



*New Jersey's Long and Winding Road
To
Treatment, Wellness and Recovery*

**Governor's Task Force on Mental Health
Final Report**

March 31, 2005

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March 31, 2005

Dear Acting Governor Codey,

On behalf of the Task Force on Mental Health, the more than 150 Advisory Committee members, the almost 600 people in attendance at the public hearings, and the family members, professionals and individuals with mental illness in New Jersey, it is with great honor and privilege that we present the final report of the Governor's Task Force on Mental Health.

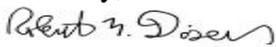
Throughout your years of public service, you have continued to be the voice of hope for those persons with mental illness and for improvement, fairness and civility in New Jersey's mental health system.

November 16, 2004 was truly a new day for the mental health of this great state's residents. Through your actions in establishing this Task Force, a ripple of hope and dignity was felt throughout the provider community, the families and persons suffering from mental illness and other co-occurring disorders.

This report represents movement of New Jersey's mental health system away from a status quo characterized by stigma and isolation, towards a Treatment, Wellness and Recovery model. It identifies priority recommendations to achieve immediate relief for an overburdened and under-funded infrastructure. It also provides a blueprint for developing quality, consumer and family directed care and systems while including longer-term recommendations. These recommendations will continue to carry the momentum of change for New Jersey's mental health system and for the mental health of our most precious resources, the people of New Jersey.

The members of this Task Force stand ready and willing to continue to serve and work towards implementation, education and a continuum of quality care, of which we can all be proud.

Sincerely,


Robert N. Davison, Chair


Kimberly S. Ricketts, Executive Director

Dedication

The work of New Jersey Acting Governor Richard J. Codey, The Governor's Task Force on Mental Health and this resulting report are dedicated to the thousands of individuals in our state whose lives are affected by serious mental illness.

These most vulnerable citizens...
often disenfranchised by their illnesses
and by the current mental health system, include...

- ...those who are homeless and at risk
- ... those without adequate health insurance
- ... those who are in prison instead of in treatment
- ...those adults with mental illness relying on their aging and elderly parents for care
- ...those who are involved in juvenile detention instead of appropriate care
- ...those children who are at risk of having their dreams denied
- ... those who live life in a state hospital because they have no other home
- ...those who struggle towards recovery but must live in sub-standard housing
- ... those who are searching for recovery, but do not know where to turn.

Special Appreciation and Dedication to
New Jersey First Lady, Mary Jo Codey
whose courage, compassion,
and commitment to consumer advocacy
stand as inspiring proof that
successful treatment and recovery
can rise above hope to become reality.

The Task Force also wishes to express its sincere appreciation to Shazbre Scott, Administrative Assistant, Office of the Governor and Steven Ryan, Director of Development at the Mental Health Association of Essex County. To Shazbre, thank you for helping to keep us organized on track. And to Steve, thank you for your incredible writing and editing skills.

New Jersey's Case for Reform

Summary

In November 2004, Governor Richard J. Codey signed an executive order creating a task force that would recommend specific improvements in the mental health system enhancing the lives of consumers and their families.

A comprehensive review of New Jersey's Mental Health System was conducted over a four-month period. Input from the Public was obtained at three hearings conducted in various parts of the State.

As a result of an extensive review of the system including public input, several significant themes emerged and include:

- Stigma and discrimination associated with mental illness is still prevalent and seriously undermines our citizens from getting the help they need and even in using the health benefits available to them.
- The stigma and discrimination experienced by people with mental illness often leads to their impoverishment and isolation.
- Initial efforts to encourage and develop consumer and family driven systems of care are present in the adult and child behavioral areas and should be continued.
- An over-reliance on institutional care to serve individuals with serious mental illness exists in New Jersey.
- Insufficient or inadequate rehabilitative services and supported housing options to facilitate consumer recovery along with a consistent, experienced professional staff to assist in the endeavor.
- A fragmented, uncoordinated service system that far too often leads to consumers with serious mental illness being housed in jails, prisons and juvenile facilities.
- High unemployment and disability for individuals with serious mental illness
- An emerging system of care for children and adolescents, which is now five years in progress and merits a thorough evaluation of vision, design, cost, outcomes and operations.
- A system designed around failing first or becoming seriously mentally ill before intensive services can be made available is too prevalent.
- Current funding and contracting mechanisms limit persons with mental illness from achieving wellness and recovery and valued roles of full citizenship.

The Cost of Continuing the Current Course

A. State and County Hospitals

Every decision has an associated cost. Thus, a decision to do nothing would have associated costs. Currently, almost 50 percent (1,000 patients) of New Jersey's state hospital patients are clinically ready for discharge but housing, treatment and support services are not available for these patients.

The average cost to maintain one state hospital bed is \$146,000 per annually. Almost half of the state's mental health budget or \$483 million dollars pays for the cost of caring for an average 3,300 patients in State and County facilities on any given day. Given that almost half of the State hospital patients are clinically ready for discharge, housing them in State hospitals is very expensive. Without a local system of care to coordinate an array of services and supports for persons who are seriously mentally ill, again, if we do nothing, the Task Force finds a significant number of State hospital beds (400) would need to be added given current admission, discharge and average daily population trends. Such a use of institutional care would be unfortunate and inappropriate.

The lost potential in human terms is incalculable. Lives have been lost, spirits broken and families devastated.

B. Jail and Prisons

The population of prisons and jails in New Jersey and the nation has increased dramatically in the last two decades. Individuals with mental illness are disproportionately represented among the inmate population. It is generally accepted that 16 percent of persons incarcerated are mentally ill. Many are incarcerated for non-violent crimes. The cost to provide treatment in the community is significantly less expensive.

C. Juvenile Detention

Approximately 20 percent of the children in Juvenile Detention are mentally ill and most are incarcerated on low-level offenses. By and large they are there because they are mentally ill. The cost of not providing appropriate care to these children is moral bankruptcy.

D. Homelessness

The estimated number of persons with mental illness who are chronically homeless in New Jersey is close to 8,000. Often, these individuals find their way into psychiatric and/or medical units of local hospitals after evaluation in an emergency room. These encounters are at significant cost to the healthcare system and ultimately employers and taxpayers. In many cases, the hospitals become the housing option for mentally ill homeless individuals.

E. Cost of Untreated Mental Illness

- More than 50 million adults – nearly 25 percent of the U.S. adult population – suffer from mental disorders or substance abuse disorders on an annual basis.
- 18 million Americans are affected by depression annually. A recent study examining six major medical conditions – including hypertension, diabetes, lung diseases and arthritis – found only severe heart disease to be associated with more disability and interruption of daily functioning than depression.
- The National Institute of Mental Health has shown that success rates of treatment for disorders such as schizophrenia 60 percent, depression (70-80 percent) and panic disorder (70-90 percent) surpass those of other medical conditions (heart disease, for example, has a treatment success rate of 45-50 percent).
- The high costs to society of untreated and under-treated mental illnesses are well documented.
- Providing equal and appropriate coverage for all illnesses makes good economic sense; when mental illnesses go untreated, social costs begin to escalate. The National Institute of Mental Health estimates that the annual cost of untreated mental illnesses exceeds \$300 billion primarily due to productivity losses (missed days of work and premature death) of \$150 billion, health care costs of \$70 billion, and societal costs (increased use of the criminal justice system and social welfare benefits) of \$80 billion.
- In 1990, our nation's direct medical care costs and indirect costs from mental illness, alcohol, and drug abuse totaled more than \$313 billion. That was more than cancer (\$104 billion in 1987), respiratory disease (\$99 billion in 1990), AIDS (\$66 billion in 1991) or coronary artery disease (\$43 billion in 1987).

New Jersey must provide the opportunity, support and treatment to individuals with mental illness so that they may achieve valued roles as defined by the individual, within the overall community and become fully contributing members of our society and become economically independent.

The case for reform is clear, both morally and fiscally. It is in New Jersey's financial interest to make the appropriate investments in mental health care. It is a question of paying now for timely, quality services or paying more in the future as a result of doing nothing. Either way, the citizens of New Jersey pay. Morally New Jersey must provide quality mental health care and housing for those who are seriously mentally ill. To do otherwise is not the conduct of a great State.

Improving New Jersey's Mental Health System Vision and Values

We envision a mental health system where every New Jersey citizen with a mental illness will recover and thrive; a system that is consumer driven and family involved; a system where mental illnesses are prevented or detected early; and a New Jersey where all citizens with mental illness, at any stage of life, have access to effective treatment and supports – essentials for wellness, recovery, working, learning and participating fully in the community. We envision a New Jersey that welcomes as full members of society, persons with mental illness.

The Task Force developed the following values for improving New Jersey's mental health system.

- **Driven by individuals who use mental health services and their families.**

Demand, empower and encourage the active and informed participation of individuals who use the mental health system and their families. Such participation will be promoted and supported in all aspects of system governance, including planning, delivering, and evaluating mental health services.

- **Focused on promoting wellness and recovery.**

Services and supports for individuals and family members will focus on wellness and recovery (people able to live, work, learn and participate fully in their communities), with an emphasis on an individual's natural resiliency (people able to rebound from adversity and other stresses with mastery, competence and hope). New Jersey will integrate people into community settings, providing the appropriate treatment, encouraging the use of natural supports, and promoting awareness that mental health is essential to overall health.

- **Services will be culturally competent.**

Mental health and mental illness are shaped by age, gender, race and culture as well as additional facets of diversity such as physical disability or a person's sexual orientation, which can be found within all of these population groups. The consequences of not understanding these influences can be profoundly deleterious. New Jersey will provide mental health services that are culturally competent.

- **Services will be integrated, coordinated and collaborative.**

Individuals and families in New Jersey's mental health system are often consumers of other systems, e.g. physical health, addictions, developmental disabilities, child welfare, corrections, juvenile justice, labor and other human service organizations. We will form linkages and coordinate with these other areas of service. An ideal system

is integrated -- for consumers and families facing a confusing array of services, there is no “wrong door.” All entry points will lead to coordinated care. No longer will people face inappropriate incarceration or other institutionalization due to a failure of coordination or lack of appropriate services. No one will be excluded because multiple issues complicate their individual situation.

- **Services will be held accountable and monitored at the local level.**

Local communities and citizens will have input into the design and the ongoing delivery of mental health services in their areas. New Jersey is a unique and diverse state, e.g. urban, suburban, rural, race, religion, ethnic background, etc. New Jersey will respect and embrace those differences in the design and delivery of mental health services.

- **Stigma will no longer be tolerated and education and awareness regarding mental illness and mental health will be increased and at the forefront of our mental health system.**

The Governor’s Office, state departments, consumers, family members, providers, and professionals from law enforcement, education, media, insurance, health, mental health, pharmaceutical and others will work together to create an on-going education and awareness initiative to overcome the misunderstanding of mental disorders and the stigma associated with them.

- **The State of NJ and providers will embrace a focus on best practices, quality of care, outcomes and evidenced based practices.**

The Department of Human Services, Division of Mental Health Services, Division of Children’s Behavioral Health Services will create a true partnership with the providers of care. The partnership will be based on a common, unified mission to pursue best practices, focus on outcomes, and develop the flexibility and creativity to enhance the community tenure, quality of life, recovery and wellness of consumers served.

EXECUTIVE SUMMARY

The Task Force on Mental Health, commissioned by Governor Richard J. Codey on November 16, 2004, has over the past four months completed an intense study of New Jersey's mental health system. Advisory committees were formed and public hearings were held throughout the state in an effort to obtain meaningful input from mental health consumers, family members, providers and the public.

As a result of the extensive study and public input process, several re-occurring issues emerged and are considered by the Task Force to be central in providing a roadmap for system reform, obtainable by reaching three primary goals; 1) Improving Access to Care; 2) Offering Better Quality Care and 3) Providing Better and Appropriate Community-based Services.

These goals, coupled with the re-occurring issues and recommendations for reform, mark a pivotal turning point for improving New Jersey's mental health system. For too long, our state's mental health system has churned in place, outside the limelight of other priorities. Beginning with this report, New Jersey is about to embark upon its own "long and winding road" to Treatment, Wellness and Recovery. In the true spirit of reform, the Task Force challenges the State of NJ and its respective departments to embrace this journey and to serve as innovative landmarks along the way. We urge our legislators and policy makers to set an example by incorporating the primary goals of this reform and to begin with the most basic, albeit tedious, task of reconsidering the way our mental health system is run. We must re-visit the manner in which services are provided, contracts are issued, and performance is monitored... we must review and overhaul the existing set of rules and regulations... and, collectively and at all times, we must ensure a focus on Treatment, Wellness and Recovery.

This report represents a blueprint for reform, categorizing the main issues and recommendations into four areas of implementation: Systems of Care and Services; Planning, Management and Budget; Special Populations and Issues; and Legislation and Regulation. While prioritized in the order presented, simultaneous and continuous implementation is key to a successful movement towards reform.

This "Reform 'To Do' List" is presented in the following manner: 1) the primary issues and recommendations are briefly outlined in this Executive Summary with reference to the specific Domains of Study for further details; and 2) additional recommendations for implementation in this process of reform are outlined in the Domains of Study in great detail. Each of the Advisory Committees, with the exception of the State Government Committee, submitted a report to the Task Force for review, revisions and ultimately, inclusion in the final report. Each Domain of Study represents the basic work of the respective Advisory Committee.

In addition to the issues and recommendations outlined in this Executive Summary, the Task Force further recommends the following:

1. Governor Codey extend the responsibilities of the Task Force to include a minimum of monthly meetings through December 31, 2005.
2. Governor Codey request from the Task Force and its respective Advisory Committees (via the Task Force), a Progress Report on the implementation of the recommendations in contained in this report, due to the Governor by November 30, 2005.
3. Governor Codey appoint the Task Force, with liaisons from the appropriate state departments, as the “Transformation Working Group”, in order to make application for Substance Abuse Mental Health Services Administration’s Mental Health Transformation State Incentive Grants, due June 1, 2005. ¹

CONCLUSION

As a result of Governor Codey’s visionary leadership, New Jersey’s mental health system is now a priority for state government and the challenges of mental illnesses are on the agendas of more people than ever before. We have begun breaking down the barriers of stigma one by one, and are initiating dialogue as to how we can best serve our society’s most vulnerable citizens. Of no small significance is the fact that we are doing so together... consumers, family members, service providers and policy makers. And because it’s the right thing to do, *together* we can make a lasting difference. However, we must acknowledge and accept the reality that meaningful change cannot result from the commitment of one administration or the findings of a single Task Force. If we are to truly reform and improve our programs and services for individuals with mental illnesses and the family members who love and care for them, then we must pledge to carrying forward that commitment well into the future, so that our model of today rightly becomes a thing of the past.

¹ The Mental Health Transformation State Incentive Grant program is one of SAMHSA's Infrastructure Grant programs. This program will support an array of infrastructure and service delivery improvement activities to help grantees - i.e., States, Territories, the District of Columbia, and/or federally recognized American Indian/Alaska Native Tribes or Tribal Organizations - build a solid foundation for delivering and sustaining effective mental health and related services. These grants are unique in that they will support new and expanded planning and development to promote transformation to systems explicitly designed to foster recovery and meet the multiple needs of consumers. \$18.769 million will be available to fund approximately six to ten awards ranging from \$1.5 million to \$3 million in total costs (direct and indirect) per year. Applicants may request a project period of up to 5 years.

CONCENTRATIONS OF FOCUS AND RESULTING FINDINGS/RECOMMENDATIONS

Area A: Systems of Care and Services

ISSUE #1 – WELLNESS AND RECOVERY

Consumers, family members, mental health providers and public health practitioners endorse a recovery-oriented mental health system. Recovery is defined as the process by which people are able to live, work, learn and participate fully in their communities. For some people, recovery is the ability to live a fulfilling life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Recovery involves recognizing and accepting strengths, limitations and losses and distinguishing the difference between *having* an illness and *being* the illness.

Through the recovery process a person re-establishes a sense of integrity and purpose within and beyond the limits of the disability. The goal is to live a satisfying, hopeful and contributory life, even within the limitations of the illness.

Wellness is a conscious, deliberate, ongoing process in which a person becomes aware of and makes choices toward a more satisfying lifestyle.

The mental health service delivery system must be designed to meet the needs of individuals with mental illness by providing an array of evidence-based treatments, safe and supportive environments, and competent professionals who will create opportunities that foster recovery and wellness. Inherent in a system based on wellness and recovery is family involvement. While respecting the rights of the consumer, family involvement must be the presumption of the mental health system.

Recommendation #1 -- Promote a System Based on Wellness and Recovery

The public mental health system must continue to move from an institutional system of care to a community system of care based upon the principles of wellness and recovery. Due largely to the financing, e.g., Medicaid, historical funding, there continues to be an over-reliance on state and county hospitals, highly supervised group homes and partial care programs. While some consumers need these levels of care, most require less costly, recovery-enhancing programs. The financing of the State mental health system, including what Medicaid covers, must be changed to promote state-of-the-art treatment alternatives. These alternatives would include, but not be limited to, permanent supportive housing, supportive employment, in-home services and consumer self-help. It is strongly recommended that the Department of Human Services commence an immediate review of currently licensed partial care and partial hospitalization programs and determine appropriateness of utilization and shift funding and reimbursement, where appropriate, to recovery based programming/services. It is also strongly recommended

that DHS commence an immediate review of existing rules and regulations specific to the mental health services and programs for adults and children and make the necessary revisions/changes to allow for the shift to a system based on wellness and recovery. This shift should include but not be limited to staff training, mission, vision, treatment and recovery modalities, contracting and funding.

***See Treatment, Wellness and Recovery in the Domains of Study for more detail.**

Recommendation #2 -- Adopt the Medicaid Rehabilitation Option

Given the Task Force's strong recommendation to base the mental health system on a wellness and recovery model, it is further recommended that the State Medicaid plan adopt the Medicaid Rehabilitation Option. This option would allow greater flexibility than currently exists under the "clinic option" by allowing for billing for such non-facility-based services as: outreach, peer services, family education, supportive housing services, case management, and social/recreational activities. The option would provide more flexibility to meet consumers' needs by allowing services to be community-based rather than clinic-based. The option would better maximize federal dollars, resulting in more financial resources. Governor Codey's fiscal year '06 budget proposals could be used to meet the matching requirement, e.g. \$5 million for housing supportive services.

*** See Treatment, Wellness and Recovery, Parity, and Housing in the Domains of Study for more detail**

Recommendation #3 -- Self-Help Centers

The Task Force recommended and supports Governor Codey's proposed increase of \$2.1 million in fiscal year '06 to expand outreach and programming capabilities at the 27 self-help centers in New Jersey. These centers are a key resource in the move toward a more consumer- and family-centered approach to successful treatment and recovery. The new funds will be used to expand specialized therapies such as music, art and recreation and for capital improvements to program facilities. Because Self-Help Centers are key to a Treatment, Wellness and Recovery model, appropriate levels of funding should continue in subsequent years

***See Treatment, Wellness and Recover in the Domains of Study for more detail.**

Recommendation #4 -- Expand Community Health Law Project

The Task Force recommended and supports Governor Codey's proposed increase of \$600,000 for the Community Law Project (CHLP) for the purpose of increasing representation of persons with mental illness in applying for benefits and entitlements. Approximately 90% of consumers are denied on their first submission of an application to the Federal Government. CHLP has a more than 90 percent success rate of obtaining benefits for their clients. Insurance coverage is essential to wellness and recovery. CHLP also represents individuals with mental illness living in the Residential Health Care Facilities. This increase in funding will enable CHLP to increase representation throughout the state from 7 to 10 counties.

***See Treatment, Wellness and Recovery in the Domains of Study for more detail.**

Recommendation #5 – Statewide Information and Referral System

There should be a statewide information and referral system available to individuals seeking information about mental health services. This resource should include both a website that is continually updated and access to a live person who can answer questions and advise on accessing services at all levels, including both public and private facilities. The website should be coordinated at the state level but provide links to each county with local resources listed at each county level. There should also be a statewide template developed regarding each provider's services and performance evaluation.

***See Treatment, Wellness and Recovery and Community Mental Health Infrastructure and Efficiencies in the Domains of Study for more detail.**

Recommendation #6 -- Psychiatric Advanced Directives and Consumer-Centered Treatment Planning

In order to promote recovery, consumers must be the driving force in treatment planning. The Task Force supports the pending legislation concerning Psychiatric Advanced Directives. Consumer education, provider training and legal guidance will be needed. However, it is understood that (as with medical advance directives), many consumers may not choose this legal format; consumer choices can still be promulgated by the following:

-- All levels of care should encourage and help consumers to develop a Wellness Recovery Action Plan (WRAP) or other consumer-focused treatment and recovery plan. This will require training and supervision of staff in public and private hospitals and community agencies including consumer self-help centers. Consumer providers can play an important role in this, instilling hope and survival skills. The regulations for state-funded programs should require evidence of true consumer involvement in their own treatment planning.

-- Treatment planning should consider all aspects of the consumer's life, including family involvement where appropriate, needs and environment: Level Of Care Utilization System for psychiatric and addiction services (LOCUS)(12), currently being adopted in the state hospital system, is an instrument to determine the level of care needed. LOCUS could be extended to community settings.

Note: Movement to consumer-centered treatment planning should be consistent with and follow the guidelines set by national accrediting and licensing bodies.

*** See Treatment, Wellness and Recovery in the Domains of Study for more detail**

Recommendation #7 – Provide Education Training and Screening with Regard to Post-Partum Depression

Wellness and recovery is never more important than in the case of a mother caring for her infant. The Task Force supports Governor Codey’s fiscal year ’06 budget proposal to provide \$2 million for screening uninsured mothers for postpartum depression education and \$2.5 million to implement a Postpartum Depression Education campaign. The Departments of Health and Senior Services and Human Services will coordinate these initiatives.

***See Treatment, Wellness and Recovery in the Domains of Study for more detail.**

ISSUE #2 – HOUSING

Securing and maintaining permanent, affordable housing is a crucial step along the road to recovery, and is implicit in many of the themes identified in this report. Consistent with this idea, the Task Force calls for the State of New Jersey to dramatically shift its vision to a “housing first” philosophy for individuals with mental illness. Elaborated in the Housing Advisory Committee recommendations, staggering statistics show that thousands of New Jersey citizens with mental illness do not have a place to call home. Furthermore, due to the complexity of housing issues facing people with mental illness, this philosophy demands enhanced responsibility of and coordination between multiple State departments.

Whereas, Redirection II was intended to be the foundation to address the Olmstead decision, additionally, the Task Force considers these specific Housing recommendations and those included in the Housing Domain of Study, to provide a more detailed and comprehensive blueprint for New Jersey’s plan to continue to address the Olmstead decision and recommend as such to the Governor to expedite the process of discharging those persons in the State Hospital system currently deemed as Conditional Extension Pending Placement (CEPP) status.

Recommendation #8 – “Home to Recovery” Housing Initiative

The Task Force strongly recommended and supports Governor Codey’s proposal for the creation of 10,000 permanent, affordable housing opportunities over a ten-year period. Essential to this recommendation is the creation of a \$200 million Housing Trust Fund, which would provide State capital funds that can be leveraged with other sources to help in achieving this goal. The “*Home to Recovery*” initiative establishes a focus for State government in the years to come.

***See Housing in the Domains of Study for more detail.**

Recommendation #9 – Supportive Services for Permanent Supportive Housing

Case management, counseling, education and employment training and daily living skills are vital support services that help to ensure the long-term wellness and recovery of persons with mental illness in a permanent supportive housing setting. The Task Force recommended and supports Governor Codey's fiscal year '06 budget proposal which includes an additional appropriation of approximately \$5 million for services, to be made available to the first 500 persons who take advantage of the housing opportunities provided by the Governor's Housing Trust Fund. Additional appropriations will be necessary in subsequent fiscal years as the 10,000 housing opportunities are put on line. ***See Housing in the Domains of Study for more detail.**

Recommendation #10 – Improve Residential Healthcare Facilities

The Task Force recommended and supports Governor Codey's proposal for \$2.2 million in additional State funding for FY 2006 to improve Residential Health Care Facilities (RHCF), often mistakenly referred to as 'boarding homes.' An increase of \$50 per resident would be provided in the existing subsidy to RHCF operators, along with an increase of \$10 for consumers' personal needs allowance. This investment will assist in improving the facilities and overall quality of life for those persons residing in the RHCF's.

In addition, the Task Force recommends moving the responsibility for monitoring and inspection of these facilities from the Department of Health and Senior Services to the Department of Community Affairs (DCA). DCA presently has jurisdiction over the regulation of rooming and boarding homes, facilities that are similar in nature to RHCF's. Using existing available staff within DCA's Division of Codes and Standards, this consolidation will provide a more efficient means of administering these inspections, eliminating overlap and duplication of effort.

*** See Housing in the Domains of Study for more detail.**

Recommendation #11 – Review Existing Regulations, Policies and Legislation

The state should review and revise various regulations, policies and legislation that have hindered or will hinder the process of creating the 10,000 housing opportunities. These recommendations should include allowing access to new housing from the community, prioritizing rental assistance for people with disabilities, and changes to the Council on Affordable Housing regulations.

*** See Housing in the Domains of Study for more detail**

ISSUE #3 – LOCAL SYSTEMS OF CARE

New Jersey should focus on promoting and providing services that utilize a local system of care. Wellness and recovery are enhanced if services are provided at the local level, where consumers and family members live. Governor Codey's Housing Trust Fund proposal is paramount to promoting a local system of care, as a secure and safe living arrangement is essential to wellness and recovery. Services at the local level must be expanded, and the local infrastructure of community mental health centers and hospitals must be supported.

Recommendation #12 -- Increase the Capacity of Mental Health Screening Centers

The Task Force recommended and supports Governor Codey's proposed \$10 million expansion of county-based mental health screening centers. Screening centers located in all 21 counties serve as the gateway to services at every level, including outpatient counseling, case management, self-help centers and in-patient hospitalization. The \$10 million investment will add approximately 150 new master's level clinicians for emergency screening, including mobile outreach teams and enhanced on-call resources for community-based treatment and assessment. Staff recruitment will target bi-lingual clinicians (to the degree they are available) based on the needs of specific communities and will provide an improved ability to assess and treat co-occurring disorders. Enhanced screening will provide mental health services on a 24/7 basis for individuals in crisis.

The proposed funding for FY 2006 is a significant initial investment. However, in future budget years (FY 2007, FY 2008), the state should increase that investment to \$34.5 million in order to fully fund the screening centers and allow each center to fulfill its legislated mission and responsibilities.

***See Treatment, Wellness and Recovery in the Domains of Study for more detail.**

Recommendation #13 – Expand Psychiatric Services

The Task Force recommended and supports Governor Codey's FY 2006 budget proposal to provide \$2.5 million of funding for an expansion of psychiatric services. In New Jersey, the waiting time for an appointment with a psychiatrist or an advanced practice psychiatric nurse for medication management and other psychiatric services is as long as six weeks. The funding will provide an estimated 25,000 hours of additional psychiatric time statewide.

*** See Wellness and Recovery in the Domains of Study for more detail.**

Recommendation #14 – Recruitment and Retention of Quality Staff

A most critical issue facing the community mental health system is ability to pay and retain staff. The industry's inability to pay a competitive wage results in high staff turnover and low morale, leading to a decreased quality of care.

Specifically, the Task Force recommends eliminating the salary disparity between the state workforce and non-profit sectors by implementing a three-year plan, beginning in FY 2007, to bring salaries in the community mental health system to a level equivalent with state employees, e.g., DYFS workers and state hospital employees

The Task Force recognizes the dire condition of the state's budget; however, to remain silent on this issue would be doing a disservice to the Task Force's mission.

***See Community Mental Health Infrastructure and Efficiencies for more detail.**

Recommendation #15 – Social Services Loan Redemption Program

The Task Force recommended and supports Governor Codey's FY 2006 appropriation of \$3.5 million provide to "loan forgiveness" to new graduates with qualified bachelor degrees working at a qualified state or county psychiatric hospital or state-contracted non-profit qualified facility. This program will forgive up to \$5,000 annually for each year worked in a direct care position for up to four years. This program will assist in recruitment and retention of quality staff providing direct care to some of New Jersey's most vulnerable citizens.

***See Community Mental Health Infrastructure and Efficiencies in the Domains of Study for more detail.**

Recommendation #16 – Permanent Index for the Total Cost of Community Care Contracts

The community mental health system and other disability providers have not been able to keep up with the cost of living for the past 20 years. The state should assign a permanent index for the total cost of community care contracts to be increased on an annual basis. The Task Force recommends that the state use the federal Consumer Price Index CPI – Urban Wage earners (CPI-U) for the Northeast region.

***See Community Health Infrastructure and Efficiencies in the Domains of Study for more detail**

Recommendation #17 -- Capital Improvement Fund

If contracted agencies have additional revenue and/or accruals, they should be allowed to create and maintain a working capital improvement fund of up to 10 percent of their annual operating budget for the purpose of funding capital improvements, including, but not limited to information technology infrastructure and housing.

***See Community Health Infrastructure and Efficiencies in the Domains of Study for more detail.**

Recommendation #18 – Increase Utilization of Short-term Care Facility Hospital Beds

Families and persons with mental illness prefer to receive treatment as close to home as possible. Currently, an average of two out of every three persons determined by local screening centers to be in need of hospitalization are sent directly to a state or county psychiatric hospital.

To encourage community hospitals to provide this care closer to home, the Task Force recommended and supports Governor Codey's FY 2006 budget proposal to commit approximately \$1 million to implement a pilot program to provide inpatient psychiatric hospitalization in the community short-term care facilities for up to 30 days. This program will assess whether patients can be stabilized before they are sent to a county and/or state hospital.

The Task Force highly recommends expanding this program statewide, pending a successful, independent evaluation of the pilot project's performance, and as funds become available.

*** See Hospital in the Domains of Study for more detail.**

ISSUE #4 -- CHILDREN

The care and treatment of children with emotional disturbances and/or mental illnesses is of great concern to society, the Task Force, and Governor Codey. While the Task Force acknowledges the significant progress made by the Department of Human Services in the past five years, much more needs to be done. The Governor has identified the mental health and general well being of children as a priority and it should also be noted that Governor Codey is especially concerned about the treatment of children with mental illness in juvenile detention. Accordingly, the Task Force makes the following recommendations to improve the children's mental health system.

Recommendation #19 – Divert low and mid-level offenders with mental illness from juvenile detention facilities to appropriate treatment settings. For those who are incarcerated, provide appropriate assessment and treatment

Regarding juvenile offenders with mental health/special needs, the New Jersey Juvenile Justice Commission(JJC) recently reported the following:

- The true extent of the problem is unknown due to the scarcity of data on the symptomatology / presenting problems of juvenile offenders.
- What few statistics are available demonstrate that youth with mental health issues are over-represented in the juvenile justice system.
- Youth with mental illnesses often do not fit the profile of the typical delinquent and, as a result, are not well served by traditional programs for delinquent or seriously emotionally disturbed/developmentally disabled youth.

- There is growing recognition of the high degree of co-occurrence between mental illness and substance abuse.
- The juvenile justice system becomes the default system for youth who “fall through the cracks” with mental health and behavioral problems
- It is estimated that up to 70 percent of youthful offenders are mentally ill, compared to 22 percent of the general population (Hunzker, 1993). 20 percent of these mentally ill offenders have severe disorders.

National research studies on Juvenile Justice System (JJS) youth indicate a number of important findings. Major risk factors associated with JJS-involved youth include substance abuse, poverty, academic and learning problems, and exposure to violence in the family environment. A study of youth in juvenile justice settings found Post Traumatic Stress Disorder(PTSD) rates ranging from 3 percent to more than 50 percent. Females are more likely to be suffering from PTSD and more likely to be victims of violence. Minority youth of both genders are over-represented in JJS facilities across the nation. Contrary to the stereotypes of hard-core, anti-social delinquents portrayed in the media, most youths in JJS placements are there as a result of low-level offenses. Most also have a history of maltreatment. In short, they are a vulnerable, psychologically needy and service-neglected group.

The Office of the Child Advocate (OCA) *Juvenile Detention Center Investigation* of November 2004 reported that (21percent) of all youth committed to the JJC have a serious emotional disorder. This is consistent with the over-representation of mentally ill children in detention nationwide. With more than 11,000 new youth admissions to the 17 county detention centers annually and 935 youth, on average, in detention centers daily, this leads to a conservative estimate that 200 youth experiencing serious mental health disorders are in detention in New Jersey on any given day.

The prevalence of serious mental health disorders among New Jersey’s detained youth is further illustrated by the number of youth in need of psychotropic medication. In the 14 detention centers polled, administrators reported rates of youth taking psychotropic medication ranging from 10-50 percent.

Summary: The Task Force wishes to re-emphasize the following findings of the OCA report:

- In direct violation of the law, youth are regularly held in detention centers for extended periods of time while awaiting transfer to non-secure residential programs.
- Mental health screening and assessment capacity within youth detention centers is inadequate.
- Mental health care within youth detention centers is grossly inadequate and the nominal services currently available are inconsistent from county to county.

- There were 90 suicide threats or attempts in New Jersey juvenile detention centers from January 1, 2004 through August 30, 2004, a telling indicator of severe mental health distress among youth.

In response to the OCA report, the Division of Child Behavioral Health Services (DCBHS) and the JJC announced the following steps:

1. Upon admission to secure detention, all juveniles will be screened for suicide risk. The Commission has standardized the suicide-screening tool and all counties were to be using the standardized tool by January, 2005.
2. Within 72 hours of admission, all juveniles will be screened for mental/emotional disturbance of distress using the standardized MAYS1-2 screening tool. The implementation of the MAYS1-2 is meant to alert detention center staff to mental health issues, guide decisions regarding resource allocation and highlight needs for linkage with other agencies that serve troubled youth. Statewide implementation of the MAYS1-2 is to be completed by the end of 2005.
3. If a juvenile demonstrates signs of mental health need based upon the MAYS1-2 screening or by his/her behavior or history, the county detention center is to call DCBHS, which will conduct a more comprehensive mental health assessment and provide an individualized plan and services as needed.

Task Force Recommended Action Items:

- a. JJC and DCBHS follow-through on provision of screenings as described above should be monitored for timeliness and special attention paid to the credentials and training of screeners. (See OCA recommendations for ongoing reporting and monitoring)
- b. As part of re-entry, ensure that every youth exiting the JJC has appropriate housing and wraparound services. This effort needs to be part of individualized case management and should begin well ahead of the juvenile's expected release date.
- c. With the priority being to locate youth with mental illness in the most appropriate setting, youth in need should be provided with psychiatric evaluation, medication monitoring, and integrated treatment for co-occurring mental health and substance abuse disorders while in detention until an appropriate placement can be attained. No youth should go without needed treatment simply because they are in a detention facility. Provisions for continuation of these services, post-release, should be part of the case management responsibility described directly above.
- d. Evidence-based diversion programs should be identified, piloted, and replicated specifically targeting youth who present with a combination of relatively mild anti-social/criminal histories coupled with mental health disorders. There is promising evidence that such youth respond well to treatment if kept apart from more seriously conduct-disordered peers.

- e. Evidence-based practice models should address both mental health and substance abuse issues and should be uniformly available across all JJS placements and facilities
- f. Education and vocational services in detention centers should be tailored to the population, with teachers skilled in working with “challenging youth.”
- g. Existing programs and services should be carefully reviewed to ensure that they are based upon sound clinical practices and are yielding acceptable outcomes appropriate to the specific needs of participating youth.
- h. DCBHS and JJC staff should be cross-trained regarding the special needs of JJC-involved youth with mental health disorders. Special consideration should be given to minority, bi-lingual and gender-challenged youth.
*See **Children and Criminal Justice in the Domains of Study for more detail.**

Recommendation #20 – Office of Children’s Services/Division of Children Behavioral Health Services.

The following Task Force Recommended Action Items pertain to the Division of Children Behavior Health Services.

- a. State leadership must stay as focused on the development of the Children’s Behavioral Health Initiative as on the Child Welfare Reform Plan and the court-ordered enforceables. We also recommend that the Child Welfare Reform Panel consider renegotiating some of the deadlines so that goals can be accomplished and real change can occur.
- b. Local entities (county mental health boards, county mental health administrators, local contracted providers, etc) should be included in planning and processes. Local, county-based plans should contribute to state planning initiatives and program development. Local players are best able to identify service system gaps and identify cost efficient measures to address needs and minimize administrative costs and duplication of effort.
- c. The Quality Assurance Performance Improvement (QAPI) system must produce reliable, meaningful data about the new system, which must be disseminated to all system partners. The QAPI system process should measure behavioral outcomes, client satisfaction and detailed cost benefit analysis. It should openly involve community systems partners and advocates in the corrective action process and in ongoing planning.
- d. The QAPI process needs to identify outcomes not currently measured, such as: What is the cost per child? Are children and families being better served? Is there greater access? What is it costing to administer this new system? Are children doing better in school? Are high-risk behaviors decreasing? Is there less involvement in the juvenile justice system?

- e. DCBHS must address problems identified with Value Options (a private contract service administrator) performance including requests for services taking too long to be authorized, insufficient knowledge of local resources, and the ABSolute software system that needs to be either overhauled or replaced.
- f. The state must develop performance-based contracting for all funded programs, with clear and appropriate outcomes required and monitored.
- g. DCBHS should refocus Youth Case Management on its original goal of serving children requiring a less intensive level of care and ensuring manageable caseload sizes.
- h. Service delivery to children within the same family should be unified, with one plan comprehensively addressing the needs of the entire family with the care being coordinated at the highest level involved, e.g., Care Management Organization (CMO).
- i. The Task Force recommends a complete and objective assessment, including a comprehensive analysis of the quality, quantity and cost effectiveness of the new Division of Children's Behavioral Health Services system, formerly known as the Partnership for Children. This analysis should also include a thorough review of the state's contract with Value Options. The Task Force together with the Child Welfare Reform Panel, the Department of Human Services and the Office of the Child Advocate will identify the parameters of the assessment and identify the independent expert to perform the assessments.
- j. The Children's Advisory Committee recommended that the Task Force and its charge should not end with this report but should continue in an oversight capacity in relation to the new Office of Children's Services. The Task Force, recognizing that a non-governmental body is not provided with the authority of oversight of a state department and/or division is recommending that membership of the Children's Cabinet be expanded to include two members of the Task Force on Mental Health, a minimum of two pediatricians, a minimum of two child psychiatrists and child psychologists. Additionally, we recommend that Governor designate the Commissioner of the DHS as a co-chair and will also designate a second co-chair (a professional from the community). The Cabinet will evaluate on a continuous basis the progress of the Office of Children's Services with regards to its behavioral health services and programs, including the implementation of the children and adolescent specific recommendations from this Task Force. Quarterly reports on their progress are to be submitted to the Governor and appropriate Assembly and Senate committees.
***See Children in the Domains of Study for more detail.**

Recommendation #21 – Strengthen Prevention and Early Intervention

Service delivery should take place at sites where children and families already access other services, the most obvious being pre-schools and pediatric healthcare clinics. Evidence-based best-practice models should be identified, piloted, and replicated statewide. Examples are: *Healthy Families America*, *Parents as Teachers*, and *PrePARE* (see details attached).

Personnel who interact with children in preschools, schools, healthcare facilities and juvenile justice agencies should receive ongoing training on how to identify and respond to early childhood development issues and risk factors. This training should also be organized to foster stronger connections among these systems and between them and the DCBHS.

Screening of young children for developmental and mental health issues should be implemented statewide, and follow-up assessments and linkage to services should be available to all who need them. One vehicle for this is Early Periodic Screening, Diagnosis and Treatment (EPSDT), a Medicaid-reimbursable assessment tool for identifying both medical and emotional problems.

A public awareness campaign, to include, but not limited to educators, parents, pediatricians and the general public, should be launched to alert the public to early intervention issues such as positive parenting skills, identifying at-risk children, available resources and how to access these resources.

*** See Children in the Domains of Study for more detail.**

ISSUE #5 – EMPLOYMENT

Individuals with mental illness who have learned to manage their conditions also need to provide for their own housing, education and employment in order to become fully contributing members of society. Such a goal is the essence of wellness and recovery, consistent with the American dream. New Jersey needs to promote employment opportunities for the majority of consumers who are able.

Recommendation #22 – Expand Supportive Employment

The Task Force recommended and supports Governor Codey's FY 2006 budget proposal to expand current funding for supportive employment services by \$1 million. The expansion would enable an additional 450 individuals with mental illness to participate in the program. Based on past performance, we anticipate that over 50 percent of these individuals would find competitive employment and become tax-paying citizens.

The state should consider additional expansion in subsequent years as funds become available. ***See Employment, Support and Rehabilitation Services in the Domains of Study for more detail.**

Recommendation #23 – Career Transition Services to Adulthood

The Task Force recommends creating in each county, outcome-oriented career education and development services that, provided in conjunction with treatment and other services, would facilitate the transition into adulthood for individuals 16-24 years old with mental illness. Beginning in FY 2007 this would require a state investment of \$4.2 million.

*** See Employment, Support and Rehabilitation Services in the Domains of Study for more detail.**

Recommendation #24 - Ticket to Work

A cooperative training series should be developed between Department of Labor and Department of Human Services, for individuals with mental illness, family members and providers in order to increase awareness and utilization of the Ticket to Work program to ensure that New Jersey is maximizing the benefits of this Federal program and resources for individuals with mental illness and other disabilities.

***See Employment, Support and Rehabilitation Services in the Domains of Study for more detail.**

Recommendation #25 - Post-Secondary Supported Education

It is the recommendation of the Task Force that the state develop and fund Supported Education programs throughout New Jersey. This program would create outcome oriented educational intervention services in each county that would facilitate the entry or re-entry and ongoing support of persons diagnosed with mental illness into post secondary educational and desired learning opportunities. Such opportunities might include county or senior colleges, technical trade school or apprenticeship programs or GED preparation.

*** See Employment, Support and Rehabilitation in the Domains of Study for more detail.**

ISSUE #6 -- INDIVIDUALS WITH MENTAL ILLNESS IN THE CRIMINAL JUSTICE SYSTEM

A disproportionate number of people with mental illness are incarcerated in New Jersey's jails and prisons, many as a result of a non-violent crime. The over-representation of people with mental illness in prisons and jails is due to a variety of factors. Many offenders with mental illness are poor, unemployed, underemployed or disabled and are without the benefit of effective treatment or services. These offenders may be forced to live in sub-standard housing and/or shelters, often in high-crime neighborhoods where they are subject to victimization and abuse. Stigma, discrimination and mistreatment have also blocked their access to opportunities and impeded their efforts to gain full social integration.

In addition, the lack of appropriate community services has left many with serious mental illness in need of treatment and displaying symptomatic behaviors that can often lead to arrest and incarceration. Although the incidence of criminal behavior is no greater for those with mental illness than for other groups, the lack of appropriate treatment and the presence of social problems (racism, poverty, housing problems, substance abuse, etc.) perpetuate criminal justice involvement that otherwise could be avoided.

Problems confronting youthful offenders are similar to, yet distinct from, those facing adults. The link between child maltreatment and involvement with the child welfare and juvenile justice system is now firmly established. The availability of a range of community services appropriate to their needs is essential to the effective treatment of youth at risk and youthful offenders.

Mental illness is not against the law. Incarcerating children and adults due largely to their mental illness and lack of appropriate treatment services is an American tragedy.

Recommendation #26 – Jail Diversion

Nationally, 16% of prisoners suffer from a severe mental illness. A similar situation exists among inmates in New Jersey. Studies indicate that persons with mental illness often end up in prison due to an inappropriate charge, often of a non-violent or disorderly nature, when providing access to treatment and medications would have been more appropriate. The Task Force recommended and supports Governor Codey's FY 2006 budget proposal for \$1.8 million in new funding to develop Community Treatment Liaisons, similar concept that was brought forth from Assemblyman Blee, to the judicial community in the counties with the greatest need. The Task Force is recommending that Atlantic, Union and Essex Counties participate in this pilot and that the State of New Jersey make it a priority to expand to all 21 counties over a realistic time frame, not to exceed 5 years. This will also include appropriate training for law enforcement officers, which should be included in all counties.

***See Criminal Justice in Domains of Study for more detail.**

Recommendation #27 – Pilot Re-entry Case Management

Studies indicate that, for mentally ill prisoners, re-entry treatment and related services after release are crucial to giving them the best possible chance to become productive members of society. The University of Medicine and Dentistry of New Jersey (UMDNJ) recently assumed responsibility for mental health patients currently incarcerated in New Jersey's prisons. The Task Force recommended and supports Governor Codey's FY 2006 budget proposal of \$800,000 to pilot re-entry case management services. The proposal builds on existing Intensive Case Management and Program for Assertive Community Treatment (PACT) services, with the provider directly coordinating with UMDNJ staff, for adults, beginning with pre-discharge planning. The Task Force is recommending that \$400,000 be appropriated to the State Board of Parole to begin implementation of the Program for Returning Offenders with Mental Illness Safely and Efficiently (PROMISE) (see Appendix in Criminal Justice Domain of Study) and the

balance, \$400,000, be appropriated to the Juvenile Justice Commission to provide re-entry wraparound services as referenced in Recommendation #18 “b”.

***See Criminal Justice and Children in Domains of Study for more detail.**

Recommendation #28 - Community Based Transitional Care Program for Special Needs Inmates

Despite major improvements in the rendering of mental health services to those in need, little has been done to address the treatment needs of the offenders with mental illness as they approach release to the community and upon reentry. Barriers faced by these individuals as they seek community treatment include financial instability, lack of health benefits, ineligibility for public supported benefits, and reluctance on the part of mental health providers due to safety concerns. In an effort to effectively transition these offenders to the community, the New Jersey Department of Corrections(NJDOC) has proposed the creation of a community based transitional care center. The NJDOC will soon issue a Request For Proposal to solicit bids for the contracted operation of community based transitional care for up to 250 special needs inmates (125 male and 125 female). The population would include those with mental illness as well as those with co-occurring mental illness and substance abuse disorders. Based on final proposal specifications, the program will either be located at one facility, with separate quarters by gender; or at two facilities, one for males and one for females. The program will entail a very structured milieu inclusive of assessment and therapeutic intervention provided by UMDNJ staff as well as educational and vocational opportunities, substance abuse treatment, life skills activities and comprehensive case management services offered by the contracted residential community provider agency. The ongoing dialogue and partnership between UMDNJ, the residential community provider agency and the NJDOC is an essential component in the efficient and effective operation of this new initiative. The establishment of a community based transitional care program will not require additional state funding but rather a reallocation of NJDOC existing resources.

The Task Force recommends and supports this proposed program and applauds the Department of Corrections for joining with the Governor and the Task Force in making the needs of persons with mental illness a priority and for its innovative approach to utilize existing resources.

***See Criminal Justice in Domains of Study for more detail.**

Recommendation #29 - Establish/Expand Training and Specialized Probation and Parole Caseloads

Intensive supervision of people with addictions has facilitated offenders’ successful integration into society and helped reduce recidivism. This model should be applied to offenders with serious mental illness to assist in social reintegration and to reduce the change of recidivism.

***See Criminal Justice in the Domains of Study for more detail.**

Recommendation #30 – Juvenile Justice Commission (JJC)

Ensure that every youth with mental illness or serious emotional disturbance exiting the Juvenile Justice Commission (JJC) has appropriate housing and services. This would include trans-permanent supportive housing as well as transitional housing. To accomplish this, the following must be addressed.

- Keep youth active with the Division of Child Behavioral Health Services and/or DYFS to ensure joint planning and access to services, including an extended period of follow-up support.
- Provide funding to support the additional responsibilities expected of partner agencies by the Division of Child Behavioral Services, including JJC social workers/case managers to assist with completing needs assessment (the means of entry into the behavioral health care system), and jointly arranging appropriate services via the child behavior health care system. Funding should be provided through the existing DCBHS budget and complemented with the proposed increase in appropriations for FY 2006.
- Ensure that children in detention centers receive appropriate mental health and addiction services.
- Identify a liaison with the Office of Children's Services to address coordination problems among the JJC, DYFS and DCBHS, and to participate on the JJC committee overseeing status of multi-system youth.
- Ensure that incarcerated/adjudicated youth are not excluded from services because of this status and can access care if they meet criteria for need.
* **See Criminal Justice in the Domains of Study for more detail**

ISSUE #7 – CULTURALLY COMPETENT SERVICES

Mental health and mental illness are shaped by age, gender, race and culture as well as additional facets of diversity such as physical disability or a person's sexual orientation, which can be found within all of these population groups. The consequences of not understanding these influences can be profoundly deleterious. New Jersey must provide mental health services that are culturally competent.

Recommendation #31 – Recruit Culturally Competent Staff

Services and mental health professionals need to have the necessary language and cultural skills to support racial and ethnic minority groups. The Task Force recommended and supports Governor Codey's proposal of a new investment of \$1 million in fiscal FY 2006 to expand bi-lingual and culturally diverse case management and outpatient services, specifically to serve the fastest-growing ethnic minority populations in New Jersey. This should be a continuously funded program with

expanded funding implemented as resources allow.(See additional recommendations concerning screening expansion and cultural competency.)

***See Treatment, Wellness and Recovery in the Domains of Study for more detail.**

Area B: Planning, Management and Budget

ISSUE #8 – STIGMA AND PARITY

Stigma is the primary barrier to the achievement of wellness and recovery and full social integration. It appears as discrimination, fear, distrust, and stereotyping. Stigma results in people avoiding working alongside, socializing with and/or living in close proximity to people with a mental illness. Stigma deters people from seeking help for fear that their confidentiality will be breached. It gives insurers, public and private, tacit permission to restrict coverage for mental illnesses in ways that would not be tolerated for other illnesses. Historically stigma has allowed mental health to be separated from mainstream health.

Mental health must be seen for what it is – a public health issue, no different than other medical disorders. For New Jersey to reduce the burden of mental illness, to improve housing, to improve access to care and to achieve urgently needed public education about mental illnesses and mental health, stigma must no longer be tolerated.

Recommendation #32 -- Governor’s Council on Mental Health Stigma

Establish the Governor’s Council on Mental Health, with representation from consumers and family members as well as representatives from the fields of mental health, healthcare, the media, government, the insurance and pharmaceutical industries, business, law enforcement, clergy and education. The group’s charge will be to develop a master plan to increase public awareness.

The Task Force recommended and supports Governor Codey’s FY 2006 budget proposal for \$250,000 to establish the Governor’s Council on Mental Health Stigma.

*** See Stigma in the Domains of Study for more details.**

Recommendation #33 -- Support Parity of Benefits with Medical Coverage

New Jersey should mandate full mental health parity for all state regulated plans. Full parity is defined as treating *all* mental health financing on the same basis as financing for general health services.

The coverage requirement of current State mandates are limited to biologically-based mental illnesses (BBMI), which are defined as “a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness.”

Assembly Bill A-333 mandates that all health insurers, as well as contracts purchased by the State Health Benefits Commission, *currently* providing coverage for a disorder that is included in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSMD-IV), but is not a biologically-based mental illness, extend coverage for that disorder under the same terms and conditions as provided for any other sickness. The language of the bill does not provide a “true” mandate for non-BBMI mental health coverage since it does not include policies that do not currently cover non-biologically based disorders. While the Task Force supports the concept and goal of A-333, it should be extended to require **full** mental health parity of all state regulated plans.

This would require amendments to A-333 and most likely a subsequent review by the Mandated State Health Benefits Commission. * **See Parity in the Domains of Study for more details.**

ISSUE #9 – STATE POLICY AND PLANNING FOR MENTAL HEALTH SERVICES

The structure of the public mental health system must support the goal of effective, efficient, culturally competent and compassionate mental health treatment and recovery. Full participation by consumers and family groups is essential. The following structural issues have been identified by the Task Force as interfering with the delivery of mental health services.

- Fragmented funding, uncoordinated services
- Large, centralized Division of Mental Health Services
- Lack of appropriate community input into service planning and delivery
- Insufficient funding of less restrictive treatment options, resulting in consumers receiving more restrictive and expansive care than necessary
- Lack of meaningful outcome and quality measures to improve the system

The following recommendations will encourage more local participation in state planning, resulting in better coordination and improved services.

Recommendation #34 – Strengthen the State Mental Health Board

Membership should be expanded to include more community participation and high-level representation from other departments of the state, e.g. Department of Human Services, Department of Community Affairs, Department of Corrections, etc. The state Mental Health Board should report to the Commissioner of Human Services and assist the Commissioner in evaluating the Special Assistant Commissioner of the Division of Mental Health Services and in developing a yearly comprehensive plan for mental health

to be submitted to the Governor and the Legislature. To ensure local participation, the state board should meet quarterly with the chairs and administrators of the county mental health boards. The state board should hold one annual public meeting (outside of Trenton).

***See System Design in the Domains of Study for more detail.**

Recommendation #35 – Strengthen County Mental Health Boards

The county mental health boards should operate consistent with the Community Mental Health Service Act, sub Chapter 3, 10:37, in regard to all their duties for both the adult and children's mental health system especially in regard to local planning and monitoring. The voice of local concerns represented by the county mental health boards must be heard at the state level.

***See System Design in the Domains of Study for more detail.**

Recommendation #36 – Double State Funding for County Mental Health Administrators

Beginning in FY 2007, the state should double the funding for County Mental Health Administrators in order to ensure each county's ability to fulfill the mandates of the Community Mental Health Service Act.

***See System Design in the Domains of Study for more detail.**

Recommendation #37 – Special Assistant Commissioner for Mental Health Services

The state should elevate the position of Division Director of Mental Health Services to Special Assistant Commissioner reporting directly to the Commissioner of Human Services. This action would elevate the profile of mental health within state government.

***See System Design in the Domains of Study for more detail.**

Area C: Populations and Special Issues

ISSUE #10 – OVERCROWDING OF STATE HOSPITAL SYSTEM

The Task Force toured the state psychiatric hospital system and was deeply disturbed by the conditions of overcrowding. The Task Force was, however, impressed with the quality and the commitment of the leadership at each institution. The census on March 18, 2005 was 2241, the system is designated to treat 1895. While the Task Force believes that its recommendations in total will result in long-term census reduction, the following short-term steps should be taken to reduce the overcrowding.

Recommendation #38 – Expand Greystone Park Psychiatric Hospital

The Task Force recommended and supports Governor Codey's proposal, announced on March 15, 2005, to increase the bed capacity at the proposed new Greystone Park Psychiatric Hospital from 460 beds to 510 beds.

***See Hospital in Domains of Study for more detail.**

Recommendation #39 – Expand the Care and Hope at Morris Plains Program

The Task Force recommends the Care and Hope at Morris Plains (CHAMP) program to serve as a primary model for transitional and supportive housing for individuals who have been hospitalized for significant periods of time, but have progressed and recovered to a level warranting gradual integration into the community. The CHAMP program is a ten-bed specialized residential program operated by a private provider on the grounds of Greystone Park Psychiatric Hospital. This program prepares newly discharged patients for community living. The majority of these patients are able to move to independent living. The provider has recently secured three- homes in the same location. The County of Morris is providing funds for physical plant rehabilitation. The Task Force recommends the state provide the service money, if available in FY 2006, but definitely no later than FY 2007, to expand the program by 15 beds. The cost per bed at the CHAMP program is less than half of the cost per bed at a state hospital, which is approximately \$146,000 annually.

***See Hospital in the Domains of Study for more detail.**

Recommendation #40 – Expand Program Space at Ancora Psychiatric Hospital

Ancora Psychiatric Hospital is overcrowded, resulting in a scarcity of program space. The Task Force recommends the purchase of two modular units for program space at a cost of \$600,000.

***See Hospital in the Domains of Study for more detail.**

Recommendation #41 – Continue Carrier Clinic’s Transitional In-Patient Program

Carrier Clinic has the capacity to provide transitional in-patient services to 25 patients transitioning from Trenton Psychiatric Hospital. While touring the Trenton facility, the Task Force found seven patients sleeping in rooms designed for four – a situation that is unacceptable. Individuals who are appropriate enter Carrier Clinic’s Co-Occurring program and are discharged directly from Carrier to the community with additional coping skills.

Currently, the Department of Human Services is seeking to re-engage this previously successful program for six months with limited existing funding. The Task Force is recommending that the program be expanded for an additional year to 18 months.

***See Hospital in Domains of Study for more detail.**

Recommendation #42 – Expand Program Space at Trenton Psychiatric Hospital

The Task Force recommends implementing the current capital proposal pending at the Department of Human Services to expand program space on the admissions unit of Trenton Psychiatric Hospital. Approximate cost \$2 million, if funding available in FY 2006 budget.

***See Hospital in Domains of Study for more detail.**

ISSUE #11 – CO-OCCURRING DISORDERS

Research and the experience of the Task Force members indicated that between 30 percent and 60 percent of individuals suffering with mental illness suffer from co-occurring addictive disorders. Best and most promising practices call for an integrated treatment approach. Individuals with co-occurring substance abuse and mental illnesses must be treated at the same time, at the same place, with the same treatment team. Outcomes are improved when integrated prevention, intervention and treatment strategies are applied. The Task Force applauds the merger of the Division of Addictions under the Department of Human Services, and encourages its continued collaboration with the Division of Mental Health Services in order to promote an integrated treatment approach. The mental health and addiction communities must embrace a “no wrong door” approach.

Recommendation #43 – Expand Integrated Treatment Services and Training for Co-occurring Disorders.

System-wide, the Task Force recommends that the state continue to promote the expansion of integrated treatment for persons diagnosed with co-occurring substance abuse and mental illness, as well as appropriate training. Beginning in FY 2007 the Task Force calls for a \$3.7 million investment, \$2.2 million to provide integrated treatment and \$1.5 million to provide necessary training. The Task Force is recommending that the Department of Human Services utilize the Association of Community Colleges to develop the training matrix and curriculum, similar to what was developed for the DYFS training.

*** See Employment, Support and Rehabilitation Services in the Domains of Study for more detail**

ISSUE #12 – SPECIAL POPULATIONS

Mental illness cuts across all population groups and disabilities. Many individuals who suffer from mental illness have other existing disabilities and/or illnesses, including, but not limited to developmental disabilities, Tourette syndrome, eating disorders, and traumatic brain injury. The mental health system must strive to develop the competencies to treat people with mental illnesses who have existing issues.

Recommendation #44 – Governor’s Housing Trust Fund

Governor Codey’s Housing Trust Fund, while maintaining mental health as a priority, should be inclusive of other disability groups, especially the developmentally disabled.
***See Housing in Domains of Study for more details.**

Recommendation #45 – Traumatic Brain Injury Waiver

The Task Force recommended and supports Governor Codey’s FY 2006 budget proposal of \$1.8 million in the Department of Human Services to serve more people with traumatic brain injury in a non-institutional setting. The federally approved Medicaid Traumatic Brain Injury Waiver provides home and community-based assistance services to adults who have suffered traumatic brain injury. At present, New Jersey has approval and funding for 300 slots for this particular waiver. The increase noted above will enable the Department of Human Services to fund an additional 50 slots, representing an increase of 17 percent.

