. Morris will check and reply to be send.
3. Q: Is it possible to look at transportation in the State Budget? A: No change to any transportation rates paid by DMHAS.

IV. Community Mental Health Services Block Grant And Substance Abuse Prevention Treatment Block Grant . Donna Migliorino, Suzanne Borys, Yunqing Li, Helen Staton, Nick Pecht and Mark Kruszczynski

A. We are moving into a new two-year block grant application. It is the large application that is several hundred pages in length. This was started in January

2021. The cycle going forward will be to get an early start on the applications. However, the American Recovery Plan Act Supplemental Grant and the Covid Supplemental Grant had put early preparation for the two-year Block Grant plan on hold so the plans for the supplemental grants could be developed.(DM)

1. Overview of Federal Grants
    a. Current Block Grant (2020 -2021), Implementation Report due 12/1/21
    b. New Block Grant (2022 - 2023) due 9/1/2021
    c. Covid-19 Supplemental Grant – funding expires 3/15/23
    d. American Rescue Plan Act (9/1/21 - 9/30/25)

2. Public Access to Block Grant Applications (WebBGas)
https://bgas.samhsa.gov/Module/BGAS/Users
User name: citizennj
Password: citizen

B. Layout of MH Block Grant (YL)
1. Planning Step 1: Asks states to describe how they assess strengths and organization capacity of their service system
2. Planning Step 2: Evaluate service needs and critical gaps. Describe facets of MH system, looking at needs and gaps
3. Step 3: Priority Areas and Priority Indicators
    a. Community Support Services
    b. Supportive Housing
    c. Services for First Episode Psychosis (FEP) or Coordinated Specialty Care (CSC)
    d. Cultural Competency Plan. Previously the target was not met. Goal of this priority area is to do a system wide assessment of provider services to diverse population. All Division funded agencies are to have a cultural competency plan in place. DMHAS will assess how many agencies do cultural competency plan. They will do a self-assessment and identify three areas for cultural improvement. The target is that 75% of funded agencies should complete a cultural competence plan. In the final year it is hoped that 100% agencies will have a cultural competence plan in place.
4. Fiscal Tables (to be completed in August 2021)
5. Environmental Factors: Ranging from health care parity/integration, EBPs, person centered treatment, for a total of 21 sections.

C. Service Needs & Gaps Identified by the Council (MK)
1. Concern about the time kids are waiting in emergency rooms for placement, concern that in September 2021 those numbers will increase significantly. What can the system do to mitigate wait time for kids? What can schools and CSOC do to divert kids from emergency rooms in the first place? (JB)
2. Q: Is the prison system to be included in any statewide MH improvements? A: No, MHBG dollars can only be used for community based services for individuals with an SMI/SED diagnosis and not for non-community based programs (e.g., state hospitals, jails, etc.) (DM)

3. Concern about Behavioral Health workers salaries. Clients lose due the turnover in providers who leave because it's the only way to increase income.
4. Older and aging LGBTQIA+ mental health needs being met by sensitive and knowledgeable clinicians as well as for Trans youth/people of color who have high rate of suicide/depression due to violence and lack of support/services. Dealing with depression of aging LGBTQIA+ individuals. Subgroups: fluid populations, questioning, and the need to be sensitive to their needs.

D. Substance Use Prevention and Treatment
1. Indicators, SFY21 data must be run as NJSAMS data has just been recently collected. There are many indicators: Drug injecting population, pregnant women

E. SAPT Overview:(HS)
1. The layout of the SAPT Block Grant Plan Application is the same as the MH Block Grant except for three sections which are required for the SAPT Block Grant only: Quality and Data collection narrative, Persons in need/receipt of SUD treatment chart, and Planned Prevention Priorities chart
2. There are 22 Environmental Factors, of which three are for the SAPT Block Grant only: Primary Prevention, SUD Treatment and MAT

F. Children's System of Care Priority Areas (NP)

1. Integration of community-based physical and behavioral health services for youth with chronic medical conditions and mental or behavioral health and/or substance use challenges. The Behavioral Health Home model is currently available at four care management organizations in five counties. BHH services are a "bridge" that connects prevention, primary care, and specialty care.

2. Expand system's capacity to serve youth age 0 to 5 by implementing a workforce development initiative, Zero to Five: Helping Families Thrive, which will increase community collaboration and support of families by providing 85% of Mobile Response Stabilization Services' direct service staff with 39 hours of training on early childhood social-emotional development and 24 clinicians in professional formation and reflective supervision methods and Child Parent Psychotherapy.

3. Increase access to evidence-based services and supports across the CSOC service continuum by continuing to evaluate and plan to expand the In-Home Recovery Program (IHRP), which supports families with substance use disorders, child welfare involvement, and children ages 0-3, and enhancing our Intensive In-Community services providers' ability to provide healing-centered, evidence-

based interventions, by collaborating with the CARES Institute to train clinicians in Trauma Focused Cognitive Behavioral Therapy.

4. Q&A: Difficulty to find someone trained in Cognitive Behavioral Therapy (CBT)? What qualities are you looking for? Issue is that some therapists provide "eclectic therapy" A: Folks in IIC services who provide in-home services.

V. State Partners Involvement Donna Migliorino

A. Department of Education

1. State Board of Ed approved Assistant Commissioner Kathy Ehling, who will oversee the Office of Student Support Services, Supplemental Education, and Special Education so she will be involved in a lot of NJDOE work re: mental health. She has been with DoE for a long time, is very knowledgeable and she is very experienced.
2. Dr. Kim Buxenbaum accepted a position as an assistant superintendent and is no longer at DoE, Kim Murray is acting director; a smooth transition is expected.
3. MH WorkGroup (resource manual for comprehensive school based mh resources), feedback is being collected and revisions are being made. This document is being internally reviewed at NJ DoE. Date for final stakeholder meeting will be at the end of summer, where a sneak preview of the resource manual will be shared.
4. Identifying academic gap during pandemic period: https://www.nj.gov/education/roadforward/reopening/acceleration/index.shtml
5. DREAMS program (DoE and DCF will partner with 50 School Districts for training in the "Nurtured Heart" Approach)

B. Div. of Developmental Disabilities (J. Sabin)

1. In accordance with the Centers for Medicare and Medicaid Services (CMS) Home and Community Based Services (HCBS) Final Rule, all HCBS must be delivered in settings that are integrated in, and support full access to, their community. This includes opportunities to seek employment and work in competitive settings within the community, engage in a community life, control personal resources, and receive services in a similar way as individuals who do not receive HCBS.
2. An updated site-specific HCBS Criteria Survey is required to be conducted for each existing residential and day setting to determine compliance with the HCBS Final Rule. To assist you with survey completion, the Division has developed HCBS Criteria Survey FAQs. https://www.nj.gov/humanservices/ddd/assets/documents/news/hcbs-criteria-survey-overview-faq.pdf

C. Juvenile Justice Commission (Francis Walker)

1. Return to weekly family visits
2. Returning to office schedule

VI. Open Public Comment and Announcements Donna Migliorino

A. Heather Simms wants to share sad news about passing of Karen Burke, CSP, Coordinator of Hospital Services, was instrumental in keeping peer services alive.
B. Tragic Passing of son of Tonia Ahern, funeral services will be held on 7/16/21
C. NJ State County MH Administrators Association meeting announced meeting on 7/19/21

12:00 **Adjournment** Donna Migliorino

A. Next meeting will be on 8/11/21

Microsoft Teams meeting
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Subcommittee Meetings for August 11, 2021 Meeting

9:00 Block Grant

12:00 Membership

NEW JERSEY BEHAVIORAL HEALTH PLANNING COUNCIL
August 11 2021, 10:00 am

This meeting was conducted exclusively through MS Teams video teleconference & conference call

Participants:

Phil Lubitz (Chair)	Darlema Bey(ViceChair)	Patricia Matthews	Lisa Negron
Julia Barugel	Winifred Chain	Connie Greene	Joe Gutstein
Suzanne Smith	Donna Migliorino	Damian Petino	Robin Weiss
Heather Simms	Francis Walker	Connie Greene	Barb Johnston
Rachel Morgan			

DMHAS, CSOC. DDD, DMAHS & DoH Staff:

Yunqing Li	Jonathan Sabin	Wyndee Davis
Mark Kruszczynski	Helen Staton	Suzanne Borys

Guests:

Nina Smukuluvasky	Wendy Rodgers	William Cole
Anne Smullen-Thieling		

Minutes:

I. Administrative Issues/Correspondence, Review of Previous Meeting Minutes Phil Lubitz

A. Attendance: Quorum reached (17/39 = 43.5% attendance)
B. Review of Minutes of Minutes of 7/14/21, Minutes approved.
   1. Clarification of discussion that block grant funds cannot be used for incarcerated populations.

C. Consent Decree between US Department of Justice and NJ Dept of Corrections about Edna Mahan Correctional Center for Women
(See https://www.justice.gov/usao-nj/pr/justice-department-reaches-proposed-consent-decree-new-jersey-resolve-claims-edna-mahan)

II. Community Mental Health Services Block Grant And Substance Abuse Prevention Treatment Block Grant (Donna Migliorino, Yunqing Li, Suzanne Borys, Helen Staton, Mark Kruszczynski, Nick Pecht

Public Access to Block Grant Applications (WebBGas)
https://bgas.samhsa.gov/Module/BGAS/Users
User name: citizennj
Password: citizen

A. Overview
B. Submission Deadline 9/1/21
C. Review of FFY 2022-2023 Block Grant Application: CMHSBG / Mental Health (YL)
   1. Discussion in WebBGas

2. Comments from public
    a. How are we moving along with quality improvement (continuous measurement)? [See below, III.F.2]

D. SAPTBG (Suzanne Borys)
1. Gaps Observed by Council (SSA)
2. Overview Previous Issues
    a. Key Barrier to MATI is transportation and homelessness

        Q: Are agencies being given extra funding for transportation for MAT and Mental Health? A: Block Grant does not allow for transportation to/from private providers. Medicaid does allow transportation via MotiveCare. [Anecdotally members of the Council report that MotiveCare is not a satisfactory transportation provider.] Agencies are given state funds and they should incorporate in their budget funds for transportation

    b. Block Grant should include mention of question "Is Fee for Service payment by the state sufficient to handle transportation costs to/from care for consumers to/from agencies not covered by Medicaid?"

    c. Additional housing resources to consumers receiving MAT and additional MAT services for consumers residing in homeless shelters.

    b. Services to older adults about opioid abuse

E. Children's System of Care (W. Davis)
1. Integration of SED/SUD & Primary Health.Targeted towards Block Grant funded programs but there is a much larger set of resources. **Behavioral Health Homes**, look to engage the number of youth. BHHs are in CMOs in five counties. Pre-Pandemic baseline will be used to measure use and growth of service. The C19 pandemic impacted baseline numbers. BHHs are in CMOs and are incorporated by wraparound model.

2. Expand Systems Capacities to serve **Youth/Infants and Early Childhood mental health**. Focusing on 0-5 Helping Families Thrive. Expanding staff in intensive in community resources and mobile response. Increased reflected supervision for new staff. Increased in EBPs for Child Parent Psychotherapy—cohort of 24 clinicians and 8 supervisors who can provide that specialty level of care. Plan to expand this to 400-450 moble response staff are to be trained plus 70 supervisory staff. Development of Advisory Stakeholder Group to land on outstanding elements to define success in this area.

3. Increase access to evidence-based services and supports across the CSOC service continuum by continuing to evaluate and plan to expand the In-Home Recovery Program (IHRP), which supports families with substance use disorders, child welfare involvement, and children ages 0-3, and enhancing our Intensive In-Community services providers' ability to provide healing-centered, evidence-based interventions, by collaborating with the CARES Institute to train clinicians in Trauma Focused Cognitive Behavioral Therapy.

4. Increasing competency in trauma informed care.

5. Q&A: Q: Concerns about Staffing across the children's system of care. A: For Mobile Response there are many decisions to make. Mobile's role will remain the same but additional considerations must be made. There are no new initiative nor populations but agencies will be given flexibility to bolster staffing challenges. CSOC will help agencies troubleshoot when needed.

F. Comments and Questions from Planning Council, Citizens Advisory Board and General Public

1. A focus should be made on continuous quality improvement, and total quality management for purposes of improving. Recommendation that CCBHCs capture additional client feedback on consumer outcomes. (See Minnesota Community Outcomes: depression remission)

2. The Block Grant documentation should reflect the fact that DMHAS has solicited providers of the First Episode Psychosis / Coordinated Specialty Care (CSC) to encourage families of youth/adolescents to participate in and apply for membership on the Planning Council.

