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Public Policy Platform

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Based in Mercerville, the New Jersey Association of Mental Health Agencies, Inc. (NJAMHA) is a statewide trade association representing 125 non-profit hospital-based and freestanding mental health organizations throughout New Jersey.

Annually, these providers treat hundreds of thousands of children and adults with mental health and substance abuse issues. In total, they employ an estimated 85,000 staff.

NJAMHA's mission is to champion opportunities that advance its members' abilities to deliver accessible, quality, efficient and effective integrated behavioral health, clinical and support services to adults with mental illnesses, children/adolescents and adults with co-occurring developmental disabilities and mental illnesses, children/adolescents and adults with co-occurring addiction and mental health disorders, and children and youth with serious emotional and behavioral disturbances. Families of adult and child consumers of services are also provided support and treatment, within a familial context.

NJAMHA's Public Policy Platform focuses on NJAMHA's prevailing issues as they impact NJAMHA provider members and the children/youth and adults whom they serve. We welcome feedback from other health care stakeholders, legislators and policy makers, and we are open to hearing differing viewpoints from those expressed in this document.

NJAMHA welcomes dialogue as a way of stimulating positive change.

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Funding for Mental Health Services

NJAMHA supports an immediate solution to address the current critical staffing problems that are threatening the continued viability of our community mental health system. NJAMHA is calling on the New Jersey Legislature to include a 3.6 percent cost of providing care increase in the Fiscal Year 2009 budget, based upon the Consumer Price Index (CPI) for the Northeast Region, to ensure that agencies can continue providing quality services to New Jersey's most vulnerable populations.

Due to the steady erosion of funding, nonprofit mental health provider organizations continue to experience difficulty in the recruitment and retention of mental health care workers, ranging in position from screeners, to psychiatrists to nurses. Among the final recommendations of the Governor's Task Force on Mental Health, were the elimination of 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; the assignment of a permanent index upon which to base increases in the total cost of community care contracts on an annual basis; and to improve benefits for community workers.

NJAMHA conservatively projects that what the community system desperately needs is an investment of \$210 million, phased over a three-year period, to address the salary disparity between community mental health care workers and State workers who provide similar services and to obviate the need for more expensive, and clinically unnecessary, institutional care.

New Jersey's community nonprofit provider staff delivers comparable services to those employed by the State, are closely held to stringent State regulations that are routinely monitored through State site visits and national accrediting bodies, and frequently treat the same individuals, yet their compensation remains substantially less than that of State employees.

Inflation has far outpaced the contract increases afforded community mental health providers over the last 10 years...Even a cost-of-living adjustment (COLA) of 3.6 percent, based on the more modest Northeast Urban Consumer Price Index (CPI), in State Budget FY 2009, would not enable providers to fully keep pace with double digit increases in expenses.

With starting salaries considerably lower than comparable positions with the State and lower salary ranges, less comprehensive benefits and minimal Cost of Living Adjustments (COLAs) on an inconsistent basis, community mental health care employees are at a significant disadvantage.

As a result, it is common for mental health care staff to leave their positions in the community for higher paying jobs at the State, which also provide more comprehensive and attractive benefits. Positions such as nurses, psychiatrists, and case managers, all of who serve some of the

most at-risk children and adults in the State in need of immediate and comprehensive care, are left unfilled for months at a time. Unable to fill this void, community mental health providers are forced to ask their remaining staff to fill the gaps and ensure that there is no lapse in delivery of services, which causes staff burnout and contributes to loss of staff.

This situation has worsened over the years and is approaching crisis proportions. The community mental health system requires additional funds, as substantiated by the Governor's Task Force on Mental Health, to employ and maintain

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a sufficient supply of high-quality workers as mandated by the State. Without enough staff to meet the demands of New Jersey's population, community mental health centers will be forced to close their doors on the State's most vulnerable citizens, causing their health to deteriorate and creating a potentially dangerous and life-threatening situation, not to mention leading to costly hospitalizations, family disruption, emergency room visits, incarcerations and homelessness.

For too long, the State has failed to sufficiently appreciate that the community mental health system is providing the vast majority of treatment and support services to persons with serious mental illnesses and to children with emotional and behavioral disorders. The State has also failed to provide the necessary funding that will enable community providers to continue to deliver clinically necessary mental health services at levels that meet the growing demand. It is time to recognize that in order to deliver competent, effective services, quality staff must be recruited and retained. This is why NJAMHA supports and encourages further legislative initiatives, such as those that led to the enactment of the Social Services Student Loan Redemption Program Act (P.L.2005, c.157). The State Legislature advanced the related loan redemption bills, recognizing the necessity of a stable work force in the nonprofit sectors of care, including mental health.

The Legislature also acknowledged that the staffing crisis is expected to worsen over the next two decades. The Loan Redemption Program is an excellent mechanism to begin to address the issues of staff recruitment and retention in the nonprofit system of care, where inadequate and noncompetitive salaries continue to plague nonprofits. Unfortunately, since the funding is capped, the program has not nearly reached the substantial number of staff who qualify; however, NJAMHA wholeheartedly thanks the Legislature for increasing the funds in the FY 2006-2007 State budget that allowed some expansion of the program, but there remains a dire need to annually increase the funds to address the staffing needs of nonprofit mental health and other social service programs.

Inflation has far outpaced the contract increases afforded community mental health providers over the last 10 years, leaving them on the brink of a financial crisis. Even a (COLA) of 3.6 percent based on the more modest Northeast Urban Consumer Price Index (CPI), in State Budget FY 2009, would not enable providers to fully keep pace with double digit increases in expenses including utilities, employee health insurance coverage, and gasoline for agency vehicles used to transport consumers. Most certainly, such an increase, while welcome and critical as a stopgap measure, would not come close to making up for the years of underfunding.

New Jersey gives its State Departments increases every year to address the mandatory increase in costs associated with providing services; however, community provider agencies, which deliver the actual community services on the State's behalf are the only component that does not receive an annual increase.

Further contributing to the issue of inadequate financing of nonprofit provider organizations relates to public employee contracts, which have further widened the salary gap between employees in the community nonprofit mental health system and those who provide comparable services for the State. This has resulted in a serious staffing crisis that threatens to undermine the stability and viability of New Jersey's adult and child community mental health system.

Community provider cost-of-living rate increases, when provided at all, have frequently been lower than inflation and are always susceptible to reduction or even worse, elimination in years of State budget shortfalls, which have been experienced by the State in recent budget cycles. Failure to provide sufficient inflationary increases to the nonprofit service providers may result in the erosion of community mental health services. Community providers need to pay for salary increases for staff and must provide for other escalating annual inflationary increases in their budgets. If reimbursement levels from the State are too low, and State levels of service requirements remain the

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same, some community providers may stop providing services for the State or reduce the services they routinely provide in order to not compromise quality.

According to the Governor's Task Force on Mental Health, convened by former Governor Richard Codey to assess the status of New Jersey's mental health system and make recommendations to strengthen its foundation, in its final report (March 31, 2005), the Task Force observed that *"...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 underfunding 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. Services provided by the non-profit community of care saves the State money as these services directly contribute to the redirection of individuals in need from costly State and county psychiatric hospitals and expensive emergency room care. These services must be sufficiently funded or else the State will surely end up paying more."*

Community providers struggle with unfilled vacancies in programs serving persons with serious mental illnesses and children with emotional

and behavioral health disorders. The waits for services have increased because experienced and qualified staff are leaving their positions at nonprofit provider organizations to secure higher paying jobs with the State.

Workers in the community mental health care system historically have been underpaid. When compared to State employees with similar experience and job titles in State psychiatric institutions, New Jersey's mental health community workers receive significantly lower salaries and far fewer benefits. There is a substantial discrepancy between the wages and benefits of employees at community nonprofit mental health facilities and those who provide almost identical services for the State.