***See Treatment, Wellness and Recovery in Domains of Study for more detail.**

ISSUE #13 – TRAUMA IS A PUBLIC HEALTH ISSUE AFFECTING EVERYONE IN NEW JERSEY

In the acute phases of disaster and trauma, New Jersey has a dedicated and professional group of individuals and agencies that have historically responded to the mental health needs of individuals and communities. However, the energy these providers expend on responding places an additional burden on an already stretched mental health system. As a result, the long term needs of people affected by trauma have been difficult to provide. The ongoing development and strengthening of the mental health disaster response system has been temporary and sporadic, resulting in inconsistent availability of resources. The enormous mental health needs of individuals and communities affected by September 11th (as well as the ongoing war in Iraq) magnify the areas in which the state needs to improve.

Recommendation #46 – Office of Disaster Mental Health

One of the lessons of September 11th was the importance of having readily available services to respond to the needs of victims of large-scale emergencies. The Task Force recommended and supports Governor Codey's fiscal year '06 budget proposal of \$250,000 to stabilize the current Office of Disaster Mental Health with the Division of Mental Health Services for that purpose.

Establish the Division of Mental Health Services within the Department of Human Services as the lead entity to coordinate the mental health disaster response in collaboration with other emergency response entities such as the Office of Emergency Management. Such legislation should address specific needs and a course of action. Guidelines should consider victim populations and type of disaster (i.e. natural disaster, crime, etc.) when determining appropriate responses.

Provide state disaster/emergency funding for short and long-term counseling and other mental health services provided for victims, their families and first responders in the event of a major federal, state, or county declared disaster.

It is the recommendation of the Task Force to encourage appropriations for mental health services as part of any state disaster emergency relief act passed by the Legislature as the result of a disaster or emergency condition in New Jersey.

***See Emergency/Disaster Preparedness domain of study for more detail.**

Recommendation #47 – Enhance Post-Traumatic Stress Disorder Services for Veterans

Based on prior military conflicts, approximately 15% to 25% of the returning veterans and their families will experience some form of post traumatic stress disorder. Currently, 250 veterans are waiting for counseling services. The Task Force recommended and supports Governor Codey's FY 2006 budget proposal for \$500,000 in new funding that would help reduce the existing waiting list and provide services for returning military personnel and their families and for those who have lost loved ones in battle.

***See Emergency/Disaster Preparedness domain of study for more detail.**

Recommendation #48 – Single Point of Access When Disaster Occurs

The Task Force has identified the need to develop one point of access to services when a disaster occurs. Currently, ACCESS centers exist in entities such as UMDNJ, MHANJ, Project Phoenix, NJFAM, VCCB. Others exist on a countywide level. One of these existing locations may be modified to meet the needs of a disaster response ACCESS center or a linkage created between these centers, therefore minimizing the cost. Data, tracking, needs assessments, outcomes, and provider networks would encompass the responsibilities of such a proposed center.

***See Emergency/Disaster Preparedness in the Domains of Study for more detail.**

Recommendation #49 – Uniform Credentialing Process for Mental Health Disaster/Trauma

There is an effort currently underway by the NJ Division of Mental Health Services to provide a standard for a mental health disaster workforce through a credentialing process. This effort should be continued and expanded.

*** See Emergency Preparedness/Trauma domain of study for more detail.**

Area D: Legislative and Regulatory

ISSUE #14 – EVIDENCE-BASED AND/OR PROMISING PRACTICES MODEL FOR TREATMENT DEVELOPMENT, DELIVERY AND CONTRACTING

The development and service implementation of New Jersey’s mental health system must be founded on Evidence-Based Practices (EBP) and/or Promising practices. Training in EBP models and other promising practices such as physical wellness and recovery programs is now offered in New Jersey, e.g. University of Medicine and Dentistry’s “Centers for Excellence,” but much more is needed. These models should be included in the curriculum of professional schools. To implement these practices, leadership and supervision is needed throughout the system for professionals, consumers and family members. In concert with the support of Evidenced-Based and/or Promising Practices, meaningful measures of performance and outcomes should be developed for the entire system.

Recommendation #50 – Emphasis on Evidenced-Based and/or Promising Practices

The state should continue and expand its emphasis on funding Evidence-Based and/or Promising Practices.

***See Treatment, Wellness and Recovery in the Domains of Study for more detail.**

Recommendation #51 – Performance and Outcomes Measure

Performance and outcome measures are essential to the evaluation of treatment and value (value to consumer, cost/benefit analysis). The Division of Mental Health Services should move away from its current funding paradigm, e.g., historical, to one that pays for services based upon quality performance and measurable outcomes.

***See Treatment, Wellness and Recovery domain of study for more detail.**

Recommendation #52 - HIPAA

Clearly outline the requirements for protecting privacy in compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), while streamlining the process of obtaining consent from individuals to share essential information, gain access to services, transfer essential information for the provision of high quality of care, and enroll or verify enrollment in necessary entitlement programs and distribute that information to consumers, family members and providers. It is recommended that the Community Health Law Project develop a user-friendly pamphlet and the Department incur the costs of printing and distribution.

***See Community Mental Health Infrastructure and Efficiencies in the Domains of Study for more detail.**

Recommendation #53 – Medicaid Reimbursement

The state should implement an annual index that is applied to the reimbursement structure so that costs continue to reflect the prevailing costs of doing business.

***See Community Mental Health Infrastructure domain of study for more detail.**

Recommendation #54 – Electronic Clinical Records

Immediately, as an interim step, implement a HIPAA-compliant, transferable, portable, electronic information source via a computer disk that consumers and providers can easily access. Work toward the longer-term goal of consumers having a “smart card.” These measures will lead to quicker access to services for consumers and increased efficiency of mental services as well as quality of care.

***See Community Mental Health Infrastructure and Efficiencies in the Domains of Study for more detail.**

Additional Recommendation – Involuntary Outpatient Commitment

The Task Force was directed by Governor Codey on November 16, 2004 at its organization meeting to study and make recommendations concerning Involuntary Outpatient Commitment generally and Senate Bill 1640 specifically. While the Task Force unanimously does not support S1640, a majority does support the concept of involuntary outpatient commitment. **The Task Force recommended and supports Governor Codey’s FY 2006 budget proposal of \$1.5 million to provide specialized case management in a least restrictive setting for those persons identified as difficult to engage and/or treatment resistant, but who do not meet the terms for involuntary inpatient commitment.** The purpose of this program is to ensure that the appropriate services are available for individuals committed on an outpatient basis.

Involuntary Outpatient Commitment (“IOC”), sometimes known as Assisted Outpatient Treatment, is a means by which a court may enter an order requiring a person with serious mental illness to submit to treatment. This coerced treatment differs from the commitment system in current New Jersey law in that it “commits” a person to outpatient rather than inpatient care. IOC has generated a great deal of interest in New Jersey in recent years. This interest derives in part from tragic cases in which persons with severe mental illness who were not adequately engaged in treatment caused serious, sometimes fatal, injuries to themselves or others; have fallen prey to physical violence or theft; and/or often live in sub-standard and sometimes inhumane conditions as a result of their uncontrolled mental illness. The interest also derives in part from a perception that our current system, in which coercion is available only when a person is symptomatic enough to require inpatient care, fails to protect or facilitate recovery for a group of seriously mentally ill persons whose treatment resistance is, in part, a manifestation of their illness. Those opposing IOC express concerns that coercion may not be necessary if sufficient community services are made available. There were additional concerns that IOC may even be counterproductive if the provision of treatment were to become associated with adversarial processes. Concerns were also raised that IOC could be misused to apply coercion in situations where it is not warranted.

The issues raised by those advocating and opposing IOC are serious and difficult. The Task Force devoted several meetings to considering these concerns. Experts in favor and opposed to IOC presented compelling and thoughtful arguments. Many organizations and individuals provided interesting and helpful materials to aid in the Task Force’s deliberations. Members of the Task Force recognized the complexity of the argument. In the end, although the members of the Task Force were unable to reach consensus on the current need for IOC in New Jersey, the Task Force reached strong unanimity on one important principle. That principle is that no move to IOC should take place in New Jersey unless and until adequate, appropriate services are available in the community for all who voluntarily seek them. As other states have recognized (New York, for example) it is unwise and unjust to implement IOC if the community infrastructure is not adequate to meet the treatment needs of people with serious mental illness. The Task Force unanimously agreed that making culturally competent services, based on evidence-based and promising treatments directed to achieving wellness and recovery will increase the

percentage of people with serious mental illness engaged in treatment. The availability of appropriate services will at least greatly reduce the need for IOC. The Task Force's primary principle on IOC, then, is that the development of an adequate system of community care is an absolute precondition for the adoption of IOC.

As for the underlying question – the current need for the adoption of IOC – the Task Force membership split. The majority voted to recommend the adoption of IOC consistent with four principles (detailed below): the need for adequate community services; the adoption of a unitary standard for court-ordered care (other states, including Wisconsin which has operated with a unitary standard for the past 10 years, have been successful with this model); the adoption of a least restrictive alternative rule; and a commitment to independent evaluation of the implementation of IOC. A minority, including George Brice, Jr., voted to reject IOC. The minority believed that IOC represents an extreme measure incompatible with the autonomy rights of people with serious mental illness, particularly in light of the current shortcomings of the community treatment system in New Jersey, and expressed concern that the risks of abuse of IOC significantly outweigh any positive effects it could produce.

The principles adopted by the majority of the Task Force are set out below.

1. No program of involuntary outpatient commitment should be created unless and until the availability of appropriate community treatment reaches a safe and adequate level. Satisfaction of this condition precedent will help respond to concerns that IOC will:

- *create “designed to fail” commitments, in which a person violates IOC orders due to inability to access appropriate services;
- *create a “queue jumping” problem in which IOC becomes, perversely, the only route to services that would be accepted voluntarily, if available; and
- *be constructed on the erroneous assumption that failures to engage in services are not always or usually the result of consumer disinterest – it is, on the contrary, clear that most people who are not engaged in treatment are not well-served by current community treatment systems.

2. The “dangerousness” standard for New Jersey’s inpatient commitment should be clarified to permit the recognition of danger arising in the reasonably foreseeable future, and this same standard should be applied to IOC. This clarification will:

- *corrects a concern in the inpatient commitment standard that has given rise to impetus for IOC; and
- *create a unitary standard that will limit the chance for abuse of coercive treatment orders, thereby protecting the constitutional rights of people with severe mental illness from the overly-broad use of orders of coerced treatment.

3. The commitment standard applied to inpatient and outpatient commitment should be accompanied by a “least restrictive alternative” principle. This “least restrictive alternative” principle will:

- *allow a separation of the assessment of the order for involuntary treatment to be separated from the determination of what treatment is most appropriate in a given case – inpatient or outpatient;
- *permit orders for mandated treatment in appropriate cases without mandating unnecessary hospitalizations; and
- *permit amendments of order, *e.g.*, from inpatient to outpatient treatment without a new commitment hearing.

4. The effects of IOC should be evaluated by a qualified independent researcher two years after the effective date of the change, and again five years after the effective date. The independent report should be submitted to the Governor and the Legislature. The reports should assess:

- *the effect of the clarification of the standard for involuntary treatment to determine the extent to which it is applied by screening centers, courts, and other evaluators;
- *the effect of IOC on people with severe mental illness, the rate and geographic distribution of IOC orders, the response of people under order to IOC, and the extent to which the use of IOC affects the rates of institutionalization and incarceration; and
- *the effectiveness of IOC in facilitating the provision of appropriate services to people under IOC orders, and the effect of IOC on the availability of services to other people with severe mental illness.

Task Force Membership

Recognizing the diversity and complexity of New Jersey and its mental health system and the scope of the review, evaluation and recommendation process, the membership of the Task Force was purposely appointed with individuals representing the diversity and vast responsibilities as charged by Acting Governor Codey's Executive Order Number 1.

The 11-person Task Force included individuals from the private and public sector, a national expert, complementary clinical expertise, the judicial community, provider community, mental health consumer, family member, advocacy organization as well as being culturally diverse.

The members of the Task Force, appointed by Acting Governor Codey;

Robert N. Davison, MA, LPC, Chairman: Executive Director of the Montclair-based Mental Health Association of Essex County. Davison is responsible for the day-to-day operations of a comprehensive community mental health facility serving 1,000 individuals daily. Davison is a resident of Caldwell, Essex County.

George H. Brice, Jr. MSW, Vice Chairman: Team Leader/Supervisor (Consumer) for Collaborative Support Programs of New Jersey, which provides consumer driven mental health services that support recovery and promote community living. Brice is a resident of Lindenwold, Camden County.

Sylvia Axelrod, MA, Executive Director of NAMI New Jersey (formerly New Jersey Alliance for the Mentally Ill), a leading self-help support, education and advocacy organization for individuals and families affected by serious mental illness. Axelrod is a resident of Basking Ridge, Somerset County.

Martin D. Cohen, President and CEO of MetroWest Community Health Care Foundation, Inc., a community health philanthropy that provides grants and other support to community health care organizations that meet the unmet health needs of a 25-town area west of Boston. Cohen is a nationally recognized expert on mental health issues. Cohen is a resident of Needham, Mass.

James M. Davy, Commissioner of New Jersey Human Services, an agency that serves more than 1 million of New Jersey's most vulnerable citizens. Under Davy's leadership, the Division of Mental Health Services contracts with 120 community mental health agencies and operates six psychiatric hospitals throughout the state. Davy is a resident of Pennington, Mercer County.

Linda Gochfeld, M.D., is Medical Director, SERV Behavioral Health Systems, Inc., a large multi-county program that provides a variety of housing and support services for people with serious mental illness and developmental disabilities. She is also Past President and Chair of the Public Psychiatry Committee of the New Jersey Psychiatric

Association and a Clinical Professor of Psychiatry, UMDNJ-Robert Wood Johnson Medical School. Gochfeld is a resident of Princeton, Mercer County.

John V. Jacobi, Seton Hall Law School Professor and Associate Director of the school's Institute of Law and Mental Health. Jacobi previously served as Assistant to the New Jersey Public Advocate. Jacobi is a resident of Westfield, Union County.

Jerome J. Johnson, President and CEO of Family Service Association, which provides services such as outpatient counseling, day care, partial hospitalization, and work programs. Johnson is a resident of Winslow Twp-Camden, Co. NJ and works in Egg Harbor, Twp. NJ.

Christopher Kosseff, President and CEO University Behavioral HealthCare (UBHC) of The University of Medicine and Dentistry of New Jersey. UBHC provides comprehensive behavioral healthcare to residents across New Jersey. It is one of the largest behavioral healthcare systems in the United States, serving more than 25,000 people annually. Mr. Kosseff has 30 years of experience as a clinician and administrator. Kosseff is a resident of Monroe Township, Middlesex County.

Kevin Michael Martone, President & CEO of Advance Housing, Inc., a non-profit provider of affordable housing and support services to people with mental illness throughout northern New Jersey. Mr. Martone is also the Vice President of the Supportive Housing Association of NJ (SHA), a statewide advocacy organization that promotes supportive housing opportunities for people with disabilities. Martone is a resident of Jefferson Twp, Morris County.

Ange Puig, Ph.D., a licensed psychologist in a private practice for over 25 years. His practice focus is the treatment of victims of trauma and violence, police psychology and addiction issues. He is a consulting psychologist for several children's treatment programs & a certified NOVA traumatic stress specialist. He sits on a number of community Boards & provides training for providers locally & nationally. He is a resident of Burlington County.

Acting Governor Codey also appointed an Executive Director and Senior Policy Advisor to lead the Task Force through its 4.5 month project, to assist in navigating the system, government and to ensure access to the necessary resources.

Kimberly S. Ricketts, M.Ed., Executive Director, Task Force on Mental Health, served in the Department of Community Affairs (DCA) for more than two years, most recently as Chief of Staff. Before joining DCA, Ricketts spent 13 years working in behavioral health and social services with families, children and provider organizations in North Carolina, Florida and New Jersey. Ricketts is a resident of Highland Park, Middlesex County.

Larry DeMarzo, Senior Policy Advisor, Governor's Office, serving as a Senior Policy Advisor to Acting Governor Codey since November 2004, Mr. DeMarzo was responsible for the initial selection of the members of the Governor's Mental Health Task Force and serves as an advisor to the panel. He has participated in the task force meetings, public hearings and executive sessions. On behalf of the Acting Governor, Mr. DeMarzo also works on issues relating to the Department of Human Services, as well as health, education and consumer issues. As former chief of staff in Mr. Codey's legislative office, Mr. DeMarzo was responsible for a wide range of legislative and constituent issues, with an emphasis on health care and human services – including overall responsibility for passage of the Health Care Cost Reduction Act, the Physicians Conduct Reform Act and numerous other pieces of legislation dealing with mental health, hospitals, nursing homes, and education. He worked with then-Senator Codey on his investigation of conditions at Marlboro Hospital and was responsible for subsequent legislation dealing with hiring practices at State institutions.

Additional expertise was recruited to guarantee that each of the eleven advisory committees had appropriate leadership and resources to adequately and efficiently review, evaluate and make concrete draft recommendations to the Task Force. The unconditional dedication and commitment of these individuals as Advisory Committee Chairs and Co-Chairs, was key to the success of the Task Force, the mental health initiatives in the Governor's budget and the report.

James Lape, Chair, Hospital Advisory Committee, Vice President of Behavioral Health & Psychiatry at Trinitas Hospital, Elizabeth, has been a leader in New Jersey behavioral health and human services initiatives since 1973. The Mountainside resident is a founder and first president of the New Jersey Mental Health Institute, and is a past president of the Mental Health Association of New Jersey and the New Jersey Association of Mental Health Agencies. He is also Chair of the New Jersey Hospital Association Behavioral Health Constituency Group. Mr. Lape's background reflects a broad variety of perspectives including community, state government and the profit and non-profit sectors. His experience spans juvenile and adult criminal justice, HIV and workforce development systems.

In his role at Trinitas Hospital, Mr. Lape has created the largest psychiatric service in an acute care hospital in New Jersey, with 92 inpatient beds and 190,000 outpatient visits. At Trinitas he opened a new 21-bed involuntary psychiatric unit, and a 10-bed unit for the treatment of the dually diagnosed, representing a first in New Jersey. A licensed nursing home administrator, Mr. Lape serves as the administrator of the 120-bed Brother Bonaventure Extended Care Center at Trinitas Hospital. Mr. Lape received a Masters Degree in Business Administration and a Masters in Psychology from Fairleigh Dickinson University.

Barbara Maurer, MA, LPC, CTS, Emergency Preparedness/Trauma Advisory Committee, is a Licensed Professional Counselor and Certified Trauma Specialist, credentialed by the Association of Traumatic Stress Specialist (ATSS). She is a trained art therapist, Critical Incident Stress Debriefing, EMDR therapist and clinician with 17 years postgraduate experience in clinical and administrative supervision. Ms. Maurer has served as the Director of the Trauma Institute, Director of the Psychiatric Emergency Screening Program and is one of the founding members of The Trauma in Youth Program (TYP). Currently, Ms. Maurer has a private practice and provides consultation and training. Ms. Maurer currently consults for the N.J. Partnership for Children, The Care Maintenance Organizations and the N.J. DYFS Training Academy. She is providing "Risk Assessment" identifying suicidal, homicidal and self-injury behavior in children and adolescents.

John Monahan, LCSW, Criminal Justice Advisory Committee, is the founding President & CEO of Greater Trenton Behavioral HealthCare. He is a licensed clinical social worker with over 30 years experience. He is a Past President and current board member of the New Jersey Association of Mental Health Agencies, as well as a board member of NAMI New Jersey. He is also Treasurer and board member of the New Jersey Mental Health Institute, and Treasurer and founding board member of Capital County Children's Collaborative. He also serves on numerous state and local planning bodies addressing such problems as emergency response, homelessness, criminal justice, school-based services, services to high risk children and adults, among other issues.

Robert Parker, MPA, Employment, Support and Rehabilitation Advisory Committee, Executive Director, of NewBridge Services, Inc., has 30 years of community mental health leadership and experience. For the past 12 years, Mr. Parker has served as Executive Director, where he has been responsible for overseeing operations and program development. Previously, he served as Associate Director for Planning and Development and Youth Services Director. Prior to joining NewBridge, Mr. Parker worked at Bayshore Youth Services Bureau, where he served as an Assistant Bureau Director, Outreach Services Director and Program Director. He is a member of the Board of Directors of the Supportive Housing Association of New Jersey, is immediate past President of the New Jersey Association of Mental Health Agencies, serves as a member of the Passaic and Morris Mental Health Professional Advisory Committees and is an Officer of the Board of Directors of the Morris County Mental Health Coalition. In addition he is a member of the Passaic County Advocates for Supportive Housing, Morris County PAC Housing Sub-committee, New Jersey Mental Health Coalition, Youth Council of the Morris/Sussex/Warren Workforce Investment Board, and Passaic County Addictions Professional Advisory Council.

Paula Sabreen, LCSW, Children's Advisory Committee, Executive Director, FAMILYConnections. Ms. Sabreen has dedicated more than thirty years to improving mental health services for children and adults in New Jersey. Since 1995, she has been Executive Director of FAMILYConnections, a community mental health and substance abuse treatment center in Essex County. During that time, she has overseen the development of several new evidence-based model programs for children and teenagers and their families while also serving on the Board of Directors of the New Jersey Association of Mental Health Agencies and on many local and State planning groups and advisory boards. Prior to taking over at FAMILYConnections, Ms. Sabreen was Assistant Vice President at Newark Beth Israel Medical Center, in charge of the Community Mental Health Center/Dept. of Psychiatry and the Child Day Care Center. She also worked extensively as a therapist and director in both outpatient and partial care facilities for the mentally ill, and as a field instructor and faculty advisor for Rutgers University and other Graduate Schools of Social Work

Terri Wilson, LCSW, New Jersey Department of Human Services (DHS) Deputy Commissioner Terri Wilson was appointed in June 2002. Ms. Wilson oversees five of the department's divisions, which provide services to more than one million New Jersey residents with disabilities. These divisions employ more than 14,000 employees, and include: Developmental Disabilities; Mental Health Services; Deaf & Hard of Hearing; Disability Services and the Commission for the Blind & Visually Impaired.

Ms. Wilson has extensive experience in the development of community programs, services and supports for people with disabilities; as well as with facilities certification and accreditation to meet the standards of the Centers for Medicare and Medicaid (CMS) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Prior to her joining DHS in 1988, Ms. Wilson was an Assistant Director and Executive Director of SERV Centers of NJ Inc., a private mental health services provider, for ten years.

Task Force Outreach and Public Input

Beginning with two meetings on November 16, 2004 with Acting Governor Codey, the Task Force as a whole and its Executive Team, consisting of the Task Force Chair, Executive Director and Senior Policy Advisor, began the important process of community outreach and public input to ensure the accurate collection of information entailing the current state of New Jersey's mental health system, identifying successes, failures, areas in need of improvement and new ideas.

Including the Task Force work sessions, Advisory Committee meetings, field visits, public hearings, and Executive Team meetings, all total, close to 200 meetings were conducted. Work sessions, meetings, field visits and public hearings were held across the State, from Atlantic and Burlington Counties to Bergen and Morris Counties and throughout.

The Task Force held 20 work sessions between November 2004 and March 2005; the Advisory Committees collectively held a minimum of 50 meetings and additionally three public hearings were held in January 2005 in Bergen, Middlesex and Camden Counties. The public hearings were hosted by the respective County Colleges and staffed by professionals from the Department of Transportation, Department of Human Services and the Governor's Office of Constituent Response. With a total of close to 600 people in attendance, 230 persons providing oral testimony in 13.5 hours and more in writing, the public hearings provided the Task Force with invaluable information from which issues were identified and recommendations incorporated into the final report.

Mental Health organizations provided meeting space and tours in their facilities, which provided first hand knowledge and interactions for the Task Force members and the Advisory Committee Chairpersons. These included:
Greater Trenton Behavioral Health in Mercer County;
the Juvenile Justice Commission, Hayes Girls Unit in Burlington County;
Comprehensive Behavioral Health Care CAP Drop-in Homeless Center and Bergen Pines Regional Medical Center in Bergen County;
University Behavioral Health/UMDNJ in Middlesex County;
Hispanic Family Center of Southern New Jersey in Camden County;
the ICE Program (Self-Help Center) in Atlantic County;
the CHAMP program, cooperatively operated by Community Hope and Comprehensive Behavioral Health Care, and a tour of Greystone Psychiatric Hospital in Morris County;
Anne Klein Forensic Hospital and Trenton Psychiatric Hospital in Mercer County.

Additionally, meetings and discussions, sometimes multiple occurred with the following legislators, professionals, and organizations:

Legislators:

Senator Adler, Senator Allen, Senator Cardinale, Senator Karcher
Senator Sweeney, and Senator Vitale.

Assemblyman Blee, Assemblyman Carraballo, Assemblyman Cryan, Assemblyman Fisher, Assemblyman McKeon, Assemblyman Morgan, Assemblyman Payne, and Assemblywoman Previte.

Organizations and Professionals:

- Office of the Child Advocate;
- NJ American Academy of Pediatrics;
- NJ Protection & Advocacy;
- Regional Office of the US Department of Health and Human Services; NJ Association of County Colleges;
- NJ County Mental Health Administrators;
- Communication Workers of America;
- NJBIA;
- SAMHSA;
- North Carolina mental health providers;
- Illinois mental health providers; NJAMHA;
- Department of Human Services fiscal staff;
- Youth Consultative Services;
- Consumer Public Policy Committee of the Consumer Advocacy Partnership;
- Kathi Way-Deputy Commissioner DHS;
- Tourettes Syndrome NJ Association;
- NJ Eating Disorders Association;
- Center for Family Guidance;
- Alan Kaufman, Division Director, DMHS;
- Dennis Lafer-Former Assistant Division Director DHS;
- Former DHS Commissioner William Waldman;
- NJFAM;
- Community Health Law Project;
- Associated Treatment Providers;
- NJ Home Care Association;
- Retired Judge Hyland;
- Mr. and Mrs. Katznelson;
- NJ Juvenile Fire setter Program;
- Jay Herschberg, OLS;
- NJ Hospital Association;
- Seton Hall University Intro to Social Work;
- Value Options;

- St. Peter's Medical Center;
- Hispanic Director's Association of NJ;
- NJ CARES (Martin Finkel and Esther Deblinger);
- Catholic Charities Diocese of Trenton and Diocese of Metuchen;
- The ARC of NJ;
- Cerebral Palsy of Middlesex County;
- Association of Community Treatment Providers;
- John Hulick-NCAAD;
- NASW NJ;
- Nancy Wolff of Rutgers University;
- Mary Zdanowicz of the Treatment Advocacy Center;
- Bill Dressel of the League of Municipalities;
- the NJ Child Welfare Reform Panel;
- Union County Prosecutor;
- Dr. Bipin Patel;
- Dr. Steven Kairys;
- Dr. Meg Fisher;
- Dr. Rosenberg

Public Input

When Governor Codey signed the executive order creating the Task Force on Mental Health, he purposely called for significant public input into the Task Force's review of New Jersey's mental health system and the development of recommendations for improving the delivery of and access to mental health services in New Jersey. Three public hearings were convened in Bergen, Middlesex and Camden Counties. In addition to these formal structures, the general public was also invited to share their stories about mental health care in New Jersey through a special section of the Task Force's website established for this purpose.

Public Hearings

The most important opportunities for public input into the Task Force's work were three public hearings strategically held across the state. Hearings were held at Bergen County Community College (January 5, 2005), Middlesex County Community College (January 12, 2005) and Camden County Community College (January 19, 2005). At each public hearing, Task Force members were present to receive written and oral testimony from interested community members.

In the three hearings combined, close to 600 people were in attendance and 230 individuals testified. In all, there was 13.5 hours of public testimony before the Task Force. Those testifying before the Task Force represented every aspect of New Jersey's mental health system. Testimony was received from family members, consumers, municipal and county officials, advocates, and employees of state, county and private mental health organizations.

Each person who spoke at the public hearings shared their own unique perspective about New Jersey's public mental health system. Whether it was a consumer talking about their own history with the "system", or a family member speaking about their family's ordeal in trying to get help for a loved one, the testimony was always poignant and often filled with emotion. Many of those who testified said how difficult and painful it was for them to share their stories, but how necessary it was if meaningful change was to occur.

Although each person who testified offered something new, there were several recurring issues in the 13 + hours of testimony. Many people spoke about their difficulty in trying to get treatment, especially when confronted with a psychiatric emergency, and the consequences that they and their families faced because of the lack of timely and effective treatment. Many said it was difficult to know where the "front door" to the system was, or who was ultimately responsible or accountable for the provision of mental health services in their community. Others spoke about the lack of appropriate supportive housing and rehabilitative services once they were ready to leave hospital level care. The conditions at many of the state's board and care homes were also identified as problems needing correction.

Other testimony included the difficulty that health and human services organizations in New Jersey face in trying to recruit and retain qualified mental health treatment staff. Low wages, and the lack of staff training opportunities have led to a decline in the level of expertise available to treat serious mental illnesses in the community. The need for more effective use of evidence-based best practices in the treatment of mental illness was also noted.

Perhaps the most important message received from those who spoke at these public hearings was the feeling of **hope** that people had for a better mental health system in New Jersey. Many of those who testified said that the actions of Governor Codey to create the Task Force and shine a spotlight on the needs of people with mental illness gave them hope that the system would improve. For the first time in many years, they expressed hope that there would be effective treatment available to people when they need it, a safe and affordable place to live and receive care, and competent and qualified caregivers ready to assist them in their on the road to recovery and wellness.

Web Stories

In addition to the public hearings and coordinated meetings, the general public had access to the Governor's Office and the Task Force via the website established for the Task Force on Mental Health.

There were opportunities for individuals to share success stories and tell the Task Force and Governor about programs and services that work in New Jersey as well as an opportunity for individuals to provide e-Testimony. Also included on the website was a link to the Department of Human Services, Division of Mental Health, where individuals seeking assistance for themselves, a family member, friend or colleague, could have a direct link to state professionals and resources.

All total, over 400 hundred emails were received and the topics, suggestions, ideas and stories incorporated accordingly into the process.

Overview of Mental Health and Mental Illness

Mental health—the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity; from early childhood until late life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self-esteem.

Mental illness—the term that refers collectively to all mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.

*excerpted from *A Report of the Surgeon General*; 1999²

The achievement of mental health, whether a deliberate, subconscious or instinctive effort, is an objective that we as human beings strive for every day. Good mental health is inextricably linked with overall health, and crucial to quality of life. However, mental health is not static, and many factors influence our well being on a regular basis. For many people, mental illness significantly impacts the ability to experience mental health and overall wellness. Yet, as the mental health field evolves, more people are seeking treatment and achieving better mental health.

It is important to understand, though, that mental disorders are common. An estimated 22.1 percent of Americans ages 18 and older—about 1 in 5 adults—suffer from a diagnosable mental disorder in a given year.¹ When applied to the 1998 U.S. Census residential population estimate, this figure translates to 44.3 million people.³ In addition, 4 of the 10 **leading causes of disability** in the U.S. and other developed countries are mental disorders—major depression, bipolar disorder, schizophrenia, and obsessive-compulsive disorder.ⁱⁱ Approximately 15 percent of all adults who have a mental disorder in one year also experience a co-occurring substance (alcohol or other drug) use disorder, which complicates treatment.⁴

Mental illness and mental health are experienced differently across the life span, and are influenced by many factors, including social and cultural. It is all too common for people to appreciate the impact of developmental processes in children, yet not to extend that conceptual understanding to older people. In fact, people continue to change throughout life. Different stages of life are associated with vulnerability to distinct forms of mental and behavioral disorders but also with distinctive capacities for mental health.ⁱⁱⁱ

² Regier DA, Narrow WE, Rae DS, et al. The de facto mental and addictive disorders service system. Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry*, 1993; 50(2): 85-94.

³ Murray CJL, Lopez AD, eds. *Summary: The global burden of disease: a comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020*. Cambridge, MA: Published by the Harvard School of Public Health on behalf of the World Health Organization and the World Bank, Harvard University Press, 1996.

⁴ U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General—Executive Summary*

As discussed in the Surgeon General's report on mental health in 1999, several overarching themes are evident through a review of available research. First, mental health programs, like general health programs, are rooted in a population-based public health model.⁵ This broad perspective concentrates on the health of a population in its entirety and focuses beyond just diagnosis and treatment to other areas, including prevention and access to services. Considering the pervasiveness of mental illness in the United States, mental illness is a public health issue.

A second theme is that mental disorders have a much greater impact on overall health and productivity than previously thought. In fact, mental illness is the second leading cause of disability and premature mortality in the United States. Mental disorders collectively account for more than 15 percent of the overall burden of disease from all causes and slightly more than the burden associated with all forms of cancer.^{iv}

The idea that mental health and mental illness are points on a continuum is another important theme. The differentiation between the two is not a polarized concept because mental health is not easy to define and can vary across various sub-cultures, for example. Furthermore, people will experience transitory mental health "problems" over time, those that do not reach a diagnosable disorder, for several reasons over their life span. The death of a spouse, for instance, can be debilitating, but does not mean the person has lost their mental health to mental illness. Rather, their experience is movement along the continuum between overall mental health and a disabling mental illness.

Lastly, the theme that the mind and body are inseparable is important in helping society understand that the mind is as much a part of the body as, for example, the heart. Research is demonstrating abnormalities in brain chemistry for people with mental, as well as other disorders, and that physical changes occur in the brain in response to treatment, both pharmacologically and psychosocially. Even the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision acknowledges its use of the term "mental disorder" unfortunately implies a distinction between mental and physical disorders.⁶ The stigma associated with mental illness has roots in this mind/body split. The more research supports the mind and body as one it is likely that anti-stigma efforts will succeed.

The history of treating people with mental illness dates back thousands of years. Predominating views of people who displayed symptoms of mental illness were spiritual and religious in nature, and the goal of "treatments" was to rid the mind of spirits or demons. Inhumane, deplorable treatments were gradually replaced with more scientifically based interventions, and institutional settings gained momentum in the late

⁵ Murray, C.L., & Lopez, A.D. (Eds.). (1996). *The global burden of disease. A comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020*. Cambridge, MA: Harvard University.

⁶Regier DA, Narrow WE, Rae DS, et al. The de facto mental and addictive disorders service system. Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry*, 1993; 50(2): 85-94.

19th century. A point of note, the revolutionary promoter of humane treatment, Dorothea Dix, was instrumental in opening Trenton Psychiatric Hospital in 1881. Still, however, people with mental illness suffered at the hands of treatments of the day, including lobotomies, early electroshock and insulin shock therapies.

The mid-1950's ushered in a new era of treatment with the advent of psychiatric drugs (thorazine) that revolutionized patient care and provided for the first time ways for many people with mental illness to return to society. The 1960's through the 1980's saw massive deinstitutionalization efforts, some better than others, across the country in response to more efficacious treatment, the creation of community-based services and funding cuts.

All things considered, the mental health field has rapidly evolved over the past fifty years. Scientific research on the brain and behavior is telling us more and more every day about mental illness and mental health. Advances in imaging, the understanding of molecular and cellular biology, and sophisticated cognitive and behavioral science are enabling the field to increasingly understand the functioning of the human brain.

This research is being translated into effective treatments, both pharmacological and psychosocial, as well as preventative interventions. The pharmaceutical industry is continually interpreting research findings to create better psychotropic drugs that are enabling many people to manage their symptoms. Community-based services, especially when coupled with psycho-pharmacological therapy, are demonstrating evidence-based outcomes, and providing people in the recovery process greater opportunities.

Still, though, there is no cure for mental illness yet, people face a complex system to navigate, and stigma remains prevalent. We know that the efficacy of mental health treatments is well documented, and a range of treatments exists for most mental disorders. However, there is great concern that these issues pose significant barriers to recovery for people with mental illness. In actuality, scientific research and effective treatments are ahead of the availability of services and the user-friendliness of the system. The challenge is to encourage people to seek treatment, improve access to services, and make the mental health system more consumer and family centered and easier to navigate.

The voice of the consumer and family movement is now impacting the system at large by attacking stigma, preventing discrimination in policies, fostering recovery from mental illness and encouraging self-help. The consumer and family movement demands accountability equally from government and society, and is proving the resiliency of people with mental illness. The consensus that people can recover from mental illness will likely drive positive changes in how people with mental illness and their families receive services and are perceived by society.

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Overview of New Jersey's Mental Health Services

The New Jersey Department of Human Services (DHS) is responsible for overseeing the State's public system of adult mental health and child behavioral health services. Within the Department, several Divisions work to coordinate these services throughout the State. The Division of Mental Health Services (DMHS) is responsible for adult mental health services while the newly established Office of Children's Services, Division of Child Behavioral Health Services (DCBHS) coordinates the children's behavioral health system.

New Jersey

Small geographically compared with other states, New Jersey is considered the most densely populated State with 1,134 people per square mile and an overall population of 8.4 million people.⁷ Despite its density, the State consists of a mixture of urban, suburban and rural areas that present various challenges in delivering services. The State is also experiencing suburban sprawl with population shifts being observed from urbanized northeastern counties to more suburban regions to the south and west. Of the one million new state residents recorded over the past two decades, 700,454 reside in suburban municipalities where growth totaled 23 percent. Rural municipalities grew by 37 percent while urban municipalities grew only by 3 percent.

Other demographics demonstrate the uniqueness of New Jersey. Despite being one of the wealthier States in the country, approximately 8 ½ %, almost 700,000 individuals, in New Jersey live in poverty.^{vi} Furthermore, New Jersey ranks as one of the costliest housing markets in the country presenting significant challenges to low and moderate income individuals.⁸ The state is increasingly diverse with significant increases in non-Hispanic African Americans, Hispanics and Asians since 1990. Additionally, New Jersey's aging population is projected to see 30 percent growth in people 65 years and older in the decade between 2010 and 2020.

Based upon national figures, approximately 1 in 5 people experience a mental disorder in a course of a year. This means that close to 1.7 million New Jersey residents will experience some level of a mental disorder in a course of a year. In any given year, about 5% to 7% of adults, equating to over 500,000 people in New Jersey, have a serious mental illness, according to several nationally representative studies.^{vii} A similar percentage of children — about 5% to 9% — have a serious emotional disturbance.

Division of Mental Health Services

The stated mission of the New Jersey Division of Mental Health Services is to promote opportunities for adults with serious mental illness and children and adolescents with

⁷ US Census 2000. www.census.gov

⁸Kessler, R. C., Berglund, P. A., Bruce, M. L., Koch, J. R., Laska, E. M., Leaf, P. J. et al. (2001). The prevalence and correlates of untreated serious mental illness. *Health Services Research*, 36, 987-1007.

emotional and behavioral disturbances to maximize their abilities to live, work, socialize and learn in communities of their choice. The mission is realized by application of the following operating principles:

- Services are to be delivered by means of a comprehensive system of care, which emphasizes the most appropriate, least restrictive settings to promote the highest level of functioning;
- There must be continuity of care and coordination of services within the State and between the public and private sectors;
- The range of services within the system of care must respond to the needs of the individual consumers and to the special populations served;
- The Division must assure appropriate, high quality care for the State's most severely disabled citizens in State psychiatric hospitals and for the less disabled citizens in community programs.

The State primarily bears the burden of funding the public mental health system, but these services are frequently supported by other funding sources, including both Federal and County-based. Services are predominantly based in local communities where private agencies provide a wide variety of programs and services. The DMHS contracts with 120 not-for-profit agencies, which provide over 700 programs of services to over 200,000 adults annually, 140,000 of whom have serious mental illness (SMI). DMHS directly operates five state psychiatric hospitals that provide long-term in-patient care to about 2,300 on a daily basis to people with severe and persistent mental illness.

Outside of the publicly funded system, many people with mental illness receive services from other types of providers, including for-profit agencies and private practitioners (e.g. psychiatrists, psychologists, licensed professional counselors and social workers).

Community-Based Services:

DMHS funds and oversees a variety of services to people with mental illness and their families. Depending on a person's particular situation, they may receive one or more of these services at the same time. The following categories of community-based services are available throughout much of New Jersey:

- Programs of Assertive Community Treatment (PACT)
Outpatient Services
Integrated Case Management Services (ICMS)
Intensive Family Support Services (IFSS)
Systems Advocacy
Self-Help Centers
Deaf Enhanced Screening Center
- Residential and Supportive Housing Services
Designated Screening Centers
Supported Employment Programs (SEP)
Partial Care/Partial Hospitalization Services
Homeless Services (PATH)
Jail Diversion

Locally, each of New Jersey's 21 counties has a County Mental Health Board. These Boards, generally comprised of 7-12 county residents appointed by the county's board of chosen freeholders, review progress in the development of comprehensive community mental health services in the county and make recommendations to the local agencies and the Department of Human Services. Each county typically has various committees that report to the Mental Health Board, such as a Professional Advisory Committee and Systems Review Committee.

Hospital System:

New Jersey's hospital system consists of several short term care facilities (STCF), six county-operated and five State-operated hospitals that provide in-patient psychiatric care. STCF's are acute care adult psychiatric units in general hospitals for the short term admission of individuals who meet the legal standards for commitment and require intensive treatment. All admissions to STCF's must be referred through an emergency or designated screening center. STCF's are designated by DMHS to serve a specific geographic area, usually a county.

State and county psychiatric hospitals are authorized to accept persons in need of involuntary commitment under NJS 30:4-27.2 et seq. Admissions are only accepted from emergency screening centers and short term care facilities. Both types of hospitals generally provide longer term care than in STCF's.

Office of Children's Services, Division of Child Behavioral Health Services

New Jersey's system of care for children and adolescents is highly complex and is in the midst of a multi-year initiative of reform and transition. In 2000, DHS began the implementation of the Children's System of Care Initiative, which subsequently evolved into the Partnership for Children, and finally into the Division of Child Behavioral Health Services. This is occurring at a time when New Jersey has also begun a court-ordered reworking of its Child Welfare System in response to several high profile incidents involving children. The newly created Office of Children's Services within DHS now acts as a single umbrella over the three Divisions most concerned with children's welfare: the Division of Youth and Family Services, the Division of Child Behavioral Health Services, and the Division of Prevention and Community Partnership.

The stated goal of the Division of Child Behavioral Health Services is a comprehensive system of care based on the fundamental principle that children and adolescents have the greatest opportunity for normal, healthy development when ties to community and family are maintained. New Jersey has designed a reform agenda that attempts to maintain the integrity of family and community life for children while delivering effective clinical care and social support services.

The Child Behavioral Health Services System is supposed to serve all children with emotional and behavioral disturbances and their families who enter publicly funded systems, including child welfare, mental health and juvenile justice, from ages 0-18, as well as youth 18-21 who are transitioning to the adult system. The Child Behavioral Health Services System pools resources from Child Welfare, Mental Health and Medicaid, investing in new resources and managing those resources so that services are expanded and tailored to meet the needs of each individual child and family. The establishment of a system to register and track children and services is intended to enable the state to coordinate service development and monitor service delivery and costs for children with multiple needs and their families.

New Jersey is moving to complete the reform of children's services by integrating existing traditional services and adding new components to the statewide system of care. The roles of traditional services and service providers are shifting and opportunities to provide newer in-community services are expanding. As the Child Behavioral Health Services System unfolds, families are promised access to additional services, and they are intended to play the key role in selecting those services.

New Jersey's traditional system of services consists of statewide, regional, sub-regional, and county based services. In order to provide intensive services closer to home in alternative treatment settings, the state's single remaining state operated psychiatric hospital for youth, Arthur Brisbane Child Treatment Center (ABCTC), is scheduled to close by December 31, 2005. In the future, children requiring this level of treatment will be served by the Youth Consultation Services Residential Intensive Treatment Unit, University Behavioral Healthcare at UMDNJ or other alternate settings more accessible to families. Other traditional services include the following:

Screening/Emergency Services	Partial Care Programs
Case Management	School-based Youth Services
Psychiatric Community Residences	Children's Crisis Intervention Services (CCIS)
Outpatient Services	Case Assessment Resource Teams (CART)

As part of the State's new initiative, additional services are in the process of being created. Expanded case management is provided on three tiers consisting of 1) Care Coordination done by the *Contracted System Administrator* (CSA); 2) *Youth Case Management*, a moderate level of service and; 3) Intensive Care Management done by the *Care Management Organization* (CMO).

As the overall services management entity at the state level, the CSA (Value Options) authorizes, tracks and coordinates the services and care provided to meet the needs of all children, adolescents and their families entering the system. CMO's are separate entities whose sole mission is to provide individual case management and coordinate services through a network of local, community-based providers. At this time, only ten counties have a CMO.

In addition, Family Support Organizations (FSO) connect families participating voluntarily to other parents and support services to ensure that Individual Service Plans

(ISP) are child centered and family friendly. The FSO's are particularly involved in ISPs developed for children and families with complex issues, needing care coordination and community-based care management. Currently, seven FSO's are in operation or under development.

Other expanded formal and informal services planned throughout the State will include the following:

Assessment: Screening, Evaluation, Diagnosis	Mobile Response and Stabilization Services
Out-of-Home Crisis Stabilization Services	Partial Care
Acute Inpatient Hospital Services	Intensive In-Home Services
Residential Treatment Center Care	Behavioral Assistance
Group Home Care	Wraparound Services
Treatment Homes/Therapeutic Foster Care	Family Support
Intensive Face-to-Face Care Management	Child and Family Team (CFT)
Outpatient Treatment	Liaison to the Judiciary-Trial Courts

DOMAINS OF STUDY

Stigma

Treatment, Wellness and Recovery

Housing

Children

System Design

Hospitals

Criminal Justice

Employment, Support and Rehabilitation

Community Mental Health Infrastructure and Efficiency

Emergency Preparedness/Trauma

Parity

STIGMA

FIGHTING THE STIGMA OF MENTAL ILLNESS

I. OVERVIEW

Stigma is one of the greatest barriers to treatment today. According to Surgeon General's Report on Mental Health issued in 1999: "Nearly two-thirds of all people with diagnosable mental disorders do not seek treatment (Regier et al., 1993; Kessler et al., 1996). Stigma surrounding the receipt of mental health treatment is among the many barriers that discourage people from seeking treatment (Sussman et al., 1987; Cooper-Patrick et al., 1997)."

This Surgeon General's Report on Mental Health further emphasizes the impact of stigma. "Stigmatization of people with mental disorders has persisted throughout history. It is manifested by bias, distrust, stereotyping, fear, embarrassment, anger, and/or avoidance. Stigma leads others to avoid living, socializing or working with, renting to, or employing people with mental disorders, especially severe disorders such as schizophrenia (Penn & Martin, 1998; Corrigan & Penn, 1999). It reduces patients' access to resources and opportunities (e.g., housing, jobs) and leads to low self-esteem, isolation, and hopelessness. It deters the public from seeking, and wanting to pay for, care. In its most overt and egregious form, stigma results in outright discrimination and abuse. More tragically, it deprives people of their dignity and interferes with their full participation in society."

People with mental illness are likely the most socially excluded group in New Jersey. Stereotypes about mental disorders result in discrimination by others and shame of one's self. The stereotypical association of mental illness with violence further stigmatizes all who have a mental illness, especially minority populations.

Stigma erodes the certainty that mental disorders are real, treatable health conditions similar to any medical disease. Stigma blocks individuals with mental illness from seeking employment opportunities, obtaining insurance coverage, obtaining housing and receiving appropriate treatment.

- Many people are reluctant to seek care because of the shame our society attaches to mental illness. Societal stigma leads to ridicule, ostracism, and inexcusable discrimination in housing and employment. Stigma is often internalized by individuals with mental illness, leading to hopelessness, lower self-esteem, and isolation. Even more tragically, stigma deprives them of the social support they need to recover.

- Consumers and family members face stigma and discrimination not only through community attitudes, but at times, also within the mental health system itself. Consumers have stated that in some circumstances mental health professionals may not foster attitudes that reflect wellness and recovery as realistic goals. Family members of individuals with serious mental illness have stated that mental health professionals often display attitudes that reinforce the notion that "families are to blame." and overly apply HIPPA Laws (Health Insurance Portability and Accountability Act of 1996), creating a barrier in working together to benefit from the knowledge and support family members can offer. Family members want to be allies in their loved ones' treatment but find themselves left out and uninformed of treatment plans and progress. They report this occurs even when they are the primary caregivers for their loved one with mental illness.
- **Consumers have realistic fears about disclosure of their mental illness will affect their employment, access to health insurance, friendships and daily activities. Many consumers and family members give examples of the negative impact of disclosure of mental illness underscoring the need for training and education of employers, consumers, and community members to end the stigma associated with mental illness and reduce barriers to participation in community life.**
- Insurance "dis-parity" is a profound manifestation of discrimination about mental illness. If insurers or employers sought to severely limit coverage for any other whole area of illness, the public outcry would be swift and loud.
- A related area of mental illness discrimination is in how we compensate our mental health work force. Mental Health workers working in community agencies often receive profoundly lower salaries than those doing comparable work in state facilities, education, law enforcement, health care, or child welfare. This disparity results in difficulty attracting and retaining a high quality and sufficient quantity of practitioners of psychosocial rehabilitation and related services, and sends the troubling message that people with mental illness and those who care for them are less worthy.

(See Appendix A: Sources and Types of Stigma)

II. SUMMARY OF KEY FINDINGS

It is this committee's position that combating stigma must be a top priority in our effort to create a better mental health system in New Jersey. The committee findings are consistent with the Surgeon General's Report that states: "Overall approaches to stigma reduction

involve programs of advocacy, public education, and contact with persons with mental illness through schools and other societal institutions (Corrigan & Penn, 1999).”

The President's New Freedom Commission on Mental Health also recommends the need to “Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.”

New Jersey has a multitude of mental health organizations, including governmental agencies, advocacy groups, local mental health centers, private outreach groups, etc. Each of these groups targets the mental health of our citizens in its own unique way. Many have developed programs that target community education and anti-stigma efforts. We could drastically improve the impact of mental health education and treatment in New Jersey with a unified, organized, and statewide effort to fight stigma.

- Targeted public education can increase awareness about the effectiveness of mental health services, encourage people to seek treatment, and reduce the stigma and discrimination associated with mental illnesses.
- Media-oriented and other types of mental health awareness campaigns to inform the public about where and how to obtain help, collaboration between the public and private sectors, and close coordination with consumers and other stakeholders is encouraged to reduce the sending of mixed and/or duplicated messages to the public.
- Campaigns that use a multi-faceted approach, which includes various public education strategies, direct consumer-to-target audience interpersonal contact methods, such as dialog meetings and speakers' bureaus, should address and promote the themes of recovery and the positive societal contributions that people with mental illnesses make to correct the many misperceptions associated with these illnesses.
- Research shows that the most effective way to reduce stigma is through personal contact with someone with a mental illness.

III. RecommendationS

Establish a “Governor’s Council on Stigma” ” with broad representation by consumer and family members, mental health and health professionals, media, insurance, government, pharmaceutical industry, business, law enforcement, clergy and education. The mandate of the Council will be to develop a master plan organizing the activities in the state aimed at increasing awareness and understanding of mental disorders and overcoming the stigma associated with mental illness via the coordinated efforts of existing and new initiatives.

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illness via the coordinated efforts of existing and new initiatives with activities throughout the state aimed at increasing awareness and understanding of mental disorders and overcoming the stigma associated with them.

A. Hold a Governor’s Summit on Mental Health Stigma to generate public ideas and media interest in overcoming stigma, and to highlight current and proposed education and awareness programs. A recommended time for the Summit is October during Mental Illness Awareness Week. (The first full week in October.)

B. Establish a three-year action plan that would develop strategies to partner local communities and existing organizations. The goal of these groups would be to work on efforts to promote new initiatives that would have the following objectives. (* See outline below for details.)

1. Increase community awareness
2. Promote prevention and early intervention via educational programs
3. Increase consumer and family participation
4. Promote targeted research and evaluate anti-stigma efforts

C. Provide education and awareness programs from the perspective of consumers and family members to sensitize mental health staff and providers about the impact of stigmatizing attitudes and actions that exist within the mental health system and state government including legislators. These programs will feature consumers and family members who are able to speak from first hand knowledge and experiences.

1. Utilize existing and new programs that include the first hand experiences of consumer and family members.
2. Ensure this initiative is carried out by assigning coordination functions to a council staff person or contracted agency.

* RECOMMENDED THREE-YEAR ACTION PLAN OBJECTIVES

A. Increase Community Awareness

1. Develop a Governor’s Council on Stigma Website linked to www.nj.gov/mentalhealth, which includes referral links.
2. Work with the media:
 - a. Educate media journalists (TV, radio, newspapers, magazines, movies).
 - b. Use website for supplying facts and statewide resources.
 - c. Advertising campaign: (PSAs on TV, movies, radio, and transportation locations.) Utilize celebrities speaking on mental health facts, i.e. mental illness is a medical illness, affects everyone, symptoms and resources.

- d. Promote television plot development on mental health issues.
 - e. Support “media watch” group on stigmatizing stories, etc./damage control.
3. Work with young people:
- a. Establish mandated educational programs in schools targeting students, faculty, administration and parents.
 - b. Extend all educational programs to include college students, faculty and administration.
 - c. Distribute “catchy” informative material via psa’s, pamphlets, website, and possible involvement in youth program (partner with other youth programs).
 - d. Establish joint marketing efforts with teen oriented companies.
 - e. Organize Youth Advisory Councils to help with these efforts.
4. Work with community:
- a. Reach out to local organizations.
 - b. Offer community forums/speakers bureau.
 - c. Educate volunteers
 - d. Provide advocacy
 - e. Develop resources, e.g. hotline (one aimed at adults and one aimed at youth).
 - f. Outreach to seniors, pre/post natal, and other “specialty” groups.
 - g. Develop resources to combat, NIMBY – “not in my back yard”

B. Promote prevention and early intervention via educational program

1. Raise awareness in workplace. Training programs, posters, pamphlets and identification of website for information.
2. Use role models: Athletes, celebrities to deliver message. This approach might be targeted to specific multi cultural/language populations.
3. Aim at “positive choices:” Rejecting substance abuse.
4. Promote peer Support groups: Families of individuals affected by mental illness, parent education, etc.
5. Provide multicultural/linguistic programs: Specifically provide programs aimed at early intervention (treatment at early stages of illness: pre crisis).
6. Improve training by including appropriate information about mental illness:
 - a. Primary care physicians, both in medical school as required training and continuing education for physicians. (Mandated by governor)
 - b. Judicial/Law Enforcement, Fire Departments and EMT Staff. (Mandated by governor)
 - c. Clergy (Recommended)

C. Increase consumer and family first hand testimony about their experiences with mental illness

1. **Support awareness programs that use consumers and family members in relating their person experiences about to treatment and recovery.**
2. **Encourage consumer and family member to participate in public and professional mental illness and mental health awareness programs and activities.**
3. **Include multicultural representation.**

D. Promote targeted research and evaluate anti-stigma efforts

1. School Research:
 - a. Conduct school summit.
 - b. Encourage school-based study as to best approach to educating children teachers and administration.
2. Targeted Research:
 - a. Encourage targeted studies dealing with focused projects such as dual diagnosis, substance abuse, relapse, elder care and interdisciplinary work.
 - b. Promote research about mental illness, screening and recognition of varying conditions i.e. postpartum depression, etc.
 - c. Survey and evaluate the impact of anti-stigma efforts.

Appendix A

Sources and Types of Stigma

By Robin Cunningham

The stigma and fear associated with serious mental illness is an issue because it is destructive of individuals and society, and a problem because it leads to unnecessary discrimination that is enormously expensive for the patient (“consumer”), families and government.

Serious mental illnesses are indiscriminate, affecting individuals in equal proportions regardless of their social status, financial position, education, employment, celebrity, race, ethnicity, intelligence and so on. It is now estimated that one in five US citizens will require the services of mental health care professionals during their lifetime and that in any given year, one in four families have one or more members who have a serious mental illness.

Serious mental illnesses are epidemic in our society, yet little attention is paid to these illnesses and the monies devoted to research seeking treatments and cures are miniscule compared with other illnesses of comparable frequency and severity. This lack of attention and scientific focus are the result, at least in part, of stigma.

Stigma is the product of half-truths and misinformation. These, in turn, reflect a lack of awareness of the greatly improved outcomes in the treatment of serious mental illnesses.

*Of those individuals with serious mental illnesses that **receive “best practice treatment” early in the course of their illness**, eighty per cent with depression or bipolar disorder and sixty per cent with schizophrenia, now achieve recovery, becoming productive members of society. These percentages represent better recovery rates than many other serious illnesses.*

Stigma is destructive of individuals with serious mental illnesses because fear of the associated discrimination leads many to eschew treatment. It is estimated that forty per cent of all consumers do not receive treatment, while many of those seeking treatment do not receive **best practice treatment**. Lack of efficacious treatment in the early stages of serious mental illness can lead to brain deterioration that may permanently destroy the individuals’ productive capacity. This results in years of unnecessary personal agony and enormous social costs.

The matrix of stigma in our society is extremely complex. On the pages that follow we have attempted to simplify some of these interrelationships through the use of illustrative diagrams. Although the analysis is a general in nature, it will make clear

where government can intervene first to mitigate, and then eventually to eliminate the damage produced by stigmatization of those with serious mental illness.

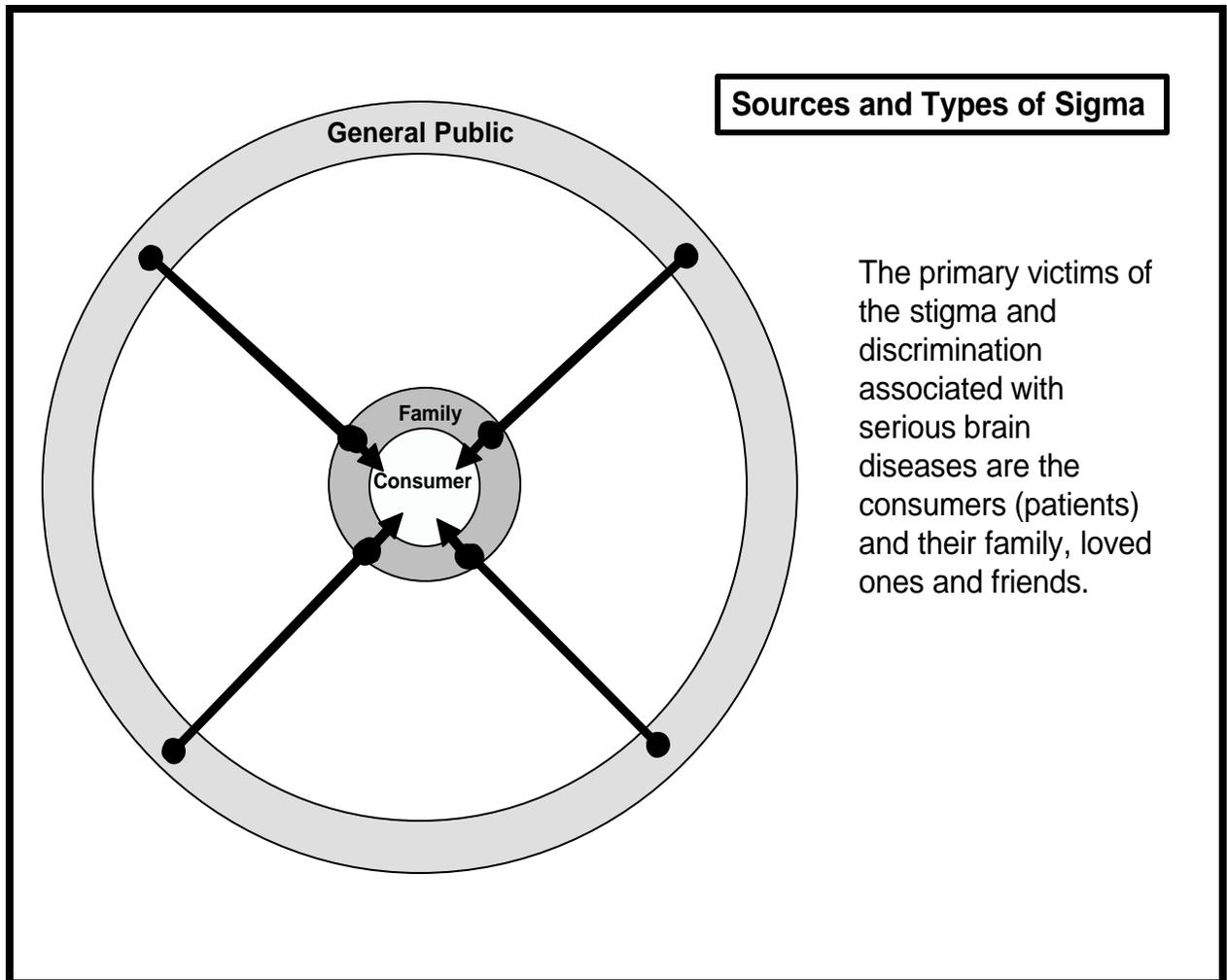


Diagram 1

Illustrates that the General Public is the Primary Source of Stigma Directed at Consumers and Their Family and Friends

The stigmatization of consumers and their families is grounded in the misconceptions of the general public.