G. No additional feedback is expected from SMHA/SSA within the next two weeks (as the Fiscal Information/Tables is forthcoming). Chair of the Council makes motion that the Council has discussed and has unanimously approved the FFY 2022-2023 Block Grant Applications (both CMHSBG and SAPTG) with one abstention.

III. State Partners Involvement Phil Lubitz

A. DCF Needs Assessment
https://www.nj.gov/dcf/about/divisions/opma/hsac_needs_assessment.html

B. Dept. of Education (Damian Petino)

1. https://www.nj.gov/education/broadcasts/
2. Mask Mandates for all school students and staff, in consultation with NJ Department of Health. Decisions are expected to me made in coming weeks that will impact September
3. Update on PerformCare's website specifically for Educators. https://www.performcarenj.org//educators/index.aspx
4. Q&A Sessions for Districts on State Funds for Mental Health.

C. Division of Developmental Disabilities (J. Sabin)

1. Effective August 16, 2021, in-person face-to-face visits shall resume as outlined in Support Coordinator Field Visits. For important visitation details please visit (https://www.nj.gov/humanservices/ddd/documents/covid19-support-coordinator-field-visits.pdf).

a. For the period from August 16, 2021 through December 31, 2021:

i. Support Coordinators are directed to resume in-person face-to-face visits.

ii. During this period, in-person face-to-face visits shall be

attempted for as many assigned individuals as possible. If an individual declines an in-person face-to-face visit the reason shall be documented on Record.

b. For the period beginning January 1, 2022:

i. Support Coordinators are directed to resume in-person face-to-face visits for all assigned individuals, scheduling as necessary to ensure this waiver requirement is met. 100% of individuals are expected to receive their in-person face-to-face visits in calendar year 2022.

D. Office of Aging (P.Matthews)

1. Elder Justice Reauthorization and Modernization Act of 2021
   Specifically, the legislation directly appropriates a substantial investment of $4 billion for new and existing Elder Justice Act programs and activities through fiscal year (FY) 2025, including a total of:
   - $1.6 billion for post-acute and long-term care worker recruitment and retention;
   - $1.4 billion for APS functions and grant programs;
   - $172.5 million for long-term care ombudsman program grants and training;
   - $500 million for supporting linkages to legal services and medical-legal partnerships (MLPs); and
   - $250 million to address social isolation and loneliness.
2. State Plan on Aging (2022-2025) was submitted recently to the Administration on Community Living for approval.
3. NJ Department of Health has designated specific staff members who have been assigned as Vaccine Ambassadors. The County Ambassadors are limited to 11 high risk counties. NJDOH would like to increase the percentage from 65 to 85. The Ambassadors will collaborate with the Area Agencies on Aging (AAAs). This initiative will complement the extraordinary effort achieved in assisting consumers with getting vaccinated.

E. Human Services Advisory County (R. Morgan)

1. The HSAC Needs Assessment Synthesis webinar for all 21 Counties was held on 8/2: The Commissioner of DCF went over the process and how we sought the 13 Needs areas (6 basic needs and 7 specialized service needs). In all 21 counties, Housing was the only one prioritized by all. The top two overall basic need priorities were housing and health care.

2. The top primary barriers to services:
   a. Lack of awareness of services
   b. Transportation
   c. Wait lists
   d. Stigma – which leads to avoidance to seeking help
   e. Cultural barriers

3. The number 1 specialized service need priority was Behavioral/Mental Health services for youth and adults follow by substance use.

4. The barriers to the specialized service needs were:

a. Lack of awareness of services
b. Lack of affordable health care
c. Limited Providers
d. Transportation
e. Stigma leading to avoidance of seeking help
f. Waitlists

5. Across the state there were 4,000 people who completed the survey and 2,000 people in the focus groups.

6. The process is going to look different based on all of the feedback they received from each county after the 2019-2020 Needs Assessment. The next phase will focus more on family and the voice of the constituents with focus groups for certain populations (i.e. ID/DD, homeless families, etc).

7. Timeline: January – June 2022.

IV. Open Public Comment and Announcements Phil Lubitz

A. NJ Legal Services did presentation on NJ Poverty, showing the real costs of living in the state of New Jersey. NJ Legal Services can be contacted to do/share this information.

B. The Burlington County Mental Health Administrator is working our NAMI's Mental Health Resource Guide for Burlington County

C. NAMI Walk is set for October 9, 2021 at a variety of locations.

V. Adjournment Phil Lubitz

A. Next meeting of the Planning Council is September 8, 2021

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NEW JERSEY BEHAVIORAL HEALTH PLANNING COUNCIL
September 9 2021, 10:00 am

This meeting was conducted exclusively through MS Teams video teleconference & conference call

Participants:

Phil Lubitz (Chair)	Lisa Negron	Julia Barugel	Winifred Chain
Suzanne Smith	Chris Morrison	Kate Brace	Robin Weiss
Tonia Ahern	Francis Walker	John Tkacz	Rachel Morgan (alt.)
Anne Smullen-Thieling (alt.)	Mark Kruszczynski (alt.)		

DMHAS, CSOC. DDD, DMAHS & DoH Staff:

Jonathan Sabin	Christina Fulham (NJ SEC)

Guests:

Nina Smukuluvasky	Wendy Rodgers	William Cole	Catherine Albrecht

I. Administrative Issues/Correspondence, Review of Previous Meeting Minutes Phil Lubitz

A. Roll Call, 14 of 39 participants, 36% attendance, quorum meet.

B. Announcements

1. Passing of Helen Williams, in August 2021. She was one of the founders of the consumer movement, a founder of the SHC in Trenton, & long term member of the Planning Council. She will be missed.
2. Return of workers to office on 10/18/21, October 13 meeting will be held via videoconference.
3. Passing of Karen Burke, CSP NJ, staunch consumer advocate and well-respected professional. She will be missed.

C. Minutes of August meeting approved without modification.

II. Ethics Training for Boards of Trustees Christina Fullam (NJ State Ethics Commission) christina.fullam@ethics.nj.gov

A. NJ State Ethnic Training for Special State Officers on Conflict of Interest Laws

B. State Ethics Commission is a small agency (10 employees) with a large task

C. Each Agency must have an ELO (Ethics Liaison Officer), DMHAS's is Lynne Alexander (Lynne.Alexander@doh.nj.gov)

D. See PowerPoint presentation that was given to the Council on 9/3/21

1. Recusals
2. Personal and Business Relationships Disclosure Form
3. Financial Disclosure Statements
4. Attendance at Events
5. Gifts
6. Political Activities
7. Outside Activities / Employment
8. Representing Parties Before Your State Agency
9 Contracting with your Agency.
10. Employment Decisions
    a. Casinos
    b. Cannabis Restrictions

11. Post Service Restrictions
12. Penalties
13. Helpful Resources, SEC website: www.nj.gov/ethics
14. When in doubt contact the DMHAS ELO, representative, Lynne.Alexander@doh.nj.gov

III. State Partners Involvement Phil Lubitz

A. Dept. of Health / State Psychiatric Hospitals (C. Morrison)
1. Vaccination rates increasing.
2. Cases of C19: "overall we are doing pretty well".
a. Comment: (P. Lubitz) Agencies who want to participate in C19 testing of staff and consumers can get a hold of the Division to arrange participation.

B. CSOC (N. Pecht). – Nothing to report.

C. DDD (J. Sabin) – Nothing new to report.

D. Juvenile Justice Commission (F. Walker)
Acting Governor Sheila Oliver today signed legislation (S2924/A4663) creating a two-year "Restorative and Transformative Justice for Youths and Communities" pilot program in the Juvenile Justice Commission at the Office of the Attorney General. This legislation appropriates $4.2 million in Fiscal Years 2022 and 2023, for a total of $8.4 million over two years, to the Juvenile Justice Commission to assist with the process of reintegrating young people released from juvenile facilities back into their communities, aiming to prevent initial and/or repeated involvement with the youth justice system.

IV. Open Public Comment and Announcements Phil Lubitz

A. Catherine Albrecht (parent) who wishes to speak on lack of mental health care of young adults (aging out). Ms. Albrecht self-identified as parent of 18 yr old high school senior who received inpatient treatment. Ms. Albrecht raises concerns of issue of parents not able to make legal decisions for 18 yr old children in behavioral health system. Challenge of young adults being placed in adult psychiatric facilities. This was deemed by Ms. Albrecht to be detrimental to the well-being of the young adult consumers.

B. Discussion / Possible Solutions (P. Lubitz):
1. Ms. Albrecht: The parents need to be able to be involved in the care of young adult children.
2. P. Lubitz: Often misunderstanding of HIPAA among providers. Ms. Albrecht's child should have been asked if she would permit her parent to be involved in her plan of care.
3. J. Barugel - Question: Was child involved in the CSOC/PerformCare before her 18th birthday? A: No.
J. Barugel: The CSOC is an important resource that is able to keep better continuity of care for children 'aging out' of the children's system of care, into the adult system of care.
4. R. Morgan: Families can still be linked to Family Support Organizations (FSO).
5. W. Rodgers: Intensive Family Support Service, for care givers of parents of children (adult) with SMI.

6. K. Baker: This challenge has been ongoing for a long time. Why aren't we giving out information at the point of acute care (for 18-26 yrs old)? Why aren't we educating people at that point in time, to help support their loved ones?
7. W. Cole: NJ Self Help Clearinghouse is a link to help find groups in their area, to find support , https://www.njgroups.org/

C. 2022-2023 Community Mental Health Services Block Grant and Substance Abuse Prevention and Treatment Block Grant applications have been successfully submitted to NJSAMHSA. See webbgas for more information.

D. 10/9/21, NAMI Your Way Walk, this will be a National Day of Hope, www.naminj.org

E. NJ Submitted its 1115 Medicaid Waiver, it will include changes for behavioral health.
1. Future agenda item: NJ Medicaid will be asked to present on the Waiver Request.

F. 988 Hotline: Suicide and Psychiatric Crisis response system, lots of progress made, it should be made available in 2022. (Future Agenda Item).

VI. Adjournment Phil Lubitz

A. The next meeting of the BHPC will be on Wednesday October 13, 2021 at 10:00 am and will be conducted via MS Teams, the login/dial in information is

Microsoft Teams meeting

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NEW JERSEY BEHAVIORAL HEALTH PLANNING COUNCIL
Minutes
October 13, 2021, 10:00 am

This meeting was conducted exclusively through MS Teams video teleconference & conference call

Participants:

Phil Lubitz (Chair)	Darlema Bey(ViceChair)	Patricia Matthews	Julia Barugel
Diane Riley	Connie Greene	Joe Gutstein	John Tkacz
Suzanne Smith	Damian Petino	Robin Weiss	Laura Richter
Heather Simms	Francis Walker	Barb Johnston	Suzanne Borys
Michele Madiou			

DMHAS, CSOC. DDD, DMAHS & DoH Staff:

Yunqing Li	Mark Kruszczynski	Donna Migliorino	Jennifer Langer-Jacobs

Guests:

Rachel Morgan	Wendy Rodgers	Kurt Baker

Minutes

I. Administrative Issues/Correspondence Review of Previous Meeting Minutes, Phil Lubitz

A. Notices of the meeting were sent to the Asbury Park Press, The Times (Trenton), Bergen Record, The Press (Pleasantville), and the Courier-Post (Cherry Hill).

B. Attendance. Quorum reached, 17/39 = 44% attendance

C. Minutes of September 2021 meeting approved.

D. Reminder for all voting members of CAB/BHPC to submit their signed State Ethics Office "Outside Questionnaire" form.

II. SFY 21 Block Grant Implementation Report Update, Donna Migliorino, Suzanne Borys, Yunqing Li, Mark Kruszczynski

A. Overview of Block Grant Implementation Report (Donna Migliorino)

1. URS Data Tables and State Performance Indicators are key pieces of the Annual Block Grant Implementation Report

2. WebBGas credentials will be sent to members of the Council. However URS data tables are not included in WebBGas.

3. New federal contractor (Hendall) is replacing NASMHPD/NRI in expediting and collecting URS data from states and territories.