In every job category, the entry level State salary in New Jersey (in 2001, approximately \$40,999 for an entry level social worker in New Jersey State Hospitals vs. \$28,000 for an entry level community mental health social worker in the nonprofit sector) is at least 30 percent to 90 percent higher than the community entry level salary. Likewise, benefits are richer for State employees as compared to those in the nonprofit community.

The gap widens as State workers receive State-union negotiated increases in addition to built-in salary range increments. Meanwhile, community workers are only allotted meager increases afforded by occasional COLAs as determined by the State within the annual State bud-

get appropriations. These increases have historically ranged from 1 percent to 2 percent and have even been denied in certain fiscal years (FY 2003-2004 being the most recent fiscal year with no COLA).

The small increases afforded to community mental health providers must be thinly spread across wage increases and ever-increasing general administrative costs, insurance, transportation, rent, utilities and other supplemental costs to keep programs operational. Community agencies are receiving health insurance increases of 11.3 percent or more; workers compensation costs have increased by as much as 50 percent; and staff have not received adequate salary increases. Without suitable State increases, community providers will face serious obstacles in maintaining services.

The result of this untenable situation is the inability of many agencies to hold onto skilled and experienced employees and to recruit new staff to fill vacancies. The turnover rate in some organizations can reach as high as 125 percent—with some positions becoming vacant twice in one year. Of utmost concern, vacancies all too often last more than six months in several high-risk programs, such as the Programs for Assertive Community Treatment (PACT) and Integrated Case Management Services (ICMS), which serve predominantly individuals discharged from State institutions who have serious mental illnesses, are treatment resistant and most at-risk of re/hospitalization.

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NJAMHA supports the establishment of an annualized cost of providing care adjustment for all Department of Human Services and Department of Children and Families contracts based upon the Northeastern Wage Earners CPI, and tied to a stable source of funding. In 2005, Assemblymen Joseph Cryan (D-Union), Francis Blee (R-Absecon) and Joseph Vas (D-Perth Amboy) sponsored legislation that called for an annualized cost of living adjustment in the Governor's budget recommendation for private organizations under contract with various State departments. Similar legislation was introduced in the Senate, but no action has been taken on either bill. NJAMHA supports this and other legislation that requires the Governor and State Legislature to include an annualized COLA for service providers in the community who are contracted with the State to provide clinical and support services to New Jersey residents with mental illnesses, and to their families.

NJAMHA also supports the passage of legislation that would allow community providers to join the state health and pension benefits package, which provides a much richer benefit for a lower premium than community providers currently pay. The addition of more attractive benefit and pension packages would go a long way in attracting and retaining qualified staff. This incentive would help to halt the community workforce crisis and create a more stable and supportive environment for staff and the adults and children they serve.

Medicaid Rates

To ensure access to quality mental health care, and to assure consumer choice of provider per federal Medicaid regulations and consumer wishes, Medicaid rates must be high enough to attract an adequate number of clinical professionals. NJAMHA strongly advocates for an increase in New Jersey Medicaid reimbursement rates to realistically reflect the actual cost of providing care in the year 2008.

While the average rate of inflation has hovered around 4.5 percent, Medicaid reimbursement rates have remained largely stagnant in most service elements or have fallen far behind the real cost of living, making it increasingly challenging to attract and retain mental health professionals in the nonprofit mental health system of care.

The payments rates at issue, most

established more than three decades ago, have not received a meaningful review and adjustment since initial implementation. *Indeed, an April 2007 study conducted by Public Citizen's Health Research Group found that New Jersey provided some of the lowest Medicaid reimbursement rates in the nation.*

Medicaid reimbursement rates for community mental health services have been eroding in New Jersey for decades, directly contributing to the difficulty of nonprofit mental health providers to remain financially solvent and competitive while continuing, against all odds, to deliver quality mental health care to New Jersey residents, especially those who are poor or of low-income or who have exhausted their medical insurance benefits, which is very easy to happen since mental health benefits are materially lower than those for physical health. Nonprofit providers serve

as the safety net for these individuals who otherwise would likely not be served.

Further illustrating the effect of abysmally insufficient Medicaid rates, particularly on psychiatric services, the New Jersey Psychiatric Association conducted a survey in 2004 to assess mental health needs and services in New Jersey. Among its conclusions, the survey found that more than 50 psychiatrists from all parts of the system who responded indicated that poor reimbursement rates "...especially from Medicaid" were among the top issues, calling New Jersey's rates "embarrassing, woefully inadequate" and using the \$9 per visit reimbursement rate for medication monitoring, as opposed to the actual cost closer to \$60, as a prime example. (*Mental Health Needs and Services in New Jersey*, prepared by the New Jersey Psychiatric Association Task Force to Assess Mental

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Health Needs and Services in New Jersey and the New Jersey Psychiatric Association Mental Health Services Committee, May 17, 2004).

Immediate relief is necessary to provide more resources for community mental health providers so that persons who have mental illnesses will not continue to be adversely affected by lack of access to, and continuity of care, due to high staff turnover, significant staff vacancies and an otherwise undersupply of professional mental health workers to handle growing caseloads. As a result of low rates, there are waits-for-service averaging six weeks across the state, during which time adult's and children's illnesses may worsen, resulting in increased high-cost hospitalizations and emergency room visits, not to mention increased disruption in the lives of those affected by mental illnesses and serious emotional and behavioral disturbances.

NJAMHA strongly feels that a long overdue significant increase in the Medicaid rates for nonprofit community mental health providers is part of the solution to the infrastructure problems that remain in New Jersey's mental health system despite welcome and long overdue initiatives in the fiscal year 2006 and 2007 State budgets.

NJAMHA recognizes the long awaited increases in Medicaid fee-for-service rates, effective Janu-

ary 1, 2008, for services, including psychiatric, provided to Medicaid beneficiaries under 21 years of age. We hope that the rate increases will attract more mental health providers, especially child psychiatrists, to the nonprofit mental health system. There is presently a dearth of child psychiatrists to meet the vast need. However, it is essential that for this to be an effective solution that enhances the ability to provide access to quality services in a timely manner, nonprofit mental health organizations must be able to retain revenue generated from Medicaid rate increases to address critical direct care and infrastructure needs. Also, attention to the needs of the adult population is also worthy, and NJAMHA will continue to pursue similar increases for adult residents of New Jersey living with serious mental illnesses.

Related to the need for Medicaid rate increases, it is important to state that any increase in Medicaid rates must not result in reductions in State contract funds; otherwise, there would be a nil effect on improving the sustainability of the nonprofit service sector, which serves as the safety net for vulnerable children and adults.

NJAMHA further believes that such increases *must not come at the expense of hospital-based mental health service providers*. It is recognized that

New Jersey hospitals are struggling financially due to a variety of funding/payment reductions and inadequate reimbursements, while there is a growing demand for Charity Care. Moreover, the FY 2007 shift from cost-based to fee-for-service Medicaid reimbursement resulted in cuts to numerous hospital-based mental health outpatient and partial hospital programs. These factors place further financial pressures on hospitals already struggling for sustainability.

The mental health system must be appropriately prepared and supported to assist children and adults in New Jersey achieve wellness and recovery through access to adequate pharmacological, psychiatric, residential, educational, vocational/career and support services needed by this population. Higher Medicaid reimbursement must be combined with other State funds to keep adults and children, with mental illnesses and emotional and behavioral disturbances, healthy in the community and out of homeless shelters, out-of-home placements, correctional facilities, hospitals and emergency rooms.