Different subcultures within our society regard and treat those with serious mental illnesses in markedly different ways. However, almost all regard consumers as somehow flawed or inferior. These suppositions have no basis in fact. Unfortunately, both the actual and the potential contributions to society by consumers are universally underestimated.

The families of persons with a serious mental illness are frequently stigmatized by association. Many consider such families dysfunctional regardless of the facts. Often they are blamed for the illness within their ranks. Mental health care professionals are accustomed to excluding families from their patients' treatment plans. The families' day-to-day exposure to their loved one with a serious mental illness can yield valuable insights into the individual's problems. These observations and insights, which can be obtained by no one else, are routinely ignored.

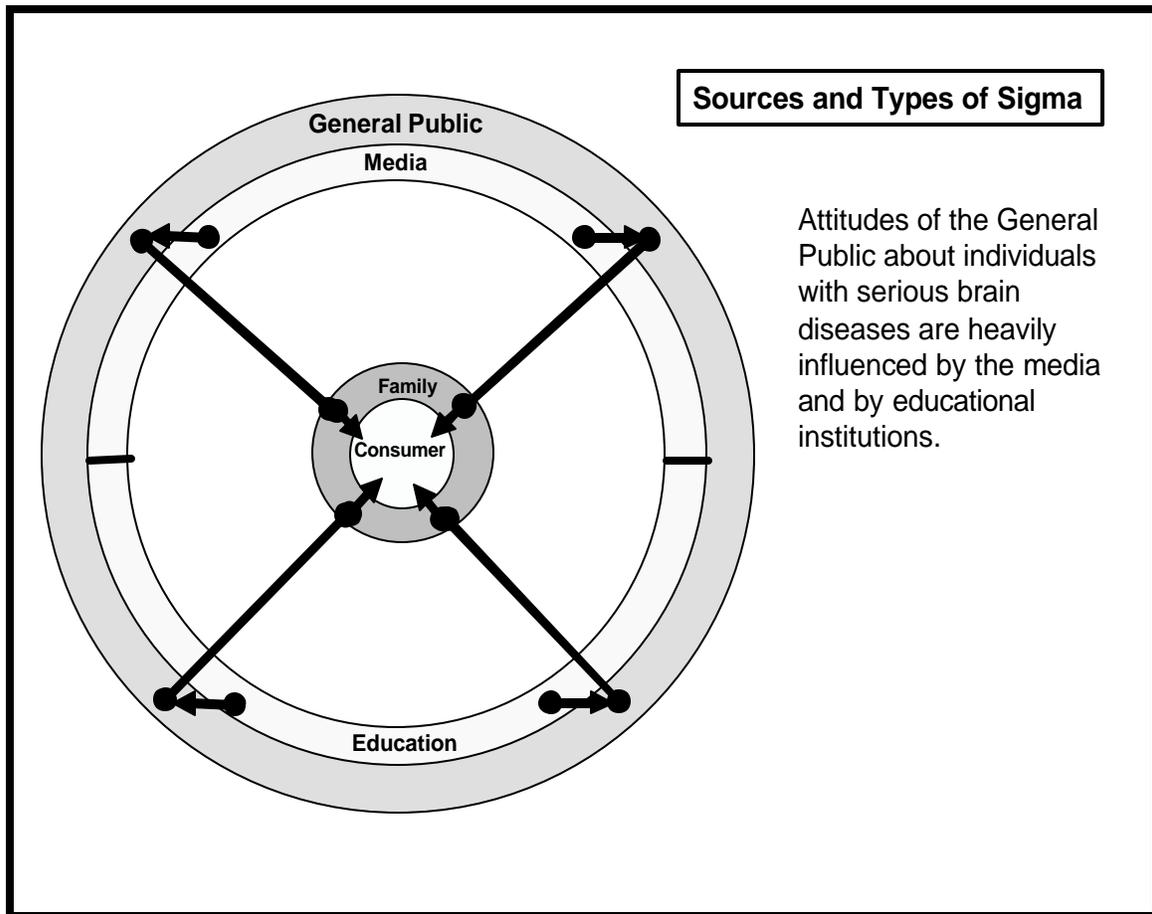


Diagram 2

Illustrates that the Media and Educational Institutions Can and Do Affect the General Public's View of Individuals with Serious Mental Illnesses.

The attitudes and knowledge of the general public about serious mental illnesses and the individuals that have these conditions are shaped by what they see and hear in the media, including news coverage and entertainment.

News coverage of events involving individuals with serious mental illnesses tends to be sensational in nature. Sensational stories about such individuals garner the public's attention. These stories increase ratings and circulation. Unfortunately, often little or no

background information or context accompanies these stories and this creates serious misconceptions.

First, such stories often give the impression that all individuals with serious mental illnesses are more dangerous than our citizenship as a whole. The facts state otherwise. Persons with serious mental illnesses are more likely to be the victims of crime than the perpetrators.

Second, murders occur every day in all our major cities. These are so common that they seldom make the evening news. However, a violent crime committed by someone with a serious mental illness often makes national headlines. This creates the misconception among the general public that they are constantly at risk.

The entertainment industry has thrived on creating “mentally ill” characters that perpetuate stereotypes, which are inaccurate in the extreme. They sell fear as an entertainment value. The cheap thrill of sensational or random slaughter is far more profitable than the boring truth. Again, the general public is encouraged to fear all individuals with a serious mental illness.

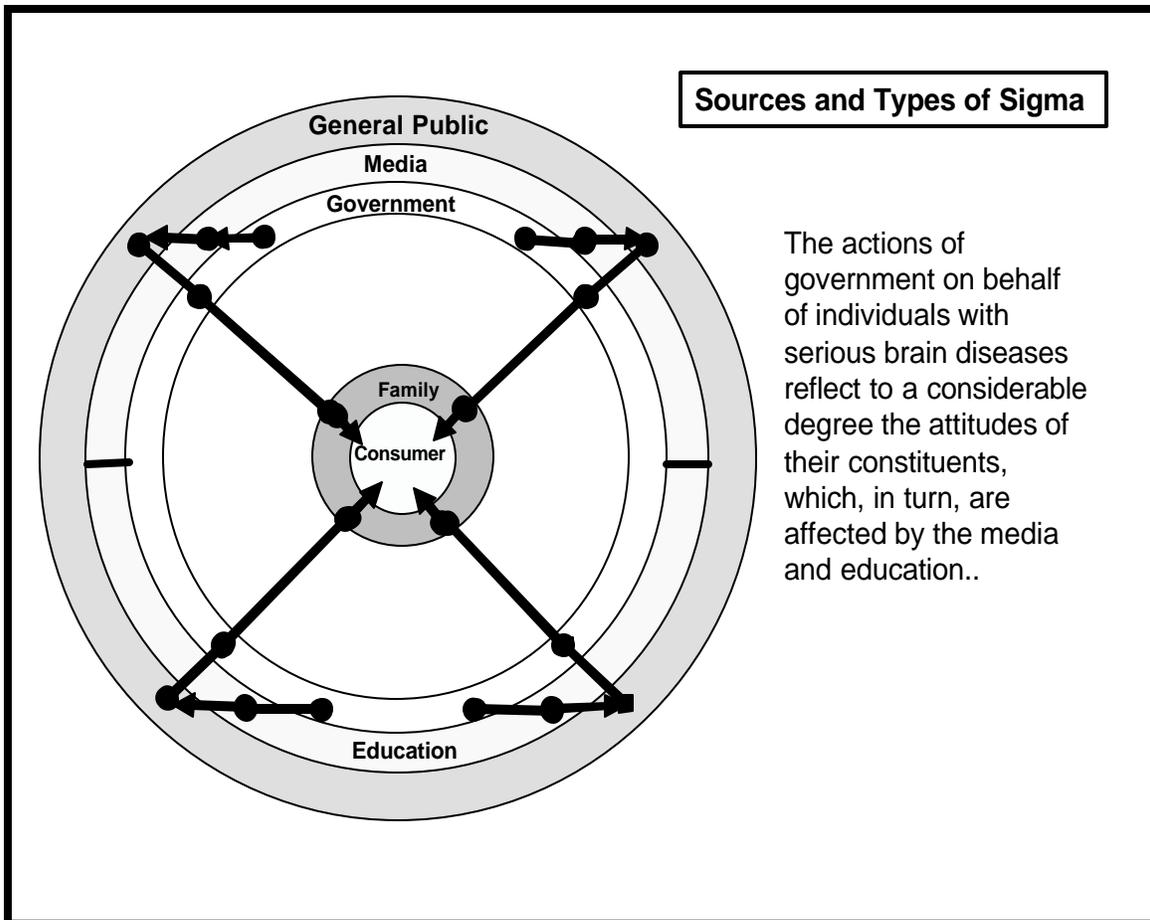


Diagram 3

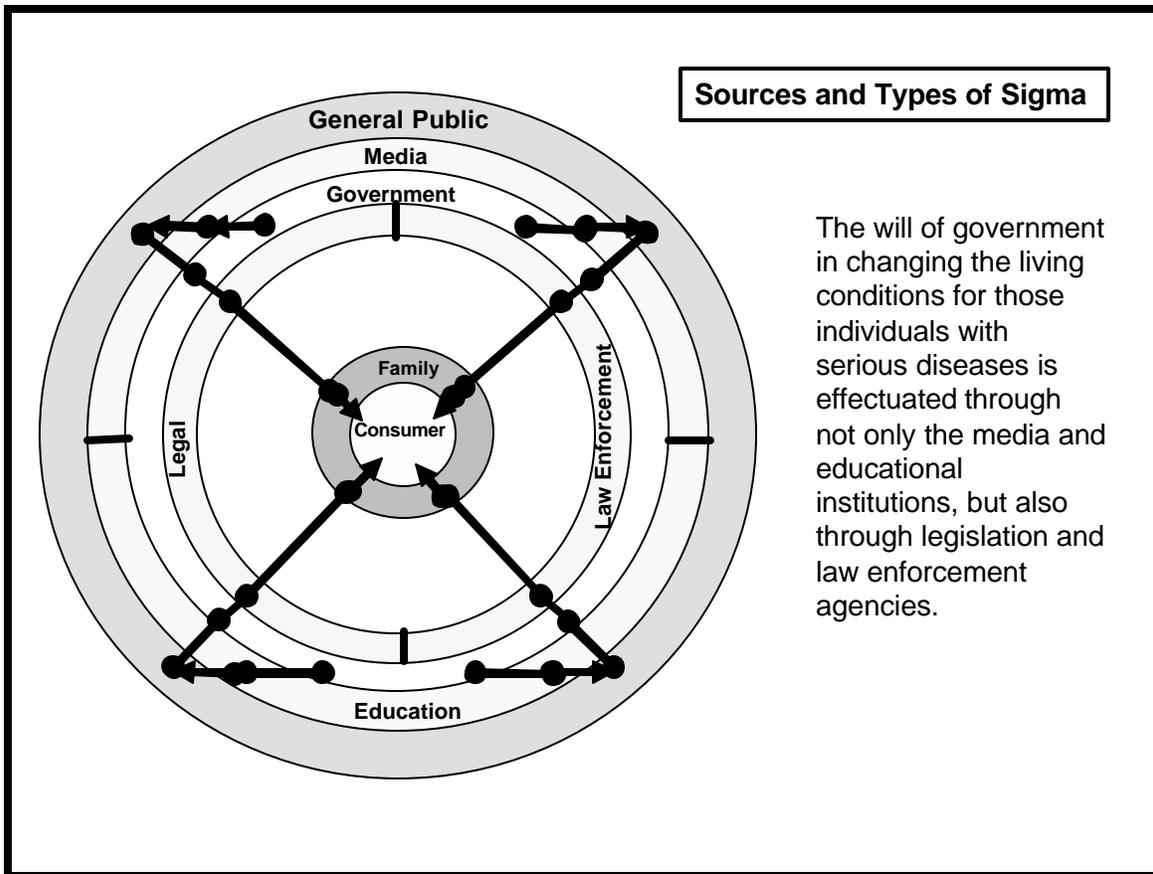
Illustrates that Government Can Use the Media and Educational Institutions to Inform the General Public Concerning Consumers and Recovery.

Society as a whole has been remiss in not providing accurate information about serious mental illnesses in the classroom. Although units in our schools' health curriculum openly discuss sexually transmitted diseases, few schools have units on mental health/illness even though a large percent of their student population is likely to face the realities of serious mental illnesses.

To make matters even worse, the stigma associated with serious mental illnesses and the fear of resulting discrimination, in conjunction with this lack of education, mean that many of our youth hide their mental health problems. This denies them the opportunity for early medical intervention and reduces the speed and degree of recovery they can ultimately expect.

The lack of education concerning serious mental illnesses affects not only consumers but their families as well. When mental illness finds its way into the typical household, i.e., a family whose only information about serious mental illnesses has been

garnered from sensational news reports and/or misguided entertainment, the family comes under enormous stress. Ignorance breeds despair. Families do not know where to turn and because of the stigma and discrimination associated with serious mental illnesses, they too try to hide the illness or slip into a state of denial. This robs the consumer of much needed early intervention and may create unbearable pressures on other family members. The introduction of serious mental illnesses into a family's dynamics often result in divorce. Consumers often become estranged, reducing even further their prospects of receiving early medical intervention.



The will of government in changing the living conditions for those individuals with serious diseases is effectuated through not only the media and educational institutions, but also through legislation and law enforcement agencies.

Diagram 4

Illustrates that Government Can Use not only the Media and Educational Institutions, but can also Employ Legal and Law Enforcement Institutions to Reduce the Affects of Stigma and Discrimination on Consumers and Their Families.

New Jersey can take direct action to reduce stigma and discrimination. Although it cannot legislate morality, government can prohibit discrimination.

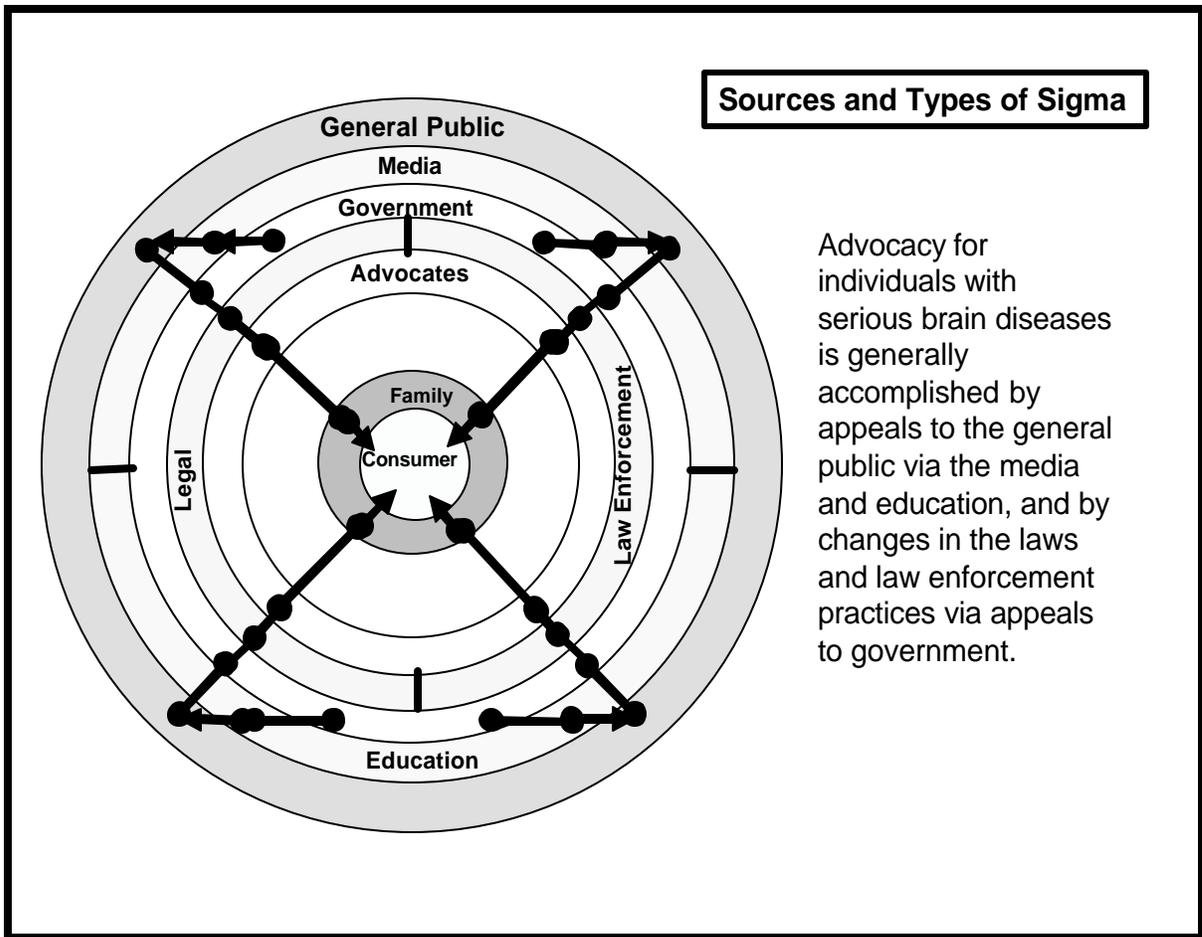


Diagram 5

Advocacy Groups Participate in the Process of Reducing Stigma and Discrimination Aimed at Consumers and Their Families and Friends.

Advocacy groups attempt to do for consumers and their families what government has not done. As a consequence, we find a patchwork of services, many redundant, that cannot provide the range, depth, continuity and coordination of services required to enable consumers to reach their full potential.

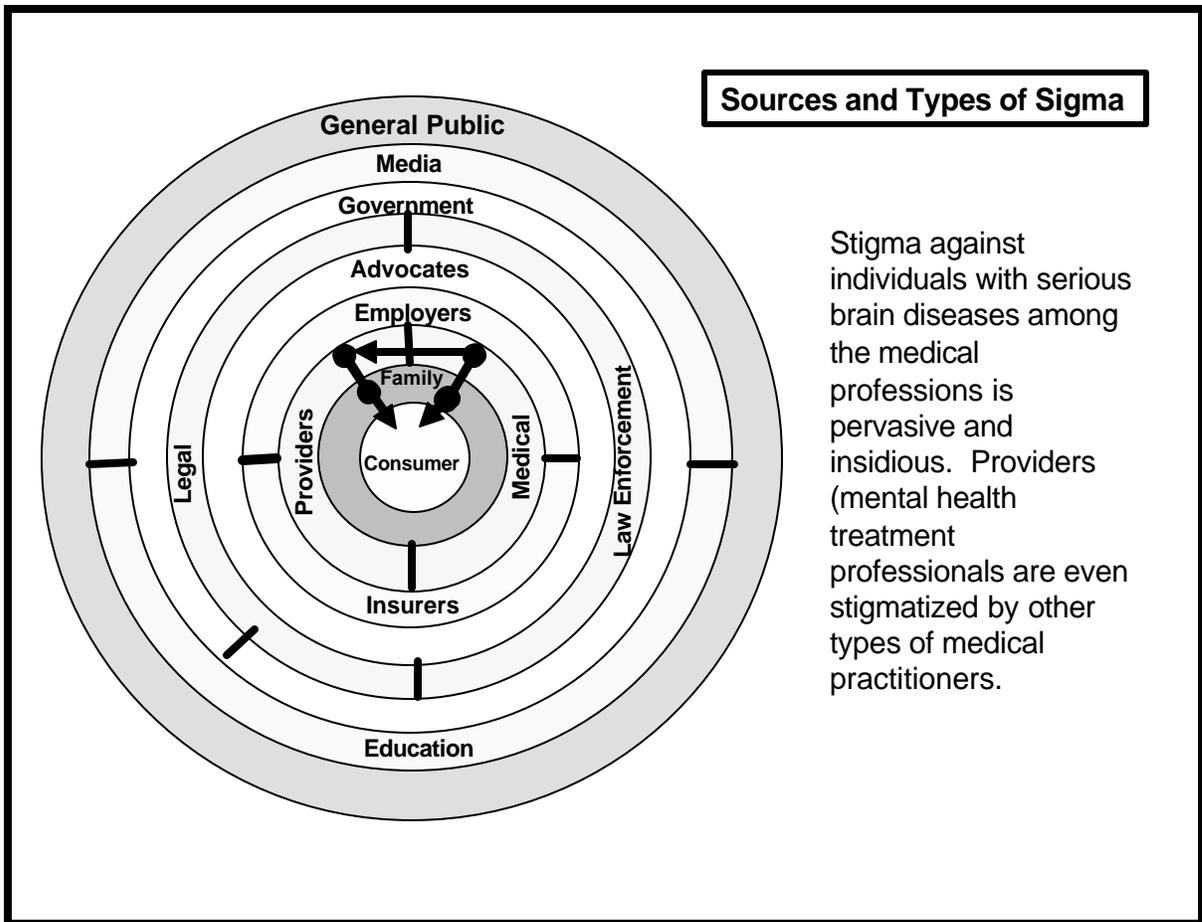


Diagram 6

This Diagrams Illustrates that in the Ideal Situation Mental Health Care Treatment Professionals are Closer to the Consumer than all but the Individual's Family Members.

Although some still cling to the old paradigm, most mental health care professionals today subscribe to the medical model of mental illness, i.e., they recognize that mental illnesses are serious brain diseases. Many, however, only see consumers that are in crisis, which makes it difficult for them to believe that recovery is possible. This may adversely affect the treatment consumers receive.

In all fairness to the general public, psychiatry for many years promulgated erroneous information concerning the causes and best treatments for serious mental illnesses. The resultant treatment led to little or no improvement in the condition of their patients. This, in turn, led to the widely held supposition that persons with serious mental illnesses cannot and do not recover.

Stigma and its resultant discrimination will continue to be a serious problem for consumers and for our society as a whole until assertive action is taken to educate our youth, reeducate the general public and provide continuing education for mental health care professionals.

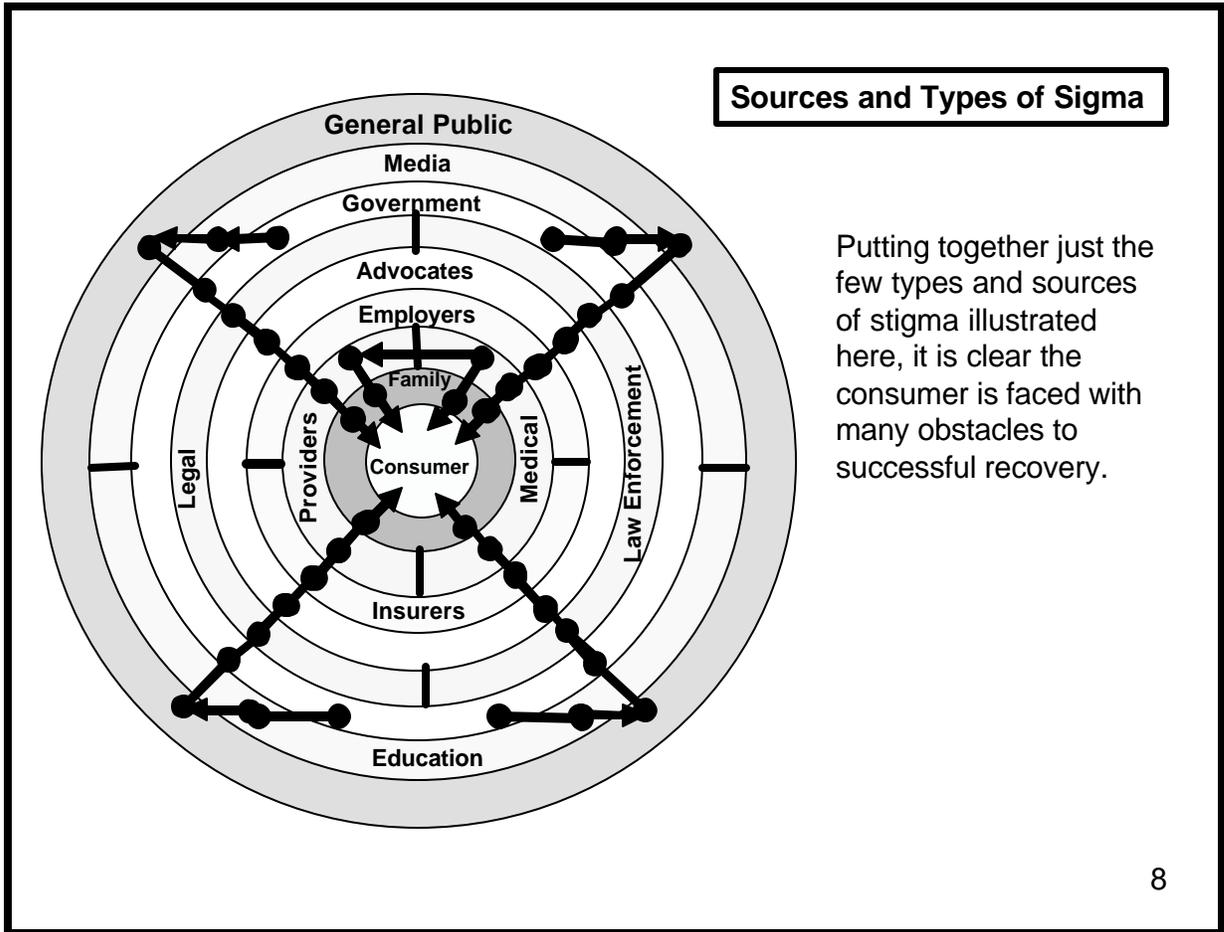


Diagram 7

This Diagram Illustrates that there are many Barriers to Efficacious Treatment for Individuals Suffering from Serious Brain Diseases.

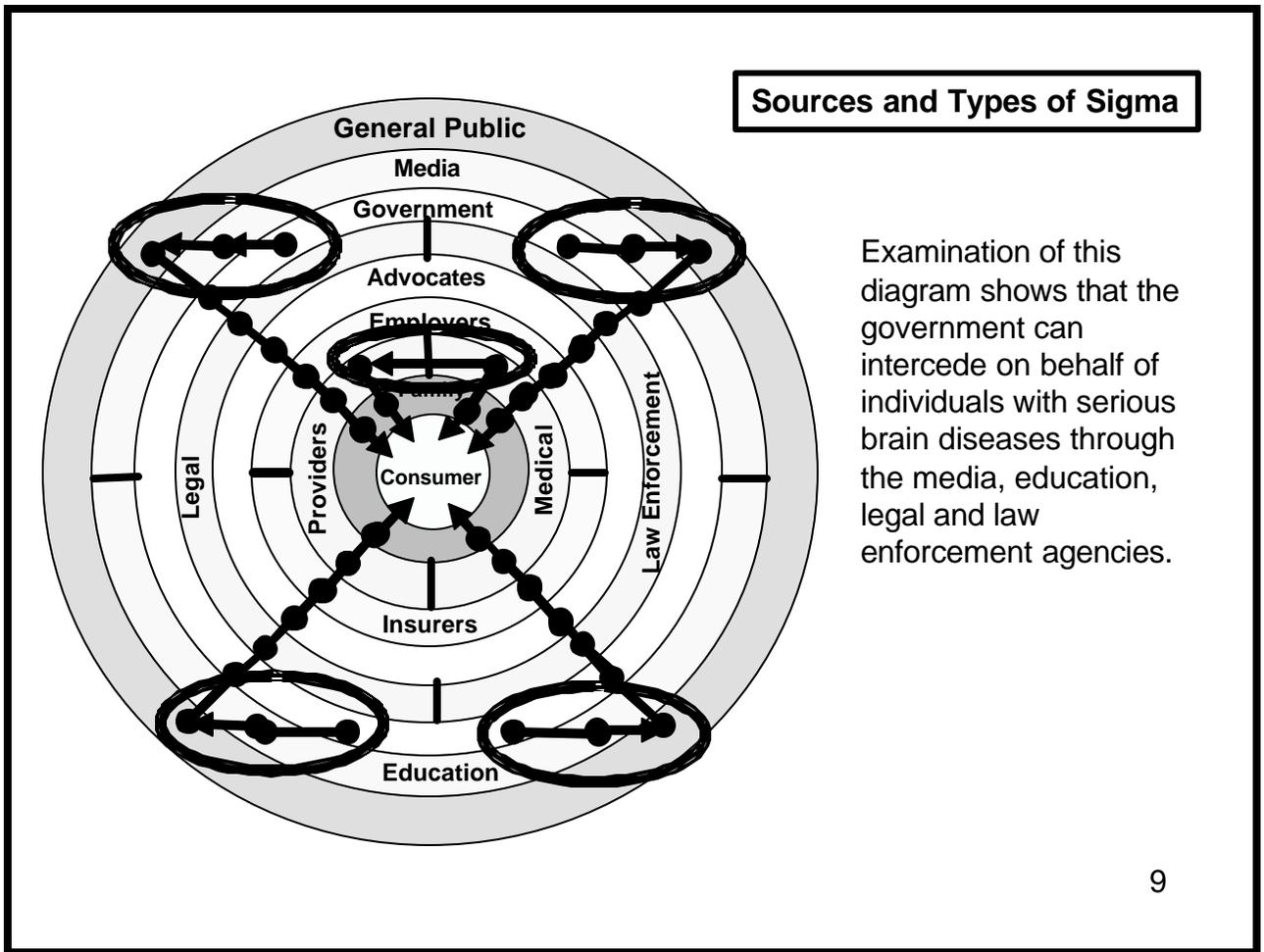


Diagram 8

It Becomes Clear in this Diagram that Government can Intervene on Behalf of Individuals with Serious Mental Illnesses to Fight Stigma through Four Different Approaches: 1) the Media, 2) Education, 3) Legal Remedies, and 4) Law Enforcement Entities.

TREATMENT, WELLNESS AND RECOVERY COMMITTEE

OVERVIEW

“Recovery is regaining one’s life in the face of the illness and associated disability.” In a recovery-oriented system, consumers and professionals are working together to achieve the consumer’s goals.(1) The recovery concept is now being discussed by national and state decision-makers. (2, 3) Committee members— consumers, professionals, educators and family members—utilized their experience and knowledge of New Jersey mental health services in regard to filling consumer needs for treatment, recovery and maintaining wellness. This committee addresses adult services only, but many similar issues affect children and adolescents. We are also not addressing the serious issues for consumers caught up in the criminal justice system.

Our review notes that there are many excellent features in New Jersey’s mental health system. The concept of the Redirection Plans to transfer resources to the community as state hospitals downsized has been consistent and well planned here, unlike many other states. The community services now in place are those that are needed, i.e. the Screening Centers and their intended crisis outreach capacity, the array of residential services including supported housing, outreach services, i.e. the Program for Assertive Community Treatment (PACT), Integrated Case Management Services (ICMS) and Intensive Family Support Services (IFSS), the consumer self-help centers, consumer training and employment opportunities, supported employment programs, etc. The Division of Mental Health Services (DMHS) has consistently worked to improve its consumer involvement and recovery orientation: employing a high-level consumer advocate, frequently using advisory groups including consumers, family members and professionals, funding many consumer-run or collaborative programs, requiring consumer staff on PACT teams, and funding the upgrading of hospital and community services through training in evidence-based practices, psycho educational and recovery models. (4)

However, there are major problems for consumers in the system regarding access and availability of services. A common complaint from all parties is that needed services are not available, are restricted to particular “high risk” populations, or require a long wait. The scarcity of affordable, appropriate housing has a negative impact on recovery. There is a general need for more flexibility and more individualized services based on the level of consumer needs. The complexity of the public and private mental health systems results in general confusion and difficulty in accessing services. Physicians in the community complain that they do not know where to refer patients for mental health treatment, and families are at a loss. In addition, many services are not made available until the consumer’s condition deteriorates--- only after admission to a state or county hospital does a consumer join the “priority population” for allocation of scarce resources. Earlier intervention could prevent a great deal of illness, misery and deterioration.

The services that exist do not focus enough on recovery. According to the Consumer Advocacy Partnership (5), “consumers meet a system of care that’s designed around ‘illness’, rather than ‘wellness and recovery’... and (may feel) dehumanized and disenfranchised by staff who...invalidate their slight hopes of returning to their lives and their dreams”. Treating symptoms is no longer enough; professionals and the treatment system must instill hope and teach the skills and knowledge for consumers to work on their own recovery and wellness, with the aid of professionals who respect their choices and believe in their capabilities, and are trained in recovery-oriented practices.

Many examples of these problems were described in the Public Forums and by committee members. A mother reported that her mentally ill son ended up in jail, where he was raped and later committed suicide as a result of this trauma. Many consumers remain in state hospitals, the most restrictive environment, only because of no suitable housing. A consumer on the committee reports his difficulty getting hospitalized when severely depressed. A consumer with private insurance reported being discharged from the hospital with two weeks of medication but could not get a doctor’s appointment for over two months and was advised to go to the emergency room. No outreach is available for consumers who cannot get to appointments. The many consumers with drug and alcohol problems are often denied needed services. Many consumers want supported employment or housing but are unable to get these services to move towards independence. Self-help and recovery-oriented programs are very limited.

II. SUMMARY OF KEY FINDINGS

Here is our review of the specific mental health services in New Jersey from the standpoint of consumer focus and recovery orientation.

The quality of treatment is also essential to recovery. In this overview, we will refer to certain Evidence-Based Practices (EBP’s) which are described by the Federal Substance Abuse and Mental Health Services Administration (SAMHSA) on their website, which also provides “Toolkits” useful for training and implementation. (6, 7) They are: Illness Management and Recovery, Medication Management, Assertive Community Treatment, Family Psychoeducation, Supported Employment, and Integrated Dual Diagnosis Treatment. These reflect the best current knowledge in their particular areas of practice. However, many other more general practices are effective and important for good treatment. The most essential is simply providing time, respect and caring.

Hospitals: State hospitals (especially Trenton and Ancora) are severely overcrowded due to population growth, increased forensic population, and inability to discharge due to lack of appropriate housing. About half of the state hospital population is on Conditional Extension Pending Placement (CEPP) status. Many consumers are homeless at admission. Hospitals have insufficient programming oriented to recovery or independent living, and little preparation for discharge. The SAMHSA-funded initiative where consumers visit hospitals and run recovery-oriented groups shows promise.

Community hospitals, the site preferred by consumers and families, are closing beds. With insurance limitations, stays are too short for stabilization, leading to multiple readmissions. Voluntary hospitalization is often not available when consumers feel they need it. Hospitals have poor communication with community providers and families to exchange information and collaborate in discharge planning; this should be required and facilitated, e.g. by a liaison from the community program. HIPAA rules are misunderstood and misapplied to further impede communication: this must be addressed.

There is a tremendous need for more secure hospital beds for specialized treatment of consumers with mental illness and forensic involvement, such as sex offenders (now about 160 in the state hospitals) and many who are now in the correctional system.

Screening Centers: Consumers and providers see serious problems. There are long waits (sometimes days) for hospital beds, often because of insurance issues. The crisis outreach originally planned is not happening due to insufficient staff and funding. No diversion or respite services are available---consumers find that it is "hospital or nothing", with no follow-up services if they are sent home. Many consumers go repeatedly seeking admission and are turned away, even when PACT or the community agency supports their admission. Voluntary admission is often not available, only hospitalization when desperately ill and committed. Consumers want alternative crisis services, including crisis respite housing, to be available when needed, to avert hospital, prison or disastrous outcomes. **[The Task Force recommended and supports Governor Codey's proposed \$10 million expansion of county-based mental health screening centers. Screening centers located in all 21 counties serve as the gateway to services at every level, including outpatient counseling, case management, self-help centers and in-patient hospitalization. The \$10 million investment will add approximately 150 new master's level clinicians for emergency screening, including mobile outreach teams and enhanced on-call resources for community-based treatment and assessment. Staff recruitment will target bi-lingual clinicians (to the degree they are available) based on the needs of specific communities and will provide an improved ability to assess and treat co-occurring disorders. Enhanced screening will provide mental health services on a 24/7 basis for individuals in crisis.]**

The proposed funding for fiscal year '06 is a significant initial investment. However, in future budget years ('07, '08), the state should increase that investment to \$34.5 million in order to fully fund the screening centers and allow each center to fulfill its legislated mission and responsibilities.]

Outpatient: Outpatient services should provide the basic care needed to maintain recovery, but these are chronically under funded. Besides medication services, psychotherapy is essential for the many consumers dealing with trauma, depression, severe personality disorders, family issues etc. The NJ Medicaid rate is the lowest in the country; clinics are understaffed and overwhelmed, and unlike some other states, no private practitioners accept Medicaid. There are also serious access problems with private insurance plans (HMO's) where low pay for providers and the "phantom networks" without sufficient psychiatrists, have led to poor service and added to the public clinic caseloads and unnecessary crises and screening center visits. Consumers

who are not designated “priority” (coming from public hospitals or screening centers) often wait months for service, even when coming from a community hospital. There is a severe shortage of psychiatric/medication services. Services should include outreach and case management services but there is no funding for this under Medicaid-- the Medicaid Rehab Option might help. There should also be regular communication and liaison with the hospitals to ease the transitions and provide information; a staff member dedicated to this worked well in the past.

Medication: Consumers need more time in medication visits to establish rapport and discuss medications and side effects, to ensure they receive appropriate treatment. DMHS has funded 58 Advanced Practice Nurses to alleviate the shortage of prescribers, but it still remains, and psychiatrists must also be available for treatment and consultation. Community agencies also need case management staff to assist consumers getting "medication only" at clinics. There is a problem with inappropriate prescribing; more information on EBP's from SAMHSA and psychiatric sources should be disseminated. Information about medication effects is often not transmitted between outpatient and hospital, leading to inappropriate changes when the consumer is hospitalized. More use of the Wellness Recovery Action Plan (WRAP) (9) could help communicate consumer response to medication. There are also problems getting the prescribed drugs depending on coverage; Medicare changes will make this worse. The current open formularies of New Jersey Medicaid and Pharmaceutical Assistance to the Aged and Disabled (PAAD) are conducive to recovery. An increasing number of uninsured consumers have no reliable medication source and must depend on samples and ever-changing pharmaceutical company programs. It would be extremely helpful if pharmacy services could be included in outpatient clinics, as occurs in some hospital-based programs. **[The Task Force recommended and supports Governor Codey's fiscal year '06 budget proposal to provide \$2.5 million of funding for an expansion of psychiatric services. In New Jersey, the waiting time for an appointment with a psychiatrist or an advanced practice psychiatric nurse for medication management and other psychiatric services is as long as six weeks. The funding will provide an estimated 25,000 hours of additional psychiatric time statewide].**

Physical Health Issues: Many consumers have significant health problems. A significantly lower life expectancy is largely due to illnesses related to smoking and obesity (which is often a side effect of medications), including the huge increase in diabetes. Access to health care is difficult due to insurance/Medicaid issues, and communication between health and mental health providers is a problem; this is another place where case management services are needed. Stigma on the part of physical healthcare providers can prevent consumers with medical issues from being taken seriously and getting appropriate care.

Outreach: This is very important in maintaining people in the community, but severely limited now to only public hospital discharges. Current outreach services have mixed reviews. ICMS is often unknown to the consumer until hospital discharge, and lasts a limited time. PACT services (an EBP for consumers who are most difficult to engage in treatment) are highly variable; due to insufficient staffing, some teams only provide

medication and few recovery goals; outside services are not allowed in the PACT program. NJ is in the forefront in requiring a consumer on PACT teams, which provides consumer employment and offers a recovery orientation. PACT and ICMS are too rigidly defined and limited and not always assigned appropriately; some consumers need less service, others need more: services should be tailored to consumer needs and be changed accordingly. Currently, only a few providers are funded for outreach; there should be broader availability and payment for these services, and they should be offered in the outpatient facility where the consumer is known and knows staff, not limited to state hospital discharges but used in a preventive way as needed to maintain community living. Outreach to consumers who are homeless and those within the criminal justice system also urgently needs to be addressed.

Housing: There is a tremendous shortage of affordable housing. State hospital stays are extended for the many consumers who are homeless or need structured living arrangements on discharge. The opportunity for respite care housing could avoid hospitalization: current rules prevent movement to more structured alternatives (e.g. group home) without hospitalization first. Consumers want more lease-based permanent supportive housing, with varied and flexible levels of support. Many want a single room with meals provided, but not the bad boarding homes. Housing in unsafe neighborhoods is an important stressor. "MICA" (dual diagnosis, mental illness and chemical abuse) housing should be more tailored to the individual motivational level with more flexible programming.

Partial Hospital/Day Treatment: "Ground has been lost" in recovery-oriented services: the consumer-run clubhouse model is gone, Medicaid is now funding only structured groups onsite, and there is little vocational orientation. Consumers want more choice in their activities and more opportunity to transition into work when ready. To provide this flexibility we would need the Medicaid Rehab Option, which we recommend. Resources are being wasted on funding more intense services than are needed, such as some long-term hospital-based programs. The current DMHS Partial Care Regulations are much more appropriate for promoting community integration than the current Medicaid regulations for these services.

Consumer-run Self-Help Centers: 27 centers funded by DMHS/Federal block grants are open 3-7 days per week and serve 12-50 people daily depending on space. Funding and resources for this service model are better than in many other states: NJ is seen as a model. These have more focus on recovery than do most partial care programs, and are an alternative or complement to the traditional mental health system. Consumers feel the centers are more flexible, don't require acceptance of medication or other requirements, provide a community and "extended family", and provide work opportunities. Some also assist consumers in developing their WRAP (9) to direct their own recovery. **[The Task Force proposes to the Governor an increase of \$2.1 million in fiscal year '06 to expand outreach and programming capabilities at the 27 self-help centers in New Jersey. These centers are a key resource in the move toward a more consumer- and family-centered approach to successful treatment and recovery. The new funds will be used to expand specialized therapies such as music, art and recreation and for**

capital improvements to program facilities. Because Self-Help Centers are key to a Treatment, Wellness and Recovery model, appropriate levels of funding should continue in subsequent State Fiscal Years]

Vocational: Altogether there is a great shortage of vocational services which consumers want. Division of Vocational Rehabilitation (DVR) programs and Ticket to Work are not very successful with people with serious mental illness. Supported Employment is the EBP in this area, but there are only 21 small programs in the state (30-40 consumers) with long waiting lists; we recommend a substantial increase in Supported Employment so that everyone who wants to work will have a chance. There should also be more opportunities for education and training (with supports if needed) leading to credentials which can lead to meaningful long-term employment and career advancement.

Family Services: Families need more support and education in all parts of the system; providers need training and programming for psychoeducation, the EBP in this area. IFSS and the National Alliance for the Mentally Ill (NAMI-New Jersey) Family to Family educational program are very good resources, but they do not include the consumer; for the best comprehensive care, these services should also be provided by the hospitals and community agencies in conjunction with the consumer's treatment. Multifamily groups are still rare.

NAMI and the Mental Health Association of NJ (MHANJ) county chapters have produced informational pamphlets or phone lines about services available. There should be a statewide information system with all the resources available, public and private; a website and 24-hour phone line for consumers and families to access information and services.

Substance Abuse Services: There is a great shortage of these services in general, and particularly not enough integrated and motivation-based services (the EBP) for the dually diagnosed. Over half of mentally ill consumers are estimated to have substance abuse as well, and substance abuse is involved in many cases of violence, so this cannot be ignored. The NJ "Parity" law for private insurance does not include coverage for substance abuse treatment. Traditional 12-step programs are often not welcoming or appropriate—we need more "Double Trouble" groups. Consumers who drink or use drugs are often denied treatment, including medication. Providers are not skilled in the effective treatment techniques, e.g. motivational interviewing and stage wise treatment to engage the consumer who is in the "contemplation" but not yet in the "action" stage. Much more staff training and work on implementing an integrated model is needed. A SAMHSA Toolkit is available for Integrated Dual Diagnosis Treatment (IDDT).

Tobacco is another big problem which needs more attention, leading to medical illness and premature death; it also adds cost in higher doses of antipsychotics due to interactions with these drugs. Smoking is much more common in mental health consumers (50-90%) than in the general population; an estimated 44% of all cigarettes in the US are sold to people with mental illness or substance abuse disorders.(8) Smoking cessation treatment should be provided in mental health settings, and nicotine replacement should be reimbursed.

Long-Term Care: The population is aging, with many medical problems. It is very hard to get medical services in mental health housing, so consumers are referred to nursing homes: 600 PASRR reviews per year are done by DMHS for nursing home referrals. These facilities have no psychiatric program and no focus on wellness or recovery. Training and outreach to nursing homes is recommended. We need more specialized health related facilities for this growing population of consumers.

Cultural Competency: Minority consumers/ and families need ongoing support and advocacy; they are often lost and mistreated in the emergency room or the criminal justice system. Agencies need to be welcoming and build trust; thus far mostly small agencies have done this but larger ones should. We need to recruit more bilingual providers, and provide training for current providers in cultural issues that impact on treatment. For example, these consumers are unlikely to challenge a doctor directly, but won't follow treatment recommendations if they have a problem with them. We recommend the use of peer advocates to help with communication.

[Services and mental health professionals need to have the necessary language and cultural skills to support racial and ethnic minority groups. The Task Force recommended and supports Governor Codey's proposal of a new investment of \$1 million in fiscal year '06 to expand bi-lingual and culturally diverse case management and outpatient services, specifically to serve the fastest-growing ethnic minority populations in New Jersey. This should be a continuously funded program with expanded funding implemented as resources allow.(See additional recommendations concerning screening expansion and cultural competency.)].

Other Issues/Recommendations:

- A. **Advance Directives:** Literature was reviewed (10, 11) and the topic was discussed. Provisions of the Washington State law were considered. The committee favors development of this process in New Jersey, but did not decide on the details of the model.

- B. **[Wellness and recovery is never more important than in the case of a mother caring for her infant. The Task Force supports Governor Codey's fiscal year '06 budget proposal to provide \$2 million for screening uninsured mothers for postpartum depression education and \$2.5 million to implement a Postpartum Depression Education campaign. The Departments of Health and Senior Services and Human Services will coordinate these initiatives.]**

- C. [The Task Force recommended and supports Governor Codey's fiscal year '06 budget proposal of \$1.8 million in the Department of Human Services to serve more people with traumatic brain injury in a non-institutional setting. The federally approved Medicaid Traumatic Brain Injury Waiver provides home and community-based assistance services to adults who have suffered traumatic brain injury. At present, New Jersey has approval and funding for 300 slots for this particular waiver. The increase noted above will enable the Department of Human Services to fund an additional 50 slots, representing an increase of 17%].**
- D. [The Task Force recommended and supports Governor Codey's proposed increase of \$600,000 for the Community Law Project (CHLP) for the purpose of increasing representation of persons with mental illness in applying for benefits and entitlements. Approximately 90% of consumers are denied on their first submission of an application to the Federal Government. CHLP has a 90%+ success rate of obtaining benefits for their clients. Insurance coverage is essential to wellness and recovery. CHLP also represents individuals with mental illness living in the Residential Health Care Facilities. This increase in funding will enable CHLP to increase representation throughout the state from 7 to 10 counties].**

III. RECOMMENDATIONS

We have a number of specific recommendations stemming from the review above. These can be grouped into a few major initiatives.

1. **Information and access to needed services:**

- A. There should be a statewide information and referral system, with both a continually updated website and a live person available to answer questions and to advise on accessing services at all levels, including both public and private facilities.
- B. A major finding is the lack of follow-up and failure to provide services. We recommend the institution of a Treatment Advocate or team to ensure that consumers are able to receive needed services. This advocate should have independent status to function as an appeal or alternative pathway when services are denied. This advocacy is also needed in the private sector for the many consumers who are unable to get services through their insurance plans due to inadequate networks or treatment denials.

A particular need for advocacy and follow-up was found in the case of people sent home from the Screening Centers. Besides outreach staff, a consumer and family member (if appropriate) could be used in these settings to give support and ensure that needed follow-up services actually occur.

The information and access system backed up by this treatment advocate should ensure appropriate treatment for everyone. In addition, it can provide information useful for system oversight and quality control, to serve as an ongoing monitor to identify the areas where more and better services are needed.

2. **Consumer-centered treatment planning.**

- A. Psychiatric Advance Directives should be provided for by legislation. This is in process. Consumer education and legal guidance will be needed. However, it is understood that (as with medical advance directives), many consumers may not choose this legal format; consumer choices can still be promulgated by the following:
 - B. All levels of care should encourage and help consumers to develop a WRAP (Wellness Recovery Action Plan) (9) or other consumer-focused treatment and recovery plan. This will require training and supervision of staff in public and private hospitals and community agencies including consumer self-help centers. Consumer providers can play an important role in this, instilling hope and survival skills. The Regulations for state-funded programs should require evidence of true consumer involvement in their own treatment planning.
 - C. Treatment planning should consider all aspects of the consumer's life, needs and environment: LOCUS (12) is an instrument to determine the level of care needed, which is being adopted in the state hospital system and could be extended to Screening Centers and other sites.

3. Increase in the services, Evidence-Based and Promising Practices, which enable recovery. Training in EBP models and other “promising practices” such as physical wellness and tobacco programs is now offered in NJ (e.g. by DMHS and UMDNJ) but much more is needed. These models should be included in the curriculum of professional schools. To implement these practices, leadership and supervision is needed throughout the system, and these teams should include professionals, consumers and family members.

Particularly needed now in New Jersey:

- A. Outpatient treatment and medication services available immediately as needed, in the public and private sector, with support services that enhance consumer engagement in treatment. Sufficient resources and continuing care at this level are essential to maintain recovery. Staff training/services should include the recovery orientation and models such as the EBP Illness Management and Recovery, which includes psycho educational, behavioral and motivational approaches. Also needed is treatment for the many survivors of family or community trauma.
- B. Integrated treatment for co-occurring disorders based on the motivational, stage wise treatment approach: this addresses the most common cause of violence and criminal justice involvement, and must be tailored to the consumer’s stage of readiness for change. The SAMHSA EBP model is called IDDT “Integrated Dual Diagnosis Treatment”; some training is being done on this model but much more is needed.
- C. Outreach services at all levels: Screening, post-hospital, and in the community when needed, not restricted to hospital discharges. These services can maintain stability and deal with crises before they go too far. These could be funded by the Medicaid Rehab Option or Targeted Case Management funding. Short-term crisis respite housing should also be available.
- D. A change in partial care and rehabilitation programs to a recovery focus, including much more supported employment (also an EBP), flexible services and off-site activities to enable true community participation.
- E. Continue and increase the many excellent current initiatives of DMHS for consumer involvement and consumer-operated programs and staff training, including the Self-Help Centers, employment of consumer providers, and consumer input into policy and services.

4. Performance Oversight and Evaluation.

Meaningful measures of performance and outcomes should be developed for the system. The current evaluation methods should be revised to include the recovery orientation of programs. There are a number of models for this; e.g. a model in development by a group of 10 states working with the Center for Mental Health Services(13), and Indicators developed by the American Association of Community Psychiatrists. (14)

In conclusion, this committee finds that New Jersey has the ability to provide an exemplary, comprehensive, recovery-oriented system. Consumers want and need state-of-the-art treatments, which are more effective and no more costly than current efforts. We already have most of the elements, but we need to make them available to all who need them. We also must provide the necessary training and reorientation to implement the recovery model at all levels.

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Also thanks to:

CSP Freehold Self Help Center, CSP New Jersey
We held one meeting there and heard from consumers.

SERV Behavioral Health System, Inc., East Brunswick Office
We held 4 long meetings there, using space, coffee and the xerox machine.

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APPENDIX

1. Recovery, Wellness, and Treatment: Conceptual Definitions

Treatment is about amelioration or elimination of psychiatric symptoms

Recovery is regaining one's life in the face of the illness and associated disability

Wellness is living a healthy lifestyle that will promote and maintain recovery

The final report of the President's New Freedom Initiative (2003, 2004) endorses a recovery-oriented mental health service delivery system and refers to recovery as the process by which people are able to live, work, learn and participate fully in their communities. For some people, recovery is the ability to live a fulfilling life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Recovery involves recognizing and accepting strengths, limitations and losses and distinguishing the difference between **having** an illness and **being** the illness. Through the recovery process a person re-establishes a sense of integrity and purpose within and beyond the limits of the disability. The goal is to live a satisfying, hopeful and contributing life, even within the limitations caused by the illness.

There is a growing recognition that people diagnosed with a psychiatric disability want to move forward in the recovery process to achieve a wellness lifestyle. Wellness is a conscious deliberate on-going process in which a person becomes aware of and makes choices towards a more satisfying lifestyle. A wellness lifestyle incorporates a self-defined balance of health habits such as adequate rest/activity, productivity, social contact/relationship. Wellness provides a holistic view of a person and includes physical, mental/emotional, spiritual, intellectual and occupational dimensions. A wellness approach builds on the strengths of these dimensions and helps the individual to be successful within the environment where he/she is living, learning and working.

Despite a diagnosis of mental illness and associated sequelae, individuals can work on their own personal recovery and can develop a wellness lifestyle that contributes to a sense of heightened life satisfaction and well-being.

The mental health service delivery system should be designed to meet the needs of individuals with SMI by providing an array of evidence based treatments, safe and supportive environments, and competent professionals who will create opportunities that foster recovery and wellness. Treatments, services and programs should teach people how to manage illness and lifestyle and foster an optimistic attitude towards dealing with stress and adversity. The provider's role is to work collaboratively to provide guidance to help an individual (re) evaluate and re-establish personal goals and lifestyle habits and assist the recovering person in his or her creation of plans and support networks that will foster recovery.

Margaret Swarbrick,, MA, OTR

2. Listing of Features which will promote recovery orientation:

1) A mental health system that promotes wellness and recovery provides programs and services that are:

- Based upon the best available evidence on effective treatments and rehabilitation
- Easily accessible, engaging individuals in all phases of their illness and phases of recovery
- Delivered in humane, respectful environments
- Minimally dependent on coercive interventions and only when other options are exhausted
- Flexibly designed to meet individual needs
- Supportive of positive risks towards promotion of independence
- Provide a broad range of supports including those from peers and through mutual self-help
- Integrated in their approach to all the needs of the individual
- Conducive to fostering a sense of purpose in the lives of consumers

2) These programs and services must be overseen, regulated, and reimbursed in a manner that ensures:

- Reimbursement focuses on the provision of services which reduce symptomatology, promote recovery, community integration, and quality of life as opposed to those services which may foster segregation, dependence, passiveness, or other iatrogenic effects;
- Providers can reasonably offer a wide range of supports through a single team, setting or program
- Consumer strengths and interests can be employed in the restoration of functions associated with disability

- Flexibility in the range and types of services across all the environments relevant to the consumers' lives is supported.
- Openness to emerging practices and innovation based on research.

3) This type of system must be staffed by professionals and other service providers of various educational backgrounds and responsibility levels (administrative, supervisory, and direct care) who are:

- Promoters of true, informed consumerism
- Optimistic and informed about recovery including:
 - Working from a strengths focus
 - Supportiveness to consumers who take positive risks
 - Respecting the importance of purpose and meaning in consumer's lives
 - Promoting - internal motivation
- Skilled in relevant interventions and best practices
- Trained and supervised in a relevant manner
- Respectful listeners and communicators
- Collaborators with consumer and families

Brief Definitions

The Best Treatments are readily available - Treatment for acute and prodromal features such as psychosis is readily accessible and includes state of art psychopharmacology as well as comprehensive early intervention services offered in the least restrictive environments.

All treatments and services are based on best available evidence - Long-term treatment, rehabilitation & support offered are based on the best available evidence and promising practices, and are offered in the home community of each consumer. These practices will help people regain the lives they had or pursue new goals perhaps for the first time.

Services Can Engage People who Need Them - People in all stages of recovery can be engaged in the services when they need to be, this includes a continuum that ranges from those who are seriously ill and do not recognize their condition as an illness to those who are very stable and maintaining wellness.

True, Informed Consumerism - In every circumstance possible, consumers of mental health services are in fact treated like consumers of any other type of service. The exploration of choices and options is available so the person can make informed choices. They are offered sufficient information so that they may guide their own treatment and make informed choices, truly choosing treatment plan goals, self-managing their illness, contributing meaningfully to treatment plans, developing WRAP plans, and having the availability of advanced directives if desired.

Optimism about recovery - Consumers, family members, staff and other stakeholders will be sufficiently informed and optimistic about the prospect of recovery.

Openness to Innovation - Service providers, systems and funding sources are open to innovation that may challenge the status quo with an emphasis on incorporating research findings.

Positive risks towards independence are supported - Individuals are effectively helped and supported in the pursuit of employment, social opportunities, as well as their chosen living arrangements and learning opportunities by encouraging and supporting a person to take positive risks related to life goals versus a strong emphasis on relapse prevention and fear of stresses inducing relapse.

Skilled staff at all educational levels – Services are delivered by skilled staff familiar with both evidence-based and promising practices. Staff are required to regularly receive relevant training and supervision

Respectful Communication - Staff communicate and listen carefully and respectfully regardless of the present mental state of the individual.

Humane, respectful environments – Environments where people receive services and treatment such as state-operated hospitals, private facilities, residences and day programs are humane and comfortable. This includes the maintenance of privacy and personal dignity particularly in any residential setting including state hospitals and group homes.

Minimal use of coercive interventions -Coercive forms of interventions, such as involuntary commitment (inpatient or outpatient), restraints and other forms of confinement are used minimally, if at all, and only when all other possibilities are exhausted.

Reimbursement practices are rational - Services provide incentives to deliver services conducive to recovery.

Collaboration among stakeholders - Professionals collaborate with the consumer and significant others

Services are flexibly designed meaning to meet the individual's needs in the context of the least restrictive environment.

Personals strengths focus- Interests, strengths, and possibilities are emphasized, de-emphasizing limitations and disability.