4. Priority Areas in MH

a. Housing Services in community support services

b. Maintaining housing stability in CSS, measured by housing occupancy rate

c. First Episode Psychosis, medication management in FEP population, # served by Coordinated Specialty Care.

d. Cultural competency plans established among providers.

i. Target not met (50% of providers to have cultural competency

plan in place)

B. SABG Implementation Report Update
1. the Report has been created on WebBGAS, and DMHAS staff have been given their assignments to complete.
2. Priority areas: a. Pregnant women/women with dependent children, b. persons c. who inject drugs, heroin/opioid users
3. Will be reported in November meeting
4. Prevention Indicators: a. tobacco, b. alcohol, c. marijuana, d. prescription drugs, e. .heroin

C. Children System of Care (Nick)
1. Priority areas:
a. increase access to EBPs,
b. increase capacity to serve youth ages 0-3,
c. increase access to integrated health and behavioral health services

----------new----------

III. DD Eligibility and Services through the CSOC, Nick Pecht, NJ CSOC/DCF

A. See PowerPoint given by N. Pecht
B. Q&A
1. Q: Is there a plan to extend crisis stabilization service (CCIS) programs. A: Oversight of CCIS is shared among various entities.
Q: One of the biggest challenges for kids with DD/SMI, who need a hospitalization, who end up with wait times for weeks, waiting for an available bed. Trinitas is often the only available qualified bed. It would be great to see some of these issues prioritized as we are seeing an increase in kids in crisis. A: A: (DMM) additional funding for technical assistance going to educate screening centers and CCIS's in terms of providing better understandings to what existing resources are.
Q: Respite, "75 hours in a 30 day period", where does that number come from? A:. CSOC and Medicaid studied uses and trends years ago. Funding was determined based on utilization rates and to make services equitable for everyone.

IV. Medicaid 1115 Waiver Update, Jennifer Langer, NJ DMAHS

A. Background; Working in Medicaid for 15+ years, driven by the desire to make a large, complex system work better for people. Lots of federal rules apply, before one gets to state Medicaid.
B. State Medicaid Waiver lets NJ handle federal regulations so that NJ can do its job more effectively.
C. See PowerPoint Presentation
https://www.state.nj.us/humanservices/dmhas/information/provider/Provider_Meetings/2021/1115%20NJ%20Family%20Care%20Comprehensive%20Demonstration%20Renewal%20Presentation.pdf

D. https://www.state.nj.us/humanservices/dmahs/home/1115_demo.html
E. Desire is to integrate mental health care with primary health care.
F. Q&A
1. Q: What are exact requests to be made in the waiver application?
A: (See Slide 10: middle and right hand box of slide with three rectangles).
Everything is on the table.
G. Public Hearing from 9/27:
https://www.state.nj.us/humanservices/dmahs/home/1115_demo.html
H. Point is for better care, by holding Managed Care Organizations (MCOs) accountable.

V. State Partners Involvement, Phil Lubitz

A. Dept. of Education (D. Petino)

1. New laws to provide support/Grants for schools to use screening tools. Screening must be private and confidential and allows for real time evaluation for timely intervention.

a. Concern is a student has a screening, but the school doesn't know what to do with that information. DoE wants to put something more robust than just sending kids to screening or private psychiatrists to obtain medical clearance to return to school.

b. Goal is to enhance wraparound supports that go beyond follow-up /collaboration between schools and behavioral health providers.

2. Phil requests presentation on DoE initiatives to help prevent kids from going to emergency screening services.

3. https://www.nj.gov/education/esser/arp/index.shtml

VI. Subcommittee Reports, Chairs of Subcommittees

A. Block Grant Subcommittee met today, 10/13/21 at 9:00 am and reviewed progress by DMHAS and CSOC on the Substance Abuse Prevention & Treatment Block Grant, and the Community Mental Health Services Block Grant Implementation report applications.

VII. Open Public Comment and Announcements, Phil Lubitz

A. Announcements

1. 76th National Disability Employment Awareness Month (DEAM)
Event: "America's Recovery: Powered by Inclusion" hosted by DVRS and JEVS HireAbility.

a. To participate in the NJ Division of Vocational Rehabilitation and the JEVS hireAbility 76th Annual National Disability Employment Awareness Month (NDEAM) Event and Job Fair, for more information see https://www.jevshumanservices.org/hireability-hosts-deam-celebration/

b. This event will take place on October 28th from 1 p.m. – 3 p.m. You can anticipate the first hour (1p.m. - 2 p.m.) to include an NDEAM celebration featuring client success stories, messages from the NJ

Division of Vocational Rehabilitation Director Karen Carroll, the NJ Dept. of Labor Dept. of Diversity Equity & Inclusion Officer, Braheim Knight, and the NJ Department of Labor Commissioner, Robert Asaro-Angelo.

c. The second part of the event (2 p.m. – 3 p.m.) will feature a job fair. The job fair format will include three rounds of 15-minutes where each employer will have their own virtual room. Employers will have the opportunity to speak about their company and the positions they are hiring for.

c. 76th National Disability Employment Awareness Month (DEAM) Event America's Recovery: Powered by Inclusion. Registration: https://www.eventbrite.com/e/disability-employment-awareness-month-event-tickets-178825962267

2. NAMI Coffeehouse, will be returning online. www.NAMINJ.org (See Expressive Arts Network), a monthly event

VIII. Adjournment, Phil Lubitz

A. The next meeting of the NJ Behavioral Health Planning Council is scheduled for Wednesday, November 10, 2021 at 10:00 am.

NEW JERSEY BEHAVIORAL HEALTH PLANNING COUNCIL
AGENDA
November 10, 2021, 10:00 am

This meeting was conducted exclusively through MS Teams video teleconference & conference call

Notices of the meeting were sent to the Asbury Park Press, The Times (Trenton), Bergen Record, The Press (Pleasantville), and the Courier-Post (Cherry Hill).

Participants:

Phil Lubitz (Chair)	Darlema Bey (Vice Chair)	Julia Barugel	Winifred Chain
Connie Greene	Shauna Moses	Robin Weiss	John Tkacz
Rachel Morgan (alt.)	Michael Ippoliti	Tracy Maksel	Suzanne Borys
Damian Petino	Joseph Gutstein	Barbara Johnston	
Tammie Smith	Patricia Matthews		

DMHAS, CSOC. DDD, DMAHS & DoH Staff:

Jonathan Sabin	Donna Migliorino	Mark Kruszczynski	Yunqing Li
Nicholas Pecht	Helen Staton	Harry Reyes	

Guests:

Nina Smukuluvasky Kurt Baker Shawn Buskirk

Planned Agenda

I. Administrative Issues/Correspondence

A. Attendance: 17/39 = 44% attendance, quorum exceeded.

B. News

1. Morris County to quickly identify individuals who get brought to a local or county jail, and prior to being released under bail reform (24/48 hours), people with mental illness will be identified and given the opportunity to connect with behavioral health services while they await trail.
2. Gov. Murphy signed law requiring certain state student ID cards to have information for Suicide Prevention Hotline information.
3. C19 Supplemental funds for SUD provider agencies.
   a. Additional RFPs will be released.
   b. SAMHSA will share information for behavioral health apps to be used by contracted agencies.
   c. Development of a crisis diversion program, under direction of Dr. Robert Eilers. A similar program exists in Baltimore, MD. The RFP is ready to go, but licensing will require more planning.
4. C19 Supplemental Funds for Mental Health: Once RFPs are formally announced, DMHAS will send out guidance soon.

C. Review of Previous Meeting Minutes from October 13, 2021 have been approved.

II. SFY 21 Block Grant Implementation Report Updates:

A. Community Mental Health Services Block Grant (Donna Migliorino & Yunqing Li, DMHAS)

1. In Sept 1, we submit joint plan. Dec 1, 2021 we are required to submit two BG Implementation Reports
2. WebBGas information was provided via email in meeting announcements.
3. Implementation Report for Mental Health DOEs not have much content in WebBGas.
4. Adult Mental Health Performance Indicators
    a. CSS tenure must check data again.
    b. CSS occupancy, target is 95%, we achieved 94%, based on PWR data from the end of SFY21
    c. First Episode Psychosis (FEP) / Coordinated Specialty Care (CSC)
        i. Indicator is medication adherence. Target is 88% medication adherence rate. Our accomplishment is 85.9% Possible reasons for not making target.
        - Staffing changes/staff turnover among clinicians & prescribers
        - Stress associated with C19 pandemic adversely impacting consumers adherence to their medication regime
        - Medication management conducted via telephone/video conference, not as effective as face to face.
    d. Cultural Competency (First Year Target is 30% of agencies will have a cultural competency plan). Part of the process, is the numbers are increasing slightly, there is a gap due to lack of consultants to agencies to work on Cultural Competency Plans. Once consultant begins work with providers will begin. The Assistant Commissioner will reinforce with all DMHAS contracted providers that Cultural Competence is mandatory. Current number is around 40%
        i. Phil requests monthly updates until the target of 50% is accomplished.
        ii. Chairman of the Council would like the Council to have additional input on making a more meaningful indicator.
5. Planning Council membership still exceeds requirement that at least 50% of members are consumers/families, etc.

B. SAPT Performance Indicators (Suzanne Borys and Helen Staton, DMHAS)

1. Target for pregnant and expecting women receiving treatment was not met, likely to due (C19) pandemic concerns among consumers. Office Based Addition Treatment (OBAT), are being replaced by remote methods of getting medication management treatment. 15.5% decrease in admissions of pregnant women.
2. Intravenous Drug Users. Second target not achieved due to pandemic and consumers not physically coming to treatment agencies. 24.4% decrease in admissions relative to baseline year.
3. Persons who use heroin and opiates. Target not met. Admissions are down 1.9% due to concerns. Indicator was supported to be "perceptions of great risk from trying heroin once or twice ages 12-17".
4. Admissions for Medication Assisted Treatment (MAT), target not achieved due to C19 concerns among consumers.
5. Tuberculosis target (85%) not achieved.

[Comment from Chairman: Not meeting targets is not always necessary bad, especially if/when targets are deliberately set high for purposes of improvement.]

6. Five prevention indicators

C. Children's Behavioral Health (Nick Pecht, DCF, CSOC)

1. Priority Area 10 states, "in coordination with New Jersey's Aligning Early Childhood with Medicaid (AECM) technical assistance project, the Children's System of Care (CSOC) will develop and implement screening, identification, and intervention among at risk children ages 0-3."

    a. In 2020, CSOC collaborated on the development of a report (Unlocking Potential: A Roadmap to Making New Jersey the Safest, Healthiest, and Most Supportive Place to Give Birth and Raise a Family) which outlines steps to expand infant mental health services in New Jersey. One of the strategies noted is to increase the supply of well-trained infant mental health professionals.

    b. In 2021, CSOC launched a new initiative to address this strategy - "Zero to Five: Helping Families Thrive," is providing staff development opportunities for Mobile Response and Stabilization Services (MRSS) and Intensive In-Community (IIC) providers. Specifically, CSOC is funding Montclair State University (MSU) to provide training for over 400 MRSS direct service providers and their supervisors. MSU will also train 72 IIC clinicians and their supervisors in an evidence-based model, Child and Parent Psychotherapy, over a 3-year period.

    c. By increasing our system's capacity to serve infants and young children, families will get the support they need earlier than ever before, hopefully preventing the need for future, more extensive intervention, and paving the way to making New Jersey the best place to raise a family.

2. Priority Area 11 states that CSOC "will continue to increase the integration of community-based physical and behavioral health services for children, youth, and young adults with mental or behavioral health challenges and/or substance use challenges and chronic medical conditions." In New Jersey, one way in which this work is being done is by bringing the Behavioral Health Home model to four Care Management Organizations operating within the system of care. Behavioral Health Homes provide eligible youth with enhanced care management teams that include medical expertise and health and wellness education. Nurse Managers and Health and Wellness Coaches identify, screen, and coordinate both primary and specialty medical care, in collaboration with the Child Family Team tasked with planning for the holistic needs of the youth.

a. The number of youth receiving this service has increased by 5% annually, but as expected, due to the public health emergency, a 5% increase for fiscal year 2021 did not occur (although there was an increase of about 1% and we exceeded the 5% increase in fiscal year 2020 by about 1%).

b. CSOC will continue to strive to expand the reach of this service to additional youth by working closely with the programs to ensure they are able to take up a more assertive, standardized approach to identifying and engaging eligible youth. This quality improvement effort will include enhanced tracking of eligible youth, youth engaged in the screening process, and youth engaged in the program. By counting youth at different decision points within the process, we will be able to identify any procedural barriers to expansion. We will also adjust our method of determining progress, by utilizing future targets based on projected increases in the overall percentage of eligible youth who have engaged in the program.

3. Priority Area 12 states that the "Children's System of Care will increase access to evidence-based services and supports across the service continuum" with the objective of planning, implementing, and evaluating at least one evidence-based program, the In-Home Recovery Program. This program supports families involved with the Department of Children and Families' Division of Child Protection and Permanency, in which a parent with a substance use disorder is actively parenting a child under 36 months old. Our target was to serve at least 36 families within the 18 month implementation phase of the program and this target was not only achieved, but exceeded, with a total of 46 families receiving this service. The program is currently being evaluated and may be considered for expansion.