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Improving children's and adolescents' mental health treatment and services continues to be a priority for NJAMHA and its members, who provide a full continuum of care for these most fragile youngsters, including residential, in-patient, outpatient, partial care, mobile response, youth case management and care management organizations. Providers treat children with co-occurring substance abuse and behavioral disorders and developmental disabilities and mental illness, in foster care and aging out of the system. Because of NJAMHA's decades of experience in children and adult mental health services, it is uniquely qualified to assess the full needs of a system that must recognize and address the complex problems of families in need and crisis.

A report from the Center for Mental Health Services states that, at any given time, at least one in five children and adolescents may have a mental health problem. Nationally, at least one in 19 or as many as six million young people may have a serious emotional disturbance (SED). In New Jersey, this figure translates into 74,614 children and adolescents having a serious emotional disturbance with the number of children from 14 to 17 years of age expected to increase dramatically in the upcoming years. Too often, children's and adolescents' mental health disorders are not recognized and appropriate help is not sought. An estimated two-thirds of all young people with mental health problems who need help are not receiving it.

New Jersey is at a critical juncture following the creation of the Department of Children and Families and the settlement of the lawsuit that challenged the State's child welfare system. As the State transforms child welfare, it should take this opportunity to address the needs of the child behavioral health system in a comprehensive and systematic manner to ensure each child and family obtains the treatment and services they need to thrive.

As New Jersey moves forward with a strategic plan for Child Behavioral Health Services, families and providers must be equal partners with the State throughout all levels of the system, from planning to implementation to review. Families and providers must have meaningful input that reflects their years of experience and their understanding of the practical implications of policies and programs.

To develop a model system of care, the following changes must be made:

- Families and providers must be true partners in all phases of planning, design, implementation and evaluation. Strengths should be emphasized and weaknesses addressed.
- Government bureaucracy must be streamlined, coordinated, responsive and efficient so as not to supplant resources that are needed for New Jersey's most vulnerable children and families
- Service models and service costs should be reexamined to ensure that funding levels are set at competitive rates that allow children and families to receive treatment and services at appropriate

levels of care. Contract expectations must be developed in direct relationship to adequate and budgeted resources.

- System design must reflect local differences and disruptions must be minimized as changes are gradually implemented.
- Comprehensive, accurate and community-focused data reflecting the needs of children must be gathered.
- A full continuum of family-focused, strengths-based care to meet the identified needs must be provided.
- Gaps in service must be remedied. The Division of Child Behavioral Health Services should carefully weigh recommendations from the University of South Florida report, "Inde-

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pendent Assessment of New Jersey's Children's Behavioral Health Care System," October 2006, in addressing these gaps.

- Adequate funding must be provided to support sufficient, experienced staff and optimum caseloads, as well as the ability to support these services
- Medicaid rates must reflect actual costs and support best practices.
- Unfunded mandates should be eliminated and the billing/reimbursement process must be streamlined and improved to assure services are promptly and accurately reimbursed.
- Comprehensive training must be provided at the State and local levels and be inclusive of providers and families.
- Care coordination must be moved from the Contracted Systems Administrator to the community.
- Realistic outcomes must be identified, tracked and evaluated through a benchmarking process.
- Stakeholders must be involved in a process to steer the treatment approach to evidence-based practices.

Background

After years of upheaval and numerous changes, it is time for the

State's behavioral and child welfare systems to get back on track and develop a stable system of care. Unfortunately, the focus on enforceables of the child welfare lawsuit has often short-circuited the child behavioral health system's progress, while constant redirection has made it difficult to gain a sense of stability.

While the State has made inroads in improving the children's system of care, gaps in the system, inadequate capacity, and insufficient funding have jeopardized the well-being of children and created hurdles for families. We must ensure that the full spectrum of needed care is available and fully integrated in order to avoid crises similar to those that plagued the child welfare system.

Core Values

The child behavioral health system must be child-centered and family-focused, with the needs of the child paramount in decision-making. The family must have meaningful involvement and participation in every aspect of the system. The system must be community based and culturally and linguistically competent.

Each child should be served in the least restrictive environment based on individual needs at the most appropriate place at the most appropriate time. To achieve this aim, a broad spectrum of appropriate services and placements must be available and the system must be designed to assign children based on their needs assessments, not on

funding streams, convenience or current availability.

Provide Appropriate Treatment and Services

It is not possible to achieve these goals without making the appropriate and strategic corrections across the entire child behavioral health system. The system must be driven by the needs of children and families. It is imperative that the State have accurate, complete data to determine the full spectrum of necessary services.

New Jersey must conduct a comprehensive evaluation to assess the true needs of the State's children and families. The data must be comprehensive, meaningful, and reliable and reflect the needs by region. In assessing need, the state should recognize the many factors that create system gaps. For example, when assessing the need for additional residential beds, there must be a recognition that some beds may be currently assigned to children who could be better, more appropriately and less expensively served in a less restrictive location if additional services were available.

Once the needs are identified, the full spectrum of care must be available. The continuum of care must include: residential, screening, mobile response, inpatient, partial hospitalization, partial care, outpatient, group homes, in home, substance abuse, crisis intervention, family support, intensive case management, moderate case management, and community care management. As New Jersey has instituted a new system of care, there has been an

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undervaluing of the more traditional clinical care programs, resulting in a serious lack of needed services. While the goal should be to provide the least restrictive environment for services, clinical settings are necessary at times to stabilize children, carefully monitor the effectiveness of medication and prepare them for stability in home and school settings. Adequately funded clinical settings that accommodate these needs must be available.

Other significant gaps in the current system of care include inadequate specialized residential services, outpatient services, a lack of options for children “aging out” of the system, and a significant shortfall in the number of child psychiatrists. These gaps result in children remaining in levels of care that may not be appropriate and therefore more costly. As noted in the 2006 University of South Florida report, “The service array is not meeting the needs of all the youth enrolled in the system... The local and State systems would benefit from collaboratively engaging in the exploration of evidence-based practices and programs, and resources and funding mechanisms to support services expansion” (pages 120-121).

Adequate Financial Support

As a more adequate level of service is identified, funding must follow. This would serve as an investment in our youth and would enable the State to save resources. For example, inadequate Medicaid funding for children’s psychiatric services in community-based programs has

contributed to the lack of child psychiatrists and long waits for service. The recent increase in rates for child psychiatrists can help address this problem, but the State must monitor the impact of the increase to assess whether additional steps are necessary to ensure adequate access to service.

Additionally, long-standing inadequate Medicaid rates for outpatient services has created long waits, pushing children to more expensive

in-home services. As NJAMHA has noted, many of these children could be served more appropriately and less expensively in the outpatient settings. The state has recently proposed numerous changes to remedy this situation.

NJAMHA is supportive of establishing regulations for the provision of BA-IIC services and ensuring that the service is clinically appropriate and effective. However, it is critical that the determination of the most appropriate level of care be made on clinical criteria, not be based on arbitrary time limits or purely in an effort to save resources. Additionally, the State should not attempt to right-size and restrict in-home services without ensuring the provision of sufficient outpatient services and other programs.

Of greatest importance, the State should not prohibit licensed social workers from providing services when they are under appropriate supervision. Since there are insufficient numbers of licensed clinical personnel to meet the needs of chil-

dren and families, providers will be unable to recruit enough personnel to staff their programs, hampering the delivery of these critical services. These personnel, under the supervision of a clinical supervisor, have the appropriate skills to perform their duties and meet the needs of children.

With the new time limits on in-home care and increased licensing standards, more children will need to turn to outpatient care to obtain the needed therapy. And while the recent—and long overdue— increase in children’s outpatient Medicaid rates is expected to improve access to services, it will take time for the system to respond to the increased rate. Additionally, NJAMHA is concerned that the State may see the increase in Medicaid as an opportunity to reduce contract dollars elsewhere. If the State provides resources with one hand and takes away resources with the other, New Jersey’s children will not experience the necessary increase in access to reduce waits for service.