A wide of range of supports are available - An array of supports including material, instrumental and social support resources available as well as relationships that are mutually beneficial including self-help and peer delivered services

Fosters a renewed sense of purpose - Treatment and rehabilitation helps the individual experience and redevelop sense of purpose, and make a commitment to a lifestyle of wellness.

Promotes internal motivation - Personal responsibility rather than reliance on external interventions is promoted.

Prepared by:

Kenneth J. Gill, Ph.D.
Margaret Swarbrick, MA, OTR

Drawn in large part from:

Pratt, C.W., Gill, K.J., Barrett, N.M. & Roberts, M.M. (2002). Psychiatric Rehabilitation. San Diego, CA: Academic Press.

3. **Consumer-Operated Initiatives, NJ Division of Mental Health Services
Treatment, Wellness & Recovery Subcommittee
Mental Health Task Force**

The NJ Division of Mental Health Services is strongly committed to operating with candid and consistent input from its mental health consumer constituents. Therefore, DMHS established a formalized mechanism by which to facilitate regular communication between representatives from the Division staff and consumer advocates from across the State to ensure that consumer input is incorporated into DMHS policy and decision-making. The Statewide Consumer Advisory Committee or “SCAC” is a formal advisory body to the Division of Mental Health Services – comprised solely of primary mental health consumers – and meeting monthly in each region of the State to discuss updates on Division initiatives, new policies, and procedures, budget issues and priorities, legislative concerns, and any DMHS related issues on the minds of mental health consumers. The feedback from consumers is then relayed to the Executive Staff of the Division for their consideration in the planning and service delivery side of DMHS operations. In addition to SCAC, there is mental health consumer representation on all major DMHS-sponsored stakeholder committees and task forces addressing issues impacting the lives of mental health consumers in NJ.

New Jersey is very rich with consumer-operated initiatives and programs. Besides the ones specifically mentioned in this brief report, there are numerous contract agencies throughout the state that maintain highly innovative and effective consumer-run programs and services under their umbrella organizations. Perhaps the most noteworthy consumer-run program in our state is Collaborative Support Programs of New Jersey (CSP-NJ), with over \$6 million dollars in consumer-operated programs and services including self-help centers, supportive housing, wellness & recovery programs, and Wellness Recovery & Action Plan (WRAP) training as well as systems advocacy. Most recently, CSP-NJ received a SAMHSA grant—with additional support from DMHS—to provide Wellness & Recovery groups using peer support and positive role-modeling to consumers who are inpatients in our adult state hospitals.

There are currently 27 self-help centers in the 21 counties across the state—all of which are consumer-operated and provide dedicated space for mental health consumers to grow in their recovery through self-help, socialization, peer support, opportunities for employment and specialized wellness programs—with particular emphasis on dual recovery. Eight of the self-help centers participate in the DMHS-sponsored Boarding Home Outreach initiative whereby members of the centers make specific efforts to include boarding home residents in self-help center activities by providing them with transportation, meals, and including them in recreational activities—culminating in two annual statewide Boarding Home Outreach events.

New Jersey has also been in the forefront in terms of employing consumers within the state's public mental health system. For example, the regulations mandate that there be a peer advocate position on all of the 31 PACT Teams within the state. In addition, the DMHS staffing requirements in the Intensive Case Management Services (ICMS) licensing standards stipulate that all provider agencies shall consider hiring a primary consumer for ICMS positions. DMHS also supports Consumer Connections, which is a statewide consumer training program offered by the Mental Health Association of NJ to provide consumers with a core curriculum and certification to pursue careers in the mental health field. Consumer Connections has had over 800 consumer graduates since its inception in 1997. In addition, DMHS wrote the initial grant that funded the Associate's Program, and has continued to provide in-kind support to the Department of Psychiatric Rehabilitation at UMDNJ, where a significant percentage of mental health consumers have been educated prior to entering the psychiatric rehabilitation field in New Jersey. Several members of the adjunct faculty are recipients of mental health services as well as 30% of the student population.

In response to the alarming disparity in physical health status between mental health consumers and the general population, the Division of Mental Health Services has initiated a number of specialized programs to address the demand for more holistic health services for consumers of mental health services. One approach is a psycho-educational model provided by UMDNJ's University Behavioral Health Care's Center for Excellence in Psychiatry that utilized some of the expertise of leading experts in the country working toward recovery strategies from serious mental illnesses. Team Solutions is an illness management program directed at the client who has schizophrenia or schizoaffective disorder to help that individual develop a better understanding of his/her illness, symptoms, treatment, medications, and in general, a better sense of mastery over one's disease process, which in turn will lead to a better quality of life. Solutions for Wellness, also provided by UBHC's Center for Excellence in Psychiatry, is a complementary program that addresses the issues of nutrition, fitness and exercise through information and suggestions on a healthier lifestyle. This is particularly useful for consumers who are struggling to combat the effects of psychotropic weight gain and sedentary lifestyles that can lead to risk factors for major illnesses that lead to premature morbidity and mortality. Both Team Solutions and Solutions for Wellness are being widely implemented in all five of our adult state hospitals. Also, the two complementary programs have been funded for implementation in six partial care programs throughout the state as well as in

three of the self-help centers. DMHS also contracted with experts at UMDNJ to collaborate on a Tobacco Cessation Program specifically geared for the mental health consumer that is also being piloted in these same nine sites across the state. The manual that was developed for this program will be revised based on feedback from the pilot sites and will be ready for wide distribution next year.

As part of Redirection II, \$260,000 was allocated towards consumer-operated wellness projects through a competitive bidding process. The following agencies were awarded grants under this initiative: Getting Together Self-Help Center (\$20,396); Better Future Self-Help Center (\$59,568); Mental Health Association of Passaic County (\$60,000—one year only); CAP of the MHA of Morris County (\$28,177); CSP-NJ (\$60,000 & \$48,400); and Project Live (14,500). All of these grants were awarded with the purpose of improving the overall health status and general well-being of the mental health consumers who frequent the chosen program or service. Almost all of the grants consisted of providing support for a Wellness Coordinator who would undertake making community linkages with local YMCA's to improve fitness, bringing in speakers on proper nutrition, diabetes, sexually transmitted diseases, and other health concerns of the membership.

In addition to the \$260,000 in consumer-operated wellness projects, the Division was able to renew \$240,000 in consumer-operated recovery-oriented projects that were funded in 2002 through Federal Block Grant dollars. Some of the projects that were able to be continued include: a specialized MICA and HIV/AIDS training curriculum for consumer providers offered by the Mental Health Association of NJ; a fully consumer-operated transportation service for consumers needing transportation to and from work in Burlington County offered by Delaware House Self-Help Center, under the auspices of Catholic Charities; a training, education and support network for parents who have a mental illness and who have children under the age of 18 living with them offered by the Mental Health Association of Passaic County; support for a consumer advocate position at Crisis House at Drenk Behavioral Health Center; a MICA Link Project to address the issues of dual recovery in the self-help centers sponsored by CSP-NJ; support for a Financial Services Coordinator who provides specialized savings and bill paying services to mental health consumers coupled with Financial Literacy Training to educate mental health consumers about making informed financial decisions in their own lives provided by CSP-NJ; and finally, a consumer-operated Chat Line at On Our Own Self-Help Center in Bergen County.

The Division's most recent initiative involving peer-operated services is the availability of funding to develop up to six pilot projects in designated screening centers or its affiliated emergency service to provide for a peer support advocate position. The role of the peer advocate will be to educate the consumer in crisis as to what he/she might expect, reduce his/her level of anxiety, and to provide general support and assistance through the duration of the screening process. The award of these contracts will be made on a competitive basis and are intended to support state funded, designated screening centers or its affiliated emergency service to further strengthen service delivery using a peer support model. These awards are designed to reduce the impact and frequency of

psychiatric crises, and to improve consumers' overall experiences with the screening process.

MM:DAZ

1-11-05taskforce

4. SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION: NATIONAL MENTAL HEALTH INFORMATION CENTER

<http://www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits>

The Substance Abuse and Mental Health Services Administration (SAMHSA) and its Center for Mental Health Services (CMHS) are pleased to introduce six Evidence-Based Practice Implementation Resource Kits to encourage the use of evidence-based practices in mental health. The Kits were developed as one of several SAMHSA/CMHS activities critical to its science-to-services strategy. We expect to identify additional practices for future Kits.

The Kits contain many useful resources, including:

- * Information Sheets for all stakeholder groups
- * Introductory videos
- * Practice demonstration videos
- * Workbook or manual for Practitioners

Each of the six Resource Kits is described below.

Illness Management and Recovery

The Illness Management and Recovery program strongly emphasizes helping people to set and pursue personal goals and to implement action strategies in their everyday lives.

The information and skills taught in the program include:

- * Recovery strategies
- * Practical facts about mental illness
- * The Stress-Vulnerability Model and strategies for treatment
- * Building social support
- * Using medication effectively
- * Reducing relapses and coping with stress
- * Coping with problems and symptoms
- * Getting needs met in the mental health system

Medication Management Approaches in Psychiatry

The Medication Management Approaches in Psychiatry program focuses on using medication in a systematic and effective way, as part of the overall treatment for severe mental illness. The ultimate goal is to ensure that medications are prescribed in a way that supports a person's recovery efforts. The program includes:

- * Guidelines and steps for medication decision making, based on current Evidence and outcomes
- * Systematic monitoring and record keeping of medications
- * Consumer and family member Involvement

Assertive Community Treatment

The goal of Assertive Community Treatment is to help people stay out of the hospital and to develop skills for living in the community, so that their mental illness is not the driving force in their lives. Assertive community treatment offers services that are customized to the individual needs of the consumer, delivered by a team of practitioners, and available 24 hours a day. The program addresses needs related to:

- * Symptom management
- * Housing
- * Finances
- * Employment
- * Medical care
- * Substance abuse
- * Family life
- * Activities of daily life

Family Psychoeducation

Family Psychoeducation involves a partnership among consumers, families and supporters, and practitioners. Through relationship building, education, collaboration, problem solving, and an atmosphere of hope and cooperation, family psychoeducation helps consumers and their families and supporters to:

- * Learn about mental illness
- * Master new ways of managing their mental illness
- * Reduce tension and stress within the family
- * Provide social support and encouragement to each other
- * Focus on the future
- * Find ways for families and supporters to help consumers in their recovery

Supported Employment

Supported Employment is a well-defined approach to helping people with mental illnesses find and keep competitive employment within their communities. Supported employment programs are staffed by employment specialists who have frequent meetings with treatment providers to integrate supported employment with mental health services. The core principles of this program include:

- * Eligibility based on consumer choices and preferences
- * Supported employment as an integrated treatment
- * Continuous follow-along supports

- * Help with moving beyond the patient role and developing new employment-related Roles as part of the recovery process

Co-occurring Disorders: Integrated Dual Diagnosis Treatment

Integrated Dual Diagnosis Treatment is for people who have co-occurring disorders, mental illness and a substance abuse addiction. This treatment approach helps people recover by offering both mental health and substance abuse services at the same time and in one setting.

This approach includes:

- * Individualized treatment, based on a person's current stage of recovery
- * Education about the illness
- * Case management
- * Help with housing
- * Money management
- * Relationships and social support
- * Counseling designed especially for people with co-occurring disorders

5. Mary Ellen Copeland: www.mentalhealthrecovery.com

Article: Guide to Developing a WRAP - Wellness Recovery Action Plan

The following handout will serve as a guide to developing Wellness Recovery Action Plans. It can be used by people who are experiencing psychiatric symptoms to develop their own guide, or by health care professionals who are helping others to develop Wellness Recovery Action Plans.

This handout, or any part of this handout, may be copied for use in working with individuals or groups.

Getting Started

The following supplies will be needed to develop a Wellness Recovery Action Plan:

1. a three ring binder, one inch thick
2. a set of five dividers or tabs
3. a package of three ring filler paper, most people preferred lined
4. a writing instrument of some kind
5. (optional) a friend or other supporter to give you assistance and feedback

Section 1-Daily Maintenance List

On the first tab write Daily Maintenance List. Insert it in the binder followed by several sheets of filler paper.

On the first page, describe, in list form, yourself when you are feeling all right.

On the next page make a list of things you need to do for yourself every day to keep yourself feeling alright.

On the next page, make a reminder list for things you might need to do. Reading through this list daily helps keep us on track.

Section 2- Triggers

External events or circumstances that, if they happen, may produce serious symptoms that make you feel like you are getting ill. These are normal reactions to events in our lives, but if we don't respond to them and deal with them in some way, they may actually cause a worsening in our symptoms.

On the next tab write "Triggers" and put in several sheets of binder paper.

On the first page, write down those things that, if they happened, might cause an increase in your symptoms. They may have triggered or increased symptoms in the past.

On the next page, write an action plan to use if triggers come up, using the Wellness Toolbox at the end of this handout as a guide.

Section 3-Early Warning Signs

Early warning signs are internal and may be unrelated to reactions to stressful situations. In spite of our best efforts at reducing symptoms, we may begin to experience early warning signs, subtle signs of change that indicate we may need to take some further action.

On the next tab write "Early Warning Signs". On the first page of this section, make a list of early warning signs you have noticed.

On the next page, write an action plan to use if early warning signs come up, using the Wellness Toolbox at the end of this handout as a guide.

Section 4- Things are Breaking Down or Getting Worse

In spite of our best efforts, our symptoms may progress to the point where they are very uncomfortable, serious and even dangerous, but we are still able to take some action on our own behalf. This is a very important time. It is necessary to take immediate action to prevent a crisis.

On the next tab write, "When Things are Breaking Down". Then make a list of the symptoms, which, for you, mean that things have worsened and are close to the crisis stage.

On the next page, write an action plan to use "When Things are Breaking Down" using the Wellness Toolbox at the end of this handout as a guide.

Section 5-Crisis Planning

In spite of our best planning and assertive action, we may find ourselves in a crisis situation where others will need to take over responsibility for our care. We may feel like we are totally out of control.

Writing a crisis plan when you are well to instruct others about how to care for you when you are not well, keeps you in control even when it seems like things are out of control. Others will know what to do, saving everyone time and frustration, while insuring that your needs will be met. Develop this plan slowly when you are feeling well. The crisis planning form includes space to write:

- * those symptoms that would indicate to others they need to take action in your behalf
- * who you would want to take this action
- * medications you are currently taking, those that might help in a crisis, and those that should be avoided
- * treatments that you prefer and those that should be avoided
- * a workable plan for at home care
- * acceptable and unacceptable treatment facilities
- * actions that others can take that would be helpful
- * actions that should be avoided
- * what my supporters should do if I am a danger to myself or others
- * instructions on when the plan no longer needs to be used

For M.E. Copeland books on developing a Wellness Recovery Action Plan see:

[Wellness Recovery Action Plan](#)

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Housing

**Overview of the Subject or Issue that the Committee is charged with
Reviewing**

The Housing Advisory Committee is charged with the following as per Governor Codey's Executive Order No. 1:

- *Assessing mental health housing needs*
- *Developing a strategy that addresses housing and services for people with mental illness;*
- *Enhancing and correcting the Residential Health Care Facilities/boarding homes/single room occupancy serving the mental health population. In this regard the Task Force should consider (a) increasing licensing monitoring by the Departments of Community Affairs and Health & Senior Services; (b) creating a fund for maintenance for owners under determined criteria; (c) expanding case management services for residents; (d) expanding training for operators in areas such as substance abuse, nutrition, first aid and the like; and (e) increasing the SSI State supplement for homes meeting an established standard.*

Abraham Maslow, widely known for his theory of human motivation, discussed the idea of actualization as the driving force of human personality in his 1954 book, *Motivation and Personality*.⁹ Whether one agrees with the particulars of his approach, his description of the importance of meeting basic human needs in an individual's pursuit of actualization is considered by many to be intuitively right. In his theory, a person's physiological and safety needs must be met before a person can begin to achieve the more advanced levels such as social, esteem and actualization. In this regard, one can deduce that housing (within a societal context) as a basic need is crucial to a person's ability to achieve "higher" levels of living; for people with mental illness, this includes recovery.

However, New Jersey is in the midst of a well documented, deepening affordable housing crisis, that when combined with the lack of, and inaccessibility of, supportive housing services, has resulted in a deteriorating quality of life for people with mental illness and their families. Furthermore, this cycle perpetuates unnecessary and extraordinary costs for the citizens of this State during difficult budgetary times. This report does not look to blame any one system for the lack of housing and fragmented services since these issues are a by-product of the various systems in New Jersey that have allowed this to occur. Thus, this is a New Jersey issue, not just one for the mental health community.

In fact, New Jersey ranks as one of the costliest housing markets in the country.¹⁰ If our staff have difficulty in securing affordable housing in the State, our consumer population fights a losing battle due to their being an impoverished, disenfranchised group. Complicating the issue, New Jersey's mental health system has historically directed the majority of its funding for mental health toward costly institutional care and clinic-based services. The problem with this approach is that it neglects the idea of housing as being therapeutic, as well as preventive, in and of itself.

⁹ Maslow, Abraham. 1954. *Motivation and Personality*. New York: Harper & Bros.

¹⁰ National Low Income Housing Coalition. (2004). *Out of Reach 2004*. <http://www.nlihc.org>

The historic Fair Housing Act, (1968, amended 1988) brought legislative and legal backing to the housing issues facing people with mental illness and other disabilities.¹¹ Additionally, the initial New Jersey Supreme Court Mt. Laurel decision (1975), and subsequent rulings over the past 30 years, have dictated that localities have a responsibility to make provisions for affordable housing to moderate and low income people.¹² However, despite these findings, the lack of teeth to the law and regulations, constant legal battles and pervasive NIMBY issues have severely hampered opportunities for people with mental illness to obtain housing. This issue must be dealt with at the State and local levels.

To counteract these problems, this report calls for the State of New Jersey to dramatically shift its vision to a “Housing First” philosophy for people with mental illness. Supporting Governor Codey’s proposal in his State of the State address, the Governor’s Task Force on Mental Health, Housing Advisory Committee leads its recommendations with the “*Home to Recovery*” **Housing Initiative**. This initiative includes the creation of 10,000 affordable, permanent housing opportunities for people with mental illness and other disabilities over the next ten years. Coupled with the housing is a new model of community-based services that is flexible, comprehensive and accessible and which meets the consumers and their families in their environment.

Support for this approach is well documented across the country in various media including Surgeon General Thatcher’s report on mental illness in 1999¹³, President Bush’s Freedom Commission report¹⁴, other state commissions on mental health and scholarly research. The need for quality, affordable, permanent housing, coupled with a flexible, comprehensive service delivery system yields very high consumer satisfaction, positive outcomes and significant cost savings to the tax payer. Yet, despite these findings, the State of New Jersey has yet to take advantage of these opportunities.

¹¹ Fair Housing Act. Title VIII of the Civil Rights Act of 1968, as amended 1988.

¹² Council on Affordable Housing. Index of COAH’s Motion Decisions. Available through Rutgers-Newark School Of Law Library; <http://www.state.nj.us/dca/coah/> Link to Page.

¹³ U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General—Executive*

Summary. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health

Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

¹⁴ President’s Freedom Commission on Mental Health. 2003. *Achieving the Promise: Transforming Mental Health Care in America*; www.mentalhealthcommission.gov

Consequently, the Housing Advisory Committee challenges the people of New Jersey, from State government through the local level, for non-profit providers and for-profit developers alike, to consider the housing status of people with mental illness as the key issue in achieving wellness, recovery and the ability to become full participants in society. The Housing Advisory Committee applauds the leadership provided by Acting Governor Codey by bringing to the forefront the importance of meeting the service and housing needs of people with mental illness in the State. With political support and vision, combined with research and legal backing, people with mental illness will see a new day in how they receive services, are perceived in society and have their housing needs met.

A. What works (best practices), what doesn't

It has been shown that programs that incorporate Best Practice approaches such as those discussed by SAMHSA (Substance Abuse and Mental Health Services Administration), Assertive Community Treatment, Illness Management and Recovery, Supported Employment and Integrated Dual Diagnosis Treatment, have demonstrated positive results in community-based services in New Jersey.

Supportive Housing Works. Supportive Housing, especially when incorporating the aforementioned Best Practice approaches from SAMHSA, has yielded positive outcomes both here in New Jersey and elsewhere.¹⁵ Similar to more traditional residential program models, supportive housing can come in many forms including apartments, townhouses and condominium, single family homes, shared and congregate living and single room occupancy. The basic premise that makes supportive housing successful is the coupling of permanent housing and services. Dropping one of these from the equation jeopardizes the success of the model.

Housing

- **Permanent:** Not time limited, not transitional (allows people to transition in place);
- **Affordable:** For people who are very low-income, including people coming out of homelessness or being discharged from a state institution; and
- **Independent:** The individual or family is a tenant, holds a lease and is responsible to pay rent and meet lease responsibilities.

Services

¹⁵ Culhane, D. P., Metraux, S., & Hadley, T. (2002). Public service reductions associated with placement of homeless

persons with severe mental illness in supportive housing. Housing Policy Debate.
www.fanniemaefoundation.org

- **Flexible:** Designed to be responsive to tenants' needs;
- **Voluntary:** Participation is not a condition of tenancy; and
- **Independent:** Focus of services is on maintaining housing stability.

Various research demonstrates the qualities of supportive housing. Consumers are much more responsive to accepting treatment after they have housing in place.¹⁶ Also, people with mental illnesses consistently report that they prefer an approach that focuses first on providing housing for consumers or families.¹⁷

Research has also found that permanent supportive housing can be cost effective when compared to the cost of homelessness.¹⁸ For example, a University of Pennsylvania study cited in the *Achieving the Promise: Transforming Mental Health Care in America* report (2003) found that homeless people with mental illness who were placed in permanent supportive housing cost the public \$16,282 less per person per year compared to their previous costs for mental health, corrections, Medicaid, and public institutions and shelters.¹⁹

Other research around the country on the impact of supportive housing for people with mental illness, chronically homeless individuals and families concludes²⁰:

- 80% of tenants coming from streets and shelters achieve housing stability for at least a year.
- Emergency room and hospital visits drop by more than 50%.
- Decreases in tenants' use of emergency detoxification services by more than 80%.
- Increases in use of preventive health care services, primary care and services to address substance abuse.
- Positive impact on employment status.
- Increases of 50% in earned income and 40% increase in rate of participant employment when employment services are provided in supportive housing.
- Significant decrease in tenant dependence on entitlements.

Though supportive housing is successful, the lack of supportive housing and services is a significant barrier to recovery. Moreover, there is a lack of ownership of the housing

¹⁶ Lipton, F. R., Nutt, S., & Sabatini, A. (1988). Housing the homeless mentally ill: Alongitudinal study of a treatment approach. *Hospital and Community Psychiatry*, 39, 40-45.

¹⁷ President's Freedom Commission on Mental Health. 2003. *Achieving the Promise: Transforming Mental Health Care in America*; www.mentalhealthcommission.gov

¹⁸ Corporation for Supportive Housing. (2002). Strategic framework for ending long-term homelessness. Available: www.housingworks.org/aidsissues/pdf/StrategicFramework.pdf

¹⁹ President's Freedom Commission on Mental Health. 2003. *Achieving the Promise: Transforming Mental Health Care in America*; www.mentalhealthcommission.gov

²⁰ Corporation for Supportive Housing. 2003. Compilation of various research.

needs of this population at the State level as evidenced by the large number of people with mental illness living in inappropriate settings. The need for affordable, supportive housing exceeds the supply. Without addressing this issue comprehensively, many people fall through the cracks or ultimately end up in the costly end of the mental health or criminal justice systems.

B. Why this is an issue:

In order for initiatives like the one being proposed to succeed, the various State agencies need to embrace a paradigm shift that acknowledges the importance of housing and accompanying services in recovery. The formidable housing issues faced by this population are precipitated by three main problems that perpetuate homelessness, institutionalization, incarceration, and sub-standard living: extreme poverty in an expensive real estate market, a lack of leadership by the State, and reluctance by community service providers to create additional housing.

First, many people with mental illness face extreme poverty. Supplemental Security Income (SSI) and/or Social Security Disability (SSD) do not provide sufficient income for a person to make ends meet. Significant disincentives to secure gainful employment exist. Compounding the issue of poverty, New Jersey is the third most expensive market in the country to secure housing.²¹ Based on the federal affordability standard of paying no more than 30% of income for housing costs, a person living anywhere in New Jersey would have to pay over 100% of their monthly income to rent an apartment at the Fair Market Rent (FMR). The Fair Market Rent is the U.S. Department of Housing and Urban Development's (HUD) best estimate of what a household seeking modest rental housing might expect to pay for rent and utilities in the local market.²²

Second, no comprehensive plan to meet the housing needs of people with mental illness exists. The role of the Department of Human Services, Division of Mental Health Services has been to provide services for people with mental illness. Over the years, this has resulted in the slow creation of residential services. Since the early 1970's, approximately 600 licensed residences have been created Statewide.²³ This capacity is far short of the actual housing needs of this population. Most of these beds are considered transitional in nature, but have few alternatives for people to move on to independent living.

The problem is that the issues people with mental illness face, such as lack of housing, cross over into other areas under various Departmental jurisdictions. When State agencies operate as silos, funding streams remain fragmented, the State as a whole does not assume leadership, and there is no cohesive focus to address the critical housing needs for this population. Leadership must buy into the importance of housing for people and prioritize this as an issue for State agencies as well as community providers.

²¹ National Low Income Housing Coalition. (2004). Out of Reach 2004. www.nlihc.org

²² National Low Income Housing Coalition. (2004). Out of Reach 2004. www.nlihc.org

²³ New Jersey Department of Human Services Statistics (2004)

Third, providers of community services do not assertively pursue housing opportunities for various reasons, including an inability, and sometimes unwillingness, to shift from the clinic model of treatment or to move from the group home model even though trends are toward more permanent, supportive housing models. Also, there is an inability to develop in-house expertise as it relates to housing planning, development and operations if not funded to do so. Additionally, without coordinated funding, agencies face significant risks both financially and professionally.

Unless these three main issues are resolved, providers will continue the inefficient, cumbersome process of creating few housing opportunities and many consumers will continue to live in inappropriate settings.

C. Examples

1. **Supportive Housing:** Supportive housing has gained respect in New Jersey, as well as nationally, as a cost-effective means of meeting the housing and service needs of people with mental illness. There are numerous examples of people moving directly from State hospitals and homelessness into supportive housing with very positive outcomes.
2. **Access:** Most new State funding is prioritized for people coming from the State hospital system. However, this approach has not reduced the State hospital census and does not acknowledge the squalid living conditions of many people such as the homeless. One of reasons for the high State hospital census is because the problems of many people living in the community are not being met. The result is that the “Front Door” to the State Hospital System is still open because preventive community-based services are lacking.

We can reasonably argue that a homeless gentleman with mental illness living on the street in the winter is in greater need of housing than a person currently in the hospital. State hospital statistics show that approximately 40% of admissions are from people who were homeless upon admission. If housing and services were available to this person, two gains could be achieved: he might not decompensate to the point of requiring commitment in the hospital, and the State would not need to bear the cost of the hospitalization.

3. The current Redirection II Plan intends to decrease the bed capacity of Greystone Park Psychiatric Hospital, and build a smaller, state of the art facility. This initiative was triggered by former Governor Christie Whitman in response to several patient care issues at the hospital that included patient assaults and poor living conditions.

While the desired outcome was to provide services more appropriately to people in the community, the planning was somewhat reactionary, lacked a coordinated approach, and was overly controlled by the State. As a result, a series of Requests for Proposals, RFP’s, were released in a very short period of time and agencies

had little opportunity to plan long term for operations and housing, funding was compartmentalized in the State's rigid contracting structure, and the initiative neglected many of the fiscal issues agencies were currently facing in difficult times.

Summary of Key Findings

The lack of permanent, affordable housing is one of the leading issues facing people with mental illness in their struggle to recover. Among the supporting evidence for this includes the following:

- Public testimony heard in the three hearings, January 2005
- Out of Reach 2004
- President Bush's Freedom Commission Report, July 2003
- Surgeon General's Report on Mental Health, December 1999
- US Supreme Court, *Olmstead versus L.C. and E.W.*, June 1999²⁴
- Other State Commission Reports (Oregon, Michigan, Ohio)

Compounding this issue are fragmented funding streams and the extreme poverty that most of our consumers experience. The result is an affordable housing crisis for people with mental illness. What is striking is that nearly every report on mental health, both nationally and in New Jersey, calls for the creation of new housing, but the reality is that this recommendation infrequently results in formal, planned housing initiatives.

Yet, the emerging trend nationally is to couple affordable, permanent supportive housing opportunities within the community with a flexible, comprehensive service system. Much of the housing development is backed by Federal US Department of Housing and Urban Development programs that have established funding priorities for permanent supportive housing. While these programs unfortunately face significant cuts in President Bush's proposed FY 2006 budget, they will still remain a large potential matching source of grant funds that New Jersey will need to take advantage of for any housing initiative.

New Jersey

Both in New Jersey and nationally, the treatment of people with mental illness has historically been done in various institutional settings or on-site at community-based mental health centers. For many people, institutional settings (e.g. psychiatric hospitals, prisons) have, in essence, become their form of housing. The Housing Advisory Committee concedes that although New Jersey has significantly reduced its State Hospital census over the past several decades, in many ways, people have been re-

²⁴ US Supreme Court, *Olmstead versus L.C. and E.W.*, June 1999

institutionalized into other inappropriate settings, such as sub-standard boarding or rooming houses or homelessness.

The majority of people with mental illness in New Jersey live in “housing” outside of the purview of the Division of Mental Health Services. As a result, many people with mental illness fall through the cracks for various reasons, including a lack of services or lack of coordination between State agencies. These various settings include, but are not limited to the following:

- *Homeless*: New Jersey has approximately 20,000 homeless people. 8,000, many of whom have a serious and persistent mental illness, are chronically homeless.²⁵
- *Boarding Homes/Rooming Houses*: The Department of Community Affairs (DCA) licenses 967 Class A rooming houses with 13,461 beds and 199 (combined) Class B&C Boarding Homes with 4,881 beds in the State with an approximate occupancy rate of only 70%. It is estimated that a significant number of those occupied beds are occupied by people with mental illness.²⁶ Note: Despite the large number of rooming house beds, this report could not fully examine rooming houses for various reasons, including insufficient information on the topic.
- *Residential Health Care Facilities (RHCF)*: The Department of Health and Senior Services (DHSS) licenses 144 RHCF's in the State with 5,992 beds. However, DHSS is uncertain about actual occupancy rates or the percentage of beds occupied by people with mental illness, but the number is suspected to be substantial.²⁷
- *State Prison System/County Jails*: The Department of Corrections reports that there are 3200 people in the State prison system diagnosed with mental illness. There is general agreement that there are more prisoners who have mental illness but not been diagnosed. Additionally, in the county jail system, there is a significantly large mental health population, but there is no accurate count.²⁸
- *CEPP*: There are approximately 1,000 people on Conditional Extension Pending Placement (CEPP) status in the State psychiatric hospital system. These are people essentially considered discharge ready, but unable to leave the hospital due to a lack of appropriate community placement options.²⁹

²⁵ New Jersey Department of Human Services Statistics (2004)

²⁶ New Jersey Department of Community Affairs Statistics (2004)

²⁷ New Jersey Department of Health and Senior Services Statistics (2004)

²⁸ New Jersey Department of Corrections Statistics (2004)

²⁹ New Jersey Department of Human Services Statistics (2004)

- *Juvenile Detention Facilities:* The Juvenile Justice Commission (JJC) reports there are approximately 75 homeless children in their system, many who have a diagnosed or developing mental illness, in need of housing options. This is believed to be the average number per year.³⁰
- *Children’s Behavioral:* Between now and 2007, approximately 793 youth, ages 16 – 21, currently in congregate living with a history of behavioral healthcare needs and/or caregiver incapacity may be in need of housing options.³¹
- *At home with aging parents:* According to NAMI, between 40 and 60 percent of all persons with a severe mental illness are living at home with their families, often without adequate services or formal plans for housing due to system inaccessibility.³² Occasionally, families are in a position financially to contribute to long-term housing needs, but the system has been inflexible to this approach.
- *Other:* There are a significant number of people with mental illness living in the community in other independent, often substandard, settings without access to services. Such settings can include apartments not monitored by DMHS, unlicensed rooms or apartments in single-family homes, YMCA’s, etc.

Current Residential Structure

The existing residential continuum has played an important role in decreasing the State hospital census over the years, and enabled many people to transition successfully to community living. The following table shows the Division of Mental Health Services licensed residential capacity throughout the State:

<u>Level of Supervision</u>	<u># of Residences</u>	<u># of Beds</u>
A+ Group Home	111	777
A GH	24	147
B GH	15	73
C GH	5	22
A+ Supervised Apartment	48	141
A SA	69	196
B SA	112	342
C SA	88	240
Youth Home Capacity	22	165
Family Care	62	111
<u>Supportive Housing</u>	<u>49</u>	<u>140</u>

³⁰ New Jersey Juvenile Justice Commission Statistics (2004)

³¹ New Jersey Department of Human Services Statistics (2004)

³² National Alliance for the Mentally Ill. Things you should know: NAMI facts. www.nami.org

TOTAL:

605

2354

Note: DMHS has an additional 1651 unlicensed supportive housing capacity. Some of these beds are unable to be licensed due to DMHS regulations, and in other instances, providers have opted not to license facilities.

Despite the role the existing continuum has played, the current bed availability is insufficient compared to the needs statewide. In recent years, New Jersey has opted to expand the supply of supportive housing versus traditional group homes. Some of the reasons for this include supportive housing's cost effectiveness, permanency and success rates. There are also less NIMBY issues experienced by providers and residents in supportive housing because the housing integrates well into the community.

Moreover, there is growing research that suggests that group home settings may not necessarily equip individuals with the independent living skills that an in vivo environment can.³³ While many of these residential programs do provide a quality service and safe, secure environment, they are also inaccessible to most people with mental illness in the State and do not offer permanent, lease-based housing. Most residential placements are restricted for people being discharged from the State psychiatric hospitals, a minority of mental health citizens in the State, comparatively, who are in need of housing and services.

There is concern that DMHS unnecessarily spends too much of its funds on the more highly supervised group homes in the State. For instance, according to DHS statistics, 62% of DMHS funding goes for 1,676 people receiving licensed residential services in New Jersey in Level A+ through Level B housing (i.e. 24 hour supervision down to approximately 4 - 12 hours/day) while roughly 30% of DMHS funding supports a larger supportive housing capacity of 1,791 licensed and unlicensed beds. The supportive housing model is more cost effective and experiences successful outcomes with many people who were traditionally thought to require intense supervision.

There is some agreement that the more highly supervised residences could be utilized better if converted to specialized residences (i.e. medically enhanced, dual diagnosis, etc.). The Housing Advisory Committee also agreed that efficiencies could be found if some programs were merged to consolidate administrative costs, some residences were converted to supportive housing, and providers were held accountable to occupancy standards. There is also concern that there are disincentives for providers to transition residents on to independent living, and as a result, efforts are not focused at assisting consumers with developing independent living skills.

Obstacles in New Development

³³ Tsemberis, Sam & Eisenberg, Ronda, F. (2000). Pathways to housing: Supported housing for street-dwelling

homeless individuals with psychiatric disabilities. *Psychiatric Services*, 51(4), 487-493.

The creation of affordable supportive housing opportunities is a challenging process for non-profits and for-profits. Considering the current funding and political climates, many providers opt not to pursue additional residential programming and maintain the focus of their operations on clinic-based services.

Several providers across the State, though, have developed capacity to create housing opportunities for people with mental illness. However, this is an arduous task for various reasons. First, there must be an in-house expertise on housing development and operations. Any housing development requires the navigation of complex, fragmented funding streams with application periods that do not overlap. Generally speaking, most agencies do not have this capacity because it has typically not been a focus of, or funded by DHS, DMHS.

A second issue is the fragmentation of funds. Agencies that have some capacity to create new housing can have projects in the pipeline every year. While the development piece is cumbersome, funding the service component is more difficult. New Jersey continues to face problems fiscally resulting in insufficient funds available to meet the service demands of people in need of these supports. Also, the rigid funding structure of DMHS, namely RFP's, contracting, and other "red tape," make it almost impossible for providers to initiate expanded housing opportunities in the State.

For instance, New Jersey's local Continuum's of Care have the opportunity to secure millions of dollars from the HUD-McKinney program each year for homeless housing and services. The McKinney program requires the leveraging of other sources, such as State funds, but New Jersey has historically not released funds for this purpose leaving willing providers unable to apply for the HUD funds. Until the State is willing to prioritize the housing and service needs of this population, the housing crisis will continue, hospitals and jails will continue to be a primary means of housing people with mental illness and New Jersey's homeless numbers will rise.

Thirdly, providers and consumers face societal challenges in creating and securing housing. NIMBY (Not In My Back Yard) issues still prevail. Many providers experience backlash from communities, and municipalities can find ways to thwart new sites by not endorsing funding streams that need municipal consent, such as the HOME program. Further, the State has its own issues geographically that can impede new housing for this population. For example, in northern New Jersey, the Highlands Act severely limits new development in this area. Also, through the Mt. Laurel Decisions, the Council on Affordable Housing (COAH) has regulations that remain controversial and provide little incentive for affordable housing for people with disabilities to be created. A municipality would rather opt not to submit a plan for certification, create age-restricted housing or sell off the municipality's obligation to another town. The for-profit sector, which has the most capacity to create new housing, has little incentive to create supportive housing for very low income people with disabilities.

What New Jersey Does Well:

New Jersey has, especially in recent years, created and provided quality services for many people with mental illness. Pertaining to housing for people with mental illness, New Jersey does well in the following five areas:

1. Despite staffing shortages, agency infrastructure issues, and complex systems to navigate, New Jersey generally has a compassionate, dedicated workforce that helps consumers strive for recovery in their current housing. The longer these staff remain in the field, the more they become an invaluable resource.
2. Supportive Housing Services: In recent years, New Jersey has successfully directed a large portion of its funding to supportive housing. People in supportive housing programs, as well as PACT teams, are demonstrating longer community tenure and report higher satisfaction than in other settings.
3. Rental assistance: DMHS has created and successfully operated a temporary rental subsidy program that consumers can utilize until they can obtain a Section 8 or other form of long-term rental assistance. This has enabled consumers to gain quicker access to housing than if they had to wait for Section 8.
4. Peer Support: Most supportive housing, PACT, ICMS and other programs are successfully incorporating consumers of mental health services into provider roles. This has provided gainful employment to consumers and made community support teams better rounded.
5. Housing: Many providers that are creating supportive housing or supervised residential programs tend to have quality facilities that are more appealing to consumers than those typically available to them on the private market.

Recommendations

People with mental illness interact with the various services, or lack of, in New Jersey depending on their access, choices and needs. However, the issue of housing is relevant to everyone with mental illness. The recommendations that follow all stem from the Housing Advisory Committee's perspective that New Jersey must adopt a "Housing First" approach to meeting the needs of people with mental illness. Enabling consumers to have a place to call "home" will make the road to recovery that much more possible.

Recommendation 1: The State should implement the "Home to Recovery" Housing Initiative:

In coordination with this Task Force, Governor Codey, in his State of the State address in January 2005, announced a goal of creating 10,000 new affordable, permanent housing opportunities for people with mental illness and other disabilities. The focus of this

initiative would be for permanent supportive housing, specialized residences, and other independent living arrangements. Along with this recommendation was the creation of a \$200 million housing trust fund that would provide State capital funds that can be leveraged with other sources to help in achieving this goal. The “Home to Recovery” initiative establishes a focus for State government in the years to come.

In order for this initiative to be successful, collaboration in the truest sense within State government must occur. Planning and implementation must include local efforts that are keenly in tune with their communities. Additionally, this initiative must be re-evaluated periodically in order to measure success, revise if necessary and also seek additional sources of revenue as the State’s economy improves.

This initiative addresses the issue as one for all people of New Jersey, and raises the bar in defining the next generation of mental health services in the State

Recommendation 1A: The Home to Recovery Initiative should incorporate Best Practice approaches, concepts and principles, including Wellness and Recovery, Illness Management and Recovery, Psychiatric Rehabilitation, Assertive Community Treatment, Supported Employment and Integrated Dual Diagnosis Treatment. Services must also be culturally competent, especially considering the great diversity in New Jersey.

Recommendation 1B: The *Home to Recovery* \$200 million Housing Trust Fund should be administered by the New Jersey Housing and Mortgage Finance Agency (HMFA). HMFA is most suited to address the housing capital funding needs and issues in the State, and is positioned well to work collaboratively with the many Departments and Divisions that will be involved in this initiative. This fund will be used to leverage other financial resources from a variety of sources, including The US Department of Housing and Urban Development, foundations, local municipal developer trust funds, private financing, etc. The trust funds can be in the form of grants or low-interest loans made to non-profits. Appendix B discusses how the \$200 million trust should be spent.

Recommendation 1C: The State should consider other financial avenues that might additionally help in achieving the initiative’s goals. Examples can include expanding the successful DMHS temporary rental assistance program, requesting additional legislative appropriations over the course of the initiative, and tapping into the significant equity that the Department of Human Services has in its already existing residences that it has funded over the years. The value of New Jersey’s real estate has sky rocketed in the past five to fifteen years which has greatly enhanced the values of the system’s current housing stock.

Recommendation 1D: Considering the size of this initiative, the Governor’s office should call on the for-profit sector, by whatever means it sees fit, to help create these new housing opportunities. The for-profit building sector has greater capacity and can work closely with non-profit service providers to ensure the initiative’s success. In order to enlist the for-profit building sector, tax incentives should be made available for

developers who specifically create supportive housing opportunities for people with mental illness and other disabilities.

Recommendation 2: In order to successfully implement the goals outlined in the Home to Recovery Initiative, the State should increase the visibility of housing across Departments considering the following mechanisms.

As previously discussed, the current Departmental and Divisional structure within State government approaches the housing needs of people with mental illness in a fragmented way. Certainly, housing opportunities exist, but the State has put this together over many years without a major focus, limited planning and inadequate funding by the Legislature. In order for the *Home to Recovery* initiative to succeed, the State, including the Executive and Legislative branches, must value the role housing plays in recovery from mental illness and raise the visibility of housing within Departments and Divisions.

Recommendation 2A: An oversight council must be created that will ensure accountability, planning and implementation of the initiative. This *Home to Recovery Planning and Implementation Council* must be comprised of executive leadership from the various stakeholder Departments, Divisions, etc, including DHS, DCA, DOC, Parole, Juvenile Justice, etc., representation from key groups in the community, as well as a key staff member from the Governor's office. Minus political backing, this process has the potential to fall apart.

This Council should be created through legislation, consist of decision makers and not become watered down over time as other councils do. Complex coordination issues need to be identified and addressed so that funding for housing and services are worked out quickly and efficiently. The housing plan should be re-evaluated as needed to ensure progress toward the goal is being made and that any issues that may impact the plan implementation over time are addressed by the Council.

The State needs a driving force to bring the “players” together to make affordable housing and services a reality for people with mental illness. Pooling resources together when other opportunities exist is necessary, but can't happen if efforts are not highly coordinated. County and local systems must be included in the process. In many instances, County and local governments provide some funding that can be leveraged with State and Federal programs. If planning is not done in a coordinated fashion, these opportunities are lost.

Recommendation 2B: Within the Department of Human Services itself, housing should have greater visibility through a more formal mechanism. This should include an Office, Bureau, or Division that has authority to coordinate programs with other Divisions and Departments, as well as plays a role in accountability, planning and implementation. This “office” would work closely with the Home to Recovery Planning and Implementation Council. Additionally, other Departments and agencies, such as Community Affairs, Corrections and Juvenile Justice, should appoint at least one point person to be involved in this initiative.

Recommendation 2C: Because the availability of services will be crucial to the success of the *Home to Recovery* initiative, services must be coupled with new housing opportunities in a highly coordinated, flexible fashion. This requires long range planning via the Planning and Implementation Council due to the length of time it takes to create new housing opportunities, but also requires rapid response when housing and service projects come to the table. Therefore, the State should adopt one streamlined review process for this initiative coordinated through the Council so that projects can be approved and implemented quickly and efficiently. This is discussed further in Recommendation 4B.

Recommendation 2D: Local Participation: County and local systems must be included in the process. Local bodies tend to be in tune with local issues and therefore, should play a role in planning and implementation. In many instances, County and local governments provide some funding that can be leveraged with State and Federal resources. If planning is not done in a coordinated fashion, these opportunities are lost. Also, this initiative will be successful if it can partner new State capital and service funds with local Continuum of Care planning for HUD McKinney grants, a continued focus of HUD despite budget cuts. Local Public Housing Authorities (PHA's) are also able to generate additional rental assistance opportunities, but planning needs to occur so that they can be confident that services will be available if they obtain additional rental assistance for consumers.

*Recommendation 2E: **New Jersey Supportive Housing Institute**:* A housing institute should be created that helps build a skilled workforce to accomplish the affordable housing and service needs of people with mental illness and other disabilities. The **New Jersey Supportive Housing Institute** can provide training, technical assistance and capacity building to providers, both non- and for-profit, on various issues that can include development, property management, HUD programs, community relations, wellness and recovery, supportive housing principles, psychiatric rehabilitation, etc. Staff from agencies can also learn how to build in-house capacity in order to successfully plan and implement housing opportunities.

The scope of the Institute can be expanded to include affordable housing in general, and should operate through a combination of some State funding, fees and foundation grants.

Recommendation 2F: Provider capacity must be built through funding for skilled positions and training. DCA should work with DHS to expand its Office of Housing Advocacy (OHA) development grants. The current capacity of providers in the State that have housing development and management experience is insufficient for this initiative. The State must assist providers in increasing their capacity so that they are in the position to create new residential opportunities. The State should also encourage service providers with little housing expertise to collaborate with experienced housing providers.

Recommendation 3: The State must ensure flexible, comprehensive services for people living in community housing by appropriating \$7.5 million for services.

The *Home to Recovery* housing initiative will be successful only if adequate services are made available. These services must be flexible, comprehensive and culturally competent and based on Best Practices. Continued funding to providers for services should be based upon quality outcome measures.

While many who will benefit from the new housing are independent and engaged in some level of services already, such as partial care, most will need new or enhanced services. This will require additional service funding through new appropriations or found through efficiencies in the system. In its first year, the Home to Recovery housing initiative is expected to generate affordable housing for five hundred people. At least \$7.5 million should be made available through State and Medicaid Rehab Option funds for services for these new opportunities.

Recommendation 3A: The State should consider streamlining its community-based outreach programs. For example, the State currently funds supportive housing, PACT, RIST, ICMS, and PATH teams that provide very similar services, but are somewhat fragmented. The State should provide flexible, comprehensive, multi-disciplinary teams that meet the consumer's needs at any given point in time and follow the consumer, whether they are in the hospital, in a different living environment or in need of a higher level of support.

By consolidating the team approach to one or two types of Community Support Teams that incorporate the Best Practice principles of each current team structure, the system will be less fragmented, consumers will gain better long term relations with providers, and administrative cost savings might be found. This streamlined approach might also fit better into any new State Medicaid Plan revision for the Rehabilitation Option.

Recommendation 3B: Medicaid: The State should pursue the Medicaid Rehabilitation Option for community-based services, including supportive housing services; the State is currently not leveraging additional Federal Medicaid dollars that it could. This is necessary in order to provide the funding that will be required to achieve services for people gaining access to the new housing opportunities. Any revisions to the Medicaid Plan should consider any changes in services recommended in this report.

Recommendation 3C: Prevention/Crisis Housing: The State should strongly consider the creation of Prevention/Crisis housing opportunities either locally or regionally to prevent unnecessary hospitalization and homelessness. These facilities can potentially serve in coordination with jail diversion programs. The State should also work with providers to secure Safe Haven funding through HUD. Safe Havens are a low demand form of housing for homeless individuals with the goal of helping them transition on to stable housing and engage in services.

Recommendation 3D: A significant amount of State resources is put into the more highly supervised group homes. The State should review its current group home model in order to find both financial and operational efficiencies in the system. The current model assumes that residents need the highest level of supervision all of the time, does not

always transition people to independent living, and often allows vacancies to last for many months until an appropriate referral comes from the State hospital.

The State should consider converting some group homes into supportive housing residences and “specialized residences” (i.e. medical, MICA, MI/DD, etc.). The State should also consider encouraging consolidation of ownership and/or management of the current residential structure so as to find efficiencies as well as begin to standardize the provision of residential services statewide.

Recommendation 3E: The service approach outlined in 3A should be made available to boarding homes, rooming houses and RHCF’s. These services can be contracted with the operators or simply made available to residents. Peer Outreach Support Teams (POST) should be included and/or coordinated with.

Recommendation 4: The State should review and revise the following recommendations relating to regulations, policies, and legislation:

It is evident that various regulations, policy and law sometimes interfere with the development, operation and accessibility of services and housing for people with mental illness. The Housing Advisory Committee acknowledges that many regulations, policies and laws were established with good intentions. The Housing Advisory Committee encourages the State, however, to view the issues that people with mental illness face on a daily basis in a broader context and consider the following recommendations in order to make the system work for the consumer versus having the consumer fit into the system mold.

Recommendation 4A: Access to new and existing housing opportunities should be available to people in community settings. For the Home to Recovery initiative, an emphasis should be given, but not limited to its most vulnerable citizens such as chronically homeless with mental illness, people living in sub-standard boarding homes, rooming houses or Residential Health Care Facilities, and people living at home with aging parents.

Current practice is that people being discharged from the State psychiatric hospital system are prioritized for any funding coming from the Division of Mental Health (DMHS). For example, nearly all residential placements go to people being discharged from State psychiatric hospitals. However, most people with mental illness in the state in need of housing already live in the community in a variety of inappropriate settings.

Within the mental health population, people experience many other significant issues that often prevent them from securing appropriate services and housing. This is not necessarily because of the nature of their issues, but more so because of lack of access and lack of housing opportunities. The State, through its new interdepartmental coordination, should also create housing and services under this new initiative for people with mental illness with other complicating issues such as:

- Medical issues
- Substance abuse
- Physical disabilities
- Juvenile justice
- Aging-out youth
- Developmental disabilities
- Veterans
- Living at home with aging parents
- Families with children
- Older adults with mental illness

Recommendation 4B: Streamline RFP/award process. The State should have one interdepartmental application and review process across Departments for the *Home to Recovery* housing initiative. This collaborative approach will ensure that funds, both capital and service, will be coordinated, awarded and dispersed in an efficient manner. An example of how this coordinated approach is beginning to be used is the Division of Youth and Family Services (DYFS) new housing initiatives that are being coordinated with DHS and Housing and Mortgage Finance Agency staff.

Recommendation 4C: Legislate/encourage DCA and various PHA's to prioritize their Section 8's for people with mental illness (disabilities), people who have "bridge" subsidies from DMHS and people who are chronically homeless. A set-aside of Project-Based Vouchers would be very helpful for providers and will facilitate development. Rental assistance is a quick way for people with mental illness to gain housing.

This recommendation applies to DCA's traditional Section 8 rental assistance program and the new State-sponsored rental assistance program; other local housing authorities should be encouraged to do this as well. In addition, people who are currently on the DMHS temporary rental assistance program would receive Section 8 more quickly, thereby allowing DMHS rental assistance to be reallocated to new consumers. Section 8 also serves the crucial role of covering the operational costs for providers seeking to develop new housing.

Recommendation 4D: Council on Affordable Housing (COAH): COAH should review its regulations and require municipalities to set aside a number of new units for special needs populations or very low income individuals, whichever will achieve the greatest number of new affordable housing opportunities for people with mental illness. The new regulations have no requirement for this and the bonus credit for very low income populations is not a strong enough incentive. This exacerbates the difficulty in creating housing for this population considering, among other things, the local movement toward senior housing. Additionally, if a town has developer's trusts, set asides for disability groups should continue to be required.

Recommendation 4E: Balanced Housing Program: In order to receive funds from the Balanced Housing Program (DCA) for affordable housing development, a provider must have municipal consent from a COAH certified town. However, obtaining municipal consent can impede a disability provider's ability to implement a project and can be argued as discriminatory. The State should explore removing the municipal endorsement requirement.

Recommendation 4F: Statewide Housing Assessment: In order to accommodate consumer choice and needs, and to plan and implement this initiative, the State should devise a standardized statewide Housing Assessment. This assessment will help individuals plan for their housing and service needs, and also enable the new *Home to Recovery Planning and Implementation Council* to better plan and implement the initiative.

Recommendation 4G: The creation of 10,000 new housing opportunities will be a challenging task, especially as it relates to community relations. Stigma and NIMBY are still prevalent. Therefore, the Good Neighbor Program should be re-implemented in order to tackle these obstacles. This program was originally promising and inexpensive to operate and can possibly be administered from the New Jersey Affordable Housing Institute, if created.

Recommendation 4H: The State should adopt a program for linking people to SSI and helping them to maintain eligibility. While the ultimate goal should be employment, SSI and Medicaid insurance are crucial for many people with mental illness. The Community Health Law Project and other legal service agencies could administer this program.

Recommendation 4I: The State should encourage a Zero Tolerance policy for discharging people with mental illness from hospitals, jails and prisons to homelessness. This is inhumane and costly to the taxpayer.

Recommendation 4J: The State should consider transferring DCA's "Homeless Prevention Program" to the DHS "Social Services for the Homeless Program." There is thinking that the programs might operate better if administered within one department.

Recommendation 4K: The children's system of care and its Child Welfare Reform Plan includes addressing residential issues. This reform plan has several housing committees already working toward achieving residential reform in the State, many of which already have specific time frames that must be met. However, with a new focus on housing, the *Planning and Implementation Council* should play an advisory role since many of these housing issues relate to the mental health system. The role of the *Council* should be to assist, not take the place of, the Child Welfare Reform work so that these initiatives are more likely to succeed.

Recommendation 4L: The State should change the current DHS licensing regulations to accommodate a supportive housing residence with two people or, as stated in the January 3, 2005 New Jersey Register, initiate a dialogue with the Department of Community Affairs prompting regulatory or administrative resolution to the issue of shared jurisdiction so that providers are not unnecessarily over regulated. Currently, in order for a provider to have a site licensed as Supportive Housing by DHS, the site must have at least three people living together. A supportive housing residence with two people, as is the case for several agencies, can not be licensed by DHS as a supportive housing residence. The problem is that this residence then falls under the jurisdiction of DCA as

a boarding/rooming house which it is clearly not. As new development occurs, the number of supportive housing residences with two people will grow.

Recommendation 4M: The Department of Human Services, Office of Mental Health Licensing should continue to work collaboratively with the provider community in reviewing and revising residential regulations in order to improve the quality of care for residents and minimize overregulation and unfunded mandates.

Recommendation 5: The State must immediately address the issues facing residents living in the board and care industry.

New Jersey has, by failure to act, determined that the board and care industry and its residents therein have little value. This critical statement is not baseless, evidenced by over twenty-five years of evaluation through task forces, committees, scholarly literature and legislative hearings that have resulted in absolutely no action. As a result, vulnerable, disenfranchised residents face a multitude of issues ranging from quality of life to life and death on a daily basis.

When New Jersey's economy was stronger, no money was made available. The existing silo structure of State agencies, could not work together. Politics interfered with human lives. As a result, this industry has been fated to face extinction, and those that survive, survive at the expense of residents.

While the information has been reviewed, the Housing Advisory Committee, within its time constraints, found little value in reinventing the work of over two decades worth of studies, hearings and recommendations. The combination of these reports offers structured recommendations for addressing system issues and improving the quality of lives of residents. However, there is widespread agreement that housing options for people with mental illness should be in higher quality, supportive housing type situations that value the resident. While there is clearly a lack of affordable housing in the community, efforts should be focused toward creating supportive housing opportunities for people with mental illness ahead of this industry's collapse.

Over the past twenty-five years, reports on New Jersey's oversight of this industry and its residents minimally include the following:

- Rooming and Boarding House Act of 1979 w/ Interdepartmental Policy Coordinating Council³⁴
- 1982 Assembly Corrections Health and Human Services Committee review of 1979 Act³⁵
- 1982 Article in Seton Hall Law Review: NJ's Rooming and Boarding House Act: Its Effects and Effectiveness³⁶

³⁴ Rooming and Boarding House Act of 1979 w/ Interdepartmental Policy Coordinating Council

³⁵ Assembly Corrections Health and Human Services Committee review of 1979 Act (1982)

- 1983 Nursing Home task Force convened
- 1984 Assembly Corrections Health and Human Services Committee report issued³⁷
- 1987 Commission of Investigation on Abuses and Irregularities in New Jersey's Boarding Home Industry; includes Senate Institutions, Health and Welfare Committee hearings in response to media reports³⁸
- 1987 Legislature implements Boarding Home Advisory Council recommended by the 1982 Assembly Committee
- 1990 Report of the New Jersey Boarding Home Advisory Council issued³⁹
- 1990 Governor's Advisory Council on Mental Health Services Planning, A Ten Year Plan for New Jersey's Mental Health System⁴⁰
- 1991 Report on Board and Care Reform By the New Jersey Department of the Public Advocate⁴¹
- 2003 Boarding Home Advisory Council Survey Report and Recommendations⁴²

In 1985, a series of Bills were put before the legislature that could have resulted in improvements to the board and care industry. Namely, these bills were Assembly No. 3415, 3416, 3417, 3418, 3427, 3428, and 3429. While the passage of these bills would not have solved the quality of care issues that residents faced, they did provide a momentum for reform which was then lost. The only bill signed into law was Assembly, No. 3416 which created the Boarding Home Advisory Council.

The failure of this industry encompasses many issues, such as the State Legislature's inability to act, the State Departments' inability to plan and work collaboratively together, and many owner/operator's disregard for the basic human needs of their residents. The Housing Advisory Committee, however, does recognize that it must put forth recommendations pertaining to this industry. Unfortunately, there is a lack of confidence that any real reform will take place and that until new housing opportunities are created, people with mental illness will continue to struggle in these facilities.

Lastly, continued neglect could raise Olmstead issues for the State, especially if people are being placed in these facilities from State institutions. It could be argued that the State, by virtue of placing people with mental illness into sub-standard board and care

³⁶ Article in Seton Hall Law Review: NJ's Rooming and Boarding House Act: Its Effects and Effectiveness (1982)

³⁷ Assembly Corrections Health and Human Services Committee report issued (1984)

³⁸ State of New Jersey. (1987). Commission of Investigation on Abuses and Irregularities in New Jersey's Boarding Home Industry.

³⁹ Report of the New Jersey Boarding Home Advisory Council issued (1990)

⁴⁰ Governor's Advisory Council on Mental Health Services Planning, A Ten Year Plan for New Jersey's Mental Health System (1990)

⁴¹ Report on Board and Care Reform By the New Jersey Department of the Public Advocate (1991)

⁴² Boarding Home Advisory Council Survey Report and Recommendations (2003)

facilities, is inadequately taking into account “the needs of others with mental disabilities” as specified in the Olmstead ruling.⁴³ While these may be less restrictive settings, they may be inappropriate placements that put consumers at risk.

Note: These recommendations relate primarily to Class B and C boarding homes and Residential Health Care Facilities. Class A Rooming Houses were not examined due to insufficient information. However, there is consensus that most rooming houses are inappropriate placements for people with mental illness and that this end of the industry should be monitored more closely.