D. **https://bgas.samhsa.gov/Module/BGAS/Users**
Username: citizennj
Passcode: citizen

E. Fiscal Tables: Will be presented at next meeting of BHPC on 12/8/21

F. Comments of Chair
1. Go to WebBGas to look at Implementation Reports
2. pandemic has changed the landscape of behavioral health

III. State Partners Involvement Phil Lubitz

A. Department of Education (D. Petino)
1. DOE working with stakeholders to determine funds necessary to conduct C19 testing/screening.
2. DOE Is at the Finish line for the Comprehensive Student Mental Health Resource Manual. A semi-finished copy will be available for review to DOE Executive Staff in a few weeks. (A presentation of this document to the Council will be presented).
3. Damian's alternate will be Dr. Maurice Ingram, NJ DOE.

B. Division of Developmental Disabilities (J. Sabin)

1. On August 6, 2021, the Murphy Administration issued Executive Order 252.
   a. This Order requires that staff working in targeted high-risk congregate settings be vaccinated or submit to testing once or twice weekly.
   b. Division policy on Support Coordinator Field Visits projects that on January 1, 2022, Support Coordinators will be returning to face-to-face visits which will require them to complete work in covered settings as well as family homes.
   c. Executive Order 252 - The Division will require Support Coordination Agencies to come into compliance with this Order by Thursday, November 18, 2021 (See covid19-support-coordination-agency-vaccination-compliance.pdf (nj.gov).
   d. Covered settings must:
      i. Comport with all federal and state laws, including but not limited to the Americans with Disabilities Act, that regulate the collection and storage of vaccination information for covered workers.
      ii. A covered setting has the ability to institute a vaccination or testing policy for staff that includes additional or stricter requirements, so long as such policy comports with the minimum requirements of this Order. A covered setting may also maintain a policy that requires more frequent testing of covered workers.
   e. Unvaccinated covered workers:
      i. Must undergo testing at minimum one to two times each week.
      ii. If testing is not provided by the covered setting, unvaccinated covered worker must submit proof of either an antigen or molecular test.
      iii. If testing is provided by the covered setting (this is not required), the covered setting may similarly elect to administer or provide access to either an antigen or molecular test.
      iv. If covered worker is not working during a week where testing would be required, testing is not required for that week.

2. On October 7, 2021, the New Jersey Department of Health released Executive Directive No. 21-011 – Protocols for Testing and Vaccination Reporting for Covered Settings Pursuant to Executive Order Nos. 252, 253, and 264. Please see PO 360, General Department (nj.gov) for details.

   a. Each covered setting shall complete a Immunization Status Report weekly and submit it to the NJ DOH upon request.

b. Covered settings should base their testing frequency on the extent of the virus in the community, and should, therefore, use the regional positivity rate reported in the Activity Level Index (CALI) Weekly Report: https://www.nj.gov/health/cd/statistics/covid/, in the prior week

3. The Division is pleased to confirm that on October 1, 2021, day services rates were increased as a result of additional funding in the Division's FY22 budget. These increases apply to: Career Planning; Community Inclusion Services; Day Habilitation; Pre-Vocational Training Individual and Group; and Supported Employment Individual and Group.

C. Department of Corrections; Introduction of Tammie Smith to Planning Council
D. Juvenile Justice Commission (Francis Walker)
   1. In October JJC had a second round of training of trauma informed approaches. All counselors and staff were involved.
   2. In October 2021 JJC allowed facilities to be opened where and when appropriate.
   3. JJC will return to office on 11/15/21.
E. Department of Health / NJ State Psychiatric Hospitals – No representative present.
F. Department of Labor.
   1. 10/28/21 Disability Awareness Day.
   2. Department of Labor Staff returned to office full time on 11/8/21
   3. https://www.nimh.nih.gov/news/science-news/2021/researchers-find-disparities-in-suicide-risk-among-lesbian-gay-and-bisexual-adults?utm_source=govd&utm_medium=email&utm_campaign=pressreleases2021

V. Open Public Comment and Announcements Phil Lubitz

A. Division of Criminal Justice is expected to release new mental health training curriculum for law enforcement. Steve Crimando is leading the training.
B. ICMS conference and training coming up.
C. Concern about mental health resources from NJ colleges and universities.
DMM: grant funds have been deployed to UBHC to handle consumers with SMI, those with non-SMI, SUD concerns. This program is geared to brief treatment. Most of it is telehealth. With additional ESR funds additional connection to services will be provided.

VI. Adjournment Phil Lubitz

A. Next meeting will be 12/8/21, 10:00 am.

Microsoft Teams meeting

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Subcommittee Meetings

9:00 None

12:00 None

NEW JERSEY BEHAVIORAL HEALTH PLANNING COUNCIL
AGENDA
December 8, 2021, 10:00 am

This meeting was conducted exclusively through MS Teams video teleconference & conference call

Notices of the meeting were sent to the Asbury Park Press, The Times (Trenton), Bergen Record, The Press (Pleasantville), and the Courier-Post (Cherry Hill).

Participants:

Phil Lubitz (Chair)	Darlema Bey (Vice Chair)	Suzanne Smith
Winifred Chain	Debra Wentz	Robin Weiss
Rachel Morgan (alt.)	Anne Smullen Thieling (alt)	Damian Petino
Joseph Gutstein	Barbara Johnston	Tammie Smith
Patricia Matthews	Diane Riley	Suzanne Borys

DMHAS, CSOC. DDD, DMAHS & DoH Staff:

Donna Migliorino	Mark Kruszczynski	Yunqing Li
Nicholas Pecht	Helen Staton	Limei Zhu

Guests:

Nina Smukuluvasky	Robert DePlatt (NJAMHAA)	Matthew George
Wendy Rodgers		

Planned Agenda

I. Administrative Issues/Correspondence — Phil Lubitz
Review of Previous Meeting Minutes

A. Attendance: Quorum Reached 15/39 = 38%
B. Minutes Approved with Revision
C. Announcement
1. Alternative Response to Residual Incidents of Violence and Escalation (ARRIVE) program to be launched in south New Jersey/\.

II. Block Grant 2021 Implementation Report: — Morris Friedman
Fiscal Tables

A. Table 3 Set Aside for Children's MH Services; Est. Actual $196.9M. There are no shortfalls in SFY21.
1. Question: CSOC doesn't receive BG funds. A: Correct.
2. Question Block Grant Supplemental (ERF and Covid19); There are AREF funds going to CSOC dollar amounts will be given.

B. Table 6: Maintenance of Effort on MH Services: SFY21 $470,176,377. No penalties expected.

Question: $13M reduction A: Driven by reductions of spending in our Division due to reduced revenues at the State level. We had to make cuts to some of our contracts based on reduced overall state revenues. Other states would be in similar situations. If you have lower appropriations, we will have lower spending. There were Medicaid revenues that were offsetting state costs, so SFY21 we captured those savings up front via contract reductions.
Question: Effect of Not having fiscal oversight over the state hospitals? Answer: Block grant funds have never been allocated for state hospitals. We do count hospital spending in table 7.

C. Table 7: MHBG MH Agency Expenditure Report ("The Big One")
1. State Hospital Spending: $324.2M
2.Question: IMD Exclusion and Medicaid Revenue, was there an increase because of a waiver? Answer: That would be separate from this because Table 7 is only for mental health.
3. Question: Reductions in state expenditures for state hospital? A: Reductions generally come when state hospital wards are actually closed; lower census doesn't indicate lower costs because staffing levels still generally remain the same.
4. Overall we have $1.8 Billion

D. Table 10: Allocation of BG Dollars, $17.9M

III. Synar Tobacco Sales Survey Report Overview Limei Zhu, Suzanne Borys

A. Project between Department of Health, Inspections and DMHAS. Block Grant funding is dependent on submitting a Synar report. This report looks for retailer violation rates of merchants selling tobacco products to youth. Age of enforcement is raised to prohibit sales to those under the age of 21.
B. Issues with staffing due to Covid-19. There were only three youth inspectors.
C. Retail violation was 11.6%, even though the sample size was lower.

IV. Presentations in CY 2022 Phil Lubitz

A. Needs for more presentations.
B. Children and Emergency Screening: Damian will coordinate something for February.
C. Importance of hearing the voices of families and consumers.
D. Idea for doing presentation on Housing (Diane Riley).
E. Idea for presentation on accessing a psychiatrist
F. t would be great to hear presentations and updates from each of the programs being funded by the block grant(s)

V. System Partner Updates

A. **DOE**
1. Ongoing Monthly Webinar on Student Mental Health
12/15/21 3:00
https://www.nj.gov/education/broadcasts/2021/oct/27/NJComprehensiveSchoolBasedMentalHealthTrainingandTechnicalAssistance.pdf
2. Good recent presentation on CSOC/Peformcare
3. Doctor Maurice Ingram, NJ DOE, Former School Psychologist.

4. The Be Smart program is a parent-driven workshop and set of resources that strives to educate parents regarding gun safety in the home. It is a non-partisan organization and does not promote gun ownership nor criticize it. Instead, they see their mission as ensuring parents who own guns keep them secure and teach basic gun safety so tragic accidents are reduced. See https://besmartforkids.org/

B. Children's System of Care (Nick Pecht)

1. The Children's System of Care is continuously making efforts to increase awareness and understanding of our system among those who interact with youth the most – educators. To that end, last month we had the opportunity to present at the New Jersey Education Association's annual

VI. Open Public Comment and Announcements Phil Lubitz

A Rowan University Neurodiversity Center [Contact D.Bey for information]

B. Burlington County just finished our 4th CIT training this year. 3 were done in the Fall alone. We usually only do 2 per year but due to demand, we doubled our training and will do 3 in 2022. We have over 500 law enforcement, MH professionals and EMS and Fire trained.

VII. Adjournment Phil Lubitz

A. January presentations:

1. Anne Smullen Thieling & Heather Simms, CSP NJ
2. CarePlus Trauma Informed Communities

B. Subsequent presentations:

1. Housing/Vouchers
2. Diverting kids from Emergency
3. Attitudes in Reverse Presentation (Kurt W.)
4. Mental Health Care for Incarcerated Populations

C. Next Meeting; Wednesday, January 12, 2022 (via video conference)

Microsoft Teams meeting

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Subcommittee Meetings

9:00 None

12:00 None

NEW JERSEY BEHAVIORAL HEALTH PLANNING COUNCIL
AGENDA
January 12, 2022, 10:00 am

Microsoft Teams meeting

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+1 609-300-7196, PIN: 451481757#

Notices of the meeting were sent to the Asbury Park Press, The Times (Trenton), Bergen Record, The Press (Pleasantville), and the Courier-Post (Cherry Hill).

Planned Agenda

10:00	**Administrative Issues/Correspondence** **Review of Previous Meeting Minutes**	Phil Lubitz
10:20	**Trauma-Informed Communities: Innovative & Compassionate Approaches**	Jennifer Velten Giesel Girona Caitlyn Yerves
11:15	**System Partner Updates**	Chairs of Subcommittees
11:30	**Open Public Comment and Announcements**	Phil Lubitz
12:00	**Adjournment**	Phil Lubitz

Subcommittee Meetings

9:00	None
12:00	None

NEW JERSEY BEHAVIORAL HEALTH PLANNING COUNCIL
Minutes
February 10, 2022, 10:00 am

This meeting was conducted exclusively through MS Teams video teleconference & conference call

Notices of the meeting were sent to the Asbury Park Press, The Times (Trenton), Bergen Record, The Press (Pleasantville), and the Courier-Post (Cherry Hill).

Participants:

Phil Lubitz	Darlema Bey (Vice Chair)	Winifred Chain	Krista Connelly
Robin Weiss	Heather Simms	Damian Petino	Diane Riley
Harry Coe	Connie Greene	Barbara Johnston	Patricia Matthews
John Tkacz	Suzanne Smith	Julia Barugel	Michele Madiou
Nick Loizzi	Suzanne Borys	Connie Greene	Francis Walker

DMHAS, CSOC. DDD, DMAHS & DoH Staff:

Donna Migliorino	Mark Kruszczynski	Jonathan Sabin	Yunqing Li

Guests:

Nina Smukuluvasky	Rachel Morgan	Wendy Rodgers	Laura Richter
Kurt Baker	Scott Sarno	Anne Smullen Thieling	
Irina Stuchinsky	Joselyn Satterfield	Mathew George	

Minutes

I. Administrative Issues/Correspondence Darlema Bey

A. Attendance: 20 members present, Quorum Reached 51%

B. S311 / 988 Bill has started journey through legislative processes, unanimously passed through NJ Senate Human Services Committee

C. Review of Minutes of January 12, 2022 General meeting, minutes approved, with minor edits.

II. Integrated Peer Services at CSPNJ Heather Simms, Anne Smullen-Thieling

A. See PowerPoint/.PDF emailed to council on 2/7/22, 4:14pm.

B. Goals: Review of different programs offered.

C. Services

1. Community Wellness Centers
2. Community Support Services
3. Hospital Wellness Centers
4. Wellness Respite Centers

D. Admission Process
E. Inclusionary Criteria
F. Wellness Planning
G. Follow Up Services
H. Q&A:
1. Q: Some counties aren't served by CSP NJ, why? A: If an RFP is put forth, then CSP could apply for it to provide services.
2. NJ Residency Requirements? A: ID is asked for on admission but if someone doesn't have an ID, it will not be a barrier to services.
3. Q: Would the Council be interested in a presentation on SUD Peer Recovery Services? A: [Phil], yes lets confer with Mark K.