Impact of Insufficient Services

The impact of the insufficient services is also seen in emergency rooms, where children going through screening are subject to excessive and often unnecessary delays, often due to hospital medical clearance requirements. Due to the physical limitations of screening centers, children in screening are maintained in a shared environment with adults, often exhibiting agitation and other behaviors that may negatively affect children.

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Numerous steps should be taken to steer children who do not need medical care away from the emergency rooms. More funds are needed to conduct more screening outreach to schools, in homes, in community mental health centers or other community settings.

Attention to State policies governing programs for children who are acting out must be scrutinized to assure that these children are contained in their program to the greatest extent feasible to avoid unnecessary and disruptive referrals to the crisis system of care. Children's system of care programs must maintain ample staffing and allow sufficient lengths of stay to fend off crises.

As in the adult mental health system, many portions of the child behavioral system suffer from a 20 to 30 percent compensation gap between entry-level staff at community behavioral health care provider agencies and State employees with similar responsibilities. This situation leads to high turnover and vacancy rates, with some programs reporting a 50 percent turnover rate annually and 25 percent vacancy rates. This situation can cause turmoil in the lives of children and families who need consistency in care.

Adequate contract and Medicaid rates are necessary to address this extraordinary compensation gap. Additionally, adequate cost of providing care increases are necessary to help keep pace with double digit utility and health insurance rate hikes, as well as to provide des-

perately needed salary increases. Contract expectations must be developed in direct relationship to adequate and budgeted resources. The system of payment must also support best practices, whereby use of pre-authorization and case rate models, such as those utilized in the adult system, would enable providers to better focus on meaningful direct services rather than processing documents.

Adequate funding must be provided for the infrastructure to support these services, as those resources previously were supplied through the adult mental health system. Sufficient, experienced and well-trained staffing is critical to the provision of quality of care for children and families.

Unfunded mandates and the inability to recoup 100 percent of billings also contribute to providers' inability to adequately meet the needs of children. The system must be designed to facilitate and simplify the cash flow process to enable providers to focus on services rather than collecting payment. Recent federal proposals to revise targeted case management in children's programs could further exacerbate the problem by unbundling services and requiring providers to spend more time documenting and filling out paperwork.

Effective and Family-focused Care

Community providers, the State and families must work together to

develop performance outcomes that are realistic and clinically appropriate and to steer the treatment approach to evidence-based practices that will lead to a better standard of care for children and families. The system must not only gauge what services are needed at the time a child enters the system, but whether the services provided were adequate, effective and responsive to the needs. Outcomes data should be tracked and evaluated through a benchmarking process whereby the success of programs could be compared and best practices can be identified.

Recently, the State has issued requests for proposals for two evidence-based programs – Family Functional Therapy and Multi-systemic Therapy. As the state explores the utilization of evidence-based programs, it should partner with providers to examine the costs of training and the practical applications of the programs in New Jersey and to assess the benefits and potential roadblocks to effective implementation.

The child care behavioral health system must be designed with a local focus and an understanding of community differences. The design should provide enough flexibility to accommodate unique aspects of the communities served and allow for easily implemented revisions as needed. Local broad-based decision-making bodies should determine the needs, available resources and the necessary modifications to make the local system of care efficient and effective.

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Providers must be respected and fully incorporated partners in the development, implementation and evaluation of proposals, regulations, programs and practices. Providers are an important resource, have decades of frontline experience and can offer valuable insight into the practical implications of proposals, as well as an understanding of the strategies necessary to effectively achieve goals.

Families should also be respected partners and involved in all phases and levels of the system. Families should have a meaningful voice in planning at the State and local levels, with involvement in the Children's Interagency Coordinating Councils and Human Services Advisory Councils. They should also have meaningful participation in decision-making at the provider level, with significant representation on either governing bodies or advisory boards. Families must be given as many options as possible when selecting services for their child and sufficient information so they can make informed choices. Family Support Organizations should be expanded so they can provide services and assist families at the intermediate care level.

In addition to providers and families, the development of comprehensive statewide and local systems of care must be composed of numerous other components, including the educational and juvenile justice systems. Additionally, there must be a partnership with the adult mental health system, as

families of children in the child behavioral and welfare systems often have mental health and substance abuse treatment needs. New Jersey cannot repair the child welfare system without providing for the necessary resources and services for the parents in the system. Additionally, the adult mental health and child behavioral health systems must work together closely to ensure services are available for aging in/out youth and provides for effective and seamless transitions.

The child welfare and child behavioral systems must work in tandem, without silos, to avoid duplication of services and inefficient use of resources.

Government bureaucracy must be streamlined, coordinated, responsive and efficient so as not to supplant resources that are needed for New Jersey's most vulnerable children and families.

Changes in the system must be accomplished through a deliberate, well-considered process that respects community differences and is not disruptive to the provision of care or families' and children's well-being. Changes and mandates under consideration should be evaluated with provider and family input with full understanding of the implications of implementation.

Last year, New Jersey banned the use of therapeutic holds in children's partial care settings. The result of the mandate without provider input was an increase in violent events in partial care settings, the loss of staff, and an increase in po-

lice response to address problems at partial care facilities. The State and providers worked together to address the issue, with providers obtaining waivers by implementing appropriate guidelines. As the State develops regulations regarding therapeutic holds, it should rely upon the expertise of providers, who are trained in the use of therapeutic holds and work with troubled children on a daily basis.

Culturally competent and linguistically appropriate services must be available at all levels of the system, particularly as families enter the system through the Contracted Systems Administrator.

Comprehensive and well-organized training focused on evidence-based practices must be offered throughout the system to ensure all staff are educated in family-centered, strength-based, wraparound and culturally competent services. Training for families should also be available on a local and statewide basis. The system must be designed to encourage and accommodate ongoing training.

Case Management and Contracted Systems Administrator

The case management system should provide a continuum of family-centered care that offers intensive, moderate and care coordination services. The system should be seamless, minimize disruption, and provide for family choice and planning. All levels of the case man-

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agement system must be adequately funded, with appropriate caseloads that are manageable. Care coordination services should be conducted at the local level to ensure appropriate needs assessment and follow up.

The Contracted Systems Administrator (CSA) must have appropriately trained staff with access to a complete and accurate listing of current resources and services. The CSA must provide access to easily accessible, understandable and reliable data, but the care coordination function should be conducted at the local level. The authorization and payment process must be streamlined and prompt and must not penalize providers for conditions outside of their control.

The state should streamline the bureaucracy, address fragmentation, and minimize silos. Through contract coordination, reduction in paperwork and simplification of rules, providers could better focus on meeting the needs of children and families rather than filling out forms.

NJAMHA applauds the State's commitment to "supporting clinically appropriate and high quality services that children and families can access with ease and timeliness."

As New Jersey moves forward with a strategic plan for Child Behavioral Health Services, families and providers must be equal partners with the State throughout all levels of the system, from planning to implementation to review. Families and providers must have meaningful input that reflects their years of experience and their understanding of the practical implications of policies and programs.

Mental Health Parity

NJAMHA supports full parity between coverage benefits for mental health and addictions as those for physical illnesses. Recovery from mental illnesses is just as possible as from physical illnesses, but the insurance community does not appear to recognize this scientifically supported fact.

Mental illnesses are diseases just as

are physical illnesses. In light of this, insurance coverage should be equivalent for both of these disorders. However, the benefits in the commercial insurance market, with relatively few exceptions, are far less for mental health and addictions treatment interventions.

The National Institute of Mental Health (NIMH) states that approximately 26.2 percent of Americans, ages 18 and up, or about one in four, is diagnosed with a mental disorder

in a given year. When applied to New Jersey's adult population, based on 2006 U.S. Census data, this translates into approximately 1.7 million New Jersey adult residents having a diagnosable mental illness in any given year. Further, mental disorders are the leading cause of disability in the United States for ages 15 to 44, according to NIMH, not to mention lost worker productivity. Yet, on both the federal and State levels, insurance coverage requirements for physical illnesses are

Mental Health Parity

vastly more expansive.