Recommendation 5A: For an industry with so many problems, it would be in the State’s best interests to reconvene the Interdepartmental Policy Coordinating Committee with decision-makers from each of the Departments or assign the existing BHAC additional authority and ability to directly influence each of the State Departments involved, as well as operators in the industry.

The Interdepartmental Policy Coordinating Committee created under the Rooming and Boarding House Act of 1979 was intended to coordinate the oversight activities of the three State Departments involved, namely the Departments of Human Services (DHS), Community Affairs (DCA) and Health (DHSS). However, over the years, powers were delegated away and an apparent lack of commitment to the importance of the committee ultimately resulted in it being folded into the Boarding Home Advisory Council (BHAC) created in 1985 by Governor Kean.

While a committed group, the BHAC became an advisory group without decision-making authority and carried little influence.

Recommendation 5B: The licensing and oversight of Residential Health Care Facility (RHCF) inspections should immediately be transferred to DCA which is more equipped to handle this task. Various issues must also be considered, however, so that one Department’s problems are not just transferred to another. DHSS has very limited numbers of inspectors, due to years of cuts, across the State to monitor facilities. This burden should not simply be transferred to DCA; DCA should increase its staffing accordingly if its staff cannot handle the additional workload. RHCF beds that are connected to nursing homes can retain their licensure through DHSS since there does not appear to be the same issues that stand alones experience. Despite consolidation of these inspections, people with mental illness will still crossover these three Departments, and the Interdepartmental Policy Coordinating Committee should have active representation from DHSS to ensure that problems do not develop in the future.

For all facility inspections, site reviews should be enhanced to work from more of a quality of life perspective and be done via a multi-disciplinary team that includes DCA staff, nurses and mental health professionals. Many facilities may meet minimum safety standards, but need improvement in various quality of life issues.

⁴³ US Supreme Court, Olmstead versus L.C. and E.W, June 1999

Recommendation 5C: The role of the Ombudsman for the Institutionalized Elderly should be expanded. Currently, the Ombudsman has broad power and authority to investigate and intervene in a variety of contexts on behalf of elderly persons in health care facilities. The role of the Ombudsman should be expanded through statutory and regulatory amendments to include disabled persons living in boarding homes, rooming houses and RHCF's.

Recommendation 5D: SSI rates should be increased, as well as the Personal Needs Allowance (PNA) for residents. However, the State should proceed cautiously in this area since the Housing Advisory Committee recommends any new appropriations should go to new supportive housing opportunities. The State, possibly in coordination with the Division of Medical Assistance and Health Services (DMAHS) and the revised structure of the BHAC, should generate true figures on the number of people in these facilities on SSI since no agency has been able to supply this data.

The Housing Advisory Committee completed a statistical analysis with questionable available data to determine additional costs to the State if the New Jersey's supplement to SSI for Boarding Home Class B & C and RHCF's was increased. See Appendix C.

In addition, various conditions must be met by operators. For instance, all facilities should meet newly established quality of care criteria during site reviews. Site reviews should be done by multi-disciplinary teams that review the facilities from a quality of care perspective in addition to physical plant issues. These teams should also review accounting records, and independent audit requirements are strongly recommended. Any increase to SSI must be shown to benefit the residents.

Assembly Bill 3295 and its Senate counterpart should not be passed in their current versions because of the significant additional allocation to RHCF operators without true accountability measures built in, as well as the fact that the Personal Needs Allowance for residents is not increased. Furthermore, the bill does not address Boarding Homes despite the fact they provide essentially the same service. Lastly, the proposed increase is a very large increase in expense to the State. While resources are scarce, the thrust of new funding should go to new housing opportunities.

Recommendation 5E: Boarding Homes and RHCF's should be required to partner/contract with local community support/supportive housing teams so that (additional) services can be brought on-site. These can include the Peer Outreach Support Teams (POST) used by several self-help centers. This new service addition should be a licensing requirement for owner/operators, and would require changes to the Rooming and Boarding House Act of 1979. Non-profits must be funded to provide services to residents living in board and care facilities (See Recommendation 5C below). By having services brought into these sites, there is the assumption that services will be better and more accountable.

Recommendation 5F: As per the Rooming and Boarding House Act, County Welfare Agency's (CWA) were delegated the authority of providing assessments of all residents

in these facilities at least semi-annually. In practice, however, the effectiveness of this role has been questionable for various reasons, including lack of funding to accomplish the goal, inherent conflict between the role of placements and oversight, and the lack of available services in the community that CWA's could link residents to.

The Interdepartmental Policy Coordinating Committee/Boarding Home Advisory Council should examine the issues that CWA's are facing in this regard. The IPCC/BHAC should determine how the CWA's could more effectively do this job, what funding this would require, and how to work with local service providers if services are to become available to board and care residents. Resident safety and quality of life issues should be a focus including transitions from sub-standard board and care facilities to new affordable housing opportunities.

Recommendation 5G: An advocacy organization should be legally empowered to insure the rights of residents in board and care facilities, as well as other issues residents face when trying to manage community living such as application for and protection of public entitlements. The Community Health Law Project, and/or similar law projects, is a good example of an organization that can fulfill this role. Adequate funding should be made available for this task.

Recommendation 5H: The home equity loan program through DCA that was used for life safety improvements by operators should be re-vitalized. As with struggling non-profits, funding is always an issue and non-profit agencies frequently carry low interest loans to support operations. An increase in SSI rates should make this more feasible and the result will be better living conditions if accountability measures are built in. This program should be expanded beyond life safety improvements to include capital improvements. ***Any grant funds made available by any means should be met dollar by dollar by the facility.***

Recommendation 5I: The State should consider contracting w/ Assisted Living facilities, and quality run Boarding Homes and RHCF's, where there are vacancies. Vacancies in these facilities could serve as at least temporary housing until more permanent housing opportunities in the community are created and would welcome a steady revenue source. As previously discussed, accountability measures must be built in.

Recommendation 5J: Operator Training: Operators, as outlined in the Board and Care Advisory Council survey done in 2003, should receive continued, formal training in the areas listed. This training can be done in conjunction with the New Jersey Affordable Housing Institute or through the Department of Human Services.

Recommendation 5K: If decent facilities become available for sale, the State should facilitate the transfer of ownership to desiring non-profits which could convert the properties to a single room occupancy (SRO) supportive housing model for residents.

Recommendation 5L: The State should facilitate receivership of board and care facilities in a timely fashion when poor conditions or issues are not remedied by operators. The

State should also consider what funds should be made available to appointed receivers in order to remedy existing problems.

Conclusion

The Housing Advisory Committee hopes that despite difficult fiscal times in New Jersey, the State will recognize the toll undesirable living conditions have on people with mental illness. By implementing the recommendations made in this report, New Jersey will take a large step in helping people with mental illness recover. At the end of the day, everyone should have the opportunity to go to the place they call “Home.”

Additional Resources

Common Ground and the Corporation for Supportive Housing. (2004) *New Beginnings: The Need for Supportive Housing for Previously Incarcerated People*. www.csh.org

Corporation for Supportive Housing. (2003). *Medicaid in Supportive Housing: Lessons for Policy-Makers*. www.csh.org

Corporation for Supportive Housing. (2004). *The Do-It Yourself Cost-Study Guide Assessing Public Costs Before and After Permanent Supportive Housing: A Guide for State and Local Jurisdictions*. www.csh.org

Corporation for Supportive Housing. (2001). *The New York/New York Agreement Cost Study: The Impact of Supportive Housing on Services Use for Homeless Mentally Ill Individuals*. www.csh.org

Gordon, Gary, D. & Lazarus, David, P. (1982). *New Jersey’s Rooming and Boarding House Act: Its effects and effectiveness*. *Seton Hall Law Review* vol. 12(3).

Rosenheck, R., Morrissey, J., Lam, J., Calloway, M., Johnsen, M., Goldman, H. et al. (1998). *Service system integration, access to services, and housing outcomes in a program for homeless persons with severe mental illness*. *American Journal of Public Health*, 88, 1610-1615.

State of Georgia, Department of Human Resources. (2001) *Medicaid Community Mental Health Center Program Manual*.

Appendix A **Housing and Services Planning Document**

Analysis:

The Governor’s proposal to create 10,000 new affordable housing opportunities across New Jersey to people with mental illness and other disabilities requires an analysis of where those opportunities should be and how much it will cost to provide services to those people over the 10 year period.

While the final results may be spread differently, the 10,000 units should be spread out throughout the State taking into consideration population trends. This would assume that other services already in place are based to a large degree on that model. However, the State should also consider the need to come out of the gates running with the idea being to create as many new opportunities in as little amount of time possible, even if this calls for the start-up funds being used in larger amounts. The goal would be to then attempt to bring additional funds as the State’s economy rebounds. By demonstrating early success of the program, a request for additional one time funds might receive support.

Therefore, the 10,000 housing opportunities should be roughly spread out in the following manner, based upon Census 2000 population data⁴⁴:

Geographic area	Current Population	% of Population	General Housing Stock		Special Needs Initiative Proposal	
			Current Housing Units	% of Housing Units	# New Units Allocated	% of New Units Allocated
New Jersey	8,414,350		3,310,275	100	10,000	100
COUNTY						
Atlantic County	252,552	3	114,090	3	300	3
Bergen County	884,118	11	339,820	10	1100	11
Burlington County	423,394	5	161,311	5	500	5
Camden County	508,932	6	199,679	6	600	6
Cape May County	102,326	1	91,047	3	300	1
Cumberland County	146,438	2	52,863	2	200	2
Essex County	793,633	9	301,011	9	900	9
Gloucester	254,673	3	95,054	3	300	3

⁴⁴ US Census 2000. www.census.gov

County						
Hudson County	608,975	7	240,618	7	700	7
Hunterdon County	121,989	1	45,032	1	100	1
Mercer County	350,761	4	133,280	4	400	4
Middlesex County	750,162	9	273,637	8	800	9
Monmouth County	615,301	7	240,884	7	700	7
Morris County	470,212	6	174,379	5	500	6
Ocean County	510,916	6	248,711	8	800	6
Passaic County	489,049	6	170,048	5	500	6
Salem County	64,285	1	26,158	1	100	1
Somerset County	297,490	4	112,023	3	300	4
Sussex County	144,166	2	56,528	2	200	2
Union County	522,541	6	192,945	6	600	6
Warren County	102,437	1	41,157	1	100	1

Note: A “Unit” is defined as a Person. For example, 300 Units = 300 People, not necessarily 300 new facilities. Some new facilities, whether acquired or constructed, will have more than one person living there. A single family house created under this initiative that provides housing for three people will be considered three “Units” not one.

It is important to note that these new opportunities will be created over a ten year period. Thus, the total cost for services will not be realized until Year 10. The cost for services will need to be ramped up over the course of the initiative as the housing opportunities are implemented. It is anticipated that in the early years of the initiative, fewer housing opportunities would be created as programs are devised and providers develop additional capacity. The majority of the new opportunities will be achieved in years 5 through 10.

Services:

Over the course of this initiative, funding for services must be increased as the housing opportunities are created or the initiative risks stalling. Important to note is that many of these people are currently receiving some type of mental health services. Certainly, additional service funds will be needed, but a significant challenge will be how the current funds being used for these people are allocated to the mix of additional services

they will need in their new housing situations. Additionally, the system will need to define how its community-based, outreach services are structured so that these people do not need to switch service elements, but have the services stay with and follow them.

For instance, many PACT or PATH consumers are receiving some services, but in need of the new housing, these services must continue for these people. PATH consumers receive some minimal level of support, by nature of the PATH program, but will need additional support. Currently, a PATH consumer receives roughly \$3,700 of services per year. That \$3,700 per year should follow the consumer, but clearly additional service funding would be needed.⁴⁵

In a variety of settings, including supportive housing, PACT, etc., an approximate cost per person currently ranges in the \$15,000 - \$25,000 range. For group home living with higher levels of supervision, the average costs can be much higher per person annually.

In the Home to Recovery Housing Initiative, which will phase in 10,000 new housing opportunities over 10 years, the first year might expect to see the creation of 500 new housing opportunities requiring services. Some of these people currently receive some level of support, but additional need is likely.

Currently, the State does not maximize its potential Federal Medicaid match because it does not use the Rehabilitation Option. For example, Supportive Housing services, for which the State has significantly expanded over the past several years, cannot bill for Medicaid. If these services were eligible, the State's current expenditure for supportive housing could free up revenues to expand services.

If the State were to make additional appropriations under this initiative, it could offset the potential cost to the State by up to 50%. However, due to various issues, such as ineligible administrative costs, the State's expenditure would be more like 70% of costs for new services. (Note: DHS, DMHS and DMAHS should be consulted for more accurate information.)

At Year 1, based upon \$15,000 for 500 people:

Using \$15,000 per person per year as a working number:

$$\$15,000 \times 500 = \$7,500,000$$

If the State takes advantage of the Medicaid Rehabilitation Option, the State could offset its expenditure.

$$\$7,500,000 \times 50\% = \$3,750,000$$

$$\begin{array}{l} \text{More Realistic: } \$7,500,000 \times 70\% \text{ (State)} = \quad \$5,250,000 \\ \qquad \qquad \qquad \$7,500,000 \times 30\% \text{ (Federal)} = \quad \underline{\$2,250,000} \end{array}$$

⁴⁵ New Jersey Department of Human Services Statistics (2004)

\$7,500,000 total budget for 500 people

At Year 10 Fully Implemented; Based upon \$15,000 for 10,000 people:

\$15,000/person X 10,000	=	\$150,000,000
\$150,000,000 X 70% (State)	=	\$105,000,000
\$150,000,000 X 30% (Federal)	=	<u>\$ 45,000,000</u>
		\$150,000,000

Note:

1. This would need to be phased in each year coordinated with the number of new housing opportunities coming on line.
2. The \$15,000/person cost will need to be re-evaluated over time due to cost of living adjustments and higher salaries.

Type of Units to be Created:

Supportive Housing: The majority of new opportunities should be permanent supportive housing in various configurations. Supportive housing can come in many forms including apartments, townhouses and condominium, single family homes, shared and congregate living and single room occupancy.

Specialized Residences: Because of the presenting problems of some people, specialized supportive housing residences may offer better quality of care. These can include, but are not limited to, the following:

- Medically enhanced
- Mental Illness and Developmental Disability
- Mental Illness and Substance Abuse
- Aging-out youth
- Parolees
- Veterans

The State should review its current residential continuum and consider how it can better utilize its existing group homes and convert some of these to specialized residences or supportive housing models. Various reasons for this recommendation include that they are already sited and current programs may be providing more costly supervision and services than is needed for the residents. Specialized residences would be more costly to operate due to their degree of specialization required as well as level of supervision.

Appendix B

Home to Recovery \$200 million Housing Trust Fund

The Home to Recovery Housing Trust Fund should be administered by the New Jersey Housing and Mortgage Finance Agency as they are the most capable agency when it comes to financing and underwriting housing development. Funds from the trust can be made as grants and/or low-interest financing, depending on specific project leveraging, to eligible non-profit organizations in order to create the proposed 10,000 new housing opportunities.

The primary focus of this initiative should be for new housing opportunities for people with mental illness. Thus, the committee is recommending that the large majority of funds be earmarked strictly for the mental health population. The balance of these funds should strongly be considered for people dually diagnosed with developmental disabilities and mental illness. The board and care industry is not an intended recipient of these funds. HMFA, in coordination with the Home to Recovery Planning and

Implementation Council can coordinate specifically how funds will be allocated to housing projects. However, the intent of this initiative is for permanent supportive housing, and is not considered transitional by nature.

Since this housing initiative crosses other State Departments, (i.e. Human Services, Community Affairs, Corrections, etc.), funds must be allocated from the trust in a coordinated, not unilateral, fashion. This requires a joint oversight process that together ensures provider capacity, that projects are supported by the Home to Recovery Planning and Implementation Council planning efforts, and assures housing and service funds are coupled together with projects. Absent this coordination, this initiative will likely not achieve its goal.

While the funds should be managed so that they can leverage the largest amount of funds for projects, HMFA and collaborating Departments and Divisions must recognize that it is very important to demonstrate quick success of this initiative. Therefore, while establishing criteria, the collaborative must be sensitive to the fact that it may be just as important to award larger amounts of funds to projects earlier on in the initiative to demonstrate to the people of New Jersey that the program has merit and can achieve success. It is hoped that over the life of this initiative, the State will recognize the benefit of appropriating additional capital funding to this initiative.

Capital improvements in group homes and other licensed residential facilities should not necessarily be an intended use of these funds. All new housing should build in reserve funds, and this should be an allowable item in DHS contracts. Furthermore, proposed DHS contract reform measures that suggest the ability to retain working capital could permit agencies to generate reserve funds for capital expenses, renovations and rehabilitation. DMHS suggests that \$8 - \$10 million is needed to do repair and maintenance work on licensed facilities. If agencies can reserve funds, these issues can be resolved on an on-going basis without having to tap into funds from this Trust. For additional costs, or for agencies that do not generate reserves, unspent funds in the mental health system at large should be kept by DHS as reserve capacity for agencies that require unexpected capital expenditures.

Appendix C

Boarding Home/RHCF Analysis for Increased State SSI Supplement

This analysis attempts to provide some estimates as to what it would cost the State if New Jersey's SSI supplement for people living in RHCF's and Class B&C Boarding Homes was increased. These estimates are based upon available data. It should be noted that quality data is not readily available which underscores the problems in this industry.

For RHCF's, the current funding structure for SSI recipients equals the following :

\$564 (Federal SSI) + \$150.05 (State Supplement) = \$714.05 PER RESIDENT/Month

\$564 (Federal SSI) + \$150.05 (State) - \$82.50 (PNA) = **\$631.55 Available to Oper.**

Proposed via Assembly Bill 3295:

In the final year of a 3 year phase-in:

\$564 (Federal SSI) + \$770 (State) - \$82.50 (PNA) = \$1251.50 Available to Operator

- Issues: 1. PNA is not increased.
 2. \$1251.50 is higher than the Fair Market Rent for a one-bedroom apartment anywhere in NJ.
 3. Bill does not consider Boarding Homes.

<u>RHCF's:</u>	<u>Facilities</u>	<u>Beds</u>	<u>Occupied</u>
As per Department of Health:	144	5,992	Unknown

Note: Statistics for the number of facilities, beds and occupied beds are inconsistent for various reasons. Statistics were received from Department of Health and Senior Services⁴⁶, as well as surveys from the Boarding House Advisory Council⁴⁷ and the Association of Residential Care Homes.⁴⁸ An average occupancy rate from these sources is **roughly** 80%.

The Association of Residential Care Providers, a large trade organization for RHCF's reports that approximately 66% of the occupied beds in its membership are with people on SSI.

Therefore,

$$5992 \times 80\% \text{ occupancy} = 4793.6 \text{ people in RHCF's in NJ.}$$

$$4793.6 \times 66\% = \mathbf{3164 \text{ people in RHCF's on SSI.}}$$

<u>Boarding Homes:</u>	<u>Facilities</u>	<u>Beds</u>	<u>Occupied</u>
Class A (Rooming House)	967	13,461	10,068
Class B	33	385	233
Class C	166	4496	2492

⁴⁶ New Jersey Department of Health and Senior Services Statistics (2004)

⁴⁷ Boarding Home Advisory Council Survey Report and Recommendations (2003)

⁴⁸ Association of Residential Care Homes, Survey October 2004.

Totals:	1166	18,342	12,793
Totals Excluding Class A:	199	4,881	2,725

The Boarding House Advisory Council's 2003 Survey sample revealed that approximately 30% of residents in Boarding Homes and RHCF's were on SSI. This number is believed to be a gross underestimate and that the numbers are closer to, and may exceed, the ARCH estimate of 66% on SSI.

Using 66% in Boarding Homes, Class B & C, as an estimate of people on SSI living in Boarding Homes equals **1799** residents on SSI.

The current rates for SSI in Boarding Homes:

\$564 (Federal SSI) + \$31.25 (State Supplement) - \$82.50 PNA = **\$512.75 Avail. To Operator**

Important Issue: This is the same rate that a person on SSI receives who is not in a Boarding Home and is living in some other independent situation or group home. Also important to note, is that SSI is the INDIVIDUAL'S entitlement, not the operator's.

CAUTION: Raising the SSI rate for people living in Boarding Homes may legally require the rate in general for New Jersey residents on SSI to be increased.

An argument has been made that RHCF's and Boarding Homes are identical in composition outside of the 12 minutes/week of nursing care required in an RHCF and that they should be streamlined into one type of Residential Service Facility. This may offer an opportunity to increase SSI rates to these facilities without having to raise the State supplement for SSI to every NJ recipient that receives SSI – the cost would be tremendous.

However, merging these facilities into one type would also add significant additional expense to the State due to the fact that the current Boarding Home rates are much less than an RHCF. The current rate structure was based upon the idea that RHCF's were providing more services – the 12 minutes/week. Also important to note, if oversight of RHCF's is transferred to DCA, Boarding Home operators may be more inclined to become RHCF's in order to generate the higher rate.

Cost Projections :

These cost projections are based upon the current system and rate structure with available data. Any changes would alter the projections.

RHCF's:

Current State rate: \$150.05 X 3164 (approximate # people on SSI currently in RHCF's)
= \$474,758 per month State expense.

\$474,758 X 12 months = \$5,697,096 annual SSI cost to State

If you increase State supplement by X:

\$25	\$175.05 X 12 X 3164 = \$6,646,298 Annual SSI cost to State
\$50	\$200.05 X 12 X 3164 = \$7,595,498
\$75	\$225.05 X 12 X 3164 = \$8,544,698
\$100	\$250.05 X 12 X 3164 = \$9,493,898

**An increase of \$25/month would cost the State an additional \$952,202 per year.
An increase of \$50/month would cost the State an additional \$1,898,402 per year.
An increase of \$75/month would cost the State an additional \$2,847,602 per year.
An increase of \$100/month would cost the State an additional \$3,796,802 per year.**

Note: Again, these are rough estimates and if actual occupancy is currently higher, the additional cost to the State would be higher. Also, the system currently experiences very high vacancy; if the occupancy rate of these facilities increased, which would likely occur if the State supplement increased, this would also increase the State expenditure.

Boarding Homes:

Current State rate: \$31.25 X 1799 (approximate # people on SSI currently in Boarding Homes Class B&C) = \$56,219 per month State expense.

\$56,219 X 12 months = \$674,628 annual SSI cost to State for people in Boarding Homes.

With the current structure, if you increase State supplement by X:

\$10	\$41.25 X 12 X 1799 = \$890,505 Annual SSI cost to State
\$15	\$46.25 X 12 X 1799 = \$998,445
\$20	\$51.25 X 12 X 1799 = \$1,106,385
\$25	\$56.25 X 12 X 1799 = \$1,214,325

An increase of \$10/month would cost the State an additional \$215,877 per year.

**An increase of \$15/month would cost the State an additional \$323,817 per year.
An increase of \$20/month would cost the State an additional \$431,757 per year.
An increase of \$25/month would cost the State an additional \$539,697per year.**

Again, these are rough estimates and if actual occupancy is currently higher, the additional cost to the State would be higher. Also, the system currently experiences very high vacancy; if the occupancy rate of these facilities increased, which would likely occur if the State supplement increased, this would also increase the State expenditure.

**Governor Codey's Task Force on Mental Health
Housing Advisory Committee**

Special thanks are given to the New Jersey Housing and Mortgage Finance Agency, the Supportive Housing Association of New Jersey and Advance Housing, Inc. for hosting and supporting the Housing Advisory Committee meetings, as well as all of those individuals who provided information, assistance and support to the committee.

Committee Members

Chairperson: Kevin Martone, LSW, Advance Housing, Inc.

Angel Gambone, Independent Survivors

Bill Connolly, Director, Division of Codes and Standards, Department of Community Affairs

Bill Conroy, Assistant Commissioner, Department of Health and Senior Services

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Sue Devlin, MA, LPC, Comprehensive Behavioral Healthcare, Inc.

Tim Touhey, MSW, Fannie Mae

William Dice, NAMI NJ

Report of the Children's Advisory Committee

Committee Members:

Chair: Ange Puig, Ph.D	Ginger Mulligan
Co-chair: Paula Sabreen, LCSW	Dean Pastras
Victor Alvarez	Mark Perrin, M.D.
Carolyn Beauchamp	Lovell Pugh-Bassett
Barbara Chayt	Shelley Slafkes
Cecelia Downey	Kathi Way
Michelle Hart-Loughlin	Cecilia Zalkind
Terriann Moore-Abrams	

I. Introduction

The Children's Advisory Committee was charged with reviewing New Jersey's children's mental health system and assessing its effectiveness in regard to access, appropriateness & accountability. Areas of special attention have included: gaps in services, barriers to treatment, issues of coordination and communication, education and training needs, and reform of the children's mental health system under the Division of Child Behavioral Health Services (DCBHS).

Throughout this review, the committee has sought out those practices and systems which enhance the health and well being of children and families. Wherever possible, we have also striven to align our recommendations with the current State plan for children's mental health services and the enforceables mandated through the child welfare reform plan.

In the course of our work, the committee has listened to testimony from hundreds of individuals and groups representing a wide range of opinions and concerns. We have also reviewed letters, faxes and e-mails from those who were unable to speak in person (see list in the appendix section of this report). The wisdom of these citizens' words and the passion of their heartfelt testimony have deeply moved every member of the committee. In turn, our members have brought their own passion and wisdom to the process and have leveraged their extensive contacts among consumers and stakeholders across New Jersey. We are therefore confident that our conclusions and recommendations are based on an up-to-date and comprehensive assessment of the current state of affairs.

II. Background to the Recommendations

For many years, New Jersey has struggled with an inadequate, fragmented mental health system for children. Funding from the Division of Mental Health Services (DMHS) has primarily supported psychiatric hospitalization, post hospitalization programs, and other institutional and traditional mental health services for the most seriously emotionally disturbed children. Some children who needed residential treatment received services from the Division of Youth and Family Services (DYFS) while children in the juvenile justice system often had little or no access to needed mental health services. There was no continuum of care and often because there were limited community based alternatives to hospitalization or residential treatment, far too many children and adolescents were placed in residential treatment centers out of State. These youngsters remained there much too long and, while they were away, their families were ignored. The system seemed to frustrate all who touched it: Family Court judges, mental health professionals, public and private agencies and most of all the children and families it was designed to serve.

These issues were well known to decision makers and service providers alike, and were often well documented in official reports and advocacy group white papers. To the state's credit, over the years there have been efforts to reform the system and address these long standing problems. The collective goals of these reforms included:

- Reducing reliance on large institutional in-patient services,
- Developing in-patient programs at the community level,
- Expanding community based services,
- Increasing family participation in decision making, and
- Providing individually tailored services.

In pursuit of these goals the State ultimately closed all state operated children's psychiatric hospitals except for the Arthur Brisbane Child Treatment Center, which is mandated to close in December 2005. In their place the State developed Children's Crisis Intervention Service (CCIS) units in general hospitals. Through these units, children could receive short-term in-patient mental health services in or near their communities and the family could be included in treatment. Along with the CCIS units, the State also established post-28 day programs to provide a step down for children who needed further stabilization but in a less restrictive setting. Initially, the lengths of stay in these community-based programs were far longer than envisioned because there were insufficient alternatives in the community. Gradually, though alternatives remained insufficient, funding constraints substantially reduced the average length of stay in existing programs, with the result that the system was always "backed up" and overloaded. The State's goal to reduce institutional care was laudable but did not adequately address the local supports and programs necessary to help children and families become stable and healthy in their communities.

To address some of these shortcomings, a statewide initiative called the Youth Incentive Program (YIP) was established in 1991, with the goal of enhancing and expanding the

system of care for youth with special emotional needs. Consultants from other States, experts in children's systems of care, were brought to New Jersey to help develop the YIP. Funding was provided to support local planning through County Interagency Coordinating Councils (CIACC) and local decision making through Case Assessment Resource Teams (CART) for youth with special needs. The Department of Human Services intended to enhance the YIP through Medicaid Rehabilitation Options with the goal of creating new services driven through a local planning process. The implementation of the YIP was inconsistent from County to County. Measurable outcome objectives were never defined by the State and there was little accountability for how funds were spent. As a result, the YIP was another well intentioned but unsuccessful effort to enhance mental health services for children.

In 2000, Governor Christine Todd Whitman announced a major effort to reform New Jersey's mental health service delivery system for children and families. Introduced as the Children's Initiative and later renamed the Partnership for Children, this initiative is now part of DCBHS. The Children's Initiative was designed to be child centered, family driven, strength based, holistic, and community based and culturally sensitive. This new system of care promised easy access to mental health services and a 'no wrong door' approach whereby children could enter the system via DYFS, the JJC, a direct call from a parent or via any other child-serving system and get the clinical interventions required to address their emotional and behavioral challenges. In addition, this new system of care would develop new community based; non-traditional resources specially tailored to meet local needs and enhanced community support services to help families keep kids at home instead of having them placed out of the home. The Children's Initiative was also conceived to allow New Jersey to draw down additional federal dollars through the Medicaid Rehabilitation Option. This additional funding would in turn allow a wider array of mental health services for children.

The Initiative's design required the State to hire a third party to manage the new system. This provider, Value Options, is the Contracted System Administrator (CSA), responsible for system management, monitoring, technical support, and quality improvement functions. At the core of these functions is the operation of the 1-800 number, which is the sole point of access to services statewide. The Children's Initiative promised to provide "one stop" shopping for parents of children with emotional and behavioral difficulties. Anyone, regardless of ability to pay, would be able to receive the level of care they needed.

To date this initiative has rolled out its structural components, including Care Management Organizations and Family Service Organizations in 12 counties of the 21 counties; 25,000 children are enrolled; 13,000 families are receiving resources. The President's New Freedom Commission on Mental Health's final report in 2003 identified New Jersey as a model program for achieving the goal of developing and implementing individual plans for children and youth with serious emotional disturbance. New services provided by the initiative include intensive in-home treatment, behavioral assistance, youth case management, mobile response and care management. While some new services exist in each county, they have not yet all been expanded across the state.

The Initiative was the most comprehensive attempt of its kind in the nation, because its scope encompassed children throughout the entire state and was envisioned as a national model. There are many reasons why implementation of this ambitious program has fallen short of what was promised. Among the reasons are the many interruptions caused by previous administrations whose commitment to the initiative was at times tenuous.

- While many hard-working and well-intentioned people at both the state and community levels are doing their best to make the current system work, testimony to this committee and extensive provider feedback reveals deep frustration instead of the integrated synergistic relationship needed for the system to work. Consumers and providers alike report spending countless hours negotiating the system, resulting in extensive and chronic waste of staff time and delays in service to those most in need. As a consequence, many community players believe that their words and concerns are not responded to with appropriate attention and partnership.

As the new system of care was being rolled out, New Jersey's child welfare system came under attack, as Children's Rights Inc (CRI) sued the State. After extensive negative publicity surrounding the death of a child, the state reached a settlement with CRI in June 2003. Although the children's mental health system was not part of the lawsuit, the reform plan subsequently developed by the state has major implications for the children's mental health system. The settlement of that lawsuit resulted in a reorganization of the Department of Human Services and the creation of a new Office of Children's Services (OCS) under the leadership of a Deputy Commissioner. This new OCS consists of:

- the Division of Youth and Family Services,
- the Division of Child Behavioral Health Services, and
- the Division of Prevention and Community Partnership.

In addition to the reorganization of the bureaucracy noted above, the reform plan includes many appropriate system changes that would appear to enhance and expand access to mental health services for traditionally underserved, vulnerable populations. For example, children involved in the Juvenile Justice System and especially those youth in County Detention centers will receive a mental health assessment and, if indicated, access to mental health treatment.

Therefore, the DHS now has the responsibility to manage simultaneously the rollout of the new child behavioral health care system, delivery of the enforceable elements of the Child Welfare Reform Plan, and implementation of the plan for the new Division of Prevention and Community Partnership. There is concern that the leadership is so focused on meeting the mandated child welfare reform deadlines that it has not focused adequately on the child behavioral health reform. Ultimately the quality of the services implemented will determine whether real change occurs.

Given this history and the extensive testimony and feedback collected by this committee, it is clear that our children's mental health system has not yet achieved the goals of its

design and principles. To move this system to effective and user-friendly, State planners, consumers, service providers, and local community leaders must unite to accomplish the goals of the comprehensive model of service delivery with jointly determined values and operationally-defined goals & objectives. We offer the following recommendations as a framework for that process so that New Jersey children get professional, non-stigmatizing, culturally competent services *when* they need them, *where* they need them, for as *long* as they need them.

III. Recommendations

The Key Recommendations of this committee are organized as follows:

- A) Prevention & Early Intervention
- B) Traumatic Stress & Violence
- C) Public Awareness & Information Campaign
- D) Education
- E) Juvenile Justice System
- F) Office of Children's Services - DCBHS
- G) Supplemental Recommendations

A. Prevention & Early Intervention

Overview:

The background information above outlines the many dramatic efforts made in the past several years to improve children's mental health services in New Jersey. But perhaps the most dramatic aspect of all these efforts (and all the money that went with them) is that *none of it went toward services for children under five years of age.*

And yet young children, age 0-5, very often endure the same social ills and environmental assaults as older children and adults. In fact it is worse for little ones because they must endure these assaults without the many defenses we develop as we mature. So exposure to crime and violence leads to higher incidence of aggression, depression, anxiety, attention deficits and poor social skills. Inadequate prenatal care leads to increased developmental delays. Family disruptions and foster care placements mean more children with histories of trauma, abuse and neglect, and thus a higher incidence of emotional and behavioral problems. To add to these grim circumstances, those people caring for infants and preschool children often lack the training necessary to recognize, understand, and address telltale symptoms and special needs.

So it is painfully clear that the failure to offer these critical ounces of prevention forces the State to provide pounds of less-effective and more costly services (mental health, special education, social services, police, courts, and detention), for older youth and adults.

Summary:

But there is hope. New long-term research confirms that quality prevention & early intervention services significantly reduce future special education placement, grade retention and criminal behavior, and improve reading and math skills *right up through high school*.⁴⁹ Of course quality services are rare. Too many programs still treat social, emotional, and cognitive/academic development as separate processes, whereas the research proves they are inextricably linked: “*Before children can learn to read, they must learn basic social and emotional skills – such as the ability to tolerate frustration without ‘melting down’ or acting aggressively, and the ability to be attentive and follow directions.*”⁵⁰

To achieve that quality in early intervention services, “...programs need to provide training and education to promote social-emotional development.” Furthermore, preschools need “a strong *preschool/mental health partnership* [which] can lead to *decisive change*...aimed at preventing more serious problems from developing later in childhood.”⁵¹

This committee therefore recommends the development of a plan for statewide implementation of quality early intervention services founded on a long-term strategy. The service delivery structure should be conceived as a funnel, with screening and prevention services for the general population, age birth to five, and progressively more concentrated levels of care for those children identified with greater needs. Specific elements of this long-term strategy should include the following:

Recommendations:

- 1) Service delivery should take place at sites where children and families already access other services, the most obvious being preschools and pediatric healthcare clinics.
- 2) Evidence based best-practice models should be identified, piloted, and replicated statewide. Examples are: *Healthy Families America*, *Parents as Teachers*, and *PrePARE* (see details attached).
- 3) Personnel who interact with children in preschools, schools, healthcare facilities and juvenile justice agencies should receive ongoing training on how to identify and respond to early childhood development issues and risk factors. This training should also be organized to foster stronger connections among these systems and between them and the DCBHS.

⁴⁹ Chapter 1 in *School Reform Proposals: The Research Evidence*, Information Age Publishing, 2002, edited by Alex Molnar.

⁵⁰ *Set for Success: Building a Strong Foundation for School Readiness Based on the Social-Emotional Development of Young Children*, Report of the Ewing Marion Kauffman Foundation’s Early Education Exchange, September, 2002.

⁵¹ *Ibid.*

- 4) Screening of young children for developmental and mental health issues should be implemented statewide, and follow-up assessments and linkage to services should be available to all who need them. One possible vehicle for this is Early Periodic Screening, Diagnosis and Treatment (EPSDT), a Medicaid-reimbursable assessment tool for identifying both medical and emotional problems.
- 5) A public awareness campaign should be launched to alert the public to early intervention issues including:
 - a) positive parenting skills,
 - b) how to identify at-risk children,
 - c) resources available, and
 - d) where & how to access services.

B. Traumatic Stress and Violence

Overview:

The effect of trauma on the development of a child can be terribly deep and abiding. Physical and sexual abuse, social deprivation and neglect, exposure to domestic and neighborhood violence, all have a critical impact in the lives of children and families. Wherever it occurs – in the home, in daycare, in school or in the community – trauma that is not properly assessed and treated places children at risk for developing serious psychiatric disorders. Research has documented that exposure to trauma increases not only a child's risk of psychiatric disorders but also increases the child's risk of engaging in a wide range of high risk behaviors including substance abuse, domestic violence, and crime.

And trauma is not limited to direct exposure to physical violence. One of the least understood, most malignant forms of trauma can occur when a child is removed by a child welfare agent from an unsafe home. To be taken from your home to a shelter, foster home or other congregate care setting is often, for the child, plain terrifying. No matter how necessary and well-intentioned, such removals, if done without appropriate social and therapeutic supports, can be psychologically devastating. Among the immediate effects is a quite natural increase in acting-out on the part of the child, which jeopardizes the success of the new placement and leads on to a vicious cycle of removals and retraumatizations. Among other long-term results of this cycle, it is worth noting that the adult population of this country's prisons is dramatically over-represented by men and women who were once in foster care.

Summary:

Because trauma plays such a pivotal and destabilizing role in the lives of children, an effective children's mental health system must include a comprehensive and

developmentally appropriate program of trauma prevention and intervention. Such a program of prevention and treatment should include the following elements:

Recommendations:

- 1) Trauma awareness training should be provided to all persons involved in children's mental health and child welfare services from Commissioner to line staff.
- 2) Traumatic stress curricula must be an integral part of the DYFS training academy.
- 3) All service providers must deliver traumatic stress training to their staffs to insure that clinicians are equipped to assess and treat traumatic stress in the populations they serve.
- 4) Screening for trauma and exposure to violence should be key elements of assessments performed on children at all points of their involvement with the children's mental health system.
- 5) Evidence-based models and other measurable-outcome models for treatment of traumatic stress and exposure to violence must be incorporated into all State-contracted treatment programs involving children and their families.
- 6) Intensive trauma intervention models should be implemented (or incorporated into existing treatment programs) for "deep-end" children, especially those children:
 - a) Placed in foster care;
 - b) Residing in group homes and shelters;
 - c) Involved with the juvenile justice system;
 - d) Having extensive histories of substance abuse;
 - e) Diagnosed with co-occurring disorders or developmental disabilities;
 - f) Classified as fire setters or sexual offenders.Without appropriate treatment, these children will continue to cycle through not only the children's mental health system but also the courts, detention centers, and homeless shelters, etc. – at a terrible cost to themselves and to society.

C. Public Awareness

Overview:

Public access is dependent on public awareness. If consumers, pediatricians, schools, and other community providers do not have clear, up-to-date information about available children's services, they obviously will not be able to access those services. Information such as that available on the Department of Human Services' website regarding DCBHS, should be distributed more broadly through additional channels.

Summary:

The committee recommends the establishment of a concerted and on-going public awareness activity regarding such issues as emotional and behavioral health care challenges, high-risk behaviors and other warning signs, available services and access instructions.

Recommendations:

- 1) Information should be disseminated via TV, radio and newspaper ads, and brochures distributed in bulk to child- and family-service organizations, preschools and schools, libraries, shelters, pediatricians, etc.
- 2) Public awareness should also be promoted at statewide conferences and other gatherings of interested professionals (NJ Education Association, United Child Care Agencies, etc.). Outreach to parent education and support programs (IFSS, NAMI Visions, Family to Family, SPAN New Jersey) is also essential.
- 3) In addition to this effort at broad dissemination of basic information, more detailed and comprehensive materials should be made available in print and on the web (in downloadable format) for use by both consumers and child- and family-serving professionals.
- 4) Special efforts should be considered which specifically target schools (school staff, students, and parents), for reasons outlined in the next section on Education.
- 5) Both print and web-based information should be organized as a resource manual which includes all available services – including contact information and eligibility criteria – organized by county and municipality and cross-referenced by service type and target population. *This information must be kept current.* Therefore, it is crucial that public awareness be treated not as a one-time project or campaign but rather as a permanent component of the children’s mental health system.

D. Education

Overview:

Children spend about 8 hours a day in a school environment, where they are regularly observed by teachers, nurses, guidance counselors, and other school personnel. School personnel often have contact and relationships with the families who have at risk children and who are in need of mental health intervention. Schools are therefore in a unique position to identify at risk children, and to provide early and effective intervention to children suffering from emotional and behavioral difficulties or who may be living in an

environment that is unsafe and unsuitable for the child to manage school. Currently, school personnel have limited knowledge and access to public mental health services.

Unfortunately, four years after the rollout of the New Jersey's most ambitious children's mental health reform, the educational and mental health systems are still operating in separate worlds, with no system coordination and little collaboration. Meanwhile, children in schools, who are in need of mental health services, have no greater access than before the new children's mental health system was developed unless they are knowledgeable about Value Options' centralized intake number.

In part this is a function of New Jersey's educational bureaucracy with 615 local school districts, with each district having a different understanding of and investment in supporting the mental health needs of children. With no centralized authority, it is difficult to provide outreach and education as would be required to include them as true systems partners.

Summary:

In order for there to be a change in the relationship between Department of Education (DOE) and DHS, the Governor must direct the Commissioner of Education and the Commissioner of Human Services to begin a dialogue as to how the two Departments can collaborate and better serve children with emotional and behavioral difficulties within the school system. The goal should be to develop a plan which delineates and expands as necessary school based initiatives to identify, prevent and intervene when children need mental health treatment.

Core elements of this plan should include:

Recommendations:

- 1) The education system should have a larger, more clearly defined role in DCBHS. The current DCBHS flow chart does not include the education community. School districts need to be knowledgeable about available programs and the procedures for assisting students and their families gain access.
- 2) Protocols need to be established to address residential placement. Districts need to be informed when a student is placed and should participate in determining his/her educational needs. Districts also need to be notified when a student is returning to school in order to ensure that appropriate programs and supports are in place when the student returns. (This is also true for youth who are returning to school after incarceration.)
- 3) An effective model for such programming already exists in the School Based Youth Services Program (SBYSP) operating out of DHS's Division of Family Development. The SBYSP model was established in 1989 and is now operating in 60 secondary schools across the state. An independent three-year study by the Annie

E. Casey Foundation and the Academy for Educational Development proves that SBYSP is highly effective in addressing students' mental health issues, increasing graduation rates, and reducing drug abuse, teen pregnancy, gang involvement, and other high-risk behaviors. As a result of SBYSP, New Jersey is considered a leader in the field of school-based youth programming and the model has attracted attention and visitors from other states and from countries around the world. The plan to expand School Based Youth Services Programs as identified in the Child Welfare Reform Plan is a positive step towards enhancing mental health and other needed services to youth. However, it is not expansive enough and serious consideration should be given to increasing both the rate and range of the expansion to far more secondary schools as well as to elementary schools.

- 4) Funding for this expansion should leverage mental health dollars and long term funding stability is essential. Specifically, funding should not be vulnerable to restrictions on school spending included in recent legislation (S1701), which limit local school districts' ability to provide support not directly tied to educational requirements such as curriculum or instruction.
- 5) In addition to the school-based model, consideration should be given to a model currently used in the Rahway Public Schools. They partner with a mental health agency to provide onsite counseling to at-risk students and their families. By partnering with a mental health provider, the schools gain access to that providers' larger network of services and its expertise at navigating the mental health system. The South Orange/Maplewood School District also contracts with a community based mental health agency whose social workers provide identified students with individual and group counseling in the middle and high schools.
- 6) A review and analysis should be conducted on how Abbott School districts are utilizing funds earmarked for Family Service workers. There is concern regarding the credentials of those individuals and whether they are fulfilling the intended purpose. It is possible that a reallocation of the funds could pay for mental health professionals in Abbott districts to assist with assessment and treatment of youth in need of mental health intervention.
- 7) Teachers lack knowledge about emotional and behavioral issues and how they affect a child's ability to learn. Training should be provided to teachers to assist them in intervening with a child in trouble and to provide guidance in handling difficult children in the classroom. This kind of training and support, again, could be provided through collaboration with a local mental health agency.

E. Juvenile Justice System

Overview:

Regarding juvenile offenders with mental health/special needs, the New Jersey Juvenile Justice Commission recently reported the following:

- The true extent of the problem is unknown due to the scarcity of data on the symptomatology / presenting problems of juvenile offenders;
- What little statistics are available demonstrate that youth with mental health issues are over-represented in the juvenile justice system;
- Youth with mental health issues often do not fit the profile of the typical delinquent and so are not well served by traditional programs for delinquent or seriously emotionally disturbed/developmentally disabled youth;
- There is growing recognition of the high degree of co-morbidity between mentally ill offenders and substance abusers;
- The juvenile justice system becomes the default system for youth who “fall through the cracks with mental health and behavioral problems”;
- It is estimated that *up to 60%* of youthful offenders are mentally ill, compared to 22% of the general population (Hunzeker, 1993). 20% of these mentally ill offenders have severe disorders.

National research studies on Juvenile Justice System (JJS) youth indicate a number of important findings. Major risk factors associated with JJS-involved youth include: substance abuse, poverty, academic & learning problems, and exposure to violence in the family environment. A study of youth in Juvenile Justice settings found PTSD rates ranging from 3% to over 50%. Females are more likely to be suffering from PTSD and more likely to be victims of violence. Minority youth of both genders are over-represented in JJS facilities across the nation. Contrary to the stereotypes of hard-core anti-social delinquents portrayed in the media, most youths in JJS placements are there as a result of low-level offenses. Most also have a history of maltreatment. In short, they are a vulnerable, psychologically needy and service-neglected group.

The Office of the Child Advocate (OCA) *Juvenile Detention Center Investigation* of November 2004, reported that:

- Twenty-one percent (21%) of all youth committed to the JJC have a serious emotional disorder, which is consistent with the over-representation of mentally ill children in detention nationwide. With over 11,000 new youth admissions to the 17 county detention centers annually, and 935 youth, on average, in detention centers daily, this leads to a conservative estimate of *200 youth experiencing serious mental health disorders are in detention in New Jersey on any given day.*
- The prevalence of serious mental health disorders among New Jersey’s detained youth is further illustrated by the number of youth in need of psychotropic

medication: In the 14 detention centers polled, administrators reported rates of youth taking psychotropic medication ranging from 10% all the way up to 50%.

Summary:

The Committee wishes to re-emphasize the following findings of the OCA report:

- In direct violation of the law, youth are regularly held in detention centers for extended period of time while awaiting transfer to non-secure residential programs.
- Mental health screening and assessment capacity within youth detention centers is inadequate.
- Mental health care within youth detention centers is grossly inadequate and what little services are available are inconsistent from county to county.
- There were 90 suicide threats or attempts in New Jersey juvenile detention centers from January 1, 2004 through August 30, 2004, a telling indicator of severe mental health distress among youth

In response to the OCA report, the DCBHS and the JJC announced the following steps:

- Upon admission to secure detention, all juveniles will be screened for suicide risk. The Commission has standardized the suicide screening tool and all counties were to be using the standardized tool by January, 2005
- Within 72 hours of admission, all juveniles will be screened for mental/emotional disturbance or distress using the standardized MAYSI-2 screening tool. The implementation of the MAYSI-2 is meant to alert detention center staff to mental health issues, guide decisions regarding resource allocation, and highlight needs for linkage with other agencies that serve troubled youth. Statewide implementation of the MAYSI-2 is to be completed by the end of 2005.
- If a juvenile demonstrates signs of mental health need based upon the MAYSI-2 screening or by his/her behavior or history, the county detention center is to call CBHS, which will conduct a more comprehensive mental health assessment and provide an individualized plan and services as needed

Recommendations:

- 1) JJC and DCBHS follow-through on provision of screenings as described above should be monitored for timeliness and special attention paid to the credentials and training of screeners. (See OCA recommendations for ongoing reporting and monitoring)

- 2) As part of re-entry, ensure that every youth exiting the JJC has appropriate housing and wraparound services. This effort needs to be part of individualized case management and should begin well ahead of the juvenile's expected release date.
- 3) Youths in need should be provided with psychiatric evaluation, medication monitoring, and integrated treatment for co-occurring mental health and substance abuse disorders. Arrangements for continuation of these services post release should be part of the case management responsibility described directly above.
- 4) Evidence based diversion programs should be identified, piloted, and replicated specifically targeting youth who present with a combination of relatively mild anti-social/criminal histories coupled with mental health disorders. There is promising evidence that such youth respond well to treatment if kept apart from more seriously conduct-disordered peers.
- 5) Evidence based practice models should address both mental health and substance abuse issues and should be uniformly available across all JJS placements and facilities.
- 6) Educational & vocational services in detention centers should be tailored to the population, with teachers skilled in working with "challenging youth."
- 7) Existing programs and services should be carefully reviewed to ensure that they are based upon sound clinical practices and are yielding acceptable outcomes appropriate to the specific needs of participating youth.
- 8) DCBHS and JJS staff should be cross trained regarding the special needs of JJS-involved youth with mental health disorders, with special attention to minority, bi-lingual and gender-challenged youth.

F. Office of Children Services – Division of Child Behavioral Health Services

Overview:

The DCBHS was created as part of the reorganization resulting from the lawsuit filed against the State by Children's Rights, Inc. The resulting settlement went far beyond the original claims and resulted in a massive reform of the State's child protective service and mental health systems. Children's mental health services were removed from the existing DMHS and organized under the new DCBHS. At the same time, the mission of DYFS was redefined to focus on child abuse & neglect, and permanency planning. The DHS was faced with simultaneously complying with federal mandates related to the Child Welfare System, creating a new Division of Prevention and Community Partnership, and implementing and monitoring the new DCHBS, which has responsibility for the systems reform known as the Partnership for Children.

Summary:

In reviewing the current system of care, the Committee surveyed providers and consumers in their local communities. Throughout the State, we heard similar concerns, themes and frustrations about what the new system of care was supposed to be versus what has evolved. To date, “New Jersey’s initiative to help emotionally-troubled children has produced some positive results, but has failed to reach the promised number of children and create the coordinated system state officials envisioned four years ago.”⁵² Multiple interruptions delayed the originally projected timeframes for the new system’s full implementation. As a consequence, only 12 counties have all the core components in place. Similarly, the capacity of each care management organization was reduced from 240 to 180 because of fiscal restraints, thus limiting the number of youth and families who can access the most intensive level of care management and forcing some children into a level of care that is inadequate for their needs. As would be anticipated, developmental problems of an initiative with this wide scope are challenging to resolve and will continue to require ongoing remediation as the system evolves. Nevertheless, thousands of children and families now have access to a wide range of individualized services to help with their complex problems.

New Jersey is a very diverse state with extreme variations in needs from one county to another. Having a true State-community partnership, rather than the current centralized control at DCBH, would improve planning to address specific county service gaps and meet the needs of individual county populations.

The concerns voiced most often to this Committee include:

- Inadequate coordination, communication and collaboration among key stakeholders;
- The role and performance of Value Options was criticized, including their having incomplete knowledge of local systems of care and an outdated data base of community providers; an inadequate software system that demands excessive time of care managers and delays service delivery; delays and disorganization regarding payments, reauthorizations and access; and requests for services take too long;
- Top down mandates with limited local planning and input;
- Continued systems fragmentation and lack of systems integration;
- No meaningful, transparent continuous quality improvement system exists to gather data that measures behavioral outcomes and family satisfaction in order to have critical analysis of trends and effectiveness of component parts of the system;

⁵² *Treating Troubled Children: Lessons Learned from New Jersey’s Partnership for Children*, Special Report of the Association for Children of New Jersey, May 2004.

- Inadequate Medicaid reimbursement for services not covered by the Medicaid Rehabilitation Option;
- Too few psychiatrists and long waiting lists for outpatient psychiatric care;
- Policies and procedures do not reflect updated process changes;
- New providers who are part of the system of care are not adequately monitored for quality.

Youth Case Management (YCM) was expanded Statewide with the goal of serving 10,000 children who needed a less intensive level of care than offered through the CMO. In reality, YCM is often asked to serve children with higher levels of need whom the CMO cannot serve because of CMO service caps. The following are additional concerns heard about YCM:

- Youth Case Managers are under-trained in the case practice model and skills for dealing with the complexity of many of their cases.
- There is no cap on YCM caseloads, and the unlimited caseloads and unrealistic expectations create frustration and confusion;
- The State does not adequately monitor outcomes for YCM but continues to use it as a “catch all” to respond to the “enforceable” elements of the Child Welfare Reform Plan.

Recommendations:

- 1) The promise to create a coordinated system that helps all children in need, regardless of where they enter the system, must remain a top priority at the highest level of government.
- 2) State leadership must stay as focused on the development of the children’s behavioral health initiative as on the Child Welfare Reform Plan and the Court-ordered enforceables. We also recommend that the Oversight Panel consider renegotiating some of deadlines so that goals can be accomplished and real change occur.
- 3) Local entities should be included in planning and processes. Local, county-based plans, should contribute to State planning initiatives and program development. Local players are best able to identify service system gaps and identify cost-efficient measures to address needs and minimize administrative costs and duplication of effort.

- 4) The Quality Assurance Performance Improvement (QAPI) system must produce reliable, meaningful data about the new system which must be disseminated to all system partners. The QAPI system process should measure behavioral outcomes, client satisfaction and detailed cost benefit analysis. It should openly involve community systems partners and advocates in the corrective action process and in ongoing planning.
- 5) The QAPI process needs to identify outcomes not currently measured, such as: What is the cost per child? Are children and families being better served? Is there greater access? What is it costing to administer this new system? Are children doing better in school? Are high-risk behaviors decreasing? Is there less involvement in the juvenile justice system?
- 6) DCBH must address problems identified with Value Options' service administration, including delays in payment to service providers; requests for services taking too long to be authorized; insufficient knowledge of local resources; and the ABSolute software system that needs to be either overhauled or replaced.
- 7) The State must develop performance-based contracting for all funded programs, with clear and appropriate outcomes required and monitored.
- 8) DCBH should refocus Youth Case Management on original goal of serving children requiring a less intensive level of care and ensure manageable caseload sizes.
- 9) Service delivery to children within the same family should be unified, with one plan comprehensively addressing the entire family's needs and care coordinated by the highest level involved, e.g., CMO.
- 10) The Committee and the Task Force recommend a complete and objective assessment, including a comprehensive analysis of the quality, quantity and cost effectiveness of the new children' behavioral health services system. This analysis should also include a thorough review of the state's contract with Value Options.

The Task Force recommends a complete and objective assessment, including a comprehensive analysis of the quality, quantity and cost effectiveness of the new Division of Children's Behavioral Health Services system, formerly known as the Partnership for Children. This analysis should also include a thorough review of the state's contract with Value Options. The Task Force together with the Child Welfare Reform Panel, the Department of Human Services and the Office of the Child Advocate will identify the parameters of the assessment and identify the independent expert to perform the assessments.

- 11) That DCBHS create a standard operations manual available to consumers & providers for the children's' MH system.

G. Supplemental Recommendations

- 1) Substance Abuse: Nationwide, alcohol and drug abuse among 12- to 17-year-olds rose throughout the '90's. Furthermore, the onset of use has been coming at earlier and earlier ages, meaning that teens and pre-teens are now entering treatment with greater developmental and neurological deficits than ever before. Add to this the many high-risk behaviors co-occurring with substance abuse (unsafe sex, gang involvement, school dropout, joy-riding, assault, rape, suicide) and it is clear that adolescents need strong, comprehensive treatment programs. Yet there is a grave shortage of such treatment for teens and pre-teens around the State. Furthermore, these programs are often not equipped to provide mental health counseling and so turn away the many teens with dual diagnoses.

Finally, while existing programs have the best intentions, their methods have often not kept up with recent research, such as the Cannabis Youth Treatment (CYT) and Adolescent Treatment Models (ATM) funded by CSAT / SAMHSA. The shortage of evidence-based services is compounded by the fact that substance abuse treatment methodology is different for teenagers than adults. Teens think they are immortal. They are more prone to dangerous behavior; more vulnerable to negative peer pressure; more impulsive; still dependent on often chaotic families and; much harder to engage and motivate because they are being forced to enter treatment, by parents, schools or the courts. All of these factors make treatment more challenging and increase the risk of relapse. Furthermore, for those youth with co-occurring disorders, traditional theory holds that substance abuse must be treated before psychiatric/mental health issues. But recent studies indicate that dually diagnosed adolescents often cannot take full advantage of substance abuse treatment unless their mental health issues are addressed simultaneously.

The Committee welcomes the recent incorporation of the Division of Addiction Services (DAS) into the Department of Human Services. We have also welcomed recent instances of DAS taking a leadership role in fostering the adoption of evidence-based practices and measurable outcome objectives among its contracted providers. The Committee therefore recommends the following:

- a) All DYFS-involved youth age 12 & up should be screened for substance abuse using a brief screening tool such as the GAIN-Q which can be administered by case workers or other non-clinical staff;
- b) Free or low-cost continuing education programs should be provided statewide to cross-train mental health clinicians and substance abuse counselors;
- c) DAS should increase its efforts to identify, pilot, and replicate evidence-based practices statewide;
- d) In conjunction with implementation of these evidence-based models, DAS should develop performance-based contracting for all funded programs.

- 2) Therapeutic Interventions regarding Reunification and Permanency: In order for children to develop and thrive, they must be able to rely on a stable home. Many children in DYFS placements live instead under a cloud of uncertainty. The resultant chronic anxiety interferes with their development and complicates any attempts at treatment. Children and families that have been separated due to abuse or neglect should receive therapeutic supervised visitation services designed to maximize their chances for reunification. Where reunification of the birth family is not advisable, alternate permanency planning processes should include therapeutic services to address children's natural anxiety and often devastating sense of grief and loss.
- 3) Cultural Competency: Staff training in cultural competency should be required for all providers in the children's mental healthy system. Ideally, the State should identify an appropriate curriculum and make it available statewide, so that there is some assurance of the quality of training received.
- 4) Screening / Commitment Law: The absence of a state-wide screening law for children, coupled with the current age of voluntary consent [14 years], often impedes parents' and providers' ability to intervene effectively on behalf of their children. A screening/commitment law that applies to children should be developed and enacted. This law should:
 - a) Include the processes and resources to conduct screenings both at screening centers and in the community;
 - b) Mandate separate quarters for children in hospital screening/emergency rooms;
 - c) Reflect best practices being developed through the Child Behavioral Health Initiative and address problems currently apparent in the system;
 - d) Provide for the capacity and direction to merge existing hospital-based services with the new DCBH Initiative.

Final Notes:

- 1) Limitations: Because of the many complexities & wide scope of New Jersey's children's mental health system, there are a number of important issues which this committee was unable to address in the time allotted. Some of these issues are:
 - Developmentally disabled children;
 - Child victims of sexual abuse;
 - Teenage parents;
 - Juvenile sex offenders;
 - Truant youth;

- Gang involved youth;
- Youth ages 18-21 with untreated PTSD
- Children with incarcerated parents;
- Lack of bilingual clinicians;
- The statewide shortage of Board Certified child psychiatrists.