III. System Partner Updates P. Lubitz

A. Supportive Housing Association (D. Riley)
1. Additional Funding Opportunities
2. 50:50 match from Medicaid
3. Medicaid Assistance Advisory Coucil (MAAC)
4. FMAP Funding, see https://nj.gov/humanservices/assets/slices/NJ%20HCBS%20Spending%20Plan%20Submission.pdf and https://www.shanj.org/past-sha-membership-meetings/

B. Department of Corrections (Dr. Krista Connelly)
1. Large number of releases (260, & 1000 on March 13, 2022) from State Prisons (2/9/22) due to Covid-19 pandemic.
2. Q&A:
a. Question about Edna Mahan Facility
b. Q: Taking into account inmates who may be released in Feb and March, how many might be re-incarcerated due to other offenses? A: Dr. Connelly will look into this.
c. Q: Peer Navigators for recently incarcerated populations? A: Services are occurring but Dr. Connelly will find out an answer. [S. Borys IRTS program (i.e., is the collaboration with Rutgers and DMHAS that provides peer navigators to recently released patients) will be expanded to assist those with mental illness whom have been recently released from incarceration populations].

C. Dept. of Education (D. Petino)
1. Mental Health resource guide from the DoE Mental Health Workgroup should be distributed within the next 48 hours

D. Children's System of Care (N. Pecht)
1. 2/3/22: Vaccination Forum
2. See https://www.nj.gov/dcf/news/OOH-provider-guidance-update1-28-22.pdf

3. Effective February 2, 2022 the Out of Home treatment admission freeze for non-emergency situations and halting of off-site visitation was lifted via a revision to the guidance released on January 4th of this year.
To assist our Out of Home providers in ensuring the best information was available to their staff as it relates to vaccinations, an Out of Home Provider Vaccination Forum was held virtually on February 3, 2022. A prominent community-based pediatrician provided his medical expertise and was available to take questions and we also had presenters from Bonnie Brae, the Carrier Clinic, and Legacy Treatment Services, who discussed the strategies they used to ensure the health and safety of both their staff and the youth they serve.

E. Division Of Vocational Rehabilitation Services (J. Tckaz):
1. DVRS is always willing and capable to help consumers in need. See https://nj.gov/labor/career-services/special-services/individuals-with-disabilities/index.shtml

F. Juvenille Justice Commission (F. Walker)
1. Expansion of work study program

G. Division of Aging (P. Matthews)
1. Income limits for the Pharmaceutical Assistance to the Aged and Disabled (PAAD) and the Senior Gold Prescription Discount medication assistance programs have increased by $10,000, making medication prices more affordable and benefitting over 20,000 seniors. Raising the income threshold, which was part of Governor Murphy's Fiscal Year 2022 budget, is the largest one-time increase in the history of both the PAAD and Senior Gold Prescription Discount drug assistance programs. This initiative is a part of the Governor's ongoing and broader commitment and programming to make health care more affordable for
2. New Jersey residents across provider, insurance, and prescription drug costs.

3. The PAAD and Senior Gold Prescription Discount medication assistant programs are available to residents 65 and older and those with disabilities. PAAD cuts medication prices to $5 for covered generic meds and $7 for covered name brands. Senior Gold cuts prices in half after a $15 copay for covered prescriptions. The PAAD program income limits are now $38,769 if single and $45,270 for a couple. The Senior Gold Prescription Discount program limits are now $48,769 if single and $55,270 if married. Assets are not an eligibility consideration for either program.

4. Income limits for the Lifeline utility assistance program and the Hearing Aid Assistance to the Aged and Disabled (HAAAD) program have also increased by $10,000, as those programs are tied to PAAD.

5. For more info go to NJSAVE webpage

IV. Open Public Comment and Announcements P. Lubitz

A. Announcements: None

B. Comments

1. Long waits for children in Emergency Rooms / CCIS Beds discussion.
2. Question about MH Administrators

V. Adjournment P. Lubitz

A. Upcoming Presentations

1. State Budget Briefing (Morris Friedman, March 9, 2022)
2. S311 / 988 MH Crisis Hotline Bill (DMM will ask Asst. Commissioner Mielke, March 9, 2022)
3. SUD Peer Recovery Services (Suzanne Borys)
3. DMHAS Cultural Competency Plans (Liz Conte)
4. Housing/Vouchers
5. Diverting kids from Emergency
6. Attitudes in Reverse Presentation (Kurt W.)
7. Mental Health Care for Incarcerated Populations

B. Next meeting, Wednesday, March 9, 2022

Microsoft Teams meeting

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1. **9:00 Membership Subcommittee** Meeting
2. **12:00 Advocacy Subcommittee** Meeting: Issue of shortage of inpatient beds for children, long waits for Emergency Rooms for kids waiting for dispositions. Invite NJHA and CSOC

Subcommittee Meetings

9:00 None

12:00 None

NEW JERSEY BEHAVIORAL HEALTH PLANNING COUNCIL
Minutes
March 9, 2022, 10:00 am

This meeting was conducted exclusively through MS Teams video teleconference & conference call

Notices of the meeting were sent to the Asbury Park Press, The Times (Trenton), Bergen Record, The Press (Pleasantville), and the Courier-Post (Cherry Hill).

Participants:

Phil Lubitz *(Chair)*	Darlema Bey (Vice Chair)	Winifred Chain	Krista Connelly
Robin Weiss	Heather Simms	Damian Petino	Connie Greene
Barbara Johnston	Patricia Matthews	John Tkacz	Suzanne Smith
Julia Barugel	Michele Madiou	Donna Migliorino	Michael Ippoliti
Laura Richter (alt.)	Debra Wentz		

DMHAS, CSOC. DDD, DMAHS & DoH Staff:

Valerie Mielke	Morris Friedman	Mark Kruszczynski	Jonathan Sabin
Shenal Pugh			

Guests:

Nina Smukuluvasky	Rachel Morgan	Wendy Rodgers	Kiersten Roseto
Anne Smullen-Thieling	Mary Abrams	Bernadette Moore	

Minutes:

I. Administrative Issues/Correspondence (Phil Lubitz)

Review of Previous Meeting Minutes

A. Attendance, 18/39, 46.1% attendance, quorum reached

B. Minutes of February Approved

II. 988 Overview (Valerie Mielke, Assistant Commissioner, DMHAS)

A. See PowerPoint

1. 988 provides ability for "someone to call, to have someone to come [respond to the caller] and somewhere [for the caller] to go, 24/7, 365 days
2. 988 Planning Grant from Vibrant Emotional Health
3. NJ has five lifeline member centers
   a. Caring Contacts
   b. Contact of Burlington County
   c. R-UBHC (contracted to respond to calls 24/7)
   d. Contact of Mercer County
   e. Mental Health Association in New Jersey (MHANJ)

4. Develop clear roadmaps: Expanding call capacity, adding statewide capacity for texts and chats, 988 network funding, communication with stakeholders and 988 network.
5. Landscape analysis of Lifeline Member Centers.
6. Monthly 988 Stakeholder Coalition Group
7. Inter-state consultation to identify and implement best practices.
8. Call centers will have process to screen and triage callers to direct them to most appropriate services, and follow-up calls.
9. Psychiatric Emergency Screening Services
10. Exploring development for statewide mobile outreach for callers when there is not a known need for law enforcement involvement.
11. Early Intervention Support Services (EISS) currently in11 counties, but expected to expand statewide in late summer 2022.
12. Crisis Receiving and Stabilization Centers - Up to 24 hour stop-in/walk-in, (but no overnight residency).
13. Community based residential crisis diversion beds.
14. 988 Key Stakeholder Coalition Membership: incl. Consumers, State govt, Law Enforcement,
15. MaryJeanWeston@dhs.nj.gov, Allison.kuszninov@dhs.nj.gov

B. Questions and Answers
1. Q: Other states implementing the 988 network? A: The National Suicide Lifelife is what is existing across the county. However 988 rolls out nation-wide later in July 2022, however individual state's responses may vary.
2. Optimistic about federal funding for crisis services.
3. Comment, Certified Community Behavioral Health Homes (CCBHCs).
4. Q: Crisis Receiving and Stabilization Centers A: Will have prescribers, nurses, individuals with lived experience, social workers, consumers have 24 hour visit availability; they are not a substitute for emergency departments.
5. Q: Where is the $13M coming from? A: State appropriations [NJ State Budget], and from feds $500k MH supplemental and $500 SU supplemental.
6. Q: Medicaid revenue and outreach? A: No in-depth analysis conducted yet, but discussions are ongoing.

III. NJ State Budget Overview (Morris Friedman, CFO, DMHAS)

A. SFY2022 State Budget
1. Growth
   a. $27M of State funding that will allow us to increase contract reimbursement ceilings and increase FFS rates (DMHAS and Medicaid) to providers. There is an estimated $12 million additional federal impact in Medicaid.
   b. $12.9M for implementation of the 988 Suicide and Crisis Helpline;
   c. $3.9M to annualize the costs of SFY22 Olmstead Placements
   d. $1.9 M in State Aid to the four county psychiatric hospitals, reflecting higher per diem rates
   e. $1.5M for the SUD Grants-in-Aid to replace some of the funds previously transferred to DMHAS from the Drug Enforcement and Demand Reduction (DEDR) Fund

f. $1.2M for increased rates to providers of diversion beds for the uninsured.
g. $400k to bolster staffing at DMHAS
f. $150k "New Beginnings" Behavioral Health; more information to come.

2. Reduction
   a. $5M community care, reflecting historical underspending.

3. Q&A
   a. Q: How might the $27M increase to contract ceilings and FFS rates impact increased wages for direct care workers? A: The Division is working to operationalize this increase with specific adjustments to each cost reimbursement contract and each FFS rate. The increased revenues to providers will be able to be leveraged as they deem necessary to meet the increasing costs for direct care workers.

IV. System Partner Updates Chairs of Subcommittees

A. Children Systems of Care (Nick Pecht)
   1. Nothing to report.
   2. 1. Children's Partiial Care, Psych Assement and Outpatient rate increases (M. Abrams)
      a. Psychiatric assessment rate disparity between adults and children, the new state budget looks to correct this.

B. Department of Education (Damian Petino)
   1. Comprehensive Mental Health Guide
      https://www.nj.gov/education/safety/wellness/mh/index.shtml
      it will be revised shortly.
   2. Office of Student Support Services is supporting Social & Emotional Learning (SEL) Day:
      https://www.njsba.org/news-publications/school-board-notes/january-25-2022-vol-xlv-no-23/schools-invited-to-participate-in-sel-day-2022/ and
      https://sel4nj.org/events/our/

C. Division of Senior Services (Patricia Matthews) - Nothing to report

D. Department of Corrections (Krista Connelly)
   1. Release of about 850 prisoners on 3/13/22
   2. Edna Mahan Correctional Facility
      a. Public hearing was recently convened, and it will be soon posted on the DOC website.
      b. Consultant hired to consider new site for women's correctional facility.
      c. New advisory board formed.
   3. Follow-up on people who are going to be released are then re-incarcerated into county jails

E. Division of Developmental Disabilities (J. Sabin)
   1. New Office of Education on Self-Directed Services

a. The Office will provide education and training on this important topic to assist DDD consumers make informed choices.
b. Anyone seeking additional information regarding this new Office is invited to visit its website at can be found https://www.state.nj.us/humanservices/ddd/individuals/community/education/.

2. Direct Service Professional (DSP) Competency and Capacity Building Steering Committee – This new, time-limited stakeholder committee will be charged with the review and adoption of a core set of competencies based on nationally recognized competency and skill sets. This will aid in the development of a training framework which will include mandatory pre-service training, initial onboarding training; ongoing professional development.

3. Updated Support Coordinator Return to Field Guidance
a. The requirement for face-to-face visits by Support Coordinators (SCs) was suspended in March 2020 due to the COVID-19 pandemic.
b. This is a reminder that face-to-face visits for Support Coordinators are to resume starting in March 2022 as outlined in Support Coordinator Field Visits.