NJAMHA strongly supports equitable treatment in the coverage of all types of addictions and mental disorders because as with physical illnesses, the cost and effectiveness of treating addiction and mental illnesses are similar to those of treating other illnesses; the cost of not treating addiction and mental illnesses far outweighs the expenses of mental health and addictions care; and enormous progress has been made in scientific research and in diagnosing and treating addiction and mental illnesses with precision and success. Providing disparate health care benefits for physical and mental illnesses only perpetuates the lack of understanding about mental disorders, the undue discrimination against persons with these illnesses and the stigma of their psychiatric illnesses.

Full parity legislation is necessary to overcome the unfair discrimination against persons with mental illnesses based on artificial and scientifically unsupported distinctions between mental and physical disorders. It is critical to make full parity mandatory. Without full parity, people with mental illnesses, and their families, will continue to be burdened with exorbitant out-of-pocket expenses or, worse, will go without treatment.

New Jersey enacted a partial mental health insurance parity law in 1999, and is among a number of states that have limited parity statutes, which require that biologically based mental illnesses be

covered on a basis equal to that of physical illnesses, but excludes certain conditions such as addictions, eating disorders, and other illnesses and disorders that may not be recognized as biologically based, even when these illnesses co-occur with biologically based diseases.

The Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV), published by the American Psychiatric Association, is the principal diagnostic reference used by mental health professionals in the United States. The DSM-IV includes a broader range of mental and nervous disorders than biologically based mental illnesses, including many children's emotional and behavioral health problems such as bulimia and anorexia and Post-Traumatic Stress Disorder.

NJAMHA favors a system that ensures that adults and children in need have access to a broad array of mental health treatment, rehabilitation and prevention services, with emphasis on treatment in the least restrictive setting, consistent with consumers' preferences and clinical needs. NJAMHA opposes the discriminatory treatment, by insurers, of individuals with mental health and addiction diagnoses. Such discriminatory policy and practices of insurance companies further stigmatize people with these behavioral health illnesses and impede wellness and recovery.

Along with the other major mental health stakeholders in New Jersey, NJAMHA actively supports New Jersey State Leg-

islative efforts to achieve mental health parity.

Assembly Bill 2512, with 40 sponsors and co-sponsors, and Senate Companion Bill 807, were introduced in early 2006. The bills would have provided full parity for insurance coverage of mental health and addiction services in New Jersey. Although Senate Bill 807 was passed by the Senate on December 4, 2006, unfortunately the Mental Health and Addiction Parity bill was not scheduled in the last voting session of New Jersey's 212th Legislative session, to the great disappointment of consumers, families, and advocates who have long struggled for parity. As a result, the bill died in that Legislative session, but NJAMHA remains steadfast in promoting the eventual enactment of comprehensive parity legislation. A State mental health parity bill was recently introduced in the new legislative session on January 8, 2008. NJAMHA will be actively advocating for its passage.

On a national level, NJAMHA supports U.S. Congressional efforts to pass parity legislation, specifically the Paul Wellstone Mental Health Parity Act of 2007 (U.S. Senate Bill 558/H.R.1424).

Both parity bills are named after the late Senator Paul Wellstone who, in the mid-90s, sponsored the first comprehensive mental health parity bill, which despite wide bipartisan support, did not advance in previous Congressional sessions.

Mental Health Parity

Both bills take the critical step of removing discriminatory barriers to health care for people with mental illnesses, by prohibiting arbitrary coverage and visit limitations on mental health and addiction disorders that are not similarly imposed on medical and surgical benefits. The bills apply to group health plans of 50 or more members. They differ in terms of preempting of State parity laws and the expansiveness of diagnoses covered.

S. 558 was introduced February 12, 2007 by Senator Peter Domenici [NM]. The Senate passed the bill on September 18, 2007 and on October 17, 2007; it was referred to the House Subcommittee on Health, Employment, Labor, and Pensions. S.558 also expands the present 1996 federal parity law, which established parity regarding annual and lifetime dollar limits, to include prohibitions on unequal day/visit limits and financial limitations. Both New Jersey Senators Frank Lautenberg and Robert Menendez are cosponsors of the bill.

H.R. 1424 was introduced March 9, 2007 by Congressman Patrick Kennedy [RI] and has 273 bipartisan co-sponsors, including 12 of New Jersey's 13 Congressional representatives. The bill was passed by the House Education and Labor Committee in July 2007 and by the House Energy and Commerce Committee in October 2007, marking the first time a House committee approved parity legislation.

The House bill provides more protections to individuals with mental

illnesses than the Senate version: it provides for the coverage of a wide range of mental health diagnoses, and it would not override "any state law that provides greater consumer protections, benefits," rights or remedies.

NJAMHA continues to advocate for mental health parity on a national level through regular visits and communications with New Jersey's Congressional delegation.

What are the costs of offering parity in mental health benefits?

The costs of parity are minimal, and vastly less than the present dollars expended due to the lack of parity.

From a national perspective, in March 2007, the Congressional Budget Office (CBO) assessed the cost impact of U.S. Senate Bill 558, the national parity bill. The CBO estimated that the direct costs of the additional services that would be newly covered by insurance because of the mandate would equal only about 0.4 percent of employer-sponsored health insurance premiums compared to having no mandate at all.

From a State perspective, according to New Jersey's Office of Legislative Services (OLS) and by estimates of the Department of the Treasury, enacting mental health parity would have cost the state \$15.7 million in FY 2007, which would have represented a 0.5 percent increase in cost to the State Health Benefits

Plan (SHBP).

State parity would also contribute to potential savings in the State budget in regard to inadequate Charity Care funding, which is driving numerous New Jersey acute care hospitals into financial distress that may result in closures. Full parity has the potential to significantly address the State's charity care cost issue in that, for individuals with health insurance, the expanded mental health and addictions benefits that would materialize under full parity, would be covered by the insurers rather than by State charity care funds that are severely limited in a time of increasing need.

New Jersey's Department of the Public Advocate, in a report titled "NJ Mental Health Insurance Parity White Paper", updated May 4, 2007, states that: For calendar year 2005, New Jersey hospitals requested over \$87 million dollars in charity care funds from DHSS [Department of Health and Senior Services] for mental health and addictions. By enacting parity, hospitals that offer mental health and addictions treatment would be better able to recoup funds from insurers, rather than having to request funds from an overburdened state charity care system.

A one-day survey conducted in February 2007 by the Department of the Public Advocate found that 14% of the patients in hospital short-term psychiatric care facilities throughout the State had private insurance plans provided through their employer or a family member's employer. If these insurance

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plans offered mental health coverage, only biologically based illnesses would fulfill current coverage requirements. Those patients who suffer from non-biologically based illnesses, but nonetheless needed treatment, would then be faced with paying a hospital bill on their own or requesting charity care. If they did neither, the hospital could include these unpaid charges when requesting state charity care aid. Hospitals could avoid requesting some charity care funds if those patients' insurers were required to pay for the cost of their treatment. This could result in a significant decrease in requests for charity care.

In a 1998 study conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), titled "The Cost and Effects of Parity for Mental Health and Substance Abuse Benefits," researchers estimated that parity for mental and addictive disorders would cost less than forecasts from many earlier studies.

SAMHSA's study analyzed some of the assumptions that led past studies to forecast higher costs. One of these was that greater parity would create a cost shift from the public sector to private benefit plans, but this has not happened in the states where full or limited parity is required by law. Nor have employers passed on the costs of parity to their employees, as once feared. In another study, "Parity in Financ-

ing Mental Health Services: Managed Care Effects on Costs, Access and Quality" conducted by the National Advisory Mental Health Council and the National Institutes of Health in 1998, researchers looked at parity laws implemented in states with managed care systems, and found that there was less than a one percent increase in the total cost of health care to insurers and employers. In systems not using managed care, introducing parity with managed care resulted in a substantial 30 percent to 50 percent reduction in total mental health costs.