- 2) Continuation: Our final recommendation is that this Committee and its charge should not end with this report but should continue in an oversight capacity in relation to the new Office of Children's Services.

The Children's Advisory Committee recommended that the Task Force and its charge should not end with this report but should continue in an oversight capacity in relation to the new Office of Children's Services. The Task Force, recognizing that a non-governmental body is not provided with the authority of oversight of a state department and/or division is recommending that membership of the Children's Cabinet be expanded to include two members of the Task Force on Mental Health, a minimum of two pediatricians, a minimum of two child psychiatrists and child psychologists. Additionally, we recommend that Governor designate the Commissioner of the DHS as a co-chair and will also designate a second co-chair (a professional from the community). The Cabinet will evaluate on a continuous basis the progress of the Office of Children's Services with regards to its behavioral health services and programs, including the implementation of the children and adolescent specific recommendations from this Task Force. Quarterly reports on their progress are to be submitted to the Governor and appropriate Assembly and Senate committees.

PrePARE

Program Summary

1) INTRODUCTION

*“Before children can learn to read, they must learn basic social and emotional skills – such as the ability to tolerate frustration without ‘melting down’ or acting aggressively, and the ability to be attentive and follow directions...”*⁵³

PrePARE, or **Pre**school **P**psychological **A**ssessment, **R**esources and **E**ducation delivers free on-site mental healthcare, advocacy, and training services to preschool children and their teachers and parents at four local preschools. The program includes:

- Individual play therapy,
- Teacher consultation/training,
- Parenting skills training and support,
- Developmental screenings,
- Language development, and
- Innovative curricula specially designed for preschoolers to develop their skills in violence prevention, empathy, problem solving, and personal safety.

By integrating these services – and forming “a strong preschool/mental health partnership”⁵⁴ – PrePARE has proven successful in nurturing and expanding children’s social skills, impulse control, empathy, and use of anger management techniques. The program also increases preschool teachers’ and parents’ skills and knowledge base and accelerates linkage to educational and wraparound services for those children identified with special needs.

Total enrollment in PrePARE has now grown to 335 children (age 3 to 6) at four preschools in Newark, West Orange, and East Orange. Based on the lessons learned thus far in developing the model, PrePARE dedicates a full-time licensed mental health clinician to work on-site at each participating preschool to deliver all of the following program components:

- 1) **Individual Play Therapy:** For each child referred (with parental consent) the clinician will provide weekly play therapy. Play therapy is a proven modality that facilitates children’s expression of inner conflicts through toys and therapeutic materials in both directive and non-directive play. It is similar to psychotherapy for adults, except that children use play as their primary mode of communication, whereas adults use words. A dedicated private space will be made available to the clinician within each of The Leaguers’ facilities and will be equipped with the

⁵³ *Set for Success: Building a Strong Foundation for School Readiness Based on the Social-Emotional Development of Young Children*, Report of the Ewing Marion Kauffman Foundation’s Early Education Exchange, September, 2002.

⁵⁴ Ibid

necessary toys, books, and art supplies.

- 2) **Violence Prevention / Problem Solving Curriculum:** Each preschool-age child will be offered the Committee for Children's "Second Step" Violence Prevention / Problem Solving Curriculum appropriate to her/his age. Each one is a program of 26 weekly group lessons employing puppets named Puppy and Snail who talk to each other, to the Clinician, and to the children. Puppy and Snail's lessons and demonstrations are supplemented by pictures, discussion and role-plays designed to foster 1) empathy skills, 2) impulse control, and 3) anger management. An independent study published in the Journal of the American Medical Association (JAMA) found that "Second Step" significantly reduced children's physical and verbal aggression and increased their positive social interactions. Our pilot program confirmed JAMA's findings and we found the curriculum particularly effective when our clinician provided the preschool teachers with follow-up activities to practice in class to solidify that week's lesson.
- 3) **"Talking About Touching: A Personal Safety Curriculum"**, also by the Committee for Children, is a prevention curriculum that addresses crises, life transitions, role competency, social functioning, and the need to identify networks of support. Due to the alarming levels of violence and danger in our children's environment, we have added this curriculum to address specific issues including gun safety; traffic safety; fire safety; what to do when lost; asking a caregiver's permission before accepting rides, gifts, or food; distinguishing between unwanted and wanted touches and what to do if an unwanted touch is received. This added component to PrePARE has proved a great favorite, not only among the children but also among the teachers and parents. Indeed, on several occasions, individual teachers have confided to our Clinician not only how grateful they are to finally have a *vocabulary* with which to discuss such issues with their children, but how much they wish *they* had received such lessons when they were little.
- 4) **Developmental Screenings:** Each child referred will receive a developmental screening based on the "Development Profile II", to evaluate the child's motor development, speech, socialization, and self-help skills. For any child found to have developmental delay(s), the Clinician will provide the parents with information, advice, and referrals to help them understand their child's special needs and rights. The Clinician will also advocate for the child before the Office of Special Education of the Newark Board of Education to initiate a prompt Child Study Team (CST) evaluation. (When a parent's request for a CST is prepared by our Clinician and the Clinician then contacts the CST staff, the waiting time for needed services for the child, is dramatically reduced.)
- 5) **Speech and Language Therapy:** Both PrePARE clinicians and school staffs have long noted an overwhelming need for language development among their preschoolers. In order to address this crucial need, beginning in September 2004, PrePARE added *The Woven Word* early literacy curriculum to its package of services. *The Woven Word* was developed by the Committee for Children, the

developer of both our personal safety and violence prevention curriculums, with which we have had great success. The curriculum focuses on building early language and literacy skills while promoting social and emotional development.

- 6) **Teacher Consultation/Training:** In our pilot project and in our outreach to The Leaguers' South Ward preschools, we have found the teachers to be highly motivated, caring and hard working – but under-trained. Our consultation/training services provide these caregivers with an in-house professional for formal and informal consultations. For example: a) to explain a child's mental health diagnosis or developmental delay in plain English and suggest how to address it therapeutically in the classroom; b) to discuss a child's specific behavioral problems and offer techniques to respond more effectively, or; c) to build understanding of how a child's past trauma and/or current conflicts at home are acted out in school – and recommend how to foster emotional healing and growth.

- 7) **Parent/Caregiver Support:** Like teachers, parents benefit from professional assistance in understanding and managing their children's behaviors and developmental issues. Our clinicians make themselves available to all parents/caregivers for formal and informal meetings to discuss individual concerns and assist with advocacy as outlined above. The Clinicians also attend at Parent Resource meetings, Open Houses, and Parent/Teacher conferences. All parents receive weekly letters explaining the content of that week's lessons, including tips on how to reinforce the lessons with at-home exercises. They also receive regular parent advice columns covering issues of parenting skills and behavioral concerns. (For examples, see Attachments)

* * *

Anecdotes About PrePARE In Action

PrePARE is meeting or exceeding its outcome objectives, and this data is an important confirmation of the program's effectiveness. But of equal importance are the individual victories we see everyday in the classrooms. Here are some comments from the preschools receiving PrePARE services:

- *Thank you so much for bringing the Talking About Touching curriculum to our school. It is so important for these children to learn how to keep themselves safe from abusive situations. I wish someone had done this for me when I was a kid. I'm bringing my own kids in to hear these lessons.*

- *PrePARE has such an impact on both social and emotional growth. The children are showing more empathy and better problem solving skills. One little girl was waiting her turn to play with a ball. The little boy who had the ball refused to give her a turn.*

Instead of fighting, the girl said “Don’t you remember what Puppy and Snail told us? We have to share the ball.” And they were able to solve their problem and play catch together.

- *A little girl fell down and scraped her knee. She was so upset, and we just could not get her to calm down. Then I tried using some of the ways the PrePARE clinician had taught the children how to calm themselves. I was surprised, but it actually worked! The child relaxed. Thank you so much.*
- *One boy who was a biter was playing with blocks when another child grabbed a block away from him. In the past, this would have led to him biting. Instead, he said, “Don’t snatch away my block! Ask for it!” Then the other child did ask for it – and the two started to play together.*
- *We have one child who has a rich fantasy life involving cartoon figures and he often withdraws into this fantasy world in times of stress. Previously, his teacher would try to ‘correct’ this behavior – and then get frustrated. The PrePARE clinician discovered and shared with the teacher that the boy’s parents have nasty fights in front of him at home. Now, when the teacher sees this boy withdraw, she talks to him about what is going on and helps him calm down and focus on reducing his stress.*
- *The children frequently use the “calm down steps” of the violence prevention curriculum. They help each other to count to four and take deep breaths. They are very proud that they remember the steps and they like to point it out to the PrePARE clinician and to their teachers.*
- *You can see how the program is affecting the kids. They are more caring toward each other. They will hug a friend who is having a bad day and try to make him feel better. One girl who was painfully shy at the beginning of the year is now more verbal and interactive. The other children help her with this by inviting her to play and taking time to talk to her about what she wants and how she feels.*



Program Outcomes - 2003/04

Total enrollment in PrePARE has now grown to 335 children (age 3 to 6) at four area preschools. The overall goal of PrePARE is to maximize the social, emotional, and behavioral health of these children. We have established seven objectives to achieve this goal. The measures of our success in this program year are as follows:

Objective 1) Individual Play Therapy: *All children referred by parents and teachers will receive weekly individual play therapy. Within 6 months, 75% of these children will*

show a reduction of their presenting symptoms. Results: 37 children were referred and all 37 have received weekly therapy. 88% demonstrated a significant reduction in presenting symptoms and an improvement in classroom behavior.

Objective 2) Violence Prevention Curriculum: *All age eligible children will receive Violence Prevention training. Within 6 months, 75% of children will demonstrate decreased aggression and increased empathy and impulse control. Results:* 100% of age-eligible children participated at all four sites. 82% demonstrated improved behavior, thus surpassing our objective. 100% of Teachers positively evaluated the Violence Prevention Curriculum.

Objective 3) Personal Safety/Sexual Abuse Awareness Curriculum: *All children will receive Personal Safety training. Within 6 months, 75% of children will demonstrate increased knowledge in the areas of personal safety skills and sexual abuse awareness skills. Results:* 79% of children demonstrated a significant increase in knowledge of personal safety skills.

Objective 4) Developmental Screenings: *All children will be evaluated for developmental delays. Those deemed appropriate will receive a developmental screening. For each child identified as having a developmental delay the PrePARE clinician will present a referral plan to both the parents and school staff and will advocate for the child's rights to receive special services from the Board of Education and other sources. Results:* 100% of children were screened for developmental delays. 13 children were identified as having developmental delays. All identified children were provided with a referral plan and referred to appropriate agencies for evaluation and services.

Objective 5) Speech Therapy: *All children referred by teachers and parents will receive individual assistance with speech/language issues. Within six months, 75% of participating children will demonstrate improvement in their particular deficits in expressive and/or receptive language skills. Results:* 14 were referred for speech and language development. 12 children received play therapy for language development by the PrePARE clinicians. 8 were assisted with outside referrals for specific speech/language services.

Objective 6) Teacher Consultation/Training: *All preschool teachers will receive clinical consultation/training regarding emotional and behavioral concerns in their classrooms. Within 6 months, 75% of teachers accessing this service will report increased knowledge and usage of intervention skills which promote emotional and behavioral growth. Results:* 100% of teachers and administrators positively evaluated consultation services received, including increased knowledge and better classroom management skills.

Objective 7) Parent Training and Support: *All preschoolers' parents will be provided with written materials, oral presentations, and formal and informal consultations to enhance their parenting skills. 75% of parents accessing this service will report*

increased knowledge and use of parenting skills which promote emotional and behavioral growth. **Results:** A parent advice column is delivered regularly to all parents, covering issues of parenting skills and behavioral concerns. (Copies attached.) All parents also receive weekly letters explaining the content of that week's Violence Prevention and Talking About Touching curricula. Ongoing additional support is provided to parents of children who receive individual play therapy. 100% of parents positively evaluated the services received.

System Design Advisory Committee

Charge to the System Design Advisory Committee

The System Design committee will study the current effectiveness and design of the mental health system in New Jersey. The committee will assess the availability, accessibility and gaps in the mental health system. A significant amount of money is spent in the public mental health system, but funding is unevenly allocated and often inefficiently spent. Quality varies across providers and regions of the state. The committee will make recommendations for the system redesign that will result in improved quality and operational efficiencies, as well as increase local planning and accountability.

The committee will explore increasing the community capacity for behavioral health services and make appropriate recommendations for such. The committee will study ways to redirect more services to the community and to divert hospitalizations.

Proposed Structure

The structure of New Jersey's mental health system plays a critical role in the actual delivery of quality mental health services throughout the entire state at all levels. The System Design Committee of the Governor's Task Force on Mental Health proposes meaningful modifications to the current structure in order to improve the provision of quality mental health care to all New Jersey residents in need of such vital services.

The following structural issues have been identified by the Committee as interfering with the delivery of mental health services. These issues are:

- Fragmented funding, uncoordinated services
- Large, centralized Division of Mental Health
- Lack of appropriate local and provider input into service planning and delivery
- Insufficient funding of less restrictive treatment options, resulting in consumers receiving more restrictive and expensive care than necessary.
- Lack of meaningful outcome and quality measures to improve the system

The structure of the public mental health system in New Jersey should support the goal of effective, efficient, culturally competent, and compassionate mental health treatment. The services should be based on the best available practices and oriented toward recovery and wellness. Full participation by consumers and family groups is essential. Continuous quality improvement must be foundation of all clinical services.

The Systems Design Committee highly recommends increasing the profile of the Division of Mental Health Services within the Department of Human Services that is responsible for establishing required services for all local mental health systems This

division will monitor the quality and efficiency of those services and take appropriate actions where services are found to be deficient. In addition, the committee recommends that costs for central administration should be kept to a minimum, and that to the extent possible, management, development and services should be at the most local level reasonable. The committee also recommends that each county have the ability to add services beyond those required

To the fullest extent possible, the use of local mental health services, hospitals and resources should be encouraged, and expanded where necessary, in order to reduce the reliance on large state and county hospitals. Screening and emergency services, including crisis housing, are crucial to the entire process and should be fully funded to provide the most effective triage and crisis intervention services possible. This must include the availability of bilingual/bicultural staff. Effective emergency services can minimize the need for more intensive levels of care, thereby reducing suffering and costs.

Benchmarks will be established for each required mental health service. Counties failing to meet the baseline standards must develop a remediation plan with time frames for full compliance.

With respect to children's behavioral health, this committee recommends greater collaboration with adult mental health services. Systems must be developed to ensure appropriate communication and integration of services.

The establishment of a Public Advocate will promote an effective, compassionate and responsive system of mental health care.

Each county must utilize their existing County Mental Health Boards
. To encourage such collaboration, it is recommended that the state funding provided for county mental health board administrators be increased, as to allow for each county to have a full-time administrator.. Counties would be encouraged to contribute to their regional services by a matching contribution from state funds(if available) to support local mental health services. In regards to vacancies on the county boards the Commissioner of Human Services should be allowed to make the appointment, with local input if county government does not respond to a vacancy within 3 months. This will ensure greater participation.

Funding for this new design and the increased services for the new housing opportunities, would come from several sources. The design, itself, does not necessarily require increased funding. However, the System Design Committee recommends the following steps in order to build community services:

- All contracts will have realistic productivity expectations. Failure to meet expectations will result in reduced funding. This is estimated to increase available support by at least 10%. It is proposed, once productivity expectations

are incorporated into contracts, that half of this be immediately put into increasing salaries of direct service staff in community settings.

- Reduce the size of the administrative staff at the state level. All savings would support local clinical care.
- Encourage smaller community providers to merge, creating administrative savings.
- To the fullest extent possible, utilize the Medicaid Rehabilitation Option for increasing community services. This will add costs to the state but bring in significant matching federal support. Gov. Codey's FY'06 proposals can act as the necessary matching dollars.
- To the extent administratively possible aggregate funding from existing resources, i.e. DDD, DAS, DVR, to provide coherent support for local services

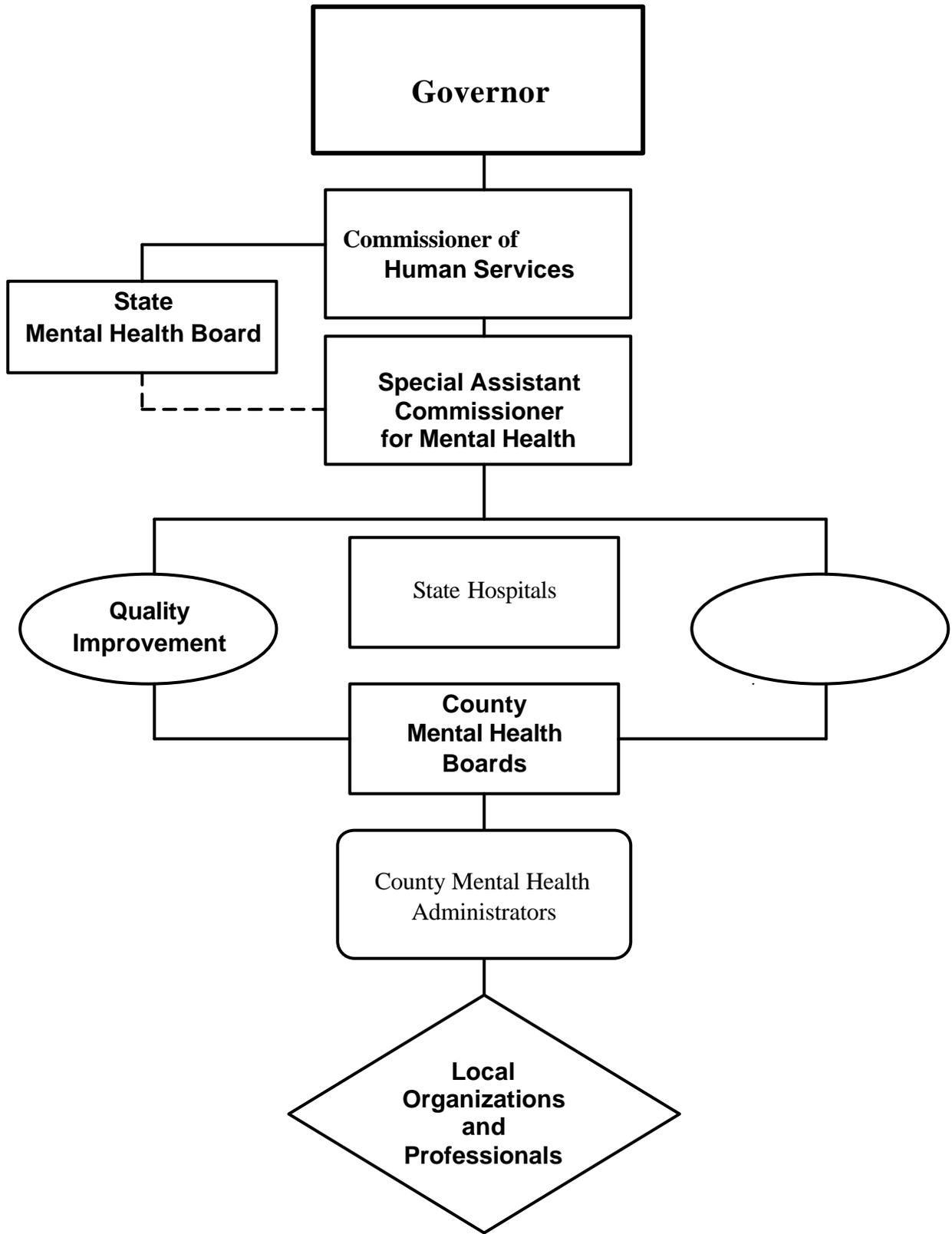
Structural Components

1. Governor –
 - Appoints Commissioner of Human Services
 - Appoints State Mental Health Board
2. Commissioner of Human Services-
 - Appoints and evaluates the Special Asst. Commissioner of Mental Health with full collaboration of the State Mental Health Board.
 - Ensures that responsibility and funding is assigned for needs that overlap divisions i.e. Co-occurring, Developmental Disabilities – Mental Health; Substance Abuse – Mental Health.
 - Ensures appropriate collaboration with other departments i.e. Corrections
 - Ex Officio member of the Mental Health Board
 - Finalizes one year and three year strategic plan with the State Mental Health Board, which clearly delineates the mandated services.
3. Mental Health Board (MHB)-
 - appointed by Governor
 - Will meet at least 10 times per year
 - Representatives:
 - Consumer groups
 - County Mental Health Boards
 - Family groups
 - Professional groups
 - MH service organizations
 - Dept. of Corrections
 - Division of Developmental Disabilities
 - Division of Addiction Services
 - Juvenile Justice Commission
 - Department of Community Affairs
 - Department of Education

- With Commissioner, establishes MH plans and goals for evaluation of Special Asst. Commissioner
 - Screening group for Special Asst. Commissioner position
 - With Commissioner, evaluates annual performance of Asst. Commissioner
 - Will make a yearly report to Governor, Commissioner of Human Services and the Legislature on goal attainment for previous year and measurable goals established for coming year. This will include level of coordination of care with other relevant departments
 - Will hold public hearings once per year to provide community input into yearly goal setting for mental health services
4. Special Asst. Commissioner for Mental Health
- Oversight of all adult(?)mental health services
 - data collection,
 - quality improvement,
 - performance monitoring
 - With MHB, establishes mandated services
 - Enacts the plan established by the Commissioner and MHB
 - Responsible for all contracting and state quality improvement programs
 - Manages state hospitals, supporting the process of moving services to the community level
 - Ensures efficient contracting process that supports local accountability.
5. County Mental Health Board (CMHB)
- 21 County Boards
 - consumers
 - professionals
 - family
 - county freeholders' appointees
 - Responsible for oversight of the adult and children's mental health systems as currently required and described in the Community Mental Health Act
 - Develops, oversees, and assumes all responsibility for local services
 - The county mental health boards should operate consistent with the Community Mental Health Service Act, sub Chapter 3, 10:37, in regard to all their duties for both the adult and children's mental health system especially in regard to local planning and monitoring. The voice of local concerns represented by the county mental health boards must be heard at the state level.
 - Beginning in SFY 07, the state should double the funding for county Mental Health Administrators in order to ensure each county's ability to fulfill the mandates of the Community Mental Health Service Act.

Minimum Required Regional Services (these are examples – would be set at the Special Asst. Commissioner level)

1. Screening and emergency services for all mental health populations
2. Outpatient – specialized, as needed
 - Developmentally Disabled
 - Substance Abuse
 - Criminal justice
3. Case Management
4. Inpatient – including short and intermediate
5. Long term support programs which include:
 - Supported housing
 - Supported employment
 - Psychoeducation
 - Family support
6. Centers of Excellence
 - Serve as consultants to other regional professionals
 - Available on fee for service basis to other regions



Participants

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Bill Sette – Preferred Behavioral Health

Jim Romer – Kimball Medical Center

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Guest

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Hospital Advisory Committee Executive Summary

- ◆ Take the necessary steps to preclude the need to expand state hospital capacity by 400 beds at an annual operating cost of \$65,000,000.
- ◆ The Task Force toured the state psychiatric hospital system and was deeply disturbed by the conditions of overcrowding. The Task Force was, however, impressed with the quality and the commitment of the leadership at each institution. The census on March 18, 2005 was 2241, the system is designated to treat 1895. While the Task Force believes that its recommendations in total will result in long-term census reduction, the following short-term steps should be taken to reduce the overcrowding.

The Task Force recommended and supports Governor Codey's proposal, announced on March 15, 2005, to increase the bed capacity at the proposed new Greystone Park Psychiatric Hospital from 460 beds to 510 beds.

The Task Force recommends the CHAMP program to serve as a primary model for transitional and supportive housing for individuals who have been hospitalized for significant periods of time, but have progressed and recovered to a level warranting gradual integration into the community. The CHAMP program is a ten-bed specialized residential program operated by a private provider on the grounds of Greystone Park Psychiatric Hospital. This program prepares newly discharged patients for community living. The majority of these patients are able to move to independent living. The provider has recently secured three homes in the same location. The County of Morris is providing funds for physical plant rehabilitation. The Task Force recommends the state provide the service money, if available in fiscal year 06, but definitely no later than fiscal year 07, to expand the program by 15 beds. The cost per bed at the CHAMP program is less than half of the cost per bed at a state hospital, which is approximately \$146,000 annually.

Carrier Clinic has the capacity to provide transitional in-patient services to 25 patients transitioning from Trenton Psychiatric Hospital. While touring the Trenton facility, the Task Force found seven patients sleeping in rooms designed for four – a situation that is unacceptable. Individuals who are appropriate enter Carrier Clinic's Co-Occurring program and are discharged directly from Carrier to the community with additional coping skills.

Currently, the Department of Human Services is seeking to re-engage this previously successful program for six months with limited existing funding. The Task Force is recommending that the program be expanded for an additional year to 18 months.

The Task Force recommends implementing the current capital proposal pending at the Department of Human Services to expand program space on the admissions unit

of Trenton Psychiatric Hospital. Approximate cost \$2 million, if funding available in fiscal year 06 budget.

Ancora Psychiatric Hospital is overcrowded, resulting in a scarcity of program space. The Task Force recommends the purchase of two modular units for program space.
Cost: \$600,000.

- ◆ Within an organized local system of care, which includes available supported housing, psychiatric treatment and other recovery oriented services, expand local acute care inpatient capability within the counties that commit 74% of consumers to state hospitals.

Expanded length of stay at the local acute care level can be accomplished by efficiently utilizing current capacity at a projected cost of 4.9 million in new state funds (total spending projected at 6.9 million). A structured outcome oriented evaluation of this initiative must be designed prior to implementation. Evaluation process should occur over a two year period. Priority projects should be identified based upon use of state and county hospitals, capacity to convert existing voluntary and involuntary beds to intermediate stays (up to 30 days) and the availability of acute care diversion and step down/post discharge services.

Families and persons with mental illness prefer to receive treatment as close to home as possible. Currently, an average of two out of every three persons determined by local screening centers to be in need of hospitalization are sent directly to a state or county psychiatric hospital.

To encourage community hospitals to provide this care closer to home, the Task Force recommended and supports Governor Codey's fiscal year '06 budget proposal to commit approximately \$1 million to implement a pilot program to provide inpatient psychiatric hospitalization in the community short-term care facilities for up to 30 days. This program will assess whether patients can be stabilized before they are sent to a county and/or state hospital.

The Task Force highly recommends expanding this program statewide, pending a successful, independent evaluation of the pilot project's performance, and as funds become available.

- ◆ With implementation of an organized local system of care, and expanded local inpatient capability, reduce the length of stay of those on Conditional Extension Pending Placement (CEPP) status to a reasonable target, especially as additional community resources become available.
- ◆ Finally, establish a clear mission for state and county psychiatric facilities to provide long-term recovery oriented services for persons with serious and persistent mental illness with the appropriate level of resources.

HOSPITAL COMMITTEE REPORT

Overview of Inpatient Services (State, County and Local)

Charge to the Committee

The Hospital Committee of the Governor's Mental Health Task Force is charged with reviewing the inpatient service component of the Mental Health System serving New Jersey residents. Specifically, we examined the extent to which this service component accomplished the mission of stabilizing, treating and successfully returning service recipients, to communities, in which they resided in prior to admission.

We have also examined the need or lack thereof for increased bed capacity at State facilities. The relationship between the various types of hospitals, state, county and local was also reviewed, specifically, as these types of settings function within the system of inpatient services in N.J. Finally, the relationship of the inpatient system component was reviewed within the context of the community care system and access to post discharge support services.

New Jersey's General Hospitals with psychiatric units and Private freestanding Psychiatric Facilities have approximately 47,000 admissions during the year (37,000 general hospitals, 10,000 private (source NJHA 2002 Psych cost report data). It is estimated that adolescents represent about 5,000 of the 47,000 admissions. In Fiscal year '04 approximately 5239 consumers were admitted to state or county facilities from screening or short term care units in general hospitals. Thus, the vast majority of general hospital admissions result in consumers being treated in local psychiatric emergency services and related involuntary and voluntary psychiatric units of acute care hospitals. Approximately, eighty-seven (87.5%) of adult NJ residents are treated, stabilized, and returned to their community of origin within 8 to 12 days. However, a recovery-oriented system to treat and support people discharged from general hospitals and private facilities is only sporadically in place. While some percentage of these individuals are readmitted within 30 to 90 days, the number, as stated earlier, is expected to be less than 10%. Almost 60% of those individuals admitted to state and county facilities are discharged from these facilities within 45 days, so state and county hospitals function as extended acute care settings for a period of time.

State Mental Health policy requires that consumers must have several hospitalizations before they are able to access intensive services like integrated case management, and Programs for Assertive Community Treatment.

Patients admitted for the first time to the hospital system are generally not eligible for intensive aftercare services, which for some would represent early intervention efforts to avert the tragic cycle of hospitalizations leading to persistent mental illness.

In our review of FY '04 psychiatric emergency services/screening and short term care facility data (attachment I) 2 out of 3 (66%) admissions to state and

county hospitals are coming from the screening centers. These transfers occur even though the STCF statewide occupancy averages 81.8% and length of stay in these units average 9.4 days. Occupancy rates for all psychiatric beds in local hospitals averages about 70%. (Source: DOHSS 2003 data).

The ability of the acute care psychiatric service system in diverting admissions to state and county hospitals appear to happen in only one of every three cases. Multiple variables and regional differences undoubtedly are operating here, and further in depth analysis is required especially before the needed additional capacity at the local level can be identified and implemented.

State and County admissions data (DMHS and County hospitals/source) indicates that at least 35% of admissions to state and county hospitals are homeless upon admission. A high percentage (more than 35%) has co-occurring substance abuse treatment needs and have or need criminal justice system involvement.

Furthermore, based upon our review of hospital uniform billing information (source DOHSS VB-92 data for 2002), 47% of all psychiatric patients admitted for psychosis or major depression to general hospitals were self-pay, charity care or Medicaid all of which are not attractive payers.

Given the fact that 38.7% of N.J. Acute Care hospitals operated in the red last year, their ability to service patients with limited or no source of payment is severely taxed (source NSHA – 38.7%). The recent implementation of Medicare prospective payment system is expected to adversely impact on general hospitals operating inpatient psychiatric services.

Local inpatient capacity is currently much smaller (279 STCF beds) than existing capacity at state hospitals (2,300 census/beds), county facilities (800 beds).

If New Jersey is to truly implement a least restrictive, community-based system of care capacity at the local level must be expanded (no. of beds and length of stay increased).

Consumers confined in State facilities are generally unemployed or underemployed and many are estranged from their families. Between 50% and 85% of them will remain at State and County facilities long past the time they have been determined to be clinically stable because adequate housing with supports are not available to them. While in the hospital, a recovery-oriented model, which includes rehabilitative, skill building services and preparation for living in supported housing is largely absent to the great majority of patients needs.

Direct care staff is challenged in assisting patients to meet rehabilitation-oriented goals and service planning becomes focused on what's available, which may have little relationship to addressing patients' needs and implementing individualized care. Upgraded qualifications and training in recovery oriented rehabilitation for line workers and references are needed.

Recent efforts to better train staff in a recovery-oriented program with UMDNJ is cited as a positive development, especially a new program at Greystone Park Psychiatric Hospital. This training can help to change the custodial orientation of services at the State hospital setting.

For many of these consumers, the courts have ruled that they can no longer be committed involuntarily because they are no longer dangerous due to mental illness but many remain unnecessarily for various reasons. For some, discharge planning and implementation is inadequate, and operational/procedural barriers must be addressed to make the process more efficient and effective. The number of consumers currently in Conditional Extension Pending Placement (CEPP) status has exceeded 1,000 or almost half of the current census. Steps must be taken to reduce the number of patients in this category.

Finally, overcrowding at state hospitals (especially Ancora and Trenton Psychiatric) is a major problem as the hospitals are unable to adequately treat and prepare patients for timely discharge. As a result, the average daily population and the CEPP numbers have grown by 5% (representing about 109 patients) since 2002.

The committee believes that without significant community mental health system expansion efforts the Average Daily Population (ADP) and related CEPP will continue to grow as it has done over the last four years and in another three years should increase by 150 patients. Furthermore, when one considers the existing overcrowding conditions, as well as, the fact that the current GPPH census is 100 over the planned capacity of the new facility, additional capacity is warranted, if options are not developed in the entire system. The overcrowding at the state hospitals impacts on all aspects of patient well-being, care and treatment. A rough estimate by the committee suggests presently at least 250 patients are being deprived of adequate space for treatment and recreation because of overcrowding.

Thus, we conclude that without any expansion of community options, 400 beds (250 to relieve current overcrowding, 50 expected census increase + 100 GPPH) will be needed to accommodate the average daily population within the next three years. Four hundred new beds at the current operating cost of \$146,000 per bed (source: state budget) plus needed staffing upgrades suggest 65 million new resources would be required.

Our ability to properly assess the extent of overcrowding at state hospitals is complicated by the fact that these facilities don't operate with a published licensed capacity. The State Division of Mental Health services is able to certify/decertify beds with the approval of the Center for Medicaid and Medicare Services. The committee strongly encourages the Division to identify an appropriate mechanism to allow the public to know when capacity limits are exceeded at all state facilities.

Summary of Findings

- To a great extent, the availability of recovery-oriented treatment and rehabilitation is either inconsistent or unavailable at state hospitals. Significant overcrowding at the facilities severely compromise the state hospitals' ability to offer service that assist

consumers to develop the necessary skills to function in the community.

- Without a significant expansion an organized locally managed system of care, the need for 400 additional state hospital beds is forecasted, within three years.
- Qualification of direct care staff must be upgraded and on-going training implemented to increase their effectiveness in assisting consumers' benefit from recovery-oriented rehabilitation.
- Another prominent cause of overcrowding is the use of state hospitals for confinement of developmentally disabled citizens, prison inmates with mental illnesses that have been neglected by the Corrections System and the jails. Inmates maxing out on sentences, who need case management and release planning, currently not provided by the Corrections System also make up this group. Substance abusers with mental illnesses for whom there are inadequate residential rehabilitation services, sex offenders, and other persons in need of community-based social services that are unavailable constitute a significant percentage of the ADP.

Because state and county facilities are used for numerous purposes as mentioned above, these facilities lack a recognized inpatient hospital mission that comports with modern principles of wellness and recovery in psychiatric rehabilitation. Without a defined mission within the larger system of care, these facilities (the most expensive in the system on a per-bed or per-capita basis) are likely to continue to be over utilized and misused for inappropriate purposes.

Increased homelessness along with substance abuse and involvement with the criminal justice system further complicate the treatment and discharge process for consumers.

Overcrowding is also attributable to the utilization of state and county facilities for acute and intermediate term hospitalization that should be provided in the community.

Qualification of direct care staff must be upgraded and on-going training implemented to increase their effectiveness in assisting consumer's benefit from recovery-oriented rehabilitation.

Discharge planning is fragmented and resources are extremely limited and coordination is required to decrease the length of stay at state and county facilities.

Strengthened hospital/community discharge planning processing must be put in place.

Consumers who need intensive rehabilitation services to address barriers to discharge often do not receive adequate services, thus increasing length of stay.

Inadequate affordable supported housing and community based support services also contribute to excessive length of stay at state and county facilities.

The vast majority of N.J. residents treated in general acute care psychiatric units are treated, stabilized and discharged to the communities in which they resided prior to admission.

Two out of 3 (66%) of admissions to state and county hospitals come directly from screening as opposed to short-term care, despite the fact that STCF occupancy rates are at 81.9% and voluntary units generally with occupancy rates of less than 70%. Multiple variables, social economic, capacity limits probably account for this finding.

Poor payer mix and related reimbursement concerns if not addressed will curtail interest in expanding STCF capability and length of stay at local hospitals. Other alternatives to promoting intermediate level of care may be necessary in selected areas, if capacity and interest from the hospital sector is not forthcoming. See attachment III for summary of all hospital data.

Recommendations

Take steps necessary to preclude the need to expand state hospital bed capacity by 400 beds. Expand the length of stay up to 30 days at local in-patient psychiatric units in the 9 counties that account for 74% of the admissions to state hospitals from specific counties. (see attachment (IV) for full description of this recommendation). Increase the number of beds in local facilities to further encourage the provision of acute psychiatric care and the development of intermediate care in local hospitals. Insure local capacity for acute and intermediate care is in place and operating according to expectation prior to any reduction of state and county capacity.

With expanded local capacity legal and/or practice, changes must be made to insure that consumers are able to seek voluntary admission prior to waiting until a condition of dangerous or significant deterioration has been reached.

The Department of Health and Senior Services needs to issue a certificate of need call for intermediate psychiatric beds (up to at least 30 days as a demonstration project). The project needs to be well-designed and outcome measures clearly defined. After a 2 or 3 year period after project implementation has occurred, an evaluation report should be required to determine further development of intermediate beds in other high need counties.

Reduce length of stay on CEPP status to a reasonable target

- First, create an organized local system of care that fixes responsibility for both inpatient and community based care for SPM1 consumers with one entity.
- Second amend the commitment statute and rule to set the appropriate limit on the duration of CEPP status.

- Better organize discharge-planning services to ensure discharges occur on expedited basis.
- Identify and address the rehabilitation needs of consumers on CEPP status whose barriers to discharge are amenable to rehabilitative services.

3. Establish a clear mission of the State and County facilities: to provide long-term recovery-oriented services for persons diagnosed with serious and persistent mental illness.

Executive branch support of local management enhanced resources (including staffing and training), and standards of effectiveness (including quality standards, evidenced-based practice methods, utilization review, staffing standards and effective quality assurance mechanisms) is required to move in this direction. This initiative includes the identification of special populations needing specially designed programs, including the following classes of consumers: substance abusers; developmentally disabled; elderly; persons with chronic and serious physical disorders; persons with physical disabilities; persons whose preferred language is other than English; and residents without green cards or necessary documentation. Recognize that State and County hospitals have a key role in providing long-term care and discharge-oriented rehabilitation care. Provide them with the resources to staff and program accordingly to insure that their important role in the system is realized. The hospital refers to either system design or children committee the areas below.

- The Hospital committee requests that the Systems Design committee design and suggest how to implement a system of care for consumers diagnosed with seriously and persistently mentally illness (SPMI) (persons) and also for individuals at risk of becoming SPMI, who utilize general acute care units and expanded length of stay options. The committee suggests that a design that fixes accountability and responsibility for these individuals with one entity be created. The identified entity should (will) be responsible for insuring the continuity of care for identified individuals regardless of setting (general hospital, private hospital, state/county facility, jail, shelter, etc.).

- The committee refers to the Systems Design committee a suggestion for quality assurance review that utilizes Consumer Satisfaction Teams as part of the overall quality assurance system. National Alliance for the Mentally Ill (NAMI) representative should be included on the team.

- CCIS Bed

The hospital committee has provided the children's committee with occupancy date for CCIS' as one source of decision-making information to make recommendation around the closure of ABTC (see attachment II).

ATTACHMENT I

ACUTE CARE SYSTEM ANALYSIS

- '04 Admissions to State and County Hospitals from STCF 1,770
34%
- '04 Admission to State/County Direct from Screening 3,469
66%
(Excluding Bergen Regional which functions as
acute care service)
- Total Admits/Screening and STCF 5,239
- Occupancy of STCFs statewide in '04 was 81.9%
- Most STCFs also operate voluntary beds and statewide average occupancy of
voluntary beds is less than 70%
- Almost twice as many admissions to state and county hospitals come from
screening rather than STCFs, although capacity exists in STCFs and voluntary
beds.

NOTE: Admissions to state and county hospitals are higher than the first total as
screening and STCF are not the exclusive way to enter state and county
facilities.

ATTACHMENT II

CCIS STATISTICS

	2000	2001	2002	2003	2004
Total Admits	4,164	4,277	4,417	4,502	
Average Occupancy	77.24%	74.59%	67.08%	70.40%	67.55%

Total Available Beds 169

ALOS (04) 11 days

Calendar Year 04 occupancy 4th quarter.

1st Q 78.23%

2nd Q 74.93%

3rd Q 52.77% (July, August, Sept.)

4th Q 64.28%

Occupancy during 5th Q calendar year 04 is 10.5% less than 4th Q 2003.

Note: Brisbane admitted only 100 children per year.

ATTACHMENT III

SUMMARY OF KEY HOSPITAL INFORMATION

General Hospital Acute Care Psychiatric Units

Annual Admissions to either general hospital acute psychiatric units or free standing psychiatric facilities numbered approximately 43,000. Less than 14% (5,600) are transferred to state and county facilities.

Occupancy rates for general hospital acute psychiatric units is about 68%.

UB 92, 2002 data reveals for the most common DRG's (430,426), 47% of the cases were either Medicaid, self-pay or charity care.

For 2003, general hospitals operated 1,129 adult acute psychiatric beds, 276 were involuntary – 853 voluntary less (Bergen Regional beds not counted here).

Length of stay in STCF Units averages 9.4 days (low/southern region 7.5)

20.2% is the median (18.5 x) amount of patients transferred to state and county facilities from STCF.

Slightly less than half (46%) of the general hospitals who provide acute psychiatric inpatient services have only adult voluntary beds (21 of 45).

All but three of the 21 hospitals with only voluntary adult beds have an occupancy rate exceeding 65%.

42% of the hospitals (9 of 21) offering only voluntary adult services operate at 55% or less occupancy.

Screening/Psych. Emergency

58,551 episodes of care for patients occurred in screening/psych emergency services (PES) in calendar year '04 (source DMHS screening info)

6% of adults served by screening/PES were admitted (cal. '04) directly from screening to a state and county hospital (3,469 admissions). Regional variations exist as follows (Central 5%, Southern 11% and North 3.9%)

State and County Hospitals

35% to 40% homeless upon admission to State and County hospitals.

60% of admissions to State and County Hospitals are discharged within 45 days so these facilities function as extended acute settings for a high percentage of patients.

Nov. '04 almost a thousand state hospital patients were CEEP status (clinically ready to go).

County Hospitals operate approximately 792 beds in 6 counties. State hospital census is around 2300 patients.

State Hospital admission often increasing approximately 100 per year from FY '02 and appear to be slightly 1/24/05 declining in FY '05 YTD over the 02 number.

Average daily census at State Hospitals appears to be increasing every year since FY '02, and will be five percent higher than the earlier period. This trend appears to reflect the increasing CEEP.

Private Psychiatric Hospitals

Private psychiatric hospitals operate about 532 beds and admit approximately 8,000 unduplicated patients in a given year (10,880).

Private psychiatric hospitals occupancy rates are about 65%.

GENERAL HOSPITAL ACUTE CARE

PSYCHIATRIC SERVICES

Based upon DOHSS licensing/occupancy data (2003) and UB '92 financial information (2002), the following findings are identified.

- ◆ Forty-five general hospitals offer acute psychiatric inpatient care to adults in 2003.
- ◆ Slightly less than half (46%) of these hospitals offer only adult voluntary beds (21).
- ◆ All but 3 of these hospitals have an occupancy rate exceeding 65%.
- ◆ 42% of the Hospitals (9 of 21) offering only voluntary adult services operate at 55% or less occupancy.
- ◆ Within 5 counties (Hudson, Bergen, Passaic, Essex, Monmouth) operate at least 2 hospitals operate voluntary units where the occupancy information suggestion potential consolidation or develop or alternatives to State and county facilities where needed and interest exists.

2003
Open Volume Adult Beds

HOSPITAL	LICENSED BEDS	OCCUPANCY/ LICENSED	COUNTY
1. Barnert	30	62%	Passaic
2. Bayonne	15	50%	Hudson
3. Chilton	20	54%	Morristown
4. Christ	20	59%	Hudson
5. Cooper	16	65%	Camden
6. Englewood	23	42%	Bergen
7. Holy Name	23	64%	Bergen
8. Hunterdon Med	14	56%	Hunterdon
9. Jersey Shore	30	67%	Monmouth
10. Morristown	16	81%	Morris
11. Overlook	21	88%	Union
12. Raritan Bay (Note: Operating 20 of 35)	35	35%	Middlesex
13. Riverview	30	63%	Monmouth
14. St. Barnabus (Note: Operating 5 of 15)	15	7%	Essex
15. St. Michael	21	55%	Essex
16. Somerset Med.	30	57%	Somerset
17. St. Joe's	46	33%	Passaic
18. St. Mary's _____ (Operates 30)	49	43%	Hudson
19. Valley	20	65%	Bergen
20. _____/ Burlington	22	54%	Burlington
21. Warren	16	34%	Warren

JL/nfr
Summary of Key Hospital Information

Attachment IV

Expansion of State Hospital Acute Care Diversion Services

I. Current Situation (State H./RD II, Screening & STCF)

A. Despite implementation of the D.M.H.S. Redirection II plan, the average daily population at state hospitals is 5% higher than before the initiative (attachment I). Increased homelessness, limited availability of involuntary (STCF) beds in community hospitals, and the need for longer stays in local units contribute to the higher than expected census. Population growth in the early 2,000s also accounts for increased demand for inpatient services. Significant overcrowding exists at many of the state hospitals and the ability of the hospital staff to provide discharged oriented rehabilitation is severely compromised.

B. Screening Center and S.T.C.F. Operations

Based upon our review of statewide fiscal year '04 screening center and STCF data, we note that 2 out of every 3 admissions to state and county hospitals come from screening. As a result, state and county hospitals function more and more like extended acute inpatient services for newly admitted patients. This admission pattern occurs despite 81.7% STCF statewide occupancy rates and less than 70% occupy in the voluntary beds. Length of stay is STCF average 9.4 days.

USTF FY'04 data (attachment VIII) supports the acute care function of the state and county hospital. Twenty five percent (25.7%) of patients admitted to state hospitals are discharged within 30 days of admission. The percentage increases to 52% (52.3) for persons discharged within 90 days of admission to a state and county hospital.

C. Patient Profile

Patients receiving extended acute care services of state and county hospitals tend to be severely and persistently mentally ill (SPMI) with complicating factors such as homelessness, substance abuse and criminal justice systems involvement.

D. Effectiveness of State/County Hospital Diversion Services

To effectively serve consumers in community settings merely expanding acute care inpatient capability will not result in success. Especially for the SPMI population with co-morbid conditions and criminal justice system

involvement, an organized system of care (housing, case management, treatment and other supports in a variety of settings) needs to be in place to avoid hospitalization where appropriate and support timely discharges, when stabilization has been reached.

II. Current Situation (County of Origins and STCF Supply)

These counties represent 74% (2363 of 3176) of admission to state hospitals in FY 04 (attachment VIII source/DMHS). Fifty nine percent of the Nov 04 CEPP population was also from these nine counties (attachment IX).

These nine counties during the first quarter of calendar year 05 operated 54% of all STCF beds (152 of 279) attachment X/N.J.H.A.).

County hospitals especially in Essex and Hudson appear to have the capacity to operate extended acute services so that admissions to state hospitals from those counties are less than 50 each in FY 04. Thus, the configuration of inpatient services in these counties should stay as they are currently operating.

III. Current Situation (local capacity/analysis)

In counties, hospitals operate 152 STCF bed. The statewide average occupancy for these is 81.9%. DOHSS 2003 state reflects the occupancy for all maintained psychiatric bed (attachment XI) voluntary and involuntary. It should be noted that the information in attachment X more currently reflects the mix of voluntary/involuntary beds.

In any event, the combined occupancy of voluntary and involuntary beds for hospitals within the 9 counties, who operate both types of bed (voluntary/involuntary) is 70.9% (mean) and 73.5% (median).

Thus, some capacity appears to exist in these facilities. According to DOHSS data the above hospitals are operating a total of 353 maintained licensed adult psychiatric beds. Fifty seven percent of these 353 are voluntary beds.

With a median occupancy of 73.5% this suggest that general hospital psychiatric units within these nine counties are using 94,701 bed days out of a maximum potential of 128,845 total possible bed days ($353 \times 365 = 128,845$ x $73.5 = 94,701$). Thus patient bed day capacity exists for 34,144 ($128,701 - 94,701$) days.

We know that 25% of those admitted to the state hospitals are discharged within 30 days or potentially 794 admissions ($3176 \times .25$). These nine counties represent 74% of all admissions to the state hospitals in FY04. Applying the 74% factor to the number of patients discharged from state

hospitals within 30 days we would estimate 587 (794 x .74) come from these 9 counties.

We also know that 2 out of these 3 admissions to state/county hospitals come directly from screening. If we assume that 587 admissions to screening stay 30 days or less in a local facility, they would consume 17,610 bed days (587 x 30) or 50% of the available capacity. Of course, operational issues including staffing, high census months make it unrealistic to operate a full capacity all of the time.

With implementation of best practice medication algorithms readily available discharge support, effective concurrent utilization review, the actual number of days would decrease and allow greater local utilization. Bed days totaling 17,610 divided by 365 days suggests that 48 intermediate level beds would be required in the nine counties

Cost Implications at appears next of this new level of care.

To divert 587 admissions from the state hospitals in the 9 counties that are responsible for 74% of admissions, to state facilities, we propose to change reimbursement from Medicaid and charity care to a per diem instead of a DRG system for approximately 14% of the psychiatric beds in nine counties. Allow hospitals to expand the length of stay up to 30 days, under a tight utilization review program, expanded STCF designated beds or through conversion of voluntary psych beds. By using 50% of the available capacity in hospitals operating voluntary and involuntary beds in the 9 counties we estimated the annualized cost to be 6.9 million dollars. (19 days x \$625 per day x 587 admissions). The cost of the first 11 days are already covered by existing reimbursement. Eleven days represents the average length of stay at time of transfer to state and county facilities. Six hundred twenty-five dollars per day is the estimated current Medicaid reimbursement for DRGs 430 & 426. The amount is also close to the base reimbursement per diem that the new Medicare payment system has established for psychiatric acute service (\$575 per day). It's further estimated that approximately 2.0 million of the 6.9 will represent Medicare payments, additional DISH payments or the state portion of Medicaid.

Expansion of state hospitals

**Attachme
nt VI
State
Hospital
Admission
s**

	<u>Actual FY 02</u>	<u>Actual FY 03</u>	<u>Actual FY 04</u>	<u>Actual NOV/04</u>	<u>Annualized 2005</u>	<u>02/'05 Annual</u>
EPPH	301	298	336	136	326	
TPH	1,068	1,151	1,083	455	1,092	
Ann Klein	598	613	653	232	557	
Ancora	1,228	1,232	1,329	490	1,176	
Hagedorn	<u>484</u>	<u>473</u>	<u>470</u>	<u>241</u>	<u>578</u>	
	3,679	3,767	3,871	1,554	3,729	+ 50 (01%)

A.D.P.

	Actual <u>02</u>	Actual <u>03</u>	Actual <u>04</u>	Actual YTD <u>05 (Nov.)</u>	02/05 <u>Annualized</u>
GPPH	553	553	551	561	+8
TPH	481	499	504	518	+37
Ann Klein	197	188	197	194	-3
Ancora	710	738	722	746	+36
Hagedorn	<u>270</u>	<u>262</u>	<u>274</u>	<u>301</u>	<u>+31</u>
	2,211	2,240	2,248	2,320	109 (05%)

Criminal Justice

Expanding Treatment & Improving Coordination Between the Mental Health & Criminal Justice Systems

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EXECUTIVE SUMMARY

The Criminal Justice Committee was asked to assess the needs of people with mental illness who come into contact with the criminal justice system. The Committee comprised stakeholders and participants in most aspects of the system – consumers, family members, providers, advocates and academics. We determined that (1) the intersection of the mental health and criminal justice system displays a lack of coordinated, appropriate services; and (2) if we are to have any success in addressing the needs of persons involved with both systems, the State must expand certain types of services at key points of interface between the two systems. This Report specifies what services are required, how access should be improved and how services can be better coordinated at all points of intersection with the criminal justice system – from initial police contact, through incarceration, to reentry into the community.

The Committee cannot emphasize too strongly, however, the importance of expanding services to this high-risk and seriously underserved population. The paucity of services available to those with serious mental illness interacting with the criminal justice system constitutes a serious public health threat that requires immediate corrective action. Without a concentrated effort on the part of the State to expand community treatment and related services, efforts to improve coordination and strengthen the interface between the mental health and criminal justice systems will have little impact. Expanding specific services where the two systems intersect is an investment that will ensure a more effective use of state resources, and increase the likelihood that offenders with serious mental illness will find their way into recovery and productive life in the community.

CRIMINAL JUSTICE COMMITTEE PRIORITIES

1. CREATION OF COUNTY-BASED CRISIS INTERVENTION/CRISIS DIVERSION SYSTEMS (CICDS). The State should expand its crisis intervention system to provide in each county the capacity for mental illness crisis response, case management, referral and follow-up support. The CICDSs should be available to consumers in crisis on a 24/7 basis to provide for crisis response and appropriate referral. Such capacity can stabilize people with symptomatic serious mental illness, in many cases diverting them from any contact with the criminal justice system. The CICDSs should also serve as trainers and liaison with police and court personnel, permitting them to exercise informed discretionary judgment. Appropriate referral and coordination services will allow informed exercise of discretionary judgment from pre-booking to disposition, allowing placements and dispositions, where appropriate, in settings other than prisons and jails.

2. DEVELOP RE-ENTRY CASE MANAGEMENT, TREATMENT & RELATED SERVICES. The State should fund discharge planning, case management and bridge treatment for prisoners re-entering the community and for youthful offenders. The focus of this planning should be the coordination of care, both among professionals in prisons and jails, and between these institutional professionals and service providers in the community. This coordination must be coupled with a commitment to ensure that appropriate services are available in the community to foster successful re-entry. Time

and resources spent on coordinated re-entry planning can help to prevent recidivism, assisting prisoners with mental illness to become productive members of society.

3. IMPLEMENT THE “PROMISE” INITIATIVE FOR ADULTS AND YOUTH.

The Promise program is an intensive reentry program developed by several State agencies to provide stable housing, treatment. The program’s design offers significant benefits for re-entering prisoners and youthful offenders.

4. ESTABLISH/EXPAND TRAINING AND SPECIALIZED PROBATION AND PAROLE CASELOADS.

Intensive supervision of people with addictions has facilitated offenders’ successful integration into society and helped reduce recidivism. This model should be applied to offenders with serious mental illness to assist in social reintegration and to reduce the chance of recidivism.

ADDITIONAL COMMITTEE RECOMMENDATIONS

PRE-ARREST/PRE-ADJUDICATION

1. EXPAND COMMUNITY TREATMENT/SERVICES FOR ADULTS/YOUTH.

This recommendation is fundamental to the success of all other recommendations. If community treatment and services are not expanded, the coordination and referral systems at the heart of the Committee’s recommendations will likely fail.

2. FUND FAMILY OMBUDSPERSONS. Create the position of family ombudsperson to assist families of incarcerated persons.

POST-ADJUDICATION

1. ENSURE BETTER USE OF ANN KLEIN FORENSIC CENTER. Referrals to Ann Klein should be coordinated and adjusted to ensure the appropriate use of this unique resource.

2. ENSURE ACCESS TO INPATIENT BEDS FOR YOUTH. Youth in need of residential treatment for serious emotional conditions should house in New Jersey settings that ensure both appropriate treatment and public safety.

3. ENSURE PRISONS/JAILS MEET COUMMUNITY STANDARDS OF CARE. Prisoners in prisons and jails should be afforded appropriate mental health treatment.

4. PROVIDE MICA SERVICES FOR PRISONERS. Substance abuse treatment should be integrated with mental health services to ensure optimal outcomes; MICA treatment should be provided to ensure eligibility for public benefits when prisoners are released.

5. IMPROVE PUBLIC OVERSIGHT OF MENTAL HEALTH TREATMENT IN PRISONS AND JAILS. Public oversight of services, similar to that provided by the former Public Advocate, should be provided to assure citizen review of care.

6. MANDATORY TRAINING/INTERFACE PROCEDURES. Improve cross training of those responsible for prisoners and youthful offenders.

7. SPECIALIZED UNITS FOR PRISONERS WITH MENTAL ILLNESS. The State should ensure the availability of effective and safe special units for prisoners and youthful offenders with mental illness.

POST-INCARCERATION

1. DEVELOP PRISONER RE-ENTRY TREATMENT & RELATED SERVICES.

Expanding targeted services at re-entry is fundamental to successful community re-integration.

2. ENSURE EFFECTIVE COORDINATION WITH DISCHARGE PLANNERS.

The State should fund designated staff at correctional facilities serving adults and youth to coordinate with community discharge planners.

3. ENSURE EFFECTIVE ENROLLMENT OF YOUTH/ADULTS ONTO SSI.

The State should develop systems for assisting SSI/SSD eligibility, and should provide bridge funding for services pending activation of benefits.

4. CREATE NEW POLICY ON DE-ACTIVATING PUBLIC BENEFITS. The State should maximize the retention of benefits eligibility for prisoners.

5. CREATE NEW POLICY ON RELEASE FROM SENTENCES. NJDOC should establish humane and effective time of day release standards for prisons and jails.

6. LEVERAGING NEW FEDERAL FUNDING. The State should maximize Medicaid participation through expansion of the Medicaid Rehab Option.

7. OPT OUT OF “FELONY DRUG BAN”. The state should opt out of the federal ban from public benefits for ex-prisoners.

8. CHANGE/REINTERPRET GA REGULATIONS. The State should ensure that the “fault” standard for eligibility for emergency housing in the General Assistance program is not interpreted so as to automatically consider an applicant’s incarceration as a bar to assistance.

Introduction

The Criminal Justice Committee of the Governor's Task Force on Mental Health has examined problems with service provision to persons with mental illness who are involved with the criminal justice system. Although this high-risk population presents with needs and risks comparable to those in state and county psychiatric hospitals, the services available to these offenders pre- and post-release are not at all comparable. This disparity in treatment poses a serious public health threat, which the Committee recommendations seek to correct. The charge from the Task Force was as follows:

The Criminal Justice Committee will develop specific recommendations concerning diversionary programs, outpatient services and outreach to the criminal justice system. The committee will assess the care provided to inmates in county jails and state prisons and make recommendations for improvement.

The Committee's recommendations address a range of service needs at specific points of intersection between the mental health and criminal justice systems. They also seek to improve the interface between the two systems, related to each of the three stages of involvement with the criminal justice system, in which offenders with mental illness find themselves: (1) pre-arrest/pre-adjudication; (2) post-adjudication; (3) post-incarceration.

The Committee was fortunate in having members and supporters (alternates/guests) with first-hand knowledge about systems problems and the needs of offenders with mental illness. Committee members included consumers, family members, and representatives of advocacy organizations, providers of services, academics, public defenders, prosecutors, corrections, police, human services, court, and parole agencies. The Committee was also fortunate to have access to many resources in completing its work, and benefited from several excellent recent studies in New Jersey and the nation.⁵⁵ The Committee was also aided by information provided by those who participated in the public hearings, and those who provided written comments.

I. Problems with Diversion, Treatment & Re-Entry Planning

Overrepresentation of Offenders with Mental Illness in Prisons/Jails

The population of prisons and jails in New Jersey and the nation has increased dramatically in the last two decades.⁵⁶ Over two million Americans are now in prisons or jails, a five-fold increase over the last 30 years,⁵⁷ with almost 5 million on probation or parole.⁵⁸ This sharp increase is largely attributable to the passage of harsher sentencing laws, many aimed at drug crimes. Communities of color have been

⁵⁵ RE-ENTRY POLICY COUNCIL, REPORT OF THE RE-ENTRY POLICY COUNCIL: CHARTING THE SAFE AND SUCCESSFUL RETURN OF PRISONERS TO THE COMMUNITY; CONSENSUS REPORT ; NEW JERSEY INSTITUTE FOR SOCIAL JUSTICE, COMING HOME FOR GOOD: MEETING THE CHALLENGE OF PRISONER REENTRY IN NEW JERSEY (2003); URBAN INSTITUTE, A PORTRAIT OF PRISONER REENTRY IN NEW JERSEY (2003).