4. Reminder - Executive Order 283
a. On January 19, 2022, Executive Order No. 283 went into effect requiring covered workers at health care facilities and high-risk congregate settings to be up-to-date with COVID-19 vaccination, including booster dose.
b. Staff in Licensed Residential and Certified Day settings are required to comply with Executive Order No. 283, Executive Order 252 and Executive Directive No. 21-011.
c. This requires them to be at least two weeks past having completed their primary vaccine series and up-to-date with their COVID-19 vaccinations (including booster).
d. Daily screening for COVID-19, as well as masking requirements, remain in place.

F. NJ State Medicaid
1. Peer recovery specialists in ER rooms and hospitals for NARCAN-reversed patients, billings will be retroactive to 2019 (reported by Connie Greene)

G. Division Of Vocational Rehabilitation Services (J. Tkacz):
DVRS is always willing and capable to help consumers in need. See https://nj.gov/labor/career-services/special1services/individuals-with-disabilities/index.shtml

V. Open Public Comment and Announcements Phil Lubitz

VI. Adjournment Phil Lubitz
A. Meeting adjourned, 11:43 am.
B. Future Agenda Items
1. CSOC Budget Outlook
2. NJ DoE Comprehensive Mental Health Guide (Maurice Ingram)
C. Next General Meeting April 13, 2022

Microsoft Teams meeting

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1. Subcommittee meetings on 4/13/22
   a. 9:00 **Membership**
   b. 12:00 **Advocacy**

NEW JERSEY BEHAVIORAL HEALTH PLANNING COUNCIL
Minutes
April 14, 2022, 10:00 am

This meeting was conducted exclusively through MS Teams video teleconference & conference call

Notices of the meeting were sent to the Asbury Park Press, The Times (Trenton), Bergen Record, The Press (Pleasantville), and the Courier-Post (Cherry Hill).

Participants:

Phil Lubitz (Chair)	Darlema Bey (Vice Chair)	Diane Riley	Krista Connelly
Robin Weiss	Heather Simms	Joseph Gutstein	Connie Greene
Barbara Johnston	John Tkacz	Suzanne Smith	Nick Pecht
Julia Barugel	Michele Madiou	Mark Kruszczynski	Tracey Maksel
Tonia Ahern	Robert DePlatt		

DMHAS, CSOC. DDD, DMAHS & DoH Staff:

Jonathan Sabin	Francis Scott Sarno	Elizabeth Conte

Guests:

Nina Smukuluvasky	Rachel Morgan	June DePonte-Sernak
Kurt Baker		

Minutes:

I. Administrative Issues/Correspondence (Phil Lubitz)

A. Attendance, 18/39, 46.15% attendance, quorum reached

B. Minutes of March 2022 General Meeting approved unanimously.

II. CSOC Budget Outlook SFY2023 and System Updates Nick Pecht

A. Budget not changed since last year.
   1. Availability of services will not be changing.
   2. We can request budget director to subsequent meeting.

B. Human Trafficking Summit provided recently by Volunteers of America

C. CSOC working with NJ Office of New Americans

D. CSOC is experiencing a significant increase for services. This will be discussed at a future meeting of the Council, potentially at the May meeting.

III. DMHAS Cultural Competency Initiative Update & Statewide Diversity Consultant Cultural Competency Review Liz Comte (DMHAS) & June DePonte-Sernak (Ctr. For Family Services)

A. DMHAS Cultural Competency Initiative
   1. DMHAS's New Cultural Competency Consultant, June DePonte-Sernak**,** Ph.D.

B. Presentation on Statewide Diversity

1. Background of Statewide Consultant
    a. Former telecomm executive, American Red Cross leader and affiliated with Rowan College. Currently with Center for Family Services

2. See PowerPoint

3. Q&A
    1. Comment (P. Lubitz): Disappointment that so few contracted providers have cultural competency plans
    2. Question: How many cultural competency plans are there in place and how many have metrics to evaluate efficacy? A: 40+ providers have cultural competency plans based on the federal EBP. Also Cultural Competency seems to be voluntary in many agencies (i.e., agency staff serving multiple functions).
    3. Comment: (P.Lubitz) Challenge of separating Cultural Competency from Quality Assurance. How can you have quality assurance without cultural competency?

IV. BHPC Subcommittees

A. Advocacy (J. Barugel)
1. Aging Out
2. Important article: https://www.nj.com/healthfit/2022/03/saving-charlie.html
3. Members of Subcommittee are encouraged to participate in the 12:00 Advocacy Meeting.

B. Membership (P.Lubitz)
1. Met in March and today. Four members of the council will be leaving the Council due to non-participation, and one member of the Citizen's Advisory Board will not be recommended for re-appointment.
2. Membership must be enhanced to more fully represent the ethnic and cultural diversity of New Jersey.

V. System Partner Updates, Chairs of Subcommittees

A. Department of Corrections (Krista Connelly)
1. Update on Edna Mahan facility see video.
https://us06web.zoom.us/rec/play/iUHP7TnSiQhKUX3LmAyHinr_KwkUoE6FbiYB4teAdkMINGOSU9NF1hD46VwMjP3CHd8Xf1eY44K1PBzR.5fi9iJmm--D8nNSy?continueMode=true
2. Q&A:
    a. Committee created.

B. Division of Developmental Disabilities (J. Sabin)
1. No new updates from DDD

C. Division of Vocational Rehabilitation Services (J. Tkacz):
1. Grant Notice for Paid Summer (9 Month) Internships to provide internships for students throughout the summer to the end of the year.
2. Contracts transitions to IGX electronic system.
3. Lots of staff movement (retirements, new hires)

VI. Open Public Comment and Announcements Phil Lubitz

A. NAMI- NJ (Darlema Bey)

1. Poetry contest from NAMI-NJ.org, deadline is fast approaching
2. Coffee house meeting involving expressive arts.
3. NAMI Walks in October 2022

B. CSPNJ:
1. Outreach via NJ Transit to homeless individuals
2. Pilot program to provide cell phones to consumers leaving state psychiatric hospitals. Planning to expand to all four state hospitals.

C. Supportive Housing Association (Diane Riley)
1. State budget: $300M for affordable housing, possibly 3K homes.
2. Two grants
   a. DDS Integrated Community Grants: Bergen, Camden and Ocean Cos.
   b. Housing Navigation to help people connect with housing.

D. Camden Count has mapped the entire flow through the judicial system as it pertains to persons with behavioral challenges. The process that one might go through by coming in contact by Police Officer through Judge or hospitalization

VII. Adjournment Phil Lubitz

A. Meeting adjourned, 11:15 am.

B. Future Agenda Items
1. NJ DoE Comprehensive Mental Health Guide (Maurice Ingram)

C. Next General Meeting May 11, 2022, 10:00 am

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1. Subcommittee meetings on 5/11/22
   a. 9:00 Membership
   b. 12:00 Advocacy

NEW JERSEY BEHAVIORAL HEALTH PLANNING COUNCIL
Minutes
May 11, 2022, 10:00 am

This meeting was conducted exclusively through MS Teams video teleconference & conference call

Notices of the meeting were sent to the Asbury Park Press, The Times (Trenton), Bergen Record, The Press (Pleasantville), and the Courier-Post (Cherry Hill).

Participants:

Phil Lubitz (Chair)	Darlema Bey (Vice Chair)	Diane Riley	Krista Connelly
Robin Weiss	Heather Simms	Joseph Gutstein	Connie Greene
Barbara Johnston	John Tkacz	Suzanne Smith	Nick Pecht
Julia Barugel	Michele Madiou	Tracey Maksel	
Tonia Ahern	Robert DePlatt	Donna Migliorino	

DMHAS, CSOC. DDD, DMAHS & DoH Staff:

Jonathan Sabin	Francis Scott Sarno	Elizabeth Conte
Mark Kruszczynski	Suzanne Borys	

Guests:

Matthew Weber Veronica Armour Kurt Baker Rachel Morgan

Minutes:

I. Administrative Issues/Correspondence (Phil Lubitz)

A. Attendance, 18/39, 46% attendance, quorum reached

B. Minutes of April 2022 General Meeting approved unanimously.

C. Welcome to Mental Health Month (May 2022)

II. An Overview of Data Trends at the NJ Children's System of Care (CSOC)

Nicholas Pecht

A. Overview

1. Pre-pandemic data
2 SFY22 data.

B. See slides shared by Mr. Pecht

C. Q&A

1. Q: Economic factors and trends. A; Economic variation was not explored in this presentation but it is a factor worth considering.
2. Q: (JB) What's the plan? First Step is Diversion. System is overwhelmed. Hiring is very difficult. A: CSOC leadership is constantly planning and information will be released as it becomes available. A necessary first step is to look at the data. Comment [JB]: It would be helpful to have a plan to have CSOC address next steps.

3. Q: (PL) Is there any data on waiting time for services? Is there data on waiting time for out of home placement? A: The response depends on the type of service involved.

4. Q: One of the slides indicated that the youth of color numbers are disproportionately placed in out of home. You made the point during your presentation. Is there any recommendations on how to address this?

5. Q: Can you provide information on the criteria used to remove a child from the home? A: You enter out of home treatment after CMO services are involved and all in-home treatment options have been expended.

6. Q: (Dave M, NJHA): We are all pretty concerned. CMO of children has been one of the most improved sections—it is better than it used to be. My fear/question with huge delays in acute placement (kids waiting for days sometimes), when these acute programming placements are scarce, then the acuity gets pushed into the community (and puts our children in danger). There should be increased in all acute pediatric mental health services. BH pediatrics have the longest wait time in emergency rooms, or all populations and specialties.
A: Wait times, the longer anyone has to wait for treatment, that is not good. We have an extensive service array; the wraparound approach is geared to maintain the child in the home.

III. Project ASPEN: A Research-Based Portal for Information about Adolescent Depression Screening Dr. Matthew Weber**,** Veronica Armour (R-UBHC). See PowerPoint

A. Ecosystem analysis, examination of policy and implementation.
B. Multiyear program looking at the issue from multiple perspectives.
C. Tracking how policy makers are interacting with available information.
D. NAMI NJ will build this information to advocate for bridging gaps between research and policy.
E. Project Aspect portal (Project ASPEN – Active Surveillance of Policy Ecosystems and Networks (rutgers.edu)) , recently released- based on over two years, studying school psychologists, social workers, psychiatrists, social workers, and review of national and state resources
F. 105 national resources identified. Resources – Project ASPEN (rutgers.edu)
G. Policy briefs: 1. Call to action on adolescence depression? 2. Identifying at-risk students Exploring barriers and facilitators of implementation 3. Adolescent depression screening instruments.
H. Q&A
   1. Q: New Jersey Resources List: Resources – Project ASPEN (rutgers.edu)
   2. Q: Parent Survey: Where did you find these parents? A: Data was collected from national survey company (parents of adolescents 12-18) and the RU Eagleton Institute.
   3. Q: Would ASPEN be able to share the work with CIACCs and other groups? A: Yes!

IV. BHPC Subcommittees

A Membership (P.Lubitz)

1. Met in April and today. Three members of the council will be leaving the formal membership of Council due to non-participation, and one member of the Citizen's Advisory Board will not be recommended for re-appointment. Letters will be sent out on week of 5/16/22.
2. 35 members is the ideal number of members
3. Additional attention will be given to families/caregivers of children served by the Children's System of Care.
4. Membership must be enhanced to more fully represent the ethnic and cultural diversity of New Jersey.
5. Statewide CIACC will be creating a Statewide Leadership Academy. Perhaps I link to the BHPCs website can be given to them.

B. Advocacy (J. Barugel)
1. Meets at 12:00 noon today.
2. Current topic is youth in emergency rooms and enormous wait times.

V. System Partner Updates, Chairs of Subcommittees

A. Department of Corrections (Krista Connelly)
1. DoC has been trying to digitalize medication administration records. E-MAR system will be up and running to improve medication record keeping.
2. Federal Monitor Jane Parnell, for Edna Mahan Women's Correctional Facility has been named. Her first report is forthcoming.

. B. Division of Developmental Disabilities (J. Sabin)

1. Employee Onboarding - The Department of Human Services (DHS) will provide expedited approval of emergency hiring requests through July 1, 2022. This includes Self-Directed Employees (SDEs). For more detail please reach out to DHS.ECCU@dhs.nj.gov.

2. Additionally, the CDC has updated its Use and Care of Masks guidance. This new guidance has been adopted by DDD. Day and/or residential providers may elect to follow this policy, or require a more restrictive policy, based on the population being served in a specific location. In no circumstance shall an alternate policy be less restrictive than the parameters outlined in the Residential and Day Screening Policy.