Researchers at the RAND Corporation found in 1994 that offering parity in mental health benefits costs employers one dollar per employee per year. This study contradicted an earlier evaluation, conducted by the Congressional Research Service, which had predicted a \$100 per enrollee, per year, increase. In fact, in a 1998 survey, released by SAMHSA, of employers on the implementation of the federal Mental Health Parity Act of 1996, then due to expire in 2007 and less comprehensive than current national parity bills, researchers found that among employers who made any changes, 86 percent made no compensatory changes to their benefits because cost increases were judged to be minimal or nonexistent.

The costs of untreated mental health care have been estimated to be nearly \$400 billion annual-

ly. Adding the provision of health coverage that does not distinguish between mental and physical disorders would lower overall national mental health expenditures by \$5.5 billion, as a result of medical cost offsets. (Substance Abuse: The Nation's Number One Health Problem, Brandeis University, Schneider Institute for Health Policy, 2001). For example, if much of the anxiety and stress associated with mental illnesses could be eliminated, there would be a lower incidence of cardiac problems, which are extremely expensive to treat.

NIMH highlighted the extensive benefits of comprehensive mental health parity in its 1997 report, "Parity in Coverage of Mental Health Services in an Era of Managed Care," by remarking that billions of dollars would be saved each year by treating people with mental illness, thereby enabling them to become more economically and socially productive in the workplace and elsewhere.

Overwhelmingly, national studies and evaluations of full parity states illustrate that the cost of full parity is fiscally immaterial, but that the costs of NOT adopting parity laws is staggering. NJAMHA strongly endorses putting coverage for treatment of mental illnesses and addictions on par with coverage for the treatment of physical illnesses.

Housing

There is a growing recognition that access to decent, safe and affordable housing, in combination with mental health supportive housing services, enhances the clinical outcomes of mental health treatment and increases the probability of recovery.

The need for affordable housing is one of the greatest hurdles facing individuals with mental illnesses. Approximately 8,000 of the homeless in New Jersey have a mental illness, while thousands more live with parents, in inadequate housing or are aging out of children's residential facilities or waiting in psychiatric facilities.

NJAMHA believes that a broad range of housing options from independent living to 24-hour residential programs must be available to support community living for persons with serious mental illnesses. NJAMHA adheres to the tenet that every citizen of the State of New Jersey should have the opportunity to reside in safe and affordable housing.

NJAMHA supports a full continuum of supportive housing, promoting individual independence while providing a safety net of support services to meet the needs and preferences of all persons who have mental illnesses.

Persons who have mental illnesses have the right to access a full range of housing options geared to their levels of functioning and that are

respectful of their choices to the extent that is feasible. Housing options can vary from highly supervised group homes to supervised apartments, to residential health care facilities/boarding homes, to independent living in apartments, to condominiums to single family homes. As the needs of different individuals vary, and as the same individuals can have different needs at different times, it is critical that the stigma of mental illness does not unlawfully and unfairly limit housing options for persons with histories of mental illnesses.

New Jersey is one of the most expensive states in the nation, reportedly with an overall cost of living 32 percent above the national average with its housing stock 73 percent above the average. Its proximity to New York is one of the major reasons attributed for the high housing costs. The average Fair Market Rent in NJ for a one-bedroom apartment in New Jersey is \$859. A January 2006 report by the Housing and Community Development Network of New Jersey reported that New Jersey is the fourth most expensive state in the nation for renters.

NJAMHA supports the continuation of the Special Needs Housing Trust Fund and other housing initiatives to increase the number of affordable housing units for persons who have mental illnesses and/or developmental disabilities throughout the State and supports that additional funds be dedicated for supportive housing services.

New Jersey's Special Needs Housing Trust Fund created in August 2005, under P.L.2005, c.163, is a result of the New Jersey State Legislature's acknowledgement of its responsibility to provide safe residences for individuals requiring supportive housing. Supportive housing options are humane alternatives to homelessness or institutionalization that all-too-often result from the lack of access to suitable and safe housing for persons stigmatized or impoverished due to a history of mental illness.

The Special Needs Housing Trust Fund is under the auspices of the New Jersey Housing and Mortgage Finance Agency (HMFA) and is funded through the issuance of bonds by the New Jersey Economic Development Authority (EDA). The funds are dedicated to the creation of 10,000 units across the State of affordable housing for persons who have mental illnesses and/or developmental disabilities.

NJAMHA promotes the continuation of the Special Needs Housing Trust Fund. With New Jersey grappling with one of the most acute shortages of affordable housing in the nation, the commitment of \$200 million toward the development of affordable housing units for people with special needs must continue to be prioritized to address this persistent problem. Persons with mental illnesses or dual mental health and addiction disorders, who often live on fixed or low incomes and frequently incur high medical expenses, are the most affected by the State's difficulty in

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addressing the problems of affordable housing.

Although NJAMHA recognizes the State's demonstrated commitment to facilitate the creation of housing for individuals with special needs, NJAMHA has great concern that the \$200 million committed to the creation of affordable housing will not go nearly far enough. Already, more than \$50 million has been committed for the creation of approximately 400 units.

NJAMHA is concerned about the ability of the State to keep pace with the objective of developing 10,000 housing units over 10 years, especially given that the high cost of developing these units is spurred by the exorbitant prices of New Jersey housing, as well as the significant costs associated with ensuring that the units are sustainable on a long-term basis. NJAMHA recommends that there be some flexibility incorporated into the structural requirements for special needs housing to increase the development of more affordable housing. Some proposed upgrades might significantly increase the cost of these units, thereby diluting the desired effect of the effort.

Additionally, by allowing a wider spectrum of housing options, such as the use of shared bathrooms, units could be built at less cost. To that end, the State should recognize there is a need for the full spectrum of housing and should consider paying for other forms of housing, such as group homes, to maximize the number of individuals served

and to meet the needs and preferences of the individuals who will be accessing special needs housing.

The State should also consider allowing providers to incur some level of debt as part of the 20 percent match. While NJAMHA acknowledges the importance of ensuring that projects are sustainable and financially viable, allowing a limited amount of debt might make the difference between a project moving forward or remaining in the planning stages.

It also must be recognized that the process of developing housing is daunting for many mental health care providers who have never undertaken such projects. The State should assist providers in increasing their capacity and help providers to develop the in-house expertise related to planning, development and operations.

Another impediment to the creation of housing is the issue of stigma. The State should take a lead role in ensuring that municipal officials, planning board members and the general public understand the need for and the importance of affordable housing. We must all have a role in battling the Not-In-My-Back-Yard (NIMBY) reaction that too often greets individuals with mental illnesses who are merely seeking their right to safe and affordable housing.

HMFA must work in close coordination with developers and mental health community providers to ensure that new units are appropri-

ately created to meet special needs and preferences of people who have mental illnesses or developmental disabilities, or both. The State must make a concerted effort to link housing developers with community provider agencies so that a unified housing and services development plan is crafted and implemented to assure the best outcomes.

As an increasing number of housing projects are put through the pipeline, there must be adequate funding for supportive services to go along with the affordable housing units. The Special Needs Housing Trust Fund is dedicated solely to the construction and maintenance of affordable housing units, given in the form of grants and loans of up to 80 percent of the construction costs, with no guarantee that supportive service dollars will accompany the new units.