⁵⁶ See MARC MAUER, RACE TO INCARCERATE (1999).

⁵⁷ *Id.* See Nancy Wolff, *Law and Disorder: The Case Against Diminished Responsibility* (August 30, 2004) (hereafter, "Law and Disorder").

⁵⁸ *Law and Disorder* at 26.

disproportionately affected by this dramatic push towards increased incarceration. In 2003, the rate of incarceration of white males was 465 per 100,000, while the rate of incarceration of black males was over seven times higher – 3,405 per 100,000.⁵⁹

Among this growing number of incarcerated persons nation-wide is a disproportionate number of people with mental illness, as 16% of those incarcerated require treatment for mental illness.⁶⁰ The percentage of people with mental illness in New Jersey's prisons/jails is no different.⁶¹ The overrepresentation of people with mental illness in prisons/jails is due to a variety of factors. Many offenders with mental illness are poor, unemployed, underemployed or disabled, without the benefit of effective treatment/services as children/youth; forced to live in sub-standard housing and/or in shelters, and in high-crime neighborhoods where they are subject to victimization and abuse. Stigma, discrimination and mistreatment have also blocked their access to opportunities and impeded their efforts to gain full social integration. In addition, the lack of appropriate community services has left many with serious mental illness in need of treatment, and displaying symptomatic behaviors that can often lead to arrest and incarceration. Although the incidence of criminal behavior is no greater for those with mental illness than for other groups, the lack of appropriate treatment and the presence of social problems (poverty, housing problems, substance abuse, etc) perpetuate criminal justice involvement that could otherwise be avoided.

Problems Confronting Adult Offenders

Problems abound with securing treatment for adults with mental illness and criminal justice involvement. Many with mental illness are arrested for non-violent, disorderly persons charges due to untreated symptomatic behavior. In such instances, diversion to treatment rather than arrest/incarceration would be the appropriate response. However, problems with accessing mental health assessment and treatment – an often time-consuming and unsuccessful process -- can leave police officers with few options beyond arrest, if they are to ensure the public safety.

For those with mental illness accorded the protections of due process who are convicted, sentenced and incarcerated, there are problems accessing and coordinating treatment in state prisons and the county/local jails. Although such problems have begun to be addressed in state prisons, treatment can often be under funded, and especially in county/local jails, limited to crisis management services. The state of mental health care

⁵⁹ See U.S. DEP'T OF JUSTICE, BUREAU OF JUSTICE STATISTICS BULLETIN: PRISONERS IN 2003 9 (November 2004) available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/p03.pdf>.

⁶⁰ See COUNCIL OF STATE GOVERNMENTS, CRIMINAL JUSTICE/MENTAL HEALTH CONSENSUS PROJECT 4 (2002) (hereafter, "CONSENSUS PROJECT").

⁶¹ See William Waldman *et al.*, *Individuals with Mental Illness in the Camden County Criminal Justice System: An Analysis of the Implications of a Tragedy and Recommendations for Cross Systems Improvements* 10 (September 20, 2004) citing N. Wolff *et al.*, *Planning for the reentry needs of inmates with mental health problems in New Jersey prisons: A Report Submitted to the DMHS/DOC/Parole Board Working Group* (2002) and N. Wolff and B. Veysey, *Correctional Health Care in New Jersey Jails* (2001). The various reports on the number of incarcerated people with mental illness apparently use different definitions and identifiers, *e.g.*, "special needs prisoners," "severely mentally ill," or prisoners on psychotropic medications. These reports agree, however, that people with mental illness are overrepresented in prisons and jails. See *Law and Disorder* at 4-5.

in prisons has been studied in recent years; there is a significant need for study of the provision of mental health services in county and local jails.

Serious problems persist with preparing prisoners for community reentry. The lack of adequate pre-release planning, case management/follow-up and community treatment, including housing supports, increases the odds that persons with serious mental illness released from prisons/jails will again become entangled in the criminal justice system.

Problems Confronting Youthful Offenders

Problems confronting youthful offenders are similar to, yet distinct from, those facing adults. The link between child maltreatment and involvement with the child welfare and juvenile justice systems is now firmly established. Essential to the appropriate treatment of youth at risk and youthful offenders is the availability of a range of community services appropriate to their needs.

Gaps have been identified, and in some cases are being addressed, regarding development and implementation of appropriate, individualized and family-focused services for youth at risk, the availability of services to ensure appropriate planning and coordination during incarceration, and coordinated and comprehensive plans for re-entry. As is true with adult offenders, these gaps and systems issues must be addressed, in large part through the development of a responsive continuum of services, performance-based standards, as well as continuing collaboration. Without improvement in the provision and coordination of services, youth with mental health problems will likely continue their path of re-incarceration, and eventually become adult incarcerated offenders.

To prevent this, the Juvenile Justice Commission, in cooperation with local and state government entities, implements a community-based system of sanctions and services for youth at risk of delinquency, or who are court-involved. Placement with the Department of Human Services, for both local community services and out-of-home placements, is one of a number of dispositional options for the courts. Steps to improve the treatment of youth at risk should focus on placing youth (before and after disposition) in the most therapeutically appropriate setting, and on coordinating institutional and community services to ensure that youthful offenders succeed in reintegrating into the community. Accomplishment of these steps requires collaboration through partnerships between state and local agencies and systems partners.

Problems with Mental Health/Criminal Justice Interface

The relationship between mental health and criminal justice is too often characterized by the lack of services and coordination between the two systems. To ensure that those with both mental illness and criminal justice involvement receive the support required, the Committee agreed on the importance of developing/increasing specific services at key points of intersection between the two systems. These services include:

- community-based mental health services, including crisis intervention, outreach, case management and treatment to relieve distress and prevent decompensation;

- social services, including housing supports and employment services;
- support services for police – including appropriate training, service availability and options for street diversion, and expeditious disposition of crisis/community care referrals;
- support services for the court system (including prosecutors, public defenders, probation and parole officers, judges, and court personnel) to permit them to exercise informed judgment and discretion with mentally ill arrestees, to permit dispositions that properly balance therapeutic and criminal justice goals, and examine alternatives to incarceration;
- adequate and coordinated mental health services in prisons and jails to permit continuity of care;
- re-entry services in prisons/jails devoted to reentry preparation, including coordination of institutional and community services;
- re-entry services in the community to permit those on probation and parole, and those maxing out sentences, to maximize the chances of successful reintegration.

The Committee believes that with better services and coordination, much of the interaction between those with serious mental illness and the criminal justice system could be avoided – to the benefit of people with mental illness and society at large. Providing a sufficient range of services, addressing service access problems, and ensuring appropriate coordination of services with criminal justice will improve the effectiveness of the mental health system in serving those involved with both systems.

II. Criminal Justice Committee Priorities

The Criminal Justice Committee has identified four priorities for funding, focused on expanding services, improving access and ensuring better service coordination between mental health and criminal justice. Although some of these priorities are the purview of other committees on the Task Force, the Criminal Justice Committee must also identify them as priorities. If these priorities remain unfunded, the Committee’s recommendations to serve offenders with mental illness cannot succeed. Those priorities, which are likely to be the purview of other committees, are noted below.

This report also provides cost estimates for certain priorities/recommendations. Although these estimates give a reasonable approximation of cost, they require more study and scrutiny before they can be finalized.

- 1. County-based Crisis Intervention/Crisis Diversion System** – The vision for county-based crisis intervention should extend beyond the hospital-based emergency, screening and crisis intervention services currently funded in every county. The State should adopt a new vision to encompass a comprehensive, county-based Crisis Intervention/Crisis Diversion System (CICDS). In addition to hospital-based services, the CICDS in each county should be funded to provide mobile access and timely crisis intervention, then linking immediately to crisis diversion and intensive follow-up support, as needed, to those in crisis. The CICDS should also provide effective interface with police, courts, etc., and appropriate training for all involved. Without

such support in each county, persons in crisis will continue to experience the worsening of symptomatic behavior, leading to decompensation and institution-based care in public psychiatric hospitals and/or correctional facilities, where the costs to the taxpayer are much greater, and the prognosis for clients much worse.

County-based CICDS's should be funded to ensure the following:

- **Compliance with Regulatory Standards of Care** – The State should (1) ensure adequate funding in all its programs, especially those in the CICDS, to meet the standards of care specified in state regulation, and (2) end the current practice of granting waivers, where programs are not able to meet state standards. (Cost to be determined.)
- **Mobile Outreach Teams** – Fund sufficient staffing capacity in each county screening center to provide 24/7 mobile screening and crisis intervention services, appropriate to meet each county's demand for mobile outreach.
Computation of Service Costs (See other committee reports.)
2 FTEs/team x 4.2 shifts/week @\$80,000/FTE = \$672,000/Team/county
Fund 20 Teams to meet demand in understaffed counties = \$13.5 million.
- **Crisis Diversion Teams** – Fund crisis diversion teams that provide intensive follow-up support, outreach, engagement, case management, crisis management/stabilization, and treatment to high-risk consumers for up to 18 months after the screening program's assessment and intervention. These teams should provide intensive support to at least 1,000 high-risk consumers throughout the state, who are not linked to ICMS or PACT. Crisis diversion teams focus on preventing symptomatic behavior from worsening into decompensation and institution-based care. Crisis Diversion Teams help persons-in-crisis manage those problems which threaten their stability in the community – including problems with family/community supports, housing, finances, medication/treatment, substance abuse, criminal justice (e.g., police, probation, parole, etc). Crisis Diversion Teams should have flexible wrap-around funds to purchase services required to halt the worsening of symptoms. Crisis diversion providers must (1) work in close coordination with screening and other CICDS programs, (2) be contractually accountable to DMHS and CICDS programs for the provision of responsive services, the acceptance of all referrals consistent with program specifications, etc; and (3) remain in compliance with contract commitments, as a condition of continued funding.
Computation of Service Costs (See other committee reports)
Costs should range from \$15,000 to \$21,500 based on level of need, or \$15 million to \$21.5 million for 1,000 high-risk persons. Funding should provide housing subsidy and medication, where needed, and gradually step down services to lower intensity, when appropriate.
- **Community Treatment Liaison to Police, Courts, etc** – Each county should have a designated community treatment liaison, similar to that proposed by Assemblyman Blee (see A-663 and subsequent amendments). Community

treatment liaisons would interface with the criminal justice system, and provide evaluation, case management and referral for treatment for people with mental illness. The community treatment liaison would work closely with screening programs and crisis diversion teams, and also interface/coordinate with police, public defenders, local and county prosecutors, and both Municipal and Superior Courts to ensure the appropriate treatment of offenders with serious mental illness. This liaison would help criminal justice personnel assure that decisions to book, prosecute and sentence are fully informed as to the condition, needs, and options of each person presented.

Computation of Service Costs:

1.5 FTEs @ \$85,000/FTE = \$127,500 x 21 counties = \$2.7 million
(Cost per FTE includes salary, fringe, OTPS and G&A)

Nationally, 16% of prisoners suffer from a severe mental illness. A similar situation exists among inmates in New Jersey. Studies indicate that persons with mental illness often end up in prison due to an inappropriate charge, often of a non-violent or disorderly nature, when providing access to treatment and medications would have been more appropriate. The Task Force recommended and supports Governor Codey's fiscal year '06 budget proposal for \$1.8 million in new funding to develop Community Treatment Liaisons, similar concept that was brought forth from Assemblyman Blee, to the judicial community in the counties with the greatest need. The Task Force is recommending that Atlantic, Union and Essex Counties participate in this pilot and that the State of NJ make it a priority to expand to all 21 Counties over a realistic time frame, not to exceed 5 years.

- **Information & Referral Data-base** – CICDS providers should be equipped with web-based, state of the art community resource databases, accessible 24/7, and coordinated centrally by DHS or via contract to ensure complete and regularly updated information regarding state, county and local programs. (Cost to be determined.)

- **Training for Police, 911 Dispatchers, First Responders, Screeners, Parole and Probation Officers** – Establish routine, mandatory training on responding in a mental health crisis as part of both initial training and continuing education. Training should focus on (1) basic knowledge of the biological nature of mental illnesses, how to recognize and deal with mental illness crises, as well as understand the role, responsibilities and constraints of county-based emergency screening centers; (2) a mandatory protocol for police, 911 dispatchers, fire, EMS and other first-responders to ensure the correct questions are asked to determine whether emergency mental health screening and treatment is required; (3) instruction in implementing the mandatory protocol as part of annual training requirements for all emergency first responders. Training should be recorded on DVDs, so that emergency

personnel can receive training and take required tests during downtime, reducing the cost of training related absences. This training should be provided by or coordinated through the enhanced County-based Crisis Intervention/Crisis Diversion System.

Computation of Service Costs:

Development of DVD – \$20,000/Implementation – Minimal

- **Police & 911 Dispatchers Training** – Because police and 911 dispatchers are typically the first responders in mental health crises, they should be given highest priority in launching this training. The Mental Illness Awareness program in Gloucester County, with proven success in police training for many years, should be used as a model.
- **Screening Center Training** – Provide DVD-based training regarding best practices for effective liaison during crises with police, courts, etc.
- **Screening Program/Police Interface** – State contracts should require that screeners expedite the transfer of custody from police officers transporting persons in crisis, so that the process takes no more than 15-20 minutes. The Gloucester screening program’s protocol should be used as the model.
Computation of Service Costs: TBD – implementation of existing protocol.

2. Develop Prisoner Re-entry Case management, Treatment & Related Services

Re-entry services targeting adult and youthful offenders, better coordination of services, and related improvements are discussed below:

Adults – Fund discharge planning, case management and treatment for prisoners with serious mental illness re-entering the community. Service levels should be

commensurate to their risk of psychiatric crisis and on a par with what is provided to persons with serious mental illness leaving state/county psychiatric hospitals. Services for state prisoners should target both prisoners maxing out their sentences and those released on parole. Services should also coordinate closely with discharge planning efforts undertaken by NJDOC, NJ State Parole Board, etc., and work closely with community providers, family/community supports and other resources. Services to county prisoners should take a comparable approach, also targeting those maxing out sentences and those released early to probation, and coordinating closely with discharge planning by county jails, probation and other providers.

Discharge planning and case management should meet the standards for ICMS and PACT services – promulgated, funded and supervised by NJDMHS – with a designated provider coordinating discharge for each service. Discharge planning should also include the following:

- Process public benefit applications and secure eligibility prior to release.
- Provide for medical appointments, sufficient medication, and a bridging prescription prior to release.
- Involve families/significant others in discharge planning.
- Provide housing support at levels appropriate to need.
- Provide support in securing and maintaining employment
- Provide on-going case management (i.e. assessment, linkage to service, advocacy, follow-up support, etc) for up to 18 months post-release
- Conform to evidence-based best practices or other promising models for discharge planning, case management and treatment.
- Adjust intensity of service to clinical and safety risks posed
- Provide transportation from prison/jail to the prisoner's housing placement

Youth Ensure that every youth exiting the JJC has appropriate housing and services, to include trans-permanent supportive housing as well as transitional housing. To accomplish this, the following must be addressed:

- Keep youth active with the Division of Child Behavioral Health Services and/or DYFS to ensure joint planning and access to services, including an extended period for follow-up support, upon release.
- Provide funding to support the additional responsibilities expected of partner agencies by the Division of Child Behavioral Health Services, including JJC Social workers/case managers to assist with (1) completing needs assessment (the means of entry into the behavioral health care system), and (2) jointly arranging appropriate services via the child behavioral health care system.
- Ensure that children in detention centers receive appropriate mental health services.
- Identify a liaison with the Office of Children's Services to: (1) address coordination problems among the JJC, DYFS and DCHBS, and (2) participate on the JJC committee overseeing status of multi-system youth.
- Ensure that incarcerated/adjudicated youth are not excluded from services because of this status, but can access care if they meet criteria for need.

Computation of Service Costs

Costs for discharge planning should range from \$15,000 to \$21,500 based on level of need, or \$30 million to \$43 million for 2,000 high risk adults and youth, leaving state or county correctional facilities. Funding should include support for housing subsidy and medication, where needed, and gradually step down services to lower intensity, when appropriate.

Studies indicate that, for mentally ill prisoners, re-entry treatment and related services after release are crucial to giving them the best possible chance to become productive members of society. The University of Medicine and Dentistry of New Jersey (UMDNJ) recently assumed responsibility for mental health patients currently incarcerated in New

Jersey's prisons. The Task Force recommended and supports Governor Codey's fiscal year '06 budget proposal of \$800,000 to pilot re-entry case management services, building on existing Intensive Case Management and Program for Assertive Community Treatment (PACT) services, with the provider directly coordinating with UMDNJ staff, for adults, beginning with pre-discharge planning. This will provide approximately 100 hours of case management for approximately 100 individuals recently discharged from prison. The Task Force is recommending that \$400,000 be appropriated to the State Board of Parole to begin implementation of the PROMISE and the balance, \$400,000, be appropriated to the Juvenile Justice Commission to provide re-entry wraparound services as referenced in Recommendation #18 "b".

Despite major improvements in the rendering of mental health services to those in need, little has been done to address the treatment needs of the offenders with mental illness as s/he approaches release to the community and upon reentry. Barriers faced by these individuals as they seek community treatment include financial instability, lack of health benefits, ineligibility for public supported benefits, and reluctance on the part of mental health providers due to safety concerns. In an effort to effectively transition these offenders to the community, the New Jersey Department of Corrections(NJDOC) has proposed the creation of a community based transitional care center. The NJDOC will soon issue a Request For Proposal to solicit bids for the contracted operation of community based transitional care for up to 250 special needs inmates (125 male and 125 female). The population would include those with mental illness as well as those with co-occurring mental illness and substance abuse disorders. Based on final proposal specifications, the program will either be located at one facility, with separate quarters by gender; or at two facilities, one for males and one for females. The program will entail a very structured milieu inclusive of assessment and therapeutic intervention provided by UMDNJ staff as well as educational and vocational opportunities, substance abuse treatment, life skills activities and comprehensive case management services offered by the contracted residential community provider agency. The ongoing dialogue and partnership between UMDNJ, the residential community provider agency and the NJDOC is an essential component in the efficient and effective operation of this new initiative. The establishment of a community based transitional care program will not require additional state funding but rather a reallocation of NJDOC existing resources.

The Task Force recommends and supports this proposed program and applauds the Department of Corrections for joining with the Governor and the Task Force in making the needs of persons with mental illness a priority and for its innovative approach to utilize existing resources.

3. **Implement the PROMISE Initiative for Adults & Youth** – The NJ State Parole Board, NJ Department of Corrections, NJ Juvenile Justice Commission, NJ Department of Human Services, NJ Department of Community Affairs, and NJ Housing Mortgage Finance Agency have developed this re-entry initiative for prisoners with mental illness to provide intensive treatment, stable housing and other community services. The PROMISE program is described in detail in Appendix 2, allocating costs based on \$21,500 per person for intensive support.

- **PROMISE Initiative for Adults** – Fund a demonstration project, as described in Appendix 2.

Computation of Service Costs: \$21,500 per person for intensive support.

- **PROMISE Initiative for Youth** – Fund a demonstration project, using the same model, possibly focused on female offenders and their children, as well as male offenders.

Computation of Service Costs: \$21,500 per person for intensive support.

4. **Establish/Expand Training & Specialized Probation/Parole Caseloads** –

- Fund specially trained adult probation and parole officers to provide specialized services targeted to offenders with serious mental illness. This program could be modeled on current intensive supervision programs.

Computation of Service Costs: \$6 million

\$100,000/FTE x 30 probation officers = \$3 million.

\$100,000/FTE x 30 parole officers = \$3 million.

- Fund training for probation and parole officers serving adults and youth, and focused on the supervision and management of offenders with mental health needs on each group's caseload. Training should be recorded on DVDs, so that participants can receive training during downtime and reduce the costs associated with training related absences.

Computation of Service Costs:

Development of DVD – \$20,000/Implementation – Minimal

III. **Additional Criminal Justice Committee Recommendations**

In addition to the Committee's four priorities, additional recommendations are provided. Some of these recommendations require funding, while others do not. The additional recommendations are divided into three categories related to the stage of involvement with the criminal justice system the offenders with mental illness find themselves: (1) pre-arrest/preadjudication; (2) post-adjudication; (3) post-incarceration.

Improving Pre-Arrest/Pre-Adjudication Interventions & Interfaces

1. Expand Funding for Community Treatment for Adults & Youth– Fundamental to all recommendations is the necessity that community mental health services be improved, increasing the capacity of service providers to ensure that all those with serious mental illness, who are at-risk of hospitalization and/or criminal justice problems receive treatment. Please see Priorities # 1-5 above.

1. a. Ensure evidence-based, best practice and other promising models for serving adjudicated adults, youth and their families, including models that address the needs of offenders with specialized needs, e.g. treatment non-compliance, sexual offending, firesetting, among other problems. Such models must ensure a sense of urgency and flexibility consistent with the court process, ready access to the full range of services through one entry point, inclusionary admission criteria, etc.

1. b. Continue support for current strategies to screen and divert youth detained inappropriately in juvenile detention centers – e.g. Juvenile Detention Alternatives Initiatives, use of the Massachusetts Youth Screening Inventory (MAYSI-2), etc.

1. c. Continue to improve the ability of detention centers to identify youth in distress who require further assessment and treatment through the child behavioral health system. These strategies will allow systems to more appropriately manage the behavior of youth, reduce the number of youth inappropriately detained, ensure court appearance, and maintain public safety.

2. Fund Family Ombudsperson – Improve the ability of families to interact effectively with the criminal justice system by funding an ombudsperson for families of persons who are incarcerated.

Improving Post-Adjudication Interventions & Interfaces

1. Ensure Better Use of Ann Klein Forensic Center (AKFC) – Corrective action is required to ensure a more effective use of this facility.

1. a. Develop Secure State Hospital Beds – Develop more secure beds in all state psychiatric hospitals to better treat patients presenting with moderate security needs. This will reduce admissions from these hospitals to AKFC, reduce the waiting list from AKFC to the state psychiatric hospitals, and ensure a more efficient/effective use of state psychiatric inpatient resources.

1. b. Re-distribute Detainer Patients – Modify the executive order and other sources of law that require detainer patients with minor charges from the Northern region to be referred for treatment to AKFC.

1. c. Monitor for Inappropriate Community Referrals – Monitor for appropriateness referrals from all county locations, and take steps to secure alternative treatment at facilities other than AKFC, if appropriate, and as indicated above.

1. d. Monitor for Inappropriate NJDOC Referrals – Monitor for appropriateness those referred to AKFC for the last weeks of their sentence, so they can receive discharge planning and linkage to community treatment. Develop discharge planning, case management and linkage to treatment for all state prison inmates in need of such support.

2. Ensure Access to Inpatient Beds for Youth

Ensure for adjudicated youth access to inpatient beds, as well as to other parts of the continuum replacing the Arthur Brisbane Child Treatment Center. These beds should be in a setting that ensures the public safety and the treatment needs of youth with the most serious behavioral health problems.

3. Ensure Services in Prisons/Jails Meet Community Standards of Care – New Jersey’s prisons are currently operating under a consent agreement describing screening and treatment provided to prisoners. New Jersey’s jails should similarly be required to provide appropriate mental health services on a uniform basis. Update NJDOC regulations to assure that appropriate mental health services, MICA treatment and related support is provided, and monitored by NJDOC.

4. Develop Services for Inmates with Co-Occurring Conditions – Prisoners with both serious mental illness and substance abuse problems, convicted of certain drug offenses, require treatment to deal with addiction/mental health needs, and to ensure eligibility for SSI, welfare, etc. MICA services should be in all state prisons and county jails, and should be integrated with mental health services rather than provided separately.

5. Oversight of Mental Health Treatment in Prisons/Jails – Provide a mechanism for oversight of mental health care in prisons/jails, similar to that which was provided by the Public Advocate. Since the latter’s demise, private litigation has dominated this field, and reports, findings, and progress have not been available to citizen review.

6. Mandatory Training/Develop Interface Procedures

- a. Adults – Fund mandatory cross training for state/county corrections officers and mental health providers in correctional facilities and the community regarding inmates’ mental health needs and related problems, and develop interface procedures for corrections and treatment staff.
- b. Youth – Implement the current training initiative that focuses on helping detention and JJC staff understand, provide appropriate services, and manage youth with mental health problems.

7. Specialized Units/Services for Prisoners with Serious Mental Illness

- a. Adults – Provide specialized units for prisoners not able to adapt to the general population in all prisons/jails, to the extent these units do not currently exist.

- b. Youth – (i) Fund the separate housing unit planned for youthful offenders with mental health needs, with UMDNJ providing treatment. (ii) Fund 3 additional clinicians by expanding JJC’s current contract with UMDNJ to address specialized needs in areas of increasing urgency, including fire-setting, animal abuse, and gangs operating within an addictive model.

Improving Interventions & Interfaces Post-Incarceration

1. Develop Prisoner Re-entry Treatment & Related Services – Please see Priorities # 1-5 above.

2. Ensure Effective Coordination with Community Discharge Planners – Fund designated staff within state and county correctional facilities for adults and youth to interface with community discharge planners regarding the mental health needs of prisoners/youthful offenders in preparation for release.

2. a. Youth Service Coordination – Assign an Office of Children’s Services “re-entry” liaison (“expeditor”) to the JJC, stationed at one of the secure facilities, to ensure that youth are prioritized and a collaborative planning process is in place that:

- expedites planning for youth in need of placement and other services upon release
- includes the family and other stakeholders and provides appropriate family interventions;
- jointly identifies needs and services;
- makes appropriate linkages in the community;
- links older children and/or families to adult services
- no youth remain beyond their certified parole dates or serve their maximum sentences with no plan in place
- youth who may be re-sentenced to more appropriate settings receive a timely response.

3. Ensure Effective Enrollment of Eligible Adults & Youth onto SSI – Develop a bridge fund providing transitional financial and medical benefits to adult prisoners and youthful offenders with serious mental illness who are re-entering the community and applying for SSI/SSD. The fund will be re-paid when approval for SSI/SSD is received.

4. Create New Policy on De-activating Public Benefits – State policy should support the maintenance of public benefits for those incarcerated for a period of 6 months after incarceration begins. Those whose benefits are deactivated should be processed for re-activation prior to release by the community agency responsible for re-entry discharge planning and case management.

5. Create New Policy on Release from Sentence – NJDOC should establish standards for dates and times of day for release from sentence to ensure service availability and coordination, so that community discharge planners can provide timely linkage to service, transportation from prison/jail, etc.

6. Leveraging New Federal Funding – Amend New Jersey’s State Plan to expand the Medicaid Rehab Option to (1) allow more flexible service approaches (e.g. home-based treatment, supported employment, etc) as reimbursable Medicaid services, and (2) use new state mental health funding as matching funds to draw down an equal amount of federal funds to be invested in mental health and substance abuse services to offenders with serious mental illness.

7. Opt Out of the “Felony Drug Ban” for Public Assistance Eligibility – This will allow offenders with serious mental illness to access public assistance and supportive services, including Medicaid, and ensure a more stable re-entry to the community, reducing the risk of decompensation, relapse and recidivism.

8. Change General Assistance Regulations – General Assistance (GA) regulations should be amended to specify that incarceration is not considered “fault” for purposes of interpreting the GA statute. This will allow ex-offenders to be eligible for GA and emergency assistance.

Conclusion

Offenders with serious mental illness present with needs and risks comparable to persons in state and county psychiatric hospitals, but do not receive comparable services. The State’s continuing neglect of these offenders’ treatment needs poses a serious public health threat. These recommendations are submitted to the Governor’s Task Force on Mental Health in the hopes of reducing this threat, providing treatment to those who require it, and improving the interface between the mental health and criminal justice systems. By improving access and increasing service availability and by improving the coordination of services within the mental health system, and between the mental health and the criminal justice systems, many persons with mental illness can be diverted from criminal justice involvement and/or avoid re-incarceration. Implementing the recommendations proposed in this report will not only improve public health and safety, but also ensure a more efficient and effective use of scarce tax dollars.

Appendix 1. Committee Members, Alternates & Guests

Special thanks is owed to the members, alternates and guests of the Criminal Justice Committee who generously donated their time, expertise and insights to help in the preparation of this Report. A complete listing is provided below.

<u>Name</u>	<u>Status</u>	<u>Affiliation</u>
John Jacobi	Member	Professor - Seton Hall University Law School
John Monahan	Member	Greater Trenton Behavioral HealthCare
John Main	Member	Ann Klein Forensic Hospital
Jack McCarthy	Member	New Jersey Administrative Office of the Courts
John Pizarro	Alternate	New Jersey Administrative Office of the Courts
Gayle Maher	Alternate	New Jersey Administrative Office of the Courts
Rick Mulvihill	Member	Atlantic County Department of Public Safety
Karl Muehter	Member	Consumer
Devon Brown	Member	New Jersey Department of Corrections
Dr. Andy Savicky	Alternate	New Jersey Department of Corrections
Howard Beyer	Member	New Jersey Juvenile Justice Commission
Barbara Chayt	Alternate	New Jersey Juvenile Justice Commission
Phil Lubitz	Member	NAMI New Jersey
Elaine Goodman	Member	NAMI New Jersey
Nancy Fishman	Member	New Jersey Institute for Social Justice
Nancy Wolff	Member	Professor - Rutgers University
Ray Deeney	Member	Professor - Seton Hall University Law School
Joe Napurano	Member	New Jersey Office of the Attorney General
Yvonne Segar	Member	New Jersey Office of the Public Defender
Bill Ng	Alternate	New Jersey Office of the Public Defender
Jean Ross	Member	Advocate - Retired Public Defender
Mary Lynn Reynolds	Member	South Jersey Mental Health Association
Judge John D'Amico	Member	New Jersey State Parole Board
Mark O'Sullivan	Alternate	New Jersey State Parole Board
Melinda Schlager	Alternate	New Jersey State Parole Board
Chris Koseff	Member	University of Medicine & Dentistry of New Jersey
Assemblyman Blee	Guest	New Jersey State Assembly
Regina Caufield	Guest	Union County Prosecutor's Office
Maureen O'Brien	Guest	Union County Prosecutor's Office
Steve Fishbein	Guest	New Jersey Division of Mental Health Services
Leah Kaiser	Guest	New Jersey Department of Corrections

Appendix 2. The PROMISE Program

DRAFT

Program for Returning Offenders with Mental Illness Safely and Effectively “P R O M I S E”

A multi-public and private agency collaboration to create a pilot program that establishes a continuum of care for effectively transitioning ex-offenders with mental disabilities into the community.

Introduction

The New Jersey State Parole Board in collaboration with the Department’s of Corrections, Human Services (Division of Mental Health Services), Community Affairs and the New Jersey Housing and Mortgage Finance Agency proposes to implement a pilot program, entitled, ‘**PROMISE**’ for offenders with mental health disorders who are reentering the community on parole. Most offenders who are diagnosed with a mental health illness are non-violent. They can re-integrate into the community with appropriate mental health treatment, rehabilitative services and a stable housing environment. With the right supports, they can be contributing members of society and their communities. The ‘‘PROMISE’’ initiative will provide ex-offenders with opportunities for successful community re-integration and will help to make our communities safer by providing services and housing for individuals at risk of homelessness and recidivism.

The intention of this program is to demonstrate a model whereby individuals ‘‘transition’’ to independence. They will be provided services as they transition from the Department of Corrections through the State Parole System into a post-release acclimation center. The program goal is to assist inmates with mental health disorders attain appropriate services in a complete continuum of care which includes permanent, stable, independent and affordable housing, in our communities.

Treatment of offenders with mental illness is critical while they are incarcerated. It is equally important to prepare earlier for and coordinate community mental health, social and workforce services, so as to ensure community tenure. It is essential therefore that there be a transitional process that begins with pre-release planning including an ‘‘individual’’ needs assessment while the individual is still incarcerated and culminating in the delivery of the critical **services** in the community. Recovery oriented wrap around services include services and resources such as medication prescriptions, outpatient therapy, partial care day programming, integrated dual diagnosis treatment (mental health and substance abuse, vocational training/education, family education and parenting classes, linkage to employment, household management skills and financial education, and permanent housing with rental subsidies).

Problem Statement

Research by Nancy Wolff, Ph.D., the Center for Mental Health Services and Criminal Justice Research, of Rutgers University, indicates that on any given day, approximately 5,400 inmates (17%) have mental health problems in New Jersey's prisons and jails⁶². However, these individuals vary in the severity of psychiatric symptoms, behavioral difficulties, presence of addiction problems and criminal histories. Of the individuals released from prison in 2002 for which data was available, eleven percent (11%) had been diagnosed with a mental illness. Over 50% were assessed to have a substance abuse problem and a growing number were dually diagnosed with mental health and substance abuse disorders⁶³. The New Jersey State Parole Board estimates that there are approximately 1,200 offenders on parole on any given day that have mental health disorders.

Inmates with mental illness, particularly those without the benefit of parole supervision, face overwhelming challenges upon return to society. These individuals struggle simultaneously with challenges associated with recovery from mental illness and challenges associated with finding housing, employment and community re-integration. There is evidence that with appropriate community supports and access to needed mental health treatment services, they can move towards recovery and independence. Without these services and their mental illness left untreated, there is a strong likelihood that they will re-offend or violate a condition of parole release. The lack of education and training that parole officers receive to help address the needs of mentally ill offenders also contributes to this cycle. While the Parole Officer has frequent contact with the ex-offender, often they are not equipped to manage or assess an offender's mental illness or to manage the offender's need for routine medical appointments. As a result offenders, with mental health issues, are at higher risk to fail on parole and are inappropriately recycled in and out of prison.

The growing number of individuals being released from prison with serious mental health disorders presents a significant challenge to public health and safety. The lack of community programs to address their housing, mental health and vocational needs and the necessary pre-release planning is a major obstacle to successful reentry. The Department of Corrections provides care and treatment to individuals inside prisons while those on the outside are oftentimes released without supportive wrap-around services. Doctors on the inside are unwilling to provide long-term prescriptions for individuals who will no longer be patients once they are released, while doctors on the outside can be a difficult resource to obtain. This can cause a disruption in care that has serious health repercussions particularly for those individuals who require medication to stabilize a mental health condition.

Currently inmates cannot apply for public benefits to cover their health care needs, or basic financial support, until they are released. Even so, reimbursement rates for community programs providing mental health treatment from sources such as Medicaid

⁶² Wolff, N. (2003) Investing in Health and Justice Outcomes, An Investment Strategy for Offenders with Mental Health Problems in New Jersey

⁶³ New Jersey Institute for Social Justice (2003) Final Report of the New Jersey Reentry Roundtable

may require supplementation to pay for the actual cost of treatment without which providers would be unable to deliver the needed services. These supplemental resources are not always available, often resulting in waiting lists or delays in provision of certain services. In addition, approximately 38 % of returning offenders have drug related convictions making them ineligible for Temporary Assistance for Needy Families (TANF), General assistance (GA), and Food Stamps, cutting them off from basic financial support at a time when they are most vulnerable. In New Jersey, non-disabled adults are ineligible for Medicaid benefits even if they meet the income guidelines.

Stable housing is an equally important component to successful offender reentry. Studies have shown that there is a connection between reentry and homelessness. Recent studies from the Bureau of Justice Statistics have found significant rates of homelessness prior to incarceration among state inmates, particularly for persons with mental illness. Housing barriers facing released offenders are significant. Not only does this group of offenders face the same lack of access to affordable housing, but also their situation is compounded by the additional stigma related to their mental illness, as well as their “ex-offender” status. Added to this are the significant barriers to employment, lack of savings and inaccessible public entitlements. In addition, landlords do not consider offenders desirable tenants. Recent changes in Federal Public Housing laws have given local housing authorities greater authority to deny housing to applicants, terminate their Section 8 assistance, and to evict tenants if any member of the family engages in a drug related or certain other criminal activity.

Program Goals

The goals of the **PROMISE** program are as follows:

To create a complete Continuum of Care for ex-offenders with mental illness who are homeless whereby each individual would be referred through a Post-Release Acclimation Center with the ultimate goal of assisting the inmate in accessing appropriate supportive services as well as placement in permanent housing.

To create a “community living” environment, where individuals will live independently in our neighborhoods and become self-sufficient.

To enhance public safety and reduce costs of incarceration by increasing the likelihood of the offender’s success on parole.

To meet the basic needs of the mentally ill offender, enhance their quality of life and increase their tenure in the community.

To prevent the inappropriate and costly re-incarceration of individuals with mental illness and the negative consequences that follow.

To reduce recidivism rates and thereby avoid significant financial impact to the State.

To improve the offender’s functioning in adult social and employment activities.

Pilot Program

In this collaborative effort by multiple state agencies, a pilot program entitled, **PROMISE** will be initiated that will target approximately 70 mentally ill offenders who are homeless during the course of a year. Offenders will be carefully selected based on a comprehensive mental health assessment conducted while they are still incarcerated. Those offenders chosen as participants will be released to parole supervision by the New Jersey State Parole Board with a condition of release that will require their participation in the pilot program.

The **PROMISE** program will utilize a multidisciplinary, mobile treatment team that will include the parole officer to deliver critical mental health services. This model will be based on the “Program of Assertive Community Treatment” or PACT. PACT is a research-based, nationally implemented, proven model of community mental health care and is regarded as a best practice model. The goals of PACT include maximizing the consumer's independence, enhancing the quality of life and promoting assimilation into the community. By attaining these goals, PACT has significantly reduced more costly hospitalization, both in terms of admission episodes as well as hospital bed days.

New Jersey has experience with the efficacy of this service in that the Division of Mental Health Services currently operates 35 PACT teams serving 1,350 persons with severe mental illness throughout the state. A number of the individuals who are served by PACT are currently under supervision by the State Parole Board.

The **PROMISE** program will be comprised of a number of steps or transitional phases that begin in the institution and continue into the community, even after individuals complete their term of parole supervision.

Institutional Phase

Parole Pact Team Members will become members of the Classification Release Committee. This will allow a member of the PACT Team access to inmates who are within 120 days of their release. As a member of this committee, they will be able to review classification and mental health documents to determine the inmate's suitability for inclusion in this program.

The Department of Corrections will provide to the PACT Team copies of the inmate's mental health file upon request. As part of the Department's mental health program, every inmate who enters our system receives a mental health evaluation to determine the level of mental health services needed by the inmate. This comprehensive mental health evaluation will be made available to the PACT Team. At the time an inmate is considered for parole, the clinician who completes this evaluation will address issues relevant to the inmate's suitability for participation in this program. Issues that need to be addressed include but are not limited to:

- mental health diagnosis;
- medication(s), if any;
- compliance with treatment;
- ability to adjust to an independent living situation with intensive supervision; and

- any other information identified by the PACT Team as relevant.

The Parole Hearing Officer will review this information and make an initial determination as to whether or not an inmate is appropriate for inclusion in the PROMISE Program. This information will be referred to the Parole Board who will make the final determination. Once identified by the Parole Board, the Parole PACT Team will begin to meet with the inmate, review relevant documents, and assist in the release process.

Post-Release Acclimation Center

Those offenders who have been selected to participate in the **PROMISE** pilot program will be paroled to a State Parole Board administered residential treatment facility for a period of 120 days (thereby allowing the unit to turn over three (3) times a year). Should any of these individuals not be able to progress to the permanent housing program, extensions of thirty days will be granted so that appropriate placement decisions can be made. This program will serve as a transition or “step down” from the institutional environment. Program services will focus on preparing the individual for return to a community setting. The focus will be on determining and securing public benefit eligibility, connecting the individual with family, friends, significant others or other community support systems, securing and maintaining appropriate medications, exploring permanent housing options and introduction to the Parole Program Assertive Community Treatment (PACT) Team. At this time and in the permanent housing program, a parole per diem subsidy will be utilized until the individual leaves Parole or attains other types of subsidies.

Parole PACT Team

PACT provides comprehensive, intensive rehabilitation, treatment and support services to a cohort of individuals who are most challenged by their mental illness. The service has been targeted specifically to those consumers who have experienced repeated involuntary hospitalizations in spite of enrollment in traditional treatment or because of refusal to participate in services upon discharge. Many of these individuals are also involved in the criminal justice system including individuals under parole supervision.

PACT is grounded in the assumption that people with serious and persistent mental illness, even those with impaired functioning can reside in normal settings in the community if adequate supports and services are provided. Implicit in its value system is the conviction that people with serious and persistent mental illness have an absolute right, as do all disability groups, to dignity and self-determination.

PACT services are delivered by a mobile multi-disciplinary treatment team and address each consumer’s basic needs including food, housing, health care, and mental health treatment. PACT teams provide or arrange for direct assistance with all aspects of community living such as teaching and assisting with activities of daily living, money management, vocational pursuits, and interpersonal relationships.

The majority of services, including the administration and provision of medication are delivered in-vivo, such as in the client's place of residence, and in the community. This approach provides a perfect fit with the principles of community supervision required of parolees. PACT staff is available 24 hours a day, 7 days a week, and all team members rotate on-call coverage. Whereas, in the past, the typical PACT enrollee would fail due to his/her non-compliance with medication and non-attendance in traditional mental health programs, in PACT, treatment goals are continuously determined by the consumer in collaboration with the team, and each consumer's status is reviewed daily by team members. While the PACT Team will typically provide treatment indefinitely, it is likely that some ex-offenders will be able to be successfully moved onto more traditional mental health services making openings on the team for new individuals.

PACT teams operated by the DMHS in New Jersey are composed of, at a minimum, eight professional staff comprised of: two RNs, one masters level clinician, one substance abuse specialist, one vocational specialist, three mental health specialists and a part-time psychiatrist. A PACT Director/Coach provides administrative oversight of the team(s). Based upon DMHS' experience with PACT, an average of 70 parolees per team would result in optimal clinical outcomes including expected reductions in hospitalizations and/or incarcerations. A modification of this configuration for the PROMISE program includes the addition of a parole officer on the team, which will insure compliance with the conditions of the offender's release and at least one of the mental health specialists, who is an ex-offender with mental illness who can act as a mentor.

Rental Subsidy

Securing stable, quality rental units is critical for community integration and recovery of parolees with severe mental illness. Stable housing coupled with individualized support services provided by the Parole PACT Team is essential to successful community tenure. A concept utilized by the DMHS provides state rental subsidies, which puts the high rental costs in New Jersey within reach of individuals with mental illness who are most often in poverty. This concept is being utilized by the PROMISE program to accomplish community integration.

Although rental costs differ in various regions of the state, the average rental subsidy of approximately \$7,500 per person (support services cost is additional) is a cost effective approach to the provision of community residential settings for parolees with serious mental illness who are able to live independently in the community. As some of the individuals on PROMISE rental subsidies will be able to move onto the federally funded Housing Choice Vouchers (Section 8), the State Parole Board will be able to "recycle" the rental subsidies to other needy clients.

Clients are generally entitled to a one-bedroom apartment unless sharing with a roommate or their own children. No client should be placed into an apartment in which the rent exceeds the current Fair Market Rent (FMR). The FMR schedule is published every October. **Clients receiving a PROMISE rental subsidy are required to pay 40% of their adjusted gross income towards the rent. The clients' portion of the rent is based solely on their gross income, not on the amount of the rent. Every**

client receiving a PROMISE rental subsidy is entitled to a \$400 disability allowance which is subtracted from their gross income in order to calculate the client's adjusted gross income.

All individuals receiving the **PROMISE** rental subsidy must apply for regular or mainstream Section 8 vouchers/certificates. These applications are published in local newspapers when available. Individuals who transition from the DMHS Subsidy to a regular subsidy will pay only 30% of their adjusted gross income towards the rent **due to the Federal Guidelines under the U.S. Department of Urban Development's (HUD) Section 8 Housing Choice Voucher Program.**

Applicants must remain on parole and in the residence for one year in order to remain eligible for the Parole rental subsidy program. After one year, 30 days written notice must be provided to the SPB if the resident intends to move out of the unit. Rent and rental subsidies will continue to be paid for up to six months during periods of hospitalization or incarceration. Consideration should be given to shortening this time frame if the resident so desires (for example, if the lease is set to expire). Rental units must meet HUD Quality Standards. Residents must allow inspection of the unit prior to occupancy and re-inspection up to 90 days before the end of each lease year to ensure these standards continue to be met. Thirty days will be allowed for corrections (twenty-four hours for life-threatening issues.)

Permanent Housing Program

The creation of a rental subsidy program in addition to the creation of a Parole PACT Team will be utilized to obtain permanent housing opportunities in our communities. The rental subsidy program will allow ex-offenders to rent apartments in scattered sites across our neighborhoods and will therefore help to resolve any site issues and the Not In My Back Yard (NIMBY) discrimination patterns that sometimes develop in our neighborhoods when developing housing for persons with special needs.

The Department of Community Affairs (DCA) and the New Jersey Housing and Mortgage Finance Agency (NJHMFA) have both agreed to utilize some of their funding and their ability to leverage other sources of funds to assist in the capital financing of any acquisition, rehabilitation and new construction of buildings that may be necessary in the development of a permanent supportive housing program.

The costs for this proposed Ex-offender Budget Initiative are as follows:

Annualized Budget for Seventy Participants

Parole PACT Team, 70 participants @ \$10,000 per participant

A. Personnel:

Team Leader @ \$50,000.....	\$50,000
Nurses @ \$48,000 x 2.....	\$96,000
MICA Specialist @ \$40,000.....	\$40,000
Vocational Specialist @ \$40,000.....	\$40,000
Mental Health Specialists X 2 @ \$36,000.....	\$72,000

Peer Advocate @ \$33,500.....	\$33,500
Administrative Assistant @ \$27,000.....	\$27,000
Fringe Benefits @ \$95,000.....	\$95,000
B. Consultation including psychiatric @ \$65,000.....	\$65,000
C. Material & Supplies @ 12,500.....	\$12,500
D. Facility Costs @ \$45,000.....	\$45,000
E. Special Assistance to Clients @ 22,000.....	\$22,000
F. Other including transportation @ 30,000.....	\$30,000
G & A @ 72,000.....	\$72,000
Total Parole PACT Team.....	\$700,000

State Subsidy for rental units/permanent housing @ \$7,500 per subsidy	\$525,000
Medication for non-Medicaid eligible participants \$5,000 average for 75% of participants	\$263,000

Total Annualized costs **\$1,488,000**

***Note: Subsequent years will require appropriations to the Department of Human Services, Division Of Mental Health Services' budget to continue Pact Team operations and state subsidy of those ex-offenders who have left State Parole supervision and who still require mental health services in order to avoid re-incarceration.

Phase in Budget – Year One

Parole PACT Team, 35 participants @ \$10,000 per participant	\$350,000
State Subsidy for rental units/permanent housing @ \$7,500 per	\$262,500
Medication for non-Medicaid eligible participants \$5,000 average for 75% of participants	\$131,250
Start-up costs including 4 cars and one van, phone system, furniture Computers, etc	\$128,000

Total Annualized costs **\$871,750**

PROMISE36A.DOC

Appendix 3:
Community Based Transitional Care Program for Special Needs Inmates

Despite major improvements in the rendering of mental health services to those in need, little has been done to address the treatment needs of the offenders with mental illness as s/he approaches release to the community and upon reentry. Barriers faced by these individuals as they seek community treatment include financial instability, lack of health benefits, ineligibility for public supported benefits, and reluctance on the part of mental health providers due to safety concerns. In an effort to effectively transition these offenders to the community, the New Jersey Department of Corrections(NJDOC) has proposed the creation of a community based transitional care center. The NJDOC will soon issue a Request For Proposal to solicit bids for the contracted operation of community based transitional care for up to 250 special needs inmates (125 male and 125 female). The population would include those with mental illness as well as those with co-occurring mental illness and substance abuse disorders. Based on final proposal specifications, the program will either be located at one facility, with separate quarters by gender; or at two facilities, one for males and one for females. The program will entail a very structured milieu inclusive of assessment and therapeutic intervention provided by UMDNJ staff as well as educational and vocational opportunities, substance abuse treatment, life skills activities and comprehensive case management services offered by the contracted residential community provider agency. The ongoing dialogue and partnership between UMDNJ, the residential community provider agency and the NJDOC is an essential component in the efficient and effective operation of this new initiative. The establishment of a community based transitional care program will not require additional state funding but rather a reallocation of NJDOC existing resources.

The Task Force recommends and supports this proposed program and applauds the Department of Corrections for joining with the Governor and the Task Force in making the needs of persons with mental illness a priority and for its innovative approach to utilize existing resources.

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SUBCOMMITTEE MEMBERSHIP

The list of members who served on The Governor's Subcommittee on Employment, Support and Rehabilitation Services are:

Robert Parker, Chair
NewBridge Services, Inc.

George Brice, Jr.
Member of Governor's Mental Health Task Force
Collaborative Support Programs – NJ

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Department of Human Services,
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Cory Storch
Bridgeway Rehabilitation Services

The Committee expresses its appreciation to Greater Trenton Community Mental Health and NAMI/NJ for the use of their offices for our meetings. In addition, Kathi Bedard from NJ/DMHS and Dave D'Antonio from Bridgeway Rehabilitation Services are acknowledged as "invited guests" on the Integrated Treatment discussion.

WORKING DEFINITIONS

Rehabilitation: A process to move people from one point to the next to thrive within the community. A process that focuses on eliminating, overcoming, or limiting impairments in reaching that success. A growth process.

Self-Efficacy: To be oneself as defined by oneself. To be in, and maintain, control of ones' life. A belief in self and self-abilities.

OVERVIEW OF EMPLOYMENT, REHABILITATION AND SUPPORT SERVICES

Employment, Support and Rehabilitation Services should be the backbone of the community mental health system. As an integral part of the process of recovery, these services are critical to ensure recovery tools and supports are in place for consumers to achieve their full recovery to become fully contributing members of our society.

If a consumer has learned to manage his/her own illness, but is not provided the supports for housing, employment, education and other needed services, their ability to achieve self-efficacy will be severely limited.

The current mental health system design and funding mechanisms impede the advancement of those in recovery. The current mental health system fosters dependence on existing services rather than having the flexibility to be tailored to meet an individual's needs. Our system needs to provide the tools necessary for an individual to achieve his/her aspirations and goals.

Clearly, national studies recognize the advancements in treatment and rehabilitation in recent years. There are clear evidenced-based practices to capitalize on those advances to ensure a path of full recovery.

There must be the development of a **RECOVERY PHILOSOPHY** which permeates the entire community mental health system focusing on the following goals:

1. The provision of opportunities for individuals to thrive in the "overall" community as required as part of citizenship.
2. Ensured integration within the overall community with other non-disabled people.
3. Ensured access to valued roles (such as neighbor, student, employee, tax payer), as defined by the individual, within the overall community.

4. Ensured opportunities for self-efficacy, (e.g. employment, education) which encourage people to be integrated into the community.
5. The development of socialization opportunities which will encourage integration with others within the overall community – to be part of the work force, community, i.e. “just another citizen”
6. The recognition and awareness of, “sub-communities” e.g. consumer groups, cultures, neighborhoods and to encourage further integration into the overall community.
7. The provision of the “tools” necessary to allow an individual to achieve their “thriving goal”:
 - a) Transportation
 - b) Access to HealthCare (physical, addictions, etc)
 - c) Educational Opportunities
 - d) Employment

SUMMARY OF KEY FINDINGS

Brief statements of findings both positive and negative

There is a perception that the State of New Jersey (DMHS) pays to keep people out of the hospital and reduce symptoms so individuals with mental illness do not stand out in the community; the system focuses on service first, the individual second. However, DMHS’ goals state a desire to enable people to live, learn and work in a recovery philosophy that should continue to be strengthened and expanded.

The public mental health service system comes out of a medical model. The medical model does not emphasize recovery and rehabilitation. In order to promote these newer approaches, a more even balance must be struck between the medical and rehabilitative/recovery models. It is not enough to add recovery-oriented services into a traditional system. The system itself must respond and change based on what the research is reveals: specifically, that medication and rehabilitation work better together than either by itself. DMHS regulations are heavily weighted towards the medical model and must be revised to support the integration of recovery and rehabilitation with the traditional medical services. Medicaid and DMHS regulations must be integrated to the greatest extent possible to better assist mental health consumers move beyond illness management to full participation in community life.

Due to funding disincentives, wellness and recovery goals are not encouraged. In fact, the funding mechanisms must be changed to encourage services to focus on the individual with mental illness and to assist that individual in achieving a full array of self-defined goals. *The state legislature must establish a high priority for funding services and support for persons with mental illness consumers to achieve their full recovery and become fully contributing members of our society.*

Consumer goals are often limited by their personal history – framed from their life experiences, education, and perceptions. Staff negatively impacts this level of awareness by their lack of practice standards, education and credentialing. Based on national statistical projections, there are 125,500 – 154,200 persons with serious mental illness in New Jersey. Between 112,000-139,000 of these are of working age, and most are unemployed. It is estimated that 5 – 15% are working while 70% desire to join the work force. Approximately fifty-one percent (51%), of Division of Vocational Rehabilitation Services' (DVRS) population has a primary or secondary diagnosis of mental illness.

DMHS, in conjunction with DVRS, does provide evidenced-based supported employment services. However, only 1% (or 1,600 consumers) are currently involved annually.

OVER ARCHING GOALS

- GOAL 1.** To seek a philosophical change in the way the mental health system does business that promotes self-efficacy, wellness and recovery.
- GOAL 2.** Employment, education and all other services must be consumer-centered.
- GOAL 3.** To utilize existing and create new training structures to re-train staff throughout the community mental health system in critical competencies to assist consumers to live, learn and work in their communities.
- GOAL 4.** The New Jersey Division of Mental health Services need to review and change existing Rules and Regulations to reflect the following:
- a) Agency's vision, mission, mandates, and operational philosophy must incorporate the principles of wellness and recovery. Services must be driven by the individual with mental illness.
 - b) Credentials, standards and competencies need to be established in the areas of rehabilitation, wellness and recovery philosophy, employment, and supported education that will include knowledge, attitude and skills required for each area. Agency staff must meet these established educational requirements, competencies, and standards which lead to "credentialed staff" working within a given area.
 - c) Agency policies to promote inclusion, rather than exclusion.
- GOAL 5.** Changes within the various funding mechanisms need to be made to eliminate disincentives to achieve desired outcomes of employment,

housing, education and other consumer-centered goals. The Medicaid Rehabilitation Option for funding should be explored and implemented to encourage appropriate services that can be developed and delivered to ensure full recovery and supports for individuals with mental illness.

GOAL 6. Design and launch a formal, funded marketing and education campaign to promote the benefits of employment to consumers and their families. The campaign will specifically address the myths and realities of the effects of working on entitlements and identifies individuals to assist in benefits planning such as NJWINS, DMHS, Supported Employment Programs and Social Security Work Incentive Liaisons.

SPECIFIC COMMITTEE RECOMMENDATIONS

EMPLOYMENT

It is the recommendation of the Governor's Subcommittee on Employment, Support and Rehabilitation Services that the State increase the availability of supported employment and other integrated employment opportunities for consumers.

The Subcommittee further recommends that each mental health service (i.e., Inpatient Psychiatric, ICMS, Partial Care, PACT, Supported Housing, Outpatient) play a more significant and active role in assisting consumers to identify, link up with and enter integrated employment.

Ticket to Work Cooperative training series between the DOL and DHS to increase awareness and utilization.

The Task Force recommended and supports Governor Codey's fiscal year '06 budget proposal to expand current funding for supportive employment services by \$1 million. The expansion would enable an additional 450 individuals with mental illness to participate in the program. Based on past performance, we anticipate that over 50% of these individuals would find competitive employment and become tax paying citizens.

The state should consider additional expansion in subsequent years as funds become available.

POST-SECONDARY SUPPORTED EDUCATION

It is the recommendation of the Governor's Subcommittee on Employment, Support and Rehabilitation Services that the State develops and funds Supported Education programs throughout New Jersey.

SUBSTANCE ABUSE TREATMENT FOR PERSONS WITH CO-OCCURRING DISORDERS

It is the recommendation of the Governor's Subcommittee on Employment, Support and Rehabilitation Services that the State promote the expansion of integrated treatment for persons diagnosed with co-occurring substance abuse and mental illness.

System-wide, the Task Force recommends that the state continue to promote the expansion of integrated treatment for persons diagnosed with co-occurring substance abuse and mental illness, as well as appropriate training. Beginning in fiscal year '07 the Task Force calls for a \$3.7 million investment, \$2.2 million to provide integrated treatment and \$1.5 million to provide necessary training. The Task Force is recommending that the Department of Human Services utilize the Association of Community Colleges to develop the training matrix and curriculum, similar to what was developed for the DYFS training.

CAREER TRANSITION SERVICES TO ADULTHOOD

The Task Force recommends creating in each county, outcome-oriented career education and development services that, provided in conjunction with treatment and other services,

would facilitate the transition into adulthood for individuals aged 16 – 24 with mental illness. Beginning in fiscal year '07 this would require a state investment of \$4.2 million.

EMPLOYMENT

Employment is the key to economic independence. The President's New Freedom Commission on Mental Health points out how important employment opportunities are and specifically recommends strengthening and expanding supported employment services to all people with psychiatric disabilities.

It is the recommendation of the Governor's Subcommittee on Employment, Support and Rehabilitation Services that the State dramatically increase the availability of supported employment and other integrated employment opportunities for consumers.

The Subcommittee further recommends that each mental health service (i.e., Inpatient Psychiatric, Integrated Case Management Services, Partial Care, PACT, Supported Housing, Outpatient) play a more significant and active role in assisting consumers to identify, link up with and enter integrated employment.

GOAL

To assist consumers to form a permanent relationship with the New Jersey workforce which leads directly to integrated employment based upon their needs, wants and desires so that they become economically independent.

OBJECTIVES

- 1) That there be a significant increase in annual state appropriations targeted to enhance and create career oriented employment services which lead directly to integrated employment with necessary critical supports to retain employment.
- 2) That all relevant mental health services such as partial care, ICMS, PACT, supported employment and supported housing be required to formally affiliate and collaborate with the Department of Labor One Stop System including DVRS in order to enhance consumer connections to employment services.
- 3) That the Medicaid Rehabilitation option be made available to key mental health services such as partial care so that services can be delivered and skills taught in the environment of need and that mental health-oriented employment supports become readily available to working consumers.
- 4) That all staff working in licensed mental health programs meet a minimum level of competence in the delivery of recovery-based mental health and rehabilitation services to consumers particularly with a focus on their entry into valued roles such as employee and student. Such competence must include a demonstrated understanding of the principles of recovery and a belief in continued growth and development.

- 5) That mental health licensing standards must be reviewed and revised to promote a recovery-oriented organizational mission, program and practice. That they require an emphasis on consumers entering valued roles such as employee, student and neighbor.
- 6) That the DMHS contracting system focus on the achievement of specific consumer outcomes such as employment or education, rather than the process of numbers of units.