B. Office on Aging (P. Matthews)
1. State Strategic Plan on Aging October 1, 2021 – September 30, 2025 has been approved by the Administration on Community Living and is posted on our website https://www.nj.gov/humanservices/doas/documents/New%20Jersey%20State%20Plan%20on%20Aging%20with%20IFF%20Placeholder%2012.9.21.pdf

C. Juvenile Justice Commission (Francis Walker)
1. New reform policy to be soon announced.

C. Department of Education (Damian Petino)
1. May 9, 2022, see: https://www.nj.gov/education/broadcasts/2022/may/9/RemindersNewJerseyDepartmentofHealthK12Guidance.pdf
2. June 8, 2022, Maurice Ingram will present to the NJBHPC

F. NJ FamilyCare (NJ Medicaid)
1. Feb 2022, 1115 Waiver, five year, current demonstration period ends June 30, 2022. State wants to continue current demonstration elements but add new programs and services.
2. P. Lubitz has requested an update/presentation.

VI. Open Public Comment and Announcements Phil Lubitz

A. 5/9/22 NYT Article of children with behavioral health boarded in hospital emergency rooms: Hundreds of Suicidal Teens Sleep in Emergency Rooms. Every Night. - The New York Times (nytimes.com)

B. Agency Updates
1. CSP NJ (H. Simms)
a. Virtual Job fair 5/18/22

https://us06web.zoom.us/j/88236918471?pwd=QWZjWkNMMjFOTFpIZkUrLzlNNlRvdz09
Meeting ID: 882 3691 8471, Passcode: 630799

C. Burlington County Stigma-Free initiatives.
D. June 8th meeting will be Phil Lubitz's last meeting as Chairman of the BHPC.
1. Darlema will be acting chair beginning in July 2022. Bylaws indicate elections in an odd year (2023)

VII. Adjournment Phil Lubitz

A. Meeting adjourned, 11:40 am.
B. Future Agenda Items
1. NJ DoE Comprehensive Mental Health Guide (Maurice Ingram), 6/8/22
2. NJ DoC Presentation (K. Connelly), 6/8/22.

C. Next General Meeting June 8, 2022, 10:00 am

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1. Subcommittee meetings on 6/8/22
a. 9:00 Advocacy
b. 12:00 n/a

NEW JERSEY BEHAVIORAL HEALTH PLANNING COUNCIL
Minutes
June 8, 2022, 10:00 am

This meeting was conducted exclusively through MS Teams video teleconference & conference call

Notices of the meeting were sent to the Asbury Park Press, The Times (Trenton), Bergen Record, The Press (Pleasantville), and the Courier-Post (Cherry Hill).

Participants:

Phil Lubitz (Chair)	Darlema Bey (Vice Chair)		
Joseph Gutstein	Connie Greene	Michael Ippolitti	Krista Connelly
Barbara Johnston	John Tkacz	Suzanne Smith	Donna Migliorino
Julia Barugel	Michele Madiou	Tracey Maksel	Mary Abrahms
Tonia Ahern			

DMHAS, CSOC. DDD, DMAHS & DoH Staff:

Jonathan Sabin	Mark Kruszczynski	Suzanne Borys	Wyndee Davis

Guests:

Herb Kaldany	Kurt Baker	Matthew George	Rachel Morgan

Minutes:

I. Administrative Issues/Correspondence (Phil Lubitz)

A. Attendance, 22/39, 56% attendance, quorum reached

B. Minutes of May 2022 General Meeting approved unanimously.

C. Reorganization:

1. Retirement of P. Lubitz from NJ BHPC, effective 6/30/22
2. Installation of D. Bey at Chair of Council. According to the By-laws, the acting Vice President will serve until next elections.
3. Elections in January 2023 for Chair and Vice-Chair

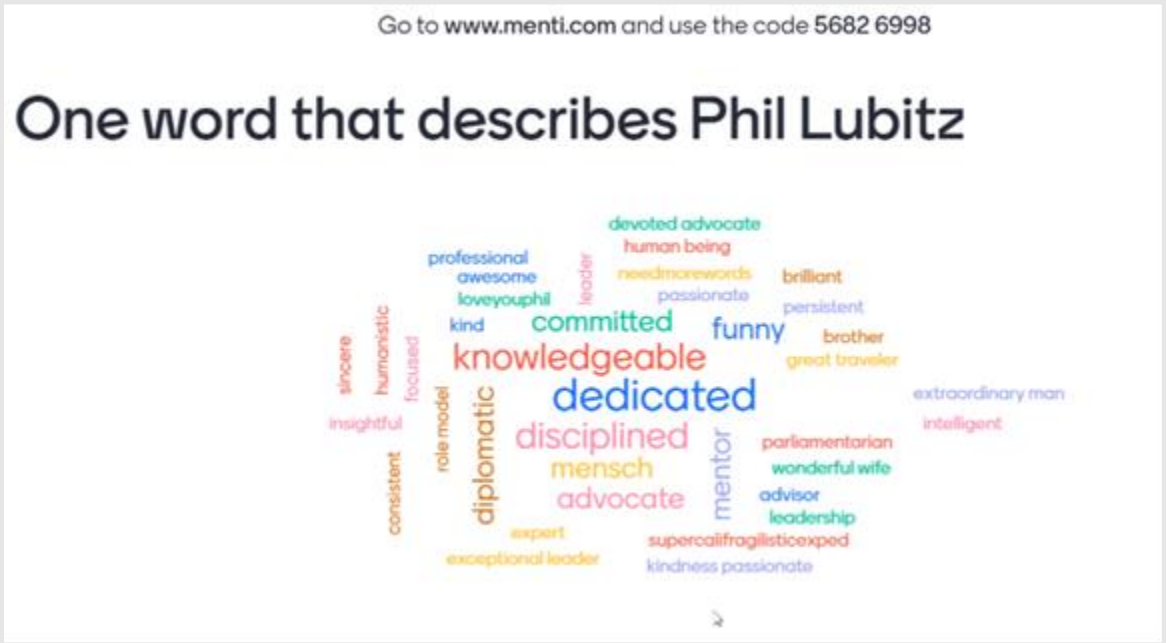
II. Recognition of Service of Phil Lubitz Valerie Mielke (Asst. Commissioner, DMHAS)

A. Sincere appreciation of Mr. Phil Lubitz as a person and a professional.

1. Since the 1980's when VM and PL began working together.
2 Consistent commitments to the people we serve.
3. Those we/Phil serves aren't simply the direct recipients of care, but their families and loved ones as well.

B. Phil's recognition of the experiences and concerned of service recipients loved ones.

C. One word that describes Phil: www.menti.com 56826998



D. Comments of Phil
   1. Collaborative
   2. The friendships and working relationships.
   3. Confident that good works and traditions will continue.
   4. Continue the passion to improve the lives of people we serve.
   5. We are dealing with the full person (wholistic).

E. Comments of Donna
   1. Working together for 18 years.
   2. Due to Phil's leadership the Council has come a long way.

F. Appreciation of Suzanne Borys.

III. Mental Health and Addiction Services in NJDOC Dr. Krista Connelly, (NJ DoC) (PowerPoint shared with the Council)

A. Requested article: https://www.nj.com/news/2022/04/njs-womens-prison-making-steady-progress-to-stop-abuse-but-still-needs-culture-change-monitor-finds.html

B. See presentation.
   1. Rutgers UCHC is the contracted provider for all of DoCs mental health services
   2. Accessing Treatment ("sick call" form, "JPay")
   3. MH Special Needs Roster (11,350, 23% of total population on MHSNR)
   4. Outpatient (12 halfway houses, individual psychotherapy, and psychiatric services). Patients can be added and removed from roster.
   5. Inpatient, 24/7 nursing coverage
      a. Transitional Care Units (TCU), like a partial hospitalization
      b. Residential Treatment Unit (RTU), similar to state psych hospitals.
      c. Stabilization Units (SUs), for patients with high acuity.
   6. Close Custody Units

7. Q&A (mental health)
   a. Q: What is level of MH practioner who meets with isolated prisoners. A: APNs and licensed practitioners.
   b. Q: RTU, is it at the prison? A: Yes, there are four state prisons with RTUs.
   c. Q: 67% of prisoners on roster are female, why is that? A: It may be that women might be more likely to seek treatment, but no conclusive studies have been conducted yet. A: (Herb K): That ratio hasn't changed over the years. Women are more social, and although the men have been approached, but many men seem less willing to seek/acknowledge need for help. Interesting trend that women who are incarcerated for the first time, tend to be older than men incarcerated for the first time.

8. Addiction Services: UCHC provides services while prisoners are incarcerated, and UBHC provides services after prisoners are released.
   a. Accessing treatment.
   b. Medications
   c. Licensed SUD Treatment (Gateway)
   d. Psycho-education (Stacked Deck (gambling), AA/NA/GA, and "Engaging the Family"

9. Services on Release
   a. Release coordination and discharge plan.
   b. Intensive Recovery Treatment Support (IRTS), collaboration between NJ DoC and NJ DMHAS. Six month prior and 12 months post release.
   c. Peer navigators and their desirability for expansion.

10. Q&A
   a. Q: Peer navigators, are they paid? A: Yes they are paid for by UBHC via DMHAS. (HK) RUBHC does a great job at providing the curriculum and training. It's an 'amazing result' when a former prisoner can assist a current prisoner…we hope it can be expanded." (SB): Mandatory training as well as two credentials are offered through NJPN.
   b. Q (Tonia A): Are there trauma-related services for males? A: (KC): I am advocating for this to be expanded.

IV. **NJ DoE Comprehensive Mental Health Guide** Dr. Maurice Ingram (NJ DoE)
(See PowerPoint Presentation):

https://www.nj.gov/education/safety/ wellness/mh/

The guide itself is at
https://www.nj.gov/education/safety/wellness/mh/docs/NJDOE_Mental_Health_Guide_Feb2022.pdf

NJ DOE MH Webinar series
https://www.nj.gov/education/broadcasts/2022/may/11/NJDOEMentalHealthWebinarSeries.pdf

A. MH resource guide purpose

B. What does Guide include (11 chapters).
C. MH Resource Guide, Key Features (three tiers)
D. Determine teams to support implementation.
E. Best ways to use the guide (based on the reader's reading style).
F. Funding the implementation of the guide- strategies: Braid funding, data based, community partnerships.
G. Resources and Supports
H. Q&A
    1. Q: (TA) To what extend are we tracking the extent to which schools are using the guide?
    2. Q: (JB): Importance of CIACCs and educational partnerships. A: (DP) Importance of making schools aware.
    3. Q: (MK) Desirability of sharing this information with NJ School Boards Association Annual Meeting in Atlantic City in October 2022.

IV. BHPC Subcommittees

A. Advocacy (J. Barugel)
    1. Met at 9:00 am earlier today (6/8/22).
    2. Current topic is youth in emergency rooms and enormous wait times.
        a. Small Number of Specialized beds.
    3. No apparent centralized "ownership" of the "throughput" of kids going through acute system of care, and connected to the larger children system of care.
    4. Anecdotal increase in suicidal ideation among children and adolescents.
    5. Letter to ask Assistant Commissioners to work on an interdepartmental level to correct this.
        a. Goal is to work on the letter offline and then complete the draft letter (and then have it reviewed at the July General Meeting)
    6. Next meeting, 7/13/22, 9:00 am.

V. System Partner Updates, Chairs of Subcommittees

. A. Division of Developmental Disabilities (J. Sabin)

    1. In accordance with P.L. 2021, Chapter 292, the New Jersey Department of Human Services (DHS) has released an Emergency Preparedness and Response Plan (EPRP) for Licensed Providers of Services for Individuals with Intellectual and Developmental Disabilities. Link - https://www.nj.gov/humanservices/ddd/providers/eprp/index.shtml

    2. The MOM2MOM NJ help line has been expanded and is now available to provide help and support to caregivers of adults with intellectual and developmental disabilities. The service connects moms, and other caregivers, of persons with special needs to moms of a similar circumstance. The helpline can be reached at 1-833-NJ-ADULT (1-833-652-3858) daily from 8:30 a.m. to 8 p.m.

    3. In 2021, DDD released a Request for Proposals for **Behavioral Health Stabilization Homes (BHSH)**. The homes will offer stabilization for persons with I/DD who are experiencing significant behaviors or behavior crises. The homes will not replace in-patient hospitalization when medically indicated, but

will help prevent hospitalization for some and will help provide a hospital discharge (i.e., step-down) option to a safe and professional environment for others. Three homes are in development. One home will be located in northern, one in central, and one in southern New Jersey, serving four persons in each location. The treatment team assigned to the homes will consist of a Board Certified Psychiatrist, Board Certified Behavior Analyst (BCBA), Registered Nurse (RN) and Transition Navigator, who will bring a person-centered, trauma-informed approach to service delivery. The contract for these homes has been awarded to YAI, Inc., a nonprofit provider that that has been providing services for people with I/DD and their families for more than 35 years.