The State must realize the value and importance of attaching supportive service money to new affordable housing units. The overall success and viability of new special needs housing units, and of the Special Needs Housing Trust Fund, are contingent upon the evidence-based and emerging best practice services and supports that have been shown to help special needs populations successfully integrate themselves into the community. Without such services, the recovery of people who have mental illnesses will be compromised, and they could deteriorate to a point where re-hospitalization becomes necessary. This, in turn, will cost the State and taxpayers in the long run.

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NJAMHA supports the continuation of the New Jersey Council on Affordable Housing's steps to encourage communities to provide group homes for people who have mental illnesses or developmental disabilities.

The Council on Affordable Housing (COAH) recently proposed new rules to increase the amount of housing for low- and middle-income families, a crucial element of Governor Corzine's commitment to create 100,000 units of affordable housing in 10 years. However, the new rules could result in higher prices for taxpayers and builders.

The new rules require one unit of affordable housing for every five-market rate units or 16 jobs created through commercial construction. By contrast, the current rules require one unit of affordable housing for every eight market-rate units or 25 jobs, which a state appellate court regarded as unconstitutional. Housing advocates who had criticized the current rules had expressed approval of the new rules. However, there are questions about funding for the much greater production of affordable units. In ad-

dition, the new rules could lead to higher taxes and builders' fees. Under the current rule, builders have paid tens of thousands of dol-

lars in fees. These fees could increase under the new rules, although some caps have been placed to limit the cost of an affordable unit to about \$250,000. COAH has asked for an extension on the new rule adoption from December 31, 2007 to June 2008 to provide opportunity for public comment. As the court is considering this request, COAH is tentatively planning five public hearings in January and February of 2008. NJAMHA is carefully following this issue out of concern that the commitment to expand housing for persons with mental illnesses may be compromised.

Each municipality in New Jersey that is developing housing has to meet minimum requirements in the creation of low- and moderate-income housing. The actual obligation may vary in conformance with the availability, type and need for low- and moderate-income housing in the community. The unit of credit given to a municipality for alternate living arrangements is defined as the bedroom. As an incentive to a community, group homes for people who have mental ill-

nesses or developmental disabilities that are licensed and regulated by the Department of Human Services (DHS) as rental housing will receive two credits toward a municipality's obligation for each single unit (bedroom) of housing from the COAH. Other types of rental housing, not including rental units restricted to the elderly, may also receive the two-for-one credit. This may include transitional facilities for the homeless, Class A, B, C, D and E boarding homes, residential health care facilities, and congregate living arrangements.

However, in January 2007, regulations were proposed that would eliminate the additional credits for this special housing. NJAMHA urges COAH to maintain the two-for-one credit to supportive housing units.

NJAMHA recommends mechanisms such as the inclusion of Special Needs Housing credits in the COAH regulations that would serve to bring developers to the table.

Also related to the importance of safe and affordable housing options for persons with special needs is the fact that people who have mental illnesses have an excellent chance to achieve recovery, and that they also respond best to treatment when residing in the least restrictive setting

Approximately 8,000 of the homeless in New Jersey have a mental illness, while thousands more live with parents, in inadequate housing or are aging out of children's residential facilities or waiting in psychiatric facilities.

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Housing

Supreme Court decision delivered in the *Olmstead v. L.C.* case, which required states to assess their institutions and reintegrate individuals assessed as clinically ready for reintegration back into the community. The court's decision clearly stated that "...it is incumbent upon each state to ensure that individuals are served in the most integrated settings possible and requires the states to provide community-based services for those persons appropriate for discharge when they desire community placements and treating professionals agree."

According to NJP&A, on any given day in New Jersey, nearly 50 percent of the individuals in the State's psychiatric hospitals are able to successfully live in the community, but are denied the right to do so. It is important to recognize that New Jersey has made significant strides in transitioning individuals from State psychiatric institutions to less restrictive settings. However, according to the State Department of the Public Advocate, Division of Mental Health Advocacy, of the approximately 2,300 patients still hospitalized in State psychiatric facilities as of July 2007, more than 1,000 are on Conditional Extension Pending Placement (CEPP) status: they are stable and eligible to be released from the hospital, but must remain in the hospital--at a significant cost to the State and taxpayers--because they have no place to go.

The State must work with community providers to develop a plan for placement of individuals on CEPP status, so that there is no lapse in their treatment and services and they can be appropriately moved into the community in accordance with the *Olmstead* decision. However, CEPP placement efforts require resources above and beyond those presently in the nonprofit mental health system. It is indisputable that without increases in funding to cover the additional requisite clinical and support services to adequately support persons transitioning from institutional living to the community, efforts to relocate individuals from State-operated psychiatric hospitals will be compromised or will fail.

Co-Occurring

NJAMHA supports the integration of services for adults and youth with co-occurring mental illness and substance abuse disorders.

Co-occurring disorders, unfortunately, are all-too-common, with about 50 percent of individuals with serious psychiatric disorders affected by substance abuse. Dual diagnosis is correlated with negative outcomes including higher relapse rates, hospitalizations, incarceration and homelessness. (Robert E. Drake, M.D., Ph.D. Susan M. Essock, Ph.D., *Psychiatric Services*, April 2001, Vol. 52 No. 4, 52:469-476, 2001). The dual disorders cross numerous vulnerable populations: children/

adolescents, adults, elderly adults, and the homeless.

In fact, statistics in the National Comorbidity Study showed even higher rates of up to 65 percent of individuals with a lifetime substance abuse disorder also have a lifetime history of at least one mental disorder, and about 51 percent of those with one or more lifetime mental disorders also have a lifetime history of at least one substance use disorder (Kessler et al., 1996).

Recognizing the vast number of adolescents and adults with co-occurring disorders of addiction and mental illness, NJAMHA applauds the State's decision to move the Di-

vision of Addiction Services (DAS) out of the Department of Health and Senior Services (DHSS) and under the Department of Human Services. NJAMHA is optimistic that this structural change will address the issue of a lack of sufficient integration between many addiction and mental health treatment providers.

It is important to note that, historically, when seeking treatment, individuals with co-occurring substance abuse and mental health disorders often do not receive integrated services that address both illnesses at the same time. As in many other States, New Jersey has created a fractured health care system in

Co-Occurring

which people seeking treatment for mental illness and substance abuse must often go to at least two different providers for appropriate mental health and substance abuse services, making navigation between systems difficult for individuals with co-occurring disorders to maneuver. Frequently, this exacerbates their illnesses and creates additional barriers to their successful recovery from both illnesses. This system runs counter to well-supported scholarly research showing the benefits and high success of treating both mental illness and substance abuse problems simultaneously, as opposed to sequentially, for people with co-occurring disorders.

In a 2005 report prepared by the National Council on Alcoholism and Drug Dependence – New Jersey (Policy Report No. 6 – 2005:

cantly more likely to have one or more subsequent admissions than mental health or substance abuse only clients.” Factors contributing to intransigent problems associated with the treatment of co-occurring disorders include stigma associated with both disorders; the lack of parity in insurance coverage (versus more liberal coverage for physical health conditions); and a lack of treatment integration. The policy report continues, “Alcohol and drug treatment and mental health treatment are parallel systems. There are two distinct therapeutic disciplines, philosophies, services, and academic preparation.”

NJAMHA supports advancing fuller integration of services and increased communication between community mental health and substance abuse providers, as well as between

occurring disorders population, and the State, through DMHS and DAS, should streamline the costly and time-consuming mental health and addiction licensure process. State licensure and inspections must be coordinated and collapsed into one process to address the existing overlap and duplication, which detract from service delivery and increases costs to agencies.

The State should make an effort to minimize and eliminate duplication of services while at the same time encouraging the coordination and, when appropriate, combination of mental health and substance abuse services in a common setting. It is through such coordination and integration that the best treatment outcomes will be reached for individuals with co-occurring disorders.