POST-SECONDARY SUPPORTED EDUCATION

When the onset of mental health problems begins during school-age years, educational systems are often ill prepared. Several studies have identified educational deficits in their clientele, who function in reading and math at a level far below their achieved grades in school (Cook et al., 1987; Cook & Solomon, 1993). Supported education models can provide assistance to consumers with their education. (Dr. David Satcher, Mental Health: A Report of the Surgeon General, 1999.)

It is the recommendation of the Governor’s Subcommittee on Employment, Support and Rehabilitation Services that the State develops and funds Supported Education programs throughout New Jersey.

GOAL

Supported Education is a post-secondary initiative built upon the psychosocial rehabilitation theoretical constructs. The goal of supported education is to facilitate the entry or re-entry of persons diagnosed with a mental illness to technical trade school programs, apprenticeship programs, institutions of higher learning or programs for persons interested in pursuing a GED. Supported education focuses on increasing the retention of consumers in educational institutions through successful completion (i.e., degrees, certifications).

OBJECTIVES

- 1) To establish Supported Education programs throughout the state, with a minimum of one program in each County.
- 2) The programs will serve as an information clearinghouse and provide direct service and support. Direct service will include the provision of a “mobile” service delivery (services provided directly to the consumer in the educational setting). These services will include teaching study skills, skills in managing stress and will provide tutoring and coaching. Supported Education Programs also will provide linkages to the following:
 - Scholarship and grant programs (especially those specifically for mental health consumers).
 - Funding sources for undergraduate education, e.g. DVRS, Plans for Achieving Self-Sufficiency (PASS) for persons receiving federal Social Security Income benefits.
 - Financial assistance (applying for financial aid, applying for loan forgiveness enabling consumers to return to school).
 - Enrollment and registration assistance.
 - Assistance and advocacy in obtaining “reasonable accommodations” from the school.

- Programs offering professional certification based on life/work experience.
- 3) To establish peer support groups regionally for persons in school and those contemplating school enrollment. This may also include establishing a self-contained learning environment to reduce consumer anxiety about re-entry into a structured learning environment.
 - 4) To increase retention rates of consumers attending school.
 - 5) To establish strong collaboration between supported employment and supported education services to better facilitate the attainment of an individual's vocational goals.

SUBSTANCE ABUSE TREATMENT FOR PERSONS WITH CO-OCCURRING DISORDERS

Substance Abuse Treatment for Persons with Co-Occurring Disorders (TIP 42) provides counselors with principles, assessment instruments, strategies, settings and models for treating consumers wherever they present for treatment, whether it be in substance abuse treatment facilities, mental health facilities, medical offices or clinics. TIP 42, created by a panel of experts and reviewed in the field, also emphasizes that outcomes for consumers are enhanced when both illnesses are addressed using an integrated approach.

Beginning in 1998 with the support of the Substance Abuse and Mental Health Services Administration (SAMHSA), the U.S. Department of Health and Human Services, the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD) entered into a partnership that resulted in the development of a new conceptual framework that presents co-occurring disorders in terms of multiple symptoms and severity instead of diagnosis. The framework provides a visual way of thinking about both the systems of care and the level of service coordination needed to improve consumer outcomes, especially the integrated care necessary for individuals with the most severe mental illnesses and substance use. This conceptual framework combines observations about the current service delivery systems with a vision for the future delivery of integrated services.

It is the recommendation of the Governor's Subcommittee on Employment, Support and Rehabilitation Services that the State promote the expansion of integrated treatment for persons diagnosed with co-occurring substance abuse and mental illness.

GOAL

"A Life in the Community for Everyone" is the Substance Abuse and Mental Health Services Administration's Guiding Principle. This principle is endorsed by this subcommittee and can be operationalized when outpatient treatment is available on demand and community supports, i.e., Peer-to-Peer and Recovery Mentors are formalized and available to all willing consumers.

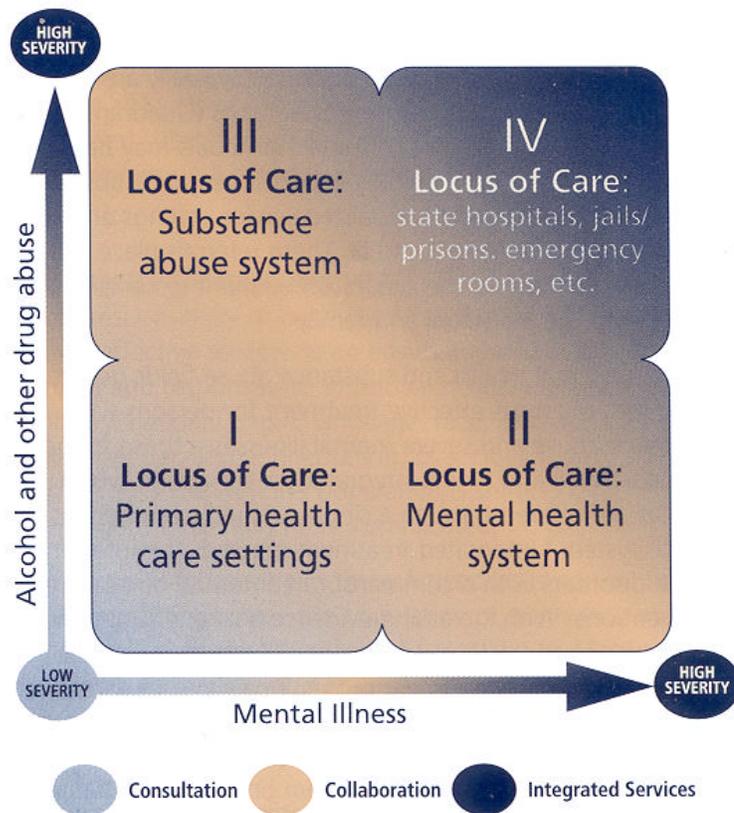
Individuals with co-occurring substance abuse and mental health illnesses will be treated for both illnesses. Research is clear that outcomes are improved when integrated prevention, intervention and treatment strategies are applied. This represents the vision of this Committee and the Department of Human Services, (DHS), the Division of Addiction Services (DAS), and the Division of Mental Health Services (DMHS).

OBJECTIVES

- 1) The severity of a co-occurring disorder be diagnosed/recognized in all individuals entering either system of care and be addressed with clinical and supportive interventions and in settings that are evidenced in the literature to be effective. Symptom identification and/or differential diagnosis require training of current practitioners at all levels in both systems. Jointly funded training actions in the Department of Human Services (DHS) be expanded.
- 2) The DAS was merged (effective 4/1/04) under DHS, therefore effectively and efficiently joining the DAS and DMHS. As studies cite, 12 percent of patients have severe mental illness and severe substance abuse (Quadrant IV); the existing DHS projects for this population require expansion. Federal and Foundation grant funds should be applied for to support this end and assure application of evidence-based practices at the point of patient care in the community-based organizations. Adequate State appropriations and Medicaid funding will be necessary for sustainability.
- 3) Incorporate all levels of certification by the Addiction Professionals Certification Board of New Jersey as viable mental health team members (Quadrant II).

Chemical Dependency Associates (CDA) and Certified Prevention Specialists (CPS) have scopes of practice that can provide screening/problem ID and concrete co-occurring patient education, treatment plan support (for patients and families), as well as, objective monitoring skill building for patient self-efficacy. Expand the number of professionals through recruitment, training and retention activities. Utilize recovery support workers for continuing care, i.e., Peer-to-Peer, Recovery Mentors, etc.
- 4) Promote integrated treatment through training for mental health agency CEOs, Directors of Clinical Services, Medical Directors, psychologist and psychiatrists on best practices for the co-occurring population. Training shall include: medication protocols, differential diagnosis, treatment plan strategies, and development of a multi-disciplinary professional team to promote best outcomes.
- 5) DMHS and DAS consolidate licensing standards for all Quadrant IV programs (severe/severe) and develop a protocol for inspections in agencies that have multi-service missions and provide treatment to distinct mental health or substance abuse patients along with the co-occurring patient population (Quadrant II and III)

Service coordination by Severity



Category

1. Less severe mental disorders / less severe substance abuse disorder.
2. More severe mental disorder/less severe substance disorder
3. Less severe mental disorder/more severe substance disorder
4. More severe mental disorder/more severe substance disorder

Setting

1. Primary health care settings, school-based clinics, community programs; no care
2. Mental health system
3. Substance abuse system
4. State hospitals, jails, prisons, forensic units, emergency rooms, homeless service programs, mental health and/or substance abuse system; no care.

CAREER TRANSITION SERVICES TO ADULTHOOD

Young adults ages 16-24 who struggle with emotional problems or who are diagnosed with a mental illness often do not receive the direction and supports needed to

successfully transition into adulthood. This is particularly true for those individuals who are economically disadvantaged and/or are involved with the Division of Youth & Family Services (DYFS) or with the juvenile justice system. By age 18 (or in some cases 21) these individuals lose their entitlements to educational, vocational and other supportive services they may have received under the children's system of care and through the Individuals with Disabilities Education Act (IDEA). Currently, services in the adult mental health system have a difficult time addressing the career exploration, job development, post-secondary education and life skill needs that are unique to young adults. This gap in services must be bridged to ensure that young adults are given appropriate opportunities to fulfill their potential and be productive members of their communities.

Goal

To create in each county, outcome-oriented career education and development services that, provided in conjunction with treatment and other services, facilitate the transition into adulthood for individuals ages 16- 24 who struggle with emotional problems or who are diagnosed with a mental illness.

Objectives

- 1) That Career Transition Service programs be established throughout the state, with a minimum of one program in each county.
- 2) That a self-discovery process to identify occupational abilities, preferences and interests be a required program outcome for agencies (i.e., Division of Youth and Family Services, Division of Vocational Rehabilitation Services (DVRS), Boards of Education, community providers) that share the responsibility of identifying and or providing post-secondary services.
- 3) That short-term work experience or internships to "try on" occupations be provided to assist young adults to gain an understanding of the demands and rewards of participation in the workforce. Internships that occur during the school day will include transportation to the work site when family members are unable to provide it themselves.
- 4) That the Department of Education ensures that local school districts include DMHS and/or community mental health representation in the development of a student's Individualized Education Plans (IEP).
- 5) That individuals leaving the school systems be formally linked to their county transition service program, local DVRS office, DMHS-funded county supported employment program or local one stop center. Memorandums of Understanding must address the need for improved coordination between the education, criminal justice, mental health treatment, substance abuse treatment, prevention and Division of Youth and Family Services (DYFS) systems.

- 6) That transition services be marketed to families, DYFS, Juvenile Justice Commission, special needs school districts, alternative high schools and other entities working with the transition population.

BUDGET

Governor's Subcommittee on Employment, Support
and Rehabilitation Services
*Budget for Subcommittee's recommended program
enhancements, expansions and developments*

Program	Gross estimated cost (in million dollar increments)
Employment	14.5
Post-Secondary Supported Education	4.2
Education/Marketing Campaign	0.5
Substance Abuse Treatment For Persons with Co- Occurring Disorders	3.7
Career Transition Services to Adulthood	4.2
Training Clearinghouse (wellness and recovery)	0.5
Total:	27.6

Community Mental Health Infrastructure and Efficiencies

Overview

The Community Mental Health Infrastructure and Efficiency Committee was charged to assess the capacity of the community mental health center system and to make recommendations for enhancement. The committee considered the economic context in which centers operate, discussed the salaries of direct care and support staff and reviewed potential operational efficiencies relative to contract reform and agency operations.

In the course of its deliberations, the committee carefully reviewed the economic context in which community centers operate, considered issues of consumer/family choice, discussed capacity and access challenges, reviewed technological approaches to increased efficiency, and evaluated the desirability of increased accountability in the system through outcome-based approaches to service delivery.

The Committee firmly holds that the recommendations coming out of its discussions represent immediate steps that must be taken to strengthen the infrastructure of the existing community system. It is noted, however, that these recommendations must be viewed only as interim steps toward an outcome-based, consumer friendly service system, which must establish points of accountability for and with consumers and families.

In this latter regard, the Committee encourages the Task Force to embrace a systems design that fully values consumer and family choice, more fully supports the economic needs of both service providers and service recipients, and infuses accountability for all systems partners.

The specific recommendations of the Committee in the following five areas are detailed below:

- Consumer Friendly Mental Health Services
- Cost of Living Adjustments for Mental Health Providers
- Contract Reform
- Information Technology
- Medicaid Reimbursement

Consumer Friendly Mental Health Services

Overview

The mental health system should support and empower all consumers through their recovery. The system itself, however, sometimes frustrates and discourages some consumers. The complexity, fragmentation, obscure eligibility criteria and a lack of published information about performance/outcomes and customer satisfaction, make it difficult for some consumers to locate, enter and feel adequately served.

Summary

- Catchment area criteria artificially restrict consumers to local providers. Consumers should be able to go where they feel they will obtain the best service.
- Some consumers lack information as to where to go for services. For these consumers, this lack of information causes frustration and confusion.
- There are multiple entry points into the mental health system and consumers should not be re-directed, to fend for themselves, if they are referred to one door but need another level of care.
- Generally, consumers cannot request specific agency clinicians/ MD's. Evidence shows consumers do best with practitioners they trust.
- Some programs do not publish any information on customer satisfaction and/or outcomes/performance data.
- Consumers who are referred to acute care need more education on what comes next and how to access ambulatory care.

Recommendations

- Eliminate catchment area criteria for eligibility for service. Any New Jersey consumer should be allowed to request service from any provider.
- Clinical need should be the sole criteria for admission.
- Implement “no wrong door” approach in all agencies. Agencies should require staff to refer and link consumers who seek a level of care not provided by that worker/service/program.
- All programs should clearly state, post and distribute to consumers and families their mission statements.

- Develop a Web-based directory of all community mental health centers (CMHCs) in New Jersey. The Division of Mental Health Services (DMHS) should take the lead on creating a highly interactive Web site and host relevant data about CMHC's.
- Require programs to develop and publish a report card with outcomes and performance data, as well as consumer satisfaction reports. Indicators relevant to consumers should be uniformly selected and resulting data published.
- Allow consumers, whenever possible, to request specific agency-based clinicians/MD's.
- Utilize existing county-based hotlines for referral information.
- Require agencies to educate consumers and families about the multiple levels of the appeal process to manage clinical disagreements.
- The Division of Mental Health Services needs to expand funding for educational/support services targeted to consumers of acute care services and their family members.
- Mental health centers need encouragement to integrate a wellness and recovery model, consistent with a growing body of best practice data.
- Providers should work more closely with self-help and family support groups for more integrated care.
- Develop a template guide for agencies to customize that would be given to consumers and family members upon entering the mental health system. This guide would describe disease states, different levels of service and treatment, and contact information for community mental health agencies and state services. The template would also include agency-specific information that describes an individual agency's services and procedures.

Cost of Living Adjustments for Mental Health Providers

I. Overview of Mental Health Staffing Crisis

The community mental health system is on the edge of a crisis. Years of skyrocketing demand coupled with inadequate or non-existent increases in funding have forced thousands of caring, dedicated community mental health workers to make the agonizing choice to leave their jobs and patients at community mental health centers for a higher paying job, usually in academia or state government. Without adequate numbers of staff, waits for service, which are already too lengthy, have increased. Additionally, high staff turnover rates have led to further deterioration for individuals with mental illnesses, who are so dependent upon continuity of care. More vulnerable citizens will through the cracks, ending up in prison, homeless, addicted to drugs or committing suicide.

II. Summary

Recently, the state has instituted new initiatives that have offered higher starting salaries for comparable jobs than those available in community mental health centers; these initiatives include programs funded by the Division of Children's Behavioral Health Services and the child welfare reform plan. Primarily, employees of the community mental health system are the ones who varied their community positions to fill the positions for both of these massive initiatives.

Many people with a master's degree earn significantly less at a community mental health agency than the new child welfare workers earn, and the child welfare positions only require a bachelor's degree. A survey of 2003 salaries for licensed master's level clinicians in small to middle sized community agencies found an average starting salary of \$34,000, while bachelor's level mental health technicians earn \$26,000. Compare that to more than \$41,000 for a bachelor's degreed family service specialist in the New Jersey Division of Youth and Family Services (DYFS). Similar disparities exist when the community system is compared to most other state positions.

The staffing crisis is severe. An example of this crisis is in the Programs for Assertive Community Treatment (PACT), which serves the consumers most at risk for hospitalization. In the PACT program, workers must visit the residences of clients, sometimes in dangerous neighborhoods. They are needed at all hours and regularly must address developing crises. Of the 256 PACT positions statewide, the vacancy rate was 15.4 percent as of June 30, 2003, and 17.6 percent as of December 31, 2002. Some critical positions have remained vacant for more than a year. These individuals serve 1,819 PACT clients, most of whom have chronic conditions and have been repeatedly hospitalized.

PACT team members work with consumers to ensure they understand the importance of their medication and take it regularly. In some instances, they must visit daily to ensure compliance. Staff also struggles to help consumers avoid homelessness and re-hospitalization. But because of the high vacancy rate, staff

members must carry higher caseloads and often are unable to see individuals as often as necessary. The program, which was designed to avert crises, instead must focus on individuals in the midst of crisis.

III. Recommendations

For community mental health centers to recruit and retain qualified professionals and to continue to reduce the population at the state's psychiatric institutions, the state must make several key changes, including:

A. Items to Include in the Task Force's Final Report

- Eliminate the salary disparity between the state and non-profit sectors, by implementing a three-year plan to bring salaries in the community mental health system up to par with state salaries.
- Assign a permanent index for the total cost of community care contracts to be increased on an annual basis. It is recommended that the State use the federal CPI – Urban Wage Earners (CPI-U) for the Northeast Region.
- Improve benefits coverage for community workers
- Develop bicultural/bilingual staff capacity.
- **The Task Force recommended and supports Governor Codey's fiscal year 06 appropriation of \$3.5million provide "loan forgiveness" to new graduates with qualified bachelor degrees working at a qualified state or county psychiatric hospital or state-contracted non-profit qualified facility. This program will forgive up to \$5,000 annually for each year worked in a direct care position for up to 4 years. This program will assist in recruitment and retention of quality staff providing direct care to some of NJ's most vulnerable citizens.**

B. Items Important to Ongoing Improvement of System

- Provide resources for recruitment of staff.
- Work with educational institutions to develop staff of the future. Special emphasis should be placed on developing bilingual and bicultural staff, as well as training capacity and cultural competency.

Contract Reform

I. Overview

- The current deficit funding contract model in combination with the “last dollar-in” philosophy, the budget modification policy, the cluster policy, and the requirement of line item budgets significantly impairs the optimum development and functioning of the community mental health system in New Jersey.
- Each year millions of dollars in state funding are wasted on unnecessary micromanagement functions such as budget modifications and line item reporting. These funds could be redirected to develop new services, expand existing services, or focus the system’s attention developing and identifying best practices and outcomes statewide.
- During the budget closeout process, funds awarded to provider agencies are lost to the agency or recaptured by the Division of Mental Health Services (DMHS) due to complicated budget modification requirements, and cluster requirements. (See example below.)

➤ **Example of Contract Closeout :**

All provider organizations in New Jersey’s Community Mental Health System are non-profit (or government affiliated) agencies. The goal of agencies is, at a minimum, to break even, and if they can, realize surplus funds at year-end, in order to improve and expand the services the public requires in line with the mission-driven nature of non-profits.

Under the current contract policies, a provider agency can losses money in a given year due to unanticipated expenses and still be subjected to additional loses at the hands of DMHS in several ways:

1. Initiative and creativity often allow agencies to find less expensive means of providing the same quality service. When this happens and the agency spends less per line item than budgeted, the state will take back those remaining grant funds, decreasing the agency’s total allocation and increasing the deficit, even if an agency needs additional funds in another line to meet expenses.
2. Should an agency overspend any of the line items in its budget, the state will not allow those costs to be reimbursed with grant funds, even if other line items have been under spent.
3. Agencies must anticipate and report all revenues received in conjunction with the delivery of services from all sources. Should an agency find the means to increase revenue in a given program over original projections, the agency is allowed to keep only 50% of

the surplus revenue even if this is not sufficient to cover deficits in other program clusters.

4. Should an agency not collect all the revenue it anticipated in its original budget projection, there is no provision for DMHS to increase grant funds to cover the loss.

- New revenue initiatives have done nothing to increase funding to providers for services. However, these initiatives have increased the risk that some portion of provider funds will be lost, and new documentation and billing requirements have significantly increased costs for providers.

II. Summary

Contract reform has been an ongoing debate in New Jersey since 1990. In that time, thousands of hours and millions of dollars have been wasted on discussing reform proposals that have never been enacted or enforced.

With the exception of FY 2004, cost of living adjustments in state funding for community mental health services have been half or less than half of the annual rate of inflation for the past 15 years. During this time, nearly all community mental health provider agencies' financial ratios have been reduced dramatically; many have dropped below one. Cash reserves are so low that many centers cannot operate for more than a few weeks without additional finances. More importantly, the lengthy history of under funding has led to a staff salary structure that is seriously non-competitive; the resulting high staff turnover ratio throughout the system threatens the quality of consumer mental health care and services in every program.

During the past 15 years, the behavioral healthcare industry throughout the country has begun an intense focus on best practices, quality of care, outcomes, and evidence-based practices. Also during this time, mental health practitioners, families, and consumers have begun to speak of recovery, long-term community tenure, return to work, quality of life, wellness and even a "cure."

In contrast to the above, in New Jersey, the Division of Mental Health Services (DMHS) has placed emphasis on the micromanagement of line item budgets, budget modification requests, and recapturing funds originally awarded to provider agencies during the budget closeout process.

Each budget year, unforeseen events change the way provider agencies must manage their funds, and under the current system, agency directors must continuously request permission from the state to move even small amounts of money from one line item to another, or one cluster to another. Failure to request and obtain that permission frequently means the loss of funding. For non-profit provider agencies that do not have working capital, these losses can be devastating and significantly impact future services.

In September 2002, the Chief Financial Officers Committee of the New Jersey Association of Mental Health Agencies (NJAMHA) analyzed the total combined cost to DMHS and provider agencies of preparing, submitting, reviewing and approving budget modification requests to be in excess of \$4 million per year. If the process produced useful results, this cost might be understandable. However, in testimony before the New Jersey Assembly Regulatory and Oversight committee on June 3, 2004, DMHS admitted that almost all of the budget modification requests submitted each year are approved.

New DMHS revenue initiatives such as the Rehabilitation Option for Adult Residential Services, designed to shift the cost of providing care from the state budget to the federal budget by leveraging additional Medicaid dollars, present additional problems for provider agencies. DMHS calculations of the costs involved in the funding shift fail to fully consider additional provider agency costs for documentation and billing now covered by contracts.

III. Recommendations

Although annual increases in state funding that keep pace with inflation are necessary to repair and maintain the community mental health system, we must also create a true partnership between the Department of Human Services (DHS), the Division of Mental Health (DMHS), and the providers of care. This partnership needs to be based on a common, unified mission to pursue best practices, focus on outcomes, and develop the flexibility and creativity to enhance the community tenure, quality of life, recovery and wellness of consumers we serve.

Contract reform can be a significant and inexpensive means to achieve that goal. In the event the state should move to adopt an alternative funding model, i.e., integrated payor model, fee for service, etc., contract reform is a necessary first or interim step. To that end, we recommend the state institute the following changes:

- Eliminate the state requirements for budget modifications. Provider organizations require an unfettered ability to manage their grant funds to meet the challenges of providing services in an ever-changing business environment. Although initial budget proposals and year-end reporting should continue, prohibitions and penalties for changes in funding allocations within the contract ceiling should be eliminated.
- With the exception of the first two years of a new revenue initiative, all revenues received by the provider agency up to and above the original budget projection should be retained by the provider agency.
- Provider agencies should be assisted in the development of a working capital fund of up to 15% of their annual operating budget over multiple contract years. Working capital would address cash flow needs, needs for unanticipated and unfunded expenses; and would allow agencies to take advantage of creative opportunities to expand and improve services.

- If agencies have additional revenues and/or accruals they should be allowed to create and maintain a working capital improvement fund up to 10% of their annual operating budget for the purpose for funding capital improvements to include information technology infrastructure.
- DHS/DMHS should work cooperatively with providers, statewide associations, such as the New Jersey Association of Mental Health Agencies, Inc. (NJAMHA), other states, and national associations or groups to identify and implement statewide outcomes and best practices in the behavioral health field.

Definitions and Example:

- Financial Ratio: Current assets divided by current liabilities. Ratios below 1 are considered a sign of fiscal instability. Ratios above 2 are considered a sign of fiscal health.
- Cash Reserves: Cash, or investments sufficiently- liquid to be converted to cash, which may be used to pay bills and expenses. Depending on the type of business, fiscally sound corporations normally hold cash reserves to carry them through three-to-six months of operating costs.
- Line Item Budget: Provider agencies are required to submit budgets projections which include the itemized costs of every full or part time position, and every type of expense, i.e., rent, electricity, paper, insurance, etc. Should an agency spend more than allocated to that line (for example, one part time residential counselor works a number of hours of overtime to cover for full time counselors on vacation or out sick), and fail to submit a budget modification and obtain State permission, those costs would be disallowed resulting in a loss of funds.
- Cluster: Certain programs, even though a part of the agencies' overall system of care and part of the overall budget, are considered a specific cluster. Revenues and expenses associated with a cluster may not be moved to another program without a budget modification.

Information Technology

I. Overview

Information technology needs to be regarded as a critical and inherent component of the community mental health system as it impacts on the quality of care and services for consumers, families, providers, and state and federal governments.

II. Summary

The areas that need to be developed include:

- The Electronic Medical Record (EMR) – A key to efficiency, the electronic medical record will facilitate communication and provide essential information within an organization for quality improvement activities, while at the same time reducing the labor intensive activities of records maintenance, retrieval of records, records review and reporting of activity. Based upon this data, the time consuming tasks of quality assurance can be automated and the staff currently involved in this can and should be shifted to analysis and quality improvement activities. This information can also be used to facilitate referral to other organizations and speed the access to essential information at times of crisis.
- Staff - Documentation of activities related to recruitment, retention, credentialing, evaluating, training and staff perceptions of services, can be automated and data reported and tracked on a regular basis as an additional measure of quality.
- Contract Monitoring – Reporting of data, based on existing minimum data sets, needs to be gathered as a regular part of the daily activities of the organizations and reported electronically using translator software to provide state and federal agencies with the data required. The mechanisms used to gather and aggregate this data need to be set up in a way that provides immediate information to the organizations about their own performance and how it compares to the performance of peer organizations providing a similar service, identified targets and best practices. Feedback loops within and between systems (at multiple levels) need to be facilitated through the use of information gathered through existing documentation.
- Consumer Choice and Access - Organizations need to build detailed consumer/family friendly electronically based information and referral mechanisms. These mechanisms need to identify the functions of each organization, its strengths and weaknesses, and be tied to outcomes data from the above reporting system. The information should be easily accessible and understandable by potential users. An example of how this information might be made easily accessible to consumers is via an

Internet-based system such as the one used by Easter Seals for consumer satisfaction. The Information Technology Project of the New Jersey Association of Mental Health Agencies, Inc. (NJAMHA) could assist in the training and technical assistance to operationalize this effort.

- Communications and Information Sharing - Electronic communications both within an organization and between organizations needs to be developed and monitored as part of a system within the guidelines outlined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). They should be designed to assure that no consumer's needs are missed in accessing services in other community-based organizations or hospital-based services. Electronic communications need to include information about entitlement programs, as well as all necessary referral and clinical information required to immediately meet the needs of the individual and their support system.

These efforts need to be undertaken in a carefully planned and well-coordinated partnership among government entities, community organizations, the consumers of the services, their families, professional and trade organizations, and vendors of electronic systems. They need to take advantage of existing efforts, including the federal government's Decision Support 2000+, the Information Technology Project of the New Jersey Association of Mental Health Agencies, Inc. (NJAMHA), the Division of Developmental Disabilities Electronic Information Initiative, and the Software And Technology Vendors' Association (SATVA), as well as other initiatives that are ongoing in the state and federal governments. The current patchwork design of the system, based upon each program's requirements for data is confusing and inefficient. Collection of data becomes the primary objective. There is already excessive data collection required; however, little analysis of this data is completed and timely feedback is virtually non-existent.

The cost of developing an effective and organized information technology system should be considered as an investment. These efforts should not be conducted in a way that forces adoption of a single system by the entire system. Rather, they should provide an open platform that would increase the alternatives available to organizations by providing a solution in the form of a central data repository. This repository would be used by organizations to benchmark services and would be available to consumers to help them choose the best provider to meet their needs.

III. Recommendations:

- Immediately, as an interim action step, implement a transferable, portable, electronic information source via a computer disk that consumers and providers can easily access. Work toward the longer-term goal of consumers having "smart cards". These measures will lead to quicker access to services for consumers and increased efficiency of mental health services, as well as quality of care.

- Develop a comprehensive information technology plan for the Department of Human Services, the Division of Mental Health Services, and community mental health agencies.
- Develop an Advanced Planning Document to draw down all available sources of funding to develop a statewide web-based management information system.
- Clearly outline the requirements for protecting privacy in line with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), while streamlining the process of gaining consent from individuals to share essential information, gaining access to services, transferring essential information for the provision of high quality care, and enrolling or verifying enrollment in necessary entitlement programs and distribute that information to consumers, family members and providers. It is recommended that the Community Health Law Project develop a user-friendly pamphlet and the Department incurs the costs of printing and distribution.
- Analyze all existing data reports and requirements by the Department of Human Services and the Division of Mental Health Services. Eliminate all data and reporting requirements that do not address a current need (e.g., meeting federal or state payor requirements) or enhance quality of care. Eliminate reports that have been historically produced, but that have no current relevance to care or other performance.
- Create a fund available to assist organizations in investing in information technology, not as an after thought or when funds are available, but as an essential part of binding the system together, making it accountable for high quality care.

Medicaid Reimbursement

I. Overview

As the President’s New Freedom Commission states, “...to achieve the promise of community living for everyone, new service delivery patterns and incentives must ensure that every American has easy and continuous access to the most current evidenced-based treatments and effective support services. Consumers and family members must have access to timely and accurate information which promotes learning, self monitoring and accountability”. The mental health system must adopt the Commission’s principles: **Services and treatments must be consumer and family centered, giving consumers real and meaningful choices in terms of treatment and providers. Secondly, care must focus on increasing consumers’ ability to successfully cope with life’s challenges, on facilitating recovery and building resilience, not merely managing symptoms.**

One of the most important sources to stimulate this change is Medicaid, the single greatest source of financing mental health care. Medicaid provides more than half of the resources for state and community mental health services. In particular, it is

the primary funding source of the public mental health system for low-income people with mental disorders. Unfortunately, Medicaid reimbursement rates have stagnated for nearly 30 years, making it extremely difficult to operate a mission-based business in the non-profit, behavioral health sector. As a result, community mental health facilities struggle to recruit and retain qualified staff and clients are forced to wait for needed clinical services, frequently being put on waiting lists averaging two-to-three months. Delays in mental health care often lead to unfortunate outcomes for clients, many of whom find their psychiatric symptoms worsening. Medicaid rates are based upon location and type of service. The unfortunate reality of this practice is the unintended effect of basing treatment/service decisions on billing rather than on the clinical needs of the consumer. Hospital based vs. non-hospital, community mental health center rates differ significantly. Consumers are put into categories of care reimbursed at specific rates rather than having their clinical needs addressed more holistically. Clinical documentation requirements coupled with the necessary general and administrative infrastructure to generate Medicaid billing put a serious strain on community agencies and exacerbate the current difficulties with the system.

Nationally, and in New Jersey, over the past two decades, there has been a significant shift of services that previously were funded by the state to the Medicaid budget. The result is that Medicaid, while an increasing percentage of the state budget, has become critical in the ability of New Jersey to provide necessary mental health services to maintain individuals in the community. State of the art treatments, based upon research are not being transferred into community settings due to fragmentation and inadequate funding. More individuals could recover from mental illness if we utilized a standard of best practices in our funding systems. We believe that services must be sufficiently flexible to support individuals in natural settings, such as their homes, places of work and schools. Services must be able to be brought to where people are. In addition, it is necessary to continue to provide facility-based services.

II. Summary

- Medicaid must be sufficiently flexible to support individuals in their natural settings, such as homes, places of work and schools.
- Medicaid reimbursement rates must reflect the cost of doing business.
- Rates need to reflect the intensity of service delivery, not be based on location or facility.
- Medicaid reimbursement for hospital-based facilities is 70-85% of the actual cost of providing the service.

- Medicaid reimbursement for clinic (non-hospital, non-profit) settings ranges between 10-40% of the actual cost of providing the service.
- Documentation requirements and the pre-authorization process are cumbersome and costly in terms of staff time and computer system billing demands.
- Medicaid and UNISYS billing staff are often as confused as providers and need technical training to properly instruct community-based billing staff. Community billing staff experience extreme difficulty obtaining correct answers, especially when asking questions about restricted Medicaid plans, such as Managed Medicaid, NJ Family Care, 3560 cards, etc.
- Frequent delays in receiving reimbursement are experienced in all sectors, both hospital and non-hospital (community non-profit agencies), both in the adult and children's mental health system.
- The mental health system needs to focus on COST AND OUTCOMES.

III. Recommendations

- **Annual Index**
There should be an annual index that is applied to the reimbursement structure so that costs continue to reflect the prevailing costs of doing business.
- **Costs and reimbursement for mental health services should be determined by best practices, not market forces**
Lengths of stay for adults and children in community hospitals have been reduced by 50% over the past 10 years - not because of best practices - but due to economic forces. If we want people to remain close to home, then we must have a reimbursement system that reflects the clinical and social needs of people.
- **Reimburse a comprehensive package of services rather than one service at a time**
Rather than paying for each service that an individual needs, a single plan of care that will offer a range of separate activities through a single plan should be reimbursed. This will allow the consumer and provider to customize a service plan based on individual needs.

Recommendations to be Considered as Part of the State's Ongoing Improvement Efforts:

- **Integrated Clinical Case Management** - After discharge from a State Hospital (Ancora, Greystone etc.), Division of Mental Health Services regulations mandate 18 months of case management. Because services are mandated, Medicaid approval for Integrated Case Management Services

(ICMS) should be automatic. Eliminate the requirement for Prior Authorization (PA) for ICMS clients. The PA for ICMS would be required after the 18 months.

- **Adult Residential Services**
 With Adult Residential Services, agencies are required to bill out the first 28 days of each month, up to a \$5,000 limit. An additional billing is required for the 29th, 30th and 31st day - twice the work. This requirement does not exist in the Children's Residential System where agencies can bill for the entire month with **one claim**. Change the Medicaid regulations to encompass the full month with a single billing. Have **CONSISTENCY** in Adult and Children's Residential Services.

- **Regulation(s) Simplification and Training**
 Training has been a cornerstone of the Child Welfare Reform process with Division of Youth and Family Services supervisors and staff. A similar effort needs to take place at the Medicaid level.

- **3560 Cards**
 The 3560 cards pay for Child Residential/Care Management Organization consumers only. They do not pay for physical examinations, which are required by Division of Mental Health Services regulations upon admission, as well as ongoing medical care; do not pay for prescriptions, vision needs (glasses, etc.), or dental care. Medicaid regulations need to be changed to encompass these medical needs. Programs cannot absorb these costs and clients/consumers are not financially able to pay for these services.

We are aware of the many proposals emanating from Washington that, if adopted, will greatly affect this critical program. We strongly believe that any changes to the system that either cap or reduce the flexibility which the state has in providing a comprehensive program to the mentally ill, should be rejected.

Emergency Preparedness/Trauma

Overview

In the acute phases of disaster and trauma, New Jersey has a dedicated and professional group of individuals and agencies that have historically responded to the mental health needs of individuals and communities. However, the energy these providers expend on responding, places and additional burden on an already stretched mental health system. As a result, the long terms needs of people affected by trauma have been difficult to provide. The ongoing development and strengthening of the mental health disaster response system has been temporary and sporadic resulting in inconsistent availability of resources. The enormous mental health needs of individuals and communities affected by September 11th magnified the areas in which we need to improve. The Advisory Board has highlighted three main areas in which we can improve how we respond to the mental health needs of people affected by disasters/trauma

To improve the system of care for individuals/families and communities we need the following;

Legislation

To organize and govern mental health services in all phases of disaster recovery including mitigation, preparedness, response and recovery for people in the aftermath of disaster/trauma.

Coordination

Clearer roles between state, private, volunteer, professional and law enforcement based on type of disaster/trauma, victim populations and needed services in all phases of disaster management.

Sustainability

To maintain services and disaster preparedness activities past the acute phase of the traumatic experience and create sustained efforts during non-disaster times.

Specific Recommendations

Legislative recommendations

Establish the Division of Mental Health Services within The Department of Human Services as the lead entity to coordinate the mental health disaster response in

collaboration with other emergency response entities; such as the Office of Emergency Management. Such legislation should address specific needs and a course of action. Guidelines should consider victim populations and type of disaster (i.e. natural disaster, crime ect.) when determining appropriate responses.

Provide State disaster/emergency funding for short and long-term counseling and other mental health services provided for victims, their families and first responders, in the event of a major Federal/State or County declared disaster.

In declared disasters, The Federal Emergency Management Agency (FEMA) grant funds are available for non-clinical crisis counseling, psycho-education and referral services. The magnitude of September 11th prompted funding for clinical services from The Substance Abuse Mental Health Service Agency (SAMHSA), private and other temporary grant relief sources; however, such funding is typically unavailable for long-term disaster recover efforts. Additionally, grant applications require time/effort to organize. We recommend that in addition to the funds that are typically made available through disaster-related grants, apportioned funds be made for unmet needs.

Longer-term services may be grant funded but not necessarily. The New Jersey Alliance of Mental Health Agencies (NJAMHA) and other professional organizations have expressed concern about unfunded mandates.

It is the recommendation of the Advisory Board to encourage appropriations for mental health services as part of any State Disaster Emergency Relief Act passed by the Legislature as the result of a disaster or emergency condition in New Jersey.

Assure that any future disaster response legislation addresses mental health needs of those affected including Homeland Security and current School Safety initiative or by creating an adjunctive component to existing legislature to expand authority for disaster mental health services. Current legislation of Domestic Preparedness and the State Emergency Management Act do not address mental health.

Coordination

Single point of entry

The advisory board has identified the need to develop one point of access to services when a disaster occurs. Currently, ACCESS centers exist in entities such

as UMDNJ, MHANJ, Project Phoenix, NJFAM, VCCB: others exist on a countywide level. One of these existing locations may be modified to meet the needs of a disaster response ACCESS Center or a linkage created between these centers, therefore minimizing the cost. Data, tracking, needs assessments, outcomes, and provider networks would encompass the responsibilities of such a proposed center.

Uniform credentialing process

There is an effort currently underway by the NJ Division of Mental Health Service to provide a standard for a mental health disaster workforce through a credentialing process.

The Advisory Board recommends the development of a statewide resource directory with automatic Web accessibility. There currently exists a statewide resource directory from a 9-11 perspective that was developed by NJFAM/ORVA. It is reasonably comprehensive and could serve as the basis in this area.

Include mental health planning and representation from the Division of Mental Health/DHS in the existing entities to include the New Jersey Domestic Security Preparedness Task Force and Entities like Department of Law and Public Safety, Office of Emergency Management, Office of Victims of Crime, New Jersey Attorney General and Division of Mental Health, ect. would be necessary participants. Commission would be responsible to:

- *Review major disaster/trauma events throughout the state to determine quality of response and areas for improvement.

- *Assure the development of standards to guide the credentialing process for all levels of interventions.

- *Assess and update interventions based on “best practice models.”

- *Assist in the development and maintenance of “Memorandums of Understanding” for entities involved. This will include public and private partnerships including by not limited to; BENS, EAP, churches, ect.

- *New Jersey is the 5th most ethnically diverse state in the country (NJ Immigration Policy Network, 2000 Census.) In order to meet the needs of our diverse citizenry, we must develop a capacity to respond to global events (e.g., the recent tsunami).

Sustainability

Stabilize the current Office of Disaster Mental Health (DMHS) by a minimum yearly allocation of \$250,000 to maintain current staffing level (grant funding will conclude in August 2005). Securing funding will allow for permanent part time staff. Sustained funding would provide for seven part time professionals. Five individuals work for up to 21 hours per week and two to work 28 hours per week. The funds provide intervention, training and some purchase of materials to support their activities.

Provide a plan for training and maintaining database and relationships during non-disaster times. Continue development and sustainability of disaster mental health workforce through ongoing training and practice exercises.

Assure sustained treatment programs for PTSD and other related disorders beyond acute phase. Providers participating with major insurance companies in New Jersey should be included.

Continue development of collaborative relationships across public and private entities during non-disaster periods to insure a coordinated response during disasters.

Maintain a current workforce that is readily accessible to key leaders, and identifies specialized skills of participants (i.e. children's services, languages spoken).

Review of revenues currently available but underutilized (ie. Churches, private corporations).

Establish a statewide Grant Researcher/Consultant position.

The Board unanimously feels there are opportunities being missed that would assist in service provision. The estimated cost \$65k - \$75k plus benefits represents a sound investment in ongoing preparedness activities, as the return of this investment would yield additional funding for enhances services and assist in further collaborations.

Vulnerable Populations

Children

A group requiring specific attention in the area of emergency response and mental health is children. Due to limited life experience, immature central nervous systems and the nature of trauma, children are more susceptible to the deleterious aftermath of disaster and trauma. Children affected by traumatic stressors can experience severe academic and social consequences. Legislatively, schools are not required to have training for staff on how trauma and bereavement affects

children. We are proposing the long-term needs of children exposed to trauma must be addressed through preventative on post-vention services.

Increase services available for returning veterans and their families.

Current funding for these programs is approximately \$300,000 annually. The office anticipates a need for at least triple this amount. The current system is overtaxed and relying on volunteers. There are 250 veterans waiting for services. It is estimated that between 15% and 35% of returning veterans will suffer from PTSD or other service related mental illness. New Jersey should thoroughly investigate the responsibility of The Federal Government to provide such services.

Cultural competence

Acknowledging that some culture will not be comfortable accessing traditional services, provide a plan for “outreach” to diverse populations having proficiency in cultural issues and language. Such a plan would be necessary to involve partnerships with existing community-based and faith-based organizations.

First Responders

First responders are a sub-culture who are always enmeshed in disaster response. Their professions often cause them to be exposed to multiple traumatic stressors and long-term exposure. There are currently specialized services in existence such as Cop2Cop and TAPER, which may be able to fulfill this need.

PARITY/ INSURANCE

Part one: Parity/ Insurance Coverage

I. OVERVIEW

The President's New Freedom Commission on Mental Health reported that: "Too many Americans are unaware that mental illnesses can be treated and recovery is possible. In fact, a wide array of effective mental health services and treatments is available to allow children and adults to be vital contributors to their communities.

Yet, too many people remain unserved, and the consequences can be shattering. Some people end up addicted to drugs or alcohol, on the streets and homeless, or in jail, prison, or juvenile detention facilities. The World Health Organization (WHO) identified mental illnesses as the leading causes of disability worldwide."

The President indicated in his speech announcing the Commission (Albuquerque, New Mexico, April 29, 2002), "Our country must make a commitment: Americans with mental illness deserve our understanding, and they deserve excellent care.

They deserve a health system that treats their illness with the same urgency as a physical illness."

A. Insurance Coverage - New Jersey's Assembly Bill 333 has been supported by New Jersey's mental health advocacy groups with the intent of providing broader coverage than the current Biologically Based Mental Illness (BBMI) mandate. The goal of advocates is to achieve **"full parity."**

The current BBMI Law mandates coverage of biologically based mental illness to the same extent as other illnesses. Other than the BBMI mandate, there is no statutory requirement that plans offer any coverage for mental health. Coverage for non-biologically based mental illness is provided only to the extent that (1) carriers offer the benefits (they are not required to), and (2) employers elect to purchase these benefits. These benefits may also be subject to different referral, pre-authorization, or utilization review requirements. The standard plans in the Individual Health Coverage and Small Employee Health markets have limited benefits for non-biologically based mental illness.

Self-funded plans are not subject to any state mandates (but may be subject to the Federal mandate).

Plans provided by employers with more than 50 employees, whether self-funded or insured, are subject to the Federal Mental Health Parity Act of 1996, 42 USC 300gg-5. This act requires that any annual lifetime and dollar limits on mental health coverage be no more restrictive than such limits as applied to medical and surgical coverage. Even as applied to affected employers, this law does not provide much in the way of parity. Its provisions do not apply to coverage for alcoholism and substance abuse. It does not require that plans cover mental illness at all. It does not prevent the application of

inpatient day limits and outpatient visit limits specific to mental illness. These Federal requirements do not preempt stronger state requirements applicable to insured plans under state regulations. (Any state regulation of self-funded plans is pre-empted under ERISA.)

Families and consumers have testified to the limitations in coverage, especially for children, under the current state mandate. They look to a “full parity” state mandate as a way to provide more expanded coverage.

B. Access to Treatment - Of equal concern is the issue of barriers to accessing treatment due to lack of outpatient mental health care providers, which lead to overwhelmed mental health crisis units. This may lead to serious cases going untreated or improperly treated due to poor staff to patient/client ratios. Furthermore, the extraordinarily long wait times in these overburdened centers cause many clients in need to leave prior to being served. The lack of trained mental health professionals such as child psychiatrist was mentioned often. Providers who are unable to offer culturally and linguistically appropriate services to “other than English speakers” and the “phantom network” of service providers have been often expressed as concerns.

C. Medicaid - Medicaid dollars currently comprise about half of State spending on community mental health services. The trend has been to increase the funding of Medicaid services in order to draw down the federal match. Funding mental health services at an adequate level to treat the many and diversified needs of the consumers are complex. **Generally**, the Medicaid authority and the mental health authority in states work together to define the mental health services that will be covered by Medicaid, the reimbursement structure of these services, the rates that will be paid to providers and the administrative responsibilities.

Medicaid rates in New Jersey for mental health services are grossly inadequate. This low reimbursement leads to fewer agencies or private practice providers offering mental health care to Medicaid clients (and certainly the lack of funding to urban, culturally relevant agencies leads to issues of service provision for the uninsured, underinsured and undocumented.)

New Jersey does provide rehabilitation services through partial hospitalization in the clinic option. It is this “partial care”, day treatment service and outpatient service which would primarily be affected by expanding the Rehab Option. Currently, the “partial care” programs through the clinic option are reimbursed by Medicaid at the rate of \$15.40 per hour with a minimum of 2 hours, and a maximum of 5 hours, per day. While the services allowed for this service are somewhat inclusive, the clinic option is also restricted to on-site services. This means that individuals must attend the “clinic” in order to be served.

Many consumers testified concerning the need for more flexibility and range of services in partial care and out patient programs to support their goals for recovery in leading a productive life in the community.

D. Medicaid Rehabilitation Option - *Over the years, as psychiatric hospitals have closed or downsized, in good part due to the success of pharmacological interventions and increased understanding of chronic mental illnesses and treatments available, services for individuals with serious mental illnesses have been placed in community organizations.*

Community organizations have traditionally provided the services for these individuals on-site at facilities in outpatient, partial care and residential services. Services were structured based on the funding sources requirements, primarily Medicaid, and in conjunction with standards promulgated by the State of New Jersey's Division of Mental Health Services.

During the past few years the State of New Jersey's Division of Mental Health Services has begun to utilize initiatives to increase Federal Medicaid dollars in order to expand community services to adults with serious mental illnesses. On the adult side, these programs include: Program for Assertive Community Treatment (PACT), Integrated Case Management Services (ICMS) and Adult Residential.

Due to a strong State initiative to increase mental health services to children, the following services have recently been developed: Children's Mobile Response; Youth Case Management; Intensive In-Community; Behavioral Assistance and the care coordination by Care Management Organizations.

Current funding, for children with serious, emotional and behavioral disorders and adults with a serious mental illness served in community organizations, is through the "Clinic Option" and not through the "Medicaid Rehabilitation Option" (or an equivalent). The latter allows for more individualized, off-site and flexible services that relate to the individualized plan of care.

New Jersey does provide rehabilitation services through partial care under the clinic option. It is this "partial care", day treatment service which would primarily be affected by expanding the Medicaid Rehabilitation Option.

Given the increased involvement of consumers and families, and the move to the Psychosocial model (versus the traditional medical model) of care, there is a case to be made for adopting the "Medicaid Rehabilitation Option" in the Partial Care Program. The traditional Partial Care Program is currently a site-based, structured day treatment program for individuals with a serious mental illness. The program is designed to maximize the client's independence and community living skills. During the day, an individual is likely to receive medication supervision, medication education, life skills training, psycho-education, counseling, pre-vocational training, socialization and a variety of groups dealing with stress, anxieties, etc. Billing for these services is "bundled" into a specific rate. The individual services provided cannot be billed separately.

II. SUMMARY OF KEY FINDINGS

A. Insurance Coverage - **The current state BBMI mandate, P.L. 1999, c.106**, requires carriers to cover biologically based mental illness under the same terms and conditions as any other disease (deductibles, copays, and benefit maximums) — so-called full parity. Although the law cites some conditions that must be treated as BBMI, it also requires treatment of uncited conditions that satisfy the definition of biologically based. Biologically based mental illness is defined as a mental or nervous condition that is caused by a biological disorder of the brain and that results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including by not limited to:

- Schizophrenia
- Schizoaffective Disorder
- Major Depressive Disorder
- Bipolar Disorder
- Paranoia and other Psychotic Disorders
- Obsessive-Compulsive Disorder
- Panic Disorder
- Pervasive Developmental Disorder or Autism

Bill A-333 provides that **IF** coverage is provided for any condition in the Diagnostic and Statistical Manual of Mental Disorders (DSMD) that is not a biologically based mental illness (BBMI), such condition must be covered under the same terms and conditions as any other illness. (This requirement presumes that coverage for BBMI is already mandated, which is the case.) The bill does not provide a “true” mandate for non-BBMI mental health coverage. Rather it permits carriers to determine if they will offer, and employers to determine if they will buy, coverage for some or all non-BBMI conditions. The bill would require that any **covered** non-BBMI conditions be subject to the same terms and conditions as other illnesses. This could have a negative effect if employers who currently offer some coverage for non-BBMI subject to day and visit limits drop coverage for non-BBMI entirely.

Caution: According to the **Mandated Health Benefits Advisory Commission (MHBAC)** this is a subtle and confusing point and the Commission recommended in their report to the Legislature that it confirm that this is its true intent, and that no more, and no less, flexibility was intended for insurers and employers

A-333 requires that drug and alcohol addiction be covered and provides that such coverage must be the same as for any other illness when determined to be necessary by a physician or licensed addiction professional based on criteria of the American Society of Addictive Medicine.

Financial Consequences: A-333, if enacted, would result in average premium increases of .3% to .7% based on Mercer Oliver Wyman (MOW) report estimates. For some

markets and products, the cost could be high as 2%. A certain number of people, perhaps up to 5,000, could lose coverage as a result of the increased cost, although the estimate of that response has much less support than the estimate of the premium increase. They were unable to definitely quantify the extent to which the mandate would actually increase the amount of mental health, alcoholism, and substance abuse treatment obtained by covered individuals, or whether it would simply make the financial impact of that treatment more affordable. For further background refer to the discussion of the impact of parity legislation, The Current Insurance Market on page 5 of the MHBAC report and a short summary of the Federal mandate on page 8 of MHBAC report. (The Mandated Health Benefits Advisory Commission Report has been used as a resource for the above information.)

The Mandated Health Benefits Advisory Commission Report recommended enactment of A-333.

B. Medicaid Rehabilitation Option - As of 2002, New Jersey was the only State which did not use the rehabilitation option as part of their Medicaid reimbursement. Over the last few years however, NJ has drawn down additional Federal Medicaid dollars through amendments to the State Plan for other programs including: PACT, ICMS, Adult Residential, Youth Case Management, Children's Mobile Crisis and Children's In-Home Intensive Treatment services.

"Rehabilitative services" is defined in the code of federal regulations as: "except as otherwise provided under this subpart, includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level."

Medicaid allows coverage in mental health for targeted case management, clinic option and the rehabilitation option. The intent of the rehabilitation option is to help the seriously mentally ill in their recovery to become as independent as possible. This option allows for a larger menu of services that are community focused, whereas, the Clinic option is focused on day treatment and outpatient services.

No regulations have been issued for the rehabilitation option. CMS looks at each state's submission to determine whether it meets the rehabilitation requirements according to the code of federal regulations. States are free to design their own programs within the federal guidelines. The mentally retarded/developmentally disabled population is excluded from receiving services under this option.

In June of 1992 the then HCFA, currently CMS, issued a policy memorandum which clarified for state Medicaid programs that they could include psychiatric services under the Rehabilitation Option, provided the goal of the service is rehabilitative. The rehabilitative services that are permitted under the Medicaid Rehabilitation Option according to federal rules are as follows:

- Basic living skills training
- Social skills training
- Residential support services - applicable to small facilities of 16 or less beds. Support services are covered in the person's own residence and other locations.
- Employment related services- geared to teaching interpersonal skills critical to successful employment. Vocational services are not covered.
- Education - academic teaching and education is excluded except as related to social and basic and daily living skills that are rehabilitative and required to meet educational goals.
- Social and recreational activities - targeted to restore the person to a maximum functioning level.
- Peer services - Consumers can offer services that are covered, such as skill-building or disability management and education. Medicaid does not cover self-help groups.
- Family education - must be related to activities that assist families in providing the individual receiving services with support.
- Substance abuse services - screening, intensive outpatient treatment, methadone maintenance, consumer-run services, and ambulatory detoxification.
- Case management can be offered in the following categories: targeted case management, assertive case management (intensive case management), assertive community treatment (ACT) services case management and administrative case management.
- Services planning - delivered as part of an overall package of Medicaid services.
- Symptom and disability management
- Advance directives
- Outreach - covered in any setting.

States are free to interpret these services and package them uniquely to fit the needs of the most serious and persistently mentally ill. It is important that services allowed under a Medicaid reimbursed service are also coordinated with non-reimbursed services in order to assure a comprehensive treatment approach.

The positive impact of adopting this option would be the expansion of services for consumers which would be supportive of the “Recovery Model” and may help achieve flexibility to develop a treatment, training, and support plan related to the consumer's assessed needs.

However, key issues must be explored in order to make a decision as to whether the rehabilitation option should be adopted in New Jersey. These issues include, but are not limited to:

- ? the budgetary situation
- ? capacity of the infrastructure
- ? clinical issues
- ? political issues
- ? stakeholders' opinions (including consumers)

- ? provider responses
- ? policy issues

III. Recommendations

Support parity of benefits (coverage) with medical coverage

New Jersey should mandate full mental health parity for all state regulated plans. **Full parity is defined as treating *all* mental health financing on the same basis as financing for general health services.**

The coverage requirement of current State mandates are limited to biologically-based mental illnesses (BBMI), which are defined as “a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness.”

Assembly Bill A-333 mandates that all health insurers, as well as contracts purchased by the State Health Benefits Commission, *currently* providing coverage for a disorder that is included in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSMD-IV), but is not a biologically-based mental illness, extend coverage for that disorder under the same terms and conditions as provided for any other sickness. The language of the bill does not provide a “true” mandate for non-BBMI mental health coverage since it does not include policies that do not currently cover non-biologically based disorders. While the Task Force supports the concept and goal of A-333, it should be extended to require **full** mental health parity of all state regulated plans.

This would require amendments to A-333 and most likely a subsequent review by the Mandated State Health Benefits Commission

1. Access must be addressed

Network adequacy: Mental Health provider access standards should be same as medical access standards with regular review and/or attestation that who is in the network is correct. DOB regulations for HMOs regarding listing network providers that do not actually provide services for that network need to be subject to corrective actions.

Attention should be paid to type of facilities and range of services; for example:

- i. Lack of specialized programs to treat eating disorders
- ii. Lack of pediatric and geriatric behavioral health providers

Reimbursement: State Medicaid provider reimbursement should be kept in a competitive range and in relation to CMS guidelines.

- b. Training (including DD): residency and fellowship slots should be funded to keep the number of state behavioral health graduates in line with demand including multicultural needs.
- c. Consider special certification procedures to include training for primary care physicians to treat certain behavioral health conditions with appropriate utilization of referrals to psychiatrists.
- d. State Medicaid rate needs to be increased to increase providers in this market.
- e. Problems of providing adequate treatment for under insured and undocumented clients in cultural and ethnic groups that are underserved needs to be addressed.
- f. Increase access for non-English speakers.
 - i. Funding specialized organizations in geographic areas who have bilingual / bi-cultural staff.
 - ii. Direct larger providers to be accountable to serve the above groups in their service area with bi-lingual and bi-cultural staff.
 - iii. Include specific residency fellowships and scholarship to bilingual and bi-cultural students etc.
- g. Include the judiciary and law enforcement in special volunteer certification training for mental health.
- h. Affordability and quality
 - i. Use evidence based guidelines to review and approve inpatient and outpatient treatment plans.

2. Move to Medicaid Rehabilitation Option

- a. Given the State's movement toward, and emphasis on, the "Recovery Model", the restrictions placed in the clinic option are not "friendly" toward that model nor are they flexible to the consumers' needs where the most effective service may be in the community (i.e. home or other location). Some services currently not available under the clinic option include: outreach, peer services, family education, and case management, social and recreational activities.

- b. Moving to the Medicaid Rehabilitation Option will:
 - i. Allow more flexibility to meet consumer's needs by allowing services to be "community based" rather than "clinic based" and expand flexibility of services in keeping with recovery goals.
 - ii. Offer more billing opportunities to providers
 - iii. Maximize Federal dollars.
 - iv. Provides funding for services already offered
- c. Implement the "Medicaid Rehabilitation Option" for mental health partial care services currently under the Medicaid "Clinic Option".
- d. Contact the Division of Mental Health Services to determine if any cost analyses were conducted in this regard.

State Government (Organizational Issues) Advisory Committee

The State Government (Organizational Issues) Advisory Committee considered the current structure of the Division of Mental Health Services within state government and considered other state departments that impact mental health consumers, i. e. DCA, DHSS, DOC, JJC, etc. The committee's charge was to recommend the most efficient and consumer-focused organization of mental health activities within state government.

The committee met several times and debated numerous issues including, but not limited to: the current size and scope of the DHS, a new cabinet-level department of children's services, the function and appropriate location of JJC, a reorganization of DMHS within DHS and the monitoring of RHCF's.

Committee members came to a consensus regarding the need to move the responsibility for monitoring RHCF's from DHSS to DCA, increasing the profile of DMHS within DHS and enhancing local input to mental health planning. Accordingly, the committee supports the recommendation of the Housing Advisory Committee and System Design Advisory committee concerning these issues.

It became clear as the process unfolded that to be able to make additional meaningful recommendations, the advisory committee would have to review the findings of the Task Force's report to the Governor and Legislature due on March 31, 2005. Therefore, the committee will make additional recommendations regarding the organization of mental health services within state government to the Task Force after the report is issued, but not later than July 1, 2005

Committee members:

Robert N. Davison, Co-chair

James Davy, Co-chair

Tom Blatner, Janus Solutions

Tom O'Neill, Leadership New Jersey

Lauri Becker, Morris County Mental Health Administrator

Terri Wilson, Dep. Commissioner-DHS

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Ana Montero, DHS

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