4. The proposed FY23 DHS budget has another 1.25 an hour DSP and Supervisor Wage Increase.

A. Office on Aging (P. Matthews)

1. New Jersey Partners: Aging Mental Health and Substance Abuse Inc. In May of 2022 the NJ Partners Board of Directors met and voted to dissolve the NJ Partners as a non-profit corporation. The reasons for this include 1) rapidly changing protocols for in-person training related to COVID-19 and 2) lack of NJ Partners infrastructure to support ongoing education and networking. New Jersey Advocates for Aging Well (NJAAW), formerly NJ Foundation for Aging, will be carrying on the NJ Partners tradition of training and networking opportunities surrounding the intersection of aging, mental health and substance use. A representative from New Jersey Advocates for Aging Well (NJAAW) should be invited to be a member of this board.

2. The Administration on Community Living is in the process of updating the federal regulations for the Older American's Act. Further information about this will be provided later, related to listening sessions, requests for information etc.

B. Division of Vocational Rehabilitation (J. Tkacz)

1. Once a year, the Division of Vocational Rehabilitation Services (DVRS) and the State Rehabilitation Council (SRC) host public forums to provide information on available services for individuals with disabilities and receive input from the community. This year, you can choose to join us virtually on either July 12th or July 21st.

2. The public forum registration is now open from June 1st to July 1st.

3. To attend these forums please click on the link below and register. The forums will be virtual so you must register to attend.
https://www.nj.gov/labor/career-services/special-services/individuals-with-disabilities/2022publicforums.shtml

4. Topics will include:
   a. Obtaining vocational services following a public health emergency
   b. Pros and cons of receiving virtual services
   c. Challenges of finding and keeping jobs during these difficult times
   d. Coordination and provision of Pre-Employment Transition Services (Pre-ETS)

e. Service provision to individuals who have high support needs

VI. Open Public Comment and Announcements Phil Lubitz

A. 988 Bill (Mary Abrams)
   1. There was going to be a fee, but that was taken out.
   2. Additional state and federal funding to be added.
   3. Not much known yet from the legislative planning committee.

B. Thank you from Phil Lubitz on all system partners on the Planning Council.

VII. Adjournment Phil Lubitz

A. Meeting adjourned, 11:40 am.

B. Future Agenda Items
   1. TBD
   2. TBD

C. Next General Meeting July 13, 2022, 10:00 am

Microsoft Teams meeting
Join on your computer or mobile app
Click here to join the meeting
Or call in (audio only)
+1 609-300-7196, PIN: 306216820#

1. Subcommittee meetings on 7/13/22
   a. 9:00 Advocacy
   b. 12:00 TBA

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.
State Medicaid Agency

Start Year: 2023 End Year: 2024

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Tonia Ahern	Family Members of Individuals in Recovery (to include family members of adults with SMI)		230 Route 50 Petersberg NJ, 08270 PH: 609-374-2526	tahern1128@aol.com
Julia Barugel	Family Members of Individuals in Recovery (to include family members of adults with SMI)		Not to be shared at request of family member Not to be shared at request of family member NJ, 08625	barugel@optonline.net
Darlema Bey	Family Members of Individuals in Recovery (to include family members of adults with SMI)		507 Arch St. Glassboro NJ, 08028 PH: 856-701-2297	darlemabey@gmail.com
Winifred Chain	Family Members of Individuals in Recovery (to include family members of adults with SMI)		21 Gateshead Drive Lumberton NJ , 08048 PH: 609-265-2079	
Harry Coe	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		152 Sunnymede St Englishtown NJ, 07726 PH: 732-851-4155	harrybcoe@gmail.com
Krista Connelly	State Employees	NJ Department of Corrections	NJ Dept. of Corrections Trenton NJ, 08625 PH: 201-741-0755	Krista.Connelly@doc.state.nj.us
Greene Connie	Providers		RWJ/Barnabas Health Eatontown NJ, 08754	cgreene@barnabashealth.org
Mary Ditir	Others (Advocates who are not State employees or providers)	New Jersey Hospital Association	NJ Hospital Association Princeton NJ, 08543 PH: 609-275-4279	mditri@njha.com
Maryanne Evanko	Family Members of Individuals in Recovery (to include family members of adults with SMI)		PH: 609-583-3128	Maryanneevanko2@gmail.com
Christina Fagan	Family Members of Individuals in Recovery (to include family members of		9 Andrew Lane Kinnelon NJ, 07405	achangefornick.cf@gmail.com

	adults with SMI)		PH: 862-432-2776	
Julian Fowler	State Employees	NJ Housing Mortgage and Finance Agency	NJHMFA Trenton NJ, 08625	jfowler@njhmfa.state.nj.us
James Fowler	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1227 East Front Street 41C Plainfield NJ, 07062 PH: 908-251-8746	fowlerjames97@yahoo.com
Joseph Gutstein	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		770 Anderson Avenue, Apt 10A Cliffside Park NJ, 07010 PH: 201-224-9626	joe@joegutstein.com
Michael Ippoliti	Youth/adolescent representative (or member from an organization serving young people)		307 Wilson Avenue Edgewater Park NJ, 08010 PH: 609-217-3573	Michael.ippoliti@gmail.com
Barbara Johnston	Providers		MHA of NJ Verona NJ, 07044	bjohnston@mhanj.org
Nick Loizzi	Others (Advocates who are not State employees or providers)	County Drug and Alcohol Directors Association	Newton NJ, 07860 PH: 973-940-5200	nloizzi@sussex.nj.us
Michele Madiou	Others (Advocates who are not State employees or providers)		NJ Assoc. of County MH Administrators Trenton NJ, 08625	mmadiou@mercercounty.org
Tracey Maksel	Others (Advocates who are not State employees or providers)		1027 Hooper Ave., Bldg. 2 Toms River NJ, 08754 PH: 732-506-5374	Tmaksel@co.ocean.nj.us
Patricia Matthews	State Employees	NJ Division of Aging Services	NJ Div.of Aging Trenton NJ, 08625 PH: 609-633-0411	Patricia.matthews@dhs.state.nj.us
Valerie Mielke	State Employees	NJ Division of Mental Health and Addiction Services	5 Commerce Way Hamilton NJ, 08625	Valerie.Mielke@dhs.nj.gov
Chris Morrison	State Employees	Nj Department of Health	140 East Front Street Trenton NJ, 08625 PH: 609-567-7365	Chris.Morrison@doh.nj.gov
Lisa Negron	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		CWC, 17 Barnard St, No. 22, Freehold NJ,	lnegron@cspnj.org
Damian Petino	State Employees	NJ Dept. of Education	NJ Dept. of Education Trenton NJ, 08625 PH: 973-766-9331	Damian.Petino@doe.nj.gov
Thomas Pyle	Family Members of Individuals in Recovery (to include family members of adults with SMI)		50 Balsam Lane Princeton NJ,	thpyle@gmail.com
Diane Riley	Others (Advocates who are not State employees or providers)	NJ Supportive Housing Assoc.	SHA NJ South Orange NJ, 07029	diane.riley@shanj.org
Heather Simms	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		CSP NJ, 11 Spring St Freehold Township , PH: 732-780-1175	hsimms@cspnj.org

Suzanne Smith	Family Members of Individuals in Recovery (to include family members of adults with SMI)		204 East Holly Avenue Sewell NJ, 08619 PH: 856-241-2166	STSSHS@aol.com
Marie Snyder	State Employees	NJ Division of Family Development (Social Services)	NJ. Division of Family Development Trenton NJ, 08625 PH: 609-588-2176	Marie.Snyder@dhs.state.nj.us
Irina Stuchinsky	State Employees	NJ Div. of Medical Assistance and Health Services	PH: 609-631-6475	Irina.Stuchinsky@dhs.state.nj.us
Pamela Taylor	Persons in recovery from or providing treatment for or advocating for SUD services		162 Brighton Avenue East Orange NJ, 07017 PH: 973-943-5751	ptaylor@mhanj.org
Richard Thompson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		11 Wolf Pack Road Hamilton NJ, 08625	cureaut@yahoo.com
John Tkacz	State Employees	NJ Division of Vocatinal Rehabilitation Services	NJ. Div. Vocation and Rehab. Services Trenton NJ, 08625 PH: 609-292-9338	John.Tkacz@dol.nj.us
Francis Walker	State Employees	NJ Juvenille Justice Commission	NJ Juvenille Justice Commission Trenton NJ, 08625	Francis.Walker@jjc.nj.gov
S. Robin Weiss	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1600 Laurel Road, E-50 Lindenwold NJ, 08021 PH: 856-956-6380	s.robin.weiss@me.com
Debra Wentz	Providers		NJAMHAA Mercerville NJ, 08619 PH: 609-838-5488	dwentz@njamhaa.org

*Council members should be listed only once by type of membership and Agency/organization represented.

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Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2023 End Year: 2024

Type of Membership	Number	Percentage
Total Membership	**40**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	7	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	8	
Parents of children with SED/SUD*	0	
Vacancies (Individuals and Family Members)	0	
Others (Advocates who are not State employees or providers)	5	
Total Individuals in Recovery, Family Members & Others	**20**	**50.00%**
State Employees	10	
Providers	3	
Vacancies	0	
Total State Employees & Providers	**13**	**32.50%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ+ Populations	5	
Providers from Diverse Racial, Ethnic, and LGBTQ+ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ+ Populations	**5**	
Persons in recovery from or providing treatment for or advocating for SUD services	1	
Representatives from Federally Recognized Tribes	0	
Youth/adolescent representative (or member from an organization serving young people)	1	

* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

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Footnotes:

The Planning Council has long known, and has long attempted to recruit families of children with SED to serve as a members of the Council, The SMHA has and continues to share this concern with representatives of the Dept of Children and Families, Children's System of Care (CSOC) in the hopes that families can be recruited by entities such as Care Management Organizations (who directly support families with SED), and at meetings of the Childrens Interagency Coordinating Council (CIACC) Meetings. Membership Subcommittee Meetings of the Council have been held on 8/11/21, 3/9/22, 4/13/22, 5/11/22, where this issue was discussed explicitly. This issue is regularly discussed in our

open public meetings as well. Our system partners at CSOC (and members of the Council who had children with SED) regularly explain that families with children with SED are under significant stress (managing the needs of their children, work, etc.) and that families are understandably reluctant. Nonetheless the BHPC/SMHA continues to promote its work and search for families of children with SED to join the Council.

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? (●) Yes ( ) No

b) Posting of the plan on the web for public comment? (●) Yes ( ) No

If yes, provide URL:

The members of the public/Behavioral Health Planning Council are given access to both previously submitted and current/draft copies of the CMHBG and SAPTBG via the url: Website: https://bgas.samhsa.gov/ Username: citizennj, password: citizen

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

Yes, via webBgas: https://bgas.samhsa.gov/ Username: citizennj, password: citizen

c) Other (e.g. public service announcements, print media) (●) Yes ( ) No

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Footnotes:

The attached Notice of Solicitation Comment was posted on the Division Mental Health and Addiction Services' website at https://www.nj.gov/humanservices/dmhas/provider/notices/.

NOTICE OF SOLICITATION OF COMMENT

The Division of Mental Health and Addiction Services (DMHAS), within the New Jersey Department of Human Services, is soliciting comment on the Fiscal Year (FY) 2023 draft Substance Abuse Prevention and Treatment and Community Mental Health Block Grant Application from any interested person, including any Federal or other public agency, during the development and after submission of the application to the Federal Substance Abuse and Mental Health Services Administration.

Please email dmhas@dhs.nj.gov to receive login credentials to view the report as it is drafted and posted online.

Written comments concerning the State application can be sent to DMHAS at the email or postal address indicated below.

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

Electronic Mail: dmhas@dhs.nj.gov

Environmental Factors and Plan

23. Syringe Services (SSP)

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs**,

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.samhsa.gov/sites/default/files/grants/ssp-guidance-for-hiv-grants.pdf ,**

2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf,**

3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf ,**

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2] Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

[4] Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a **description of the elements of an SSP** that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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Footnotes:

No SAPT Block Grant funds are used to support Syringe Services Programs (SSPs).

Environmental Factors and Plan

Syringe Services (SSP) Program Information-Table A

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Dollar Amount of SABG Funds Expended for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Narcan Provider (Yes or No)
No Data Available					

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Footnotes:

The State does not plan to expend SAPT Block Grant funds to support Syringe Services Programs (SSPs).