NJAMHA recognizes the steps made

“...New Jersey, 41 percent of the clients treated in the mental health system or substance abuse system were found to have co-occurring disorders. Clients with co-occurring disorders were significantly more likely to have one or more subsequent admissions than mental health or substance abuse only clients.” (Co-occurrence of Serious Mental Illness and Alcohol, Drug Addiction, National Council on Alcoholism and Drug Dependence – New Jersey, 2005)

Co-occurrence of Serious Mental Illness and Alcohol, Drug Addiction), it was reported that in “...New Jersey, 41 percent of the clients treated in the mental health system or substance abuse system were found to have co-occurring disorders. Clients with co-occurring disorders were signifi-

the Division of Mental Health Services (DMHS) and the DAS. NJAMHA applauds the steps taken in this direction in recent years, but much more ground needs to be covered. Community providers should provide a comprehensive array of services that meet the needs of the co-

by DMHS in enhancing co-occurring disorders services throughout the State. The new DMHS manual, *Guidelines for Best Practices in the Treatment of Co-occurring Disorders*, is an excellent toolkit and blueprint for shifting the focus and reorienting the community mental health sys-

Co-Occurring

tem toward the identification and treatment of co-occurring disorders. Currently, the DMHS manual only acts as a guide for community mental health agencies to reorganize their services with an emphasis on co-occurring disorders. There is no similar DAS manual in existence for substance abuse providers. Both systems must be transformed if the integration of services, to the benefit of consumers with co-occurring disorders, is to be achieved.

Two critical subpopulations requiring special focus are the elderly population and the "aging out" population, as both groups frequently are prone to co-occurring disorders. However, there must be an infusion of funds dedicated to nonprofit providers so that they will be able to absorb the increased demand for services presented by individuals in these two subgroups.

Jail diversion is another area competing for attention. It has been reported that up to 73 percent of persons jailed have co-occurring disorders. Needed to address this dire problem are: community access to treatment prior to the imposition of a charge; support and treatment after adjudication; access to treatment in jails; and community-based programs after release (to break the cycle).

On the substance abuse side of co-occurring disorders, jail diversion goes through the drug courts, which increasingly collaborate with treatment providers. According to DAS, 2006 was the first year that the funds for drug court were completely exhausted. An assessment of the utilization of those funds is important to assure that whatever funds are available are used most effectively.

There are a number of counties in New Jersey that have jail diversion programs that are funded by DMHS, with some new programs recently funded. Given the magnitude of co-occurring disorders in this population, there needs to be an increase of these programs across all counties.

Another area for close collaboration is in regard to psychotropic medications. Prescribing patterns over the years, between the substance abuse and mental health sectors of care, have been at issue. NJAMHA strongly advocates for greater linkages in this area and for open formularies to address unique clinical circumstances.

It is important to note that with increased collaboration comes increased demand. NJAMHA does not support unfunded mandates or any newly integrated services that

are not accompanied with an additional investment for treatment and cross-systems training. Shifting the mental health and substance abuse service focus on co-occurring disorders will not only take time, but significant funding as well. Community provider agencies have been plagued by years of underfunding and insignificant cost-of-living adjustments for their employees.

Thankfully, the FY 2007-2008 State Budget allotted additional funds to the Division of Addiction Services for a needle exchange program, treatment beds, and outreach. However, given the magnitude of co-occurring (mental illness and addiction) disorders, more is needed. For the benefit of individuals in need of services, and other co-occurring disorders treatment stakeholders, there must be a continued investment of State dollars for further expansion of integrated services.

NJAMHA is pleased that the DAS is currently working on improving the integration between addiction and mental health services. To achieve this goal, DAS is developing a work plan using an inter-agency work-group, including involvement of DMHS. In addition, DAS has established a Co-Occurring Disorders Subcommittee.

Wellness & Recovery

On both the national and state levels, mental health transformation to a wellness and recovery philosophy has become an important goal for the health delivery system.

The United States Substance Abuse and Mental Health Services Administration within the U.S. Department of Health and Human Services and the Interagency Committee on Disability Research, in partnership with six other federal agencies convened a National Consensus Conference on Mental Health Recovery and Mental Health System Transformation which defined 10 fundamental components of recovery: 1. self direction; 2. individualized and per-

son-centered; 3. empowerment; 4. holistic; 5. non-linear; 6. strengths-based; 7. peer support; 8. respect; 9. responsibility and 10. hope.

Consistent with these basic tenets of transformation to a Wellness and Recovery model, in October 2007, the New Jersey Division of Mental Health Services issued a Wellness and Recovery Transformation Action Plan - for January 1, 2008 through December 31, 2010. This three-year plan puts into action transformational activities in three key areas: System Enhancements, Data Driven Decision Making, and Workforce Development. However, it is important to note that the Division of Mental Health

Services clearly states in the action plan's preamble that the plan "... will not resolve all of our systemic challenges upon completion..."

NJAMHA philosophically supports the tenets of wellness and recovery, but strongly cautions stakeholders, policy makers and legislators not to substitute enthusiasm for a philosophical position for concrete resources, starting from prompt access to treatment, to housing, to vocational and social supports, and to other necessary support services. Wellness and recovery can only become a reality if there is sufficient funding to support the requisite services and supports.

Charity Care

NJAMHA supports a permanent funding source to meet the mental health and addictions health care needs of members of the State's uninsured and underinsured populations that is commensurate to the actual cost of care.

The New Jersey Hospital Care Payment Assistance Program (Charity Care) is administered by the New Jersey Department of Health and Senior Services. Acute care hospitals in New Jersey are mandated by the State to provide medically necessary inpatient and outpatient services to people who are un-or underinsured; are ineligible for any private or governmental sponsored coverage, such as Medicaid, and meet the income and assets eligi-

bility criteria. Depending upon an individual's or a family's resources, this care may be provided at no cost or at a reduced cost. Charity care funds are intended to offset the uncompensated care incurred by community acute care hospitals, in meeting the State's mandate.

A recent study by the Rutgers Center for State Health Policy states found that "...[the] Charity Care Program in NJ provides a substantial volume of treatment for mental health diagnoses. These treatments, which are among the Program's costliest, are often done on an inpatient basis. Moreover, mental health issues often appear as secondary diagnoses that complicate physical health problems." (Evaluation of the Hospital Charity Care Program in New

Jersey, Derek DeLia, Ph.D., Rutgers Center for State Health Policy, January 2007). However, charity care dollars are woefully insufficient, as they come nowhere near the true cost of providing care.

The State is contemplating a move toward universal health care. Tentative plans floated to-date talk about redirecting charity care dollars to establish universal health care coverage. (Refer to NJAMHA's Public Policy Platform section on Universal Health Coverage.) Because the Charity Care Program provides a high percentage of the funds spent on mental health and substance abuse treatment, NJAMHA has voiced its concern that the establishment of universal health care include mental health and sub-

Charity Care

stance abuse treatment; otherwise NJAMHA opposes the diversion of charity care funds that pay for these necessary services to another use.

Community acute care hospitals are treating increasing numbers of individuals with serious mental illnesses who qualify for the Charity Care Program. Community hospitals increasingly fill this void. In fact, two-thirds of charity care admissions originate in hospital emergency departments (Evaluation of the Hospital Charity Care Program in New Jersey, Derek DeLia, Ph.D., Rutgers Center for State Health Policy, January 2007).

The second funding stream is the Hospital Relief Subsidy Fund for Mentally Ill and Developmentally Disabled, which totals \$20 million. There are fluctuations on hospitals' share of the subsidy fund, based on the total number of beds that exist. However, this funding source has been stagnant for years, and the subsidies hospitals receive may decrease depending on any increase in psychiatric inpatient beds that must tap into that same pot of money.

Another factor underscoring the inadequacy of the amount of charity care funds allocated, is that many individuals presenting to hospitals

through their emergency departments cannot be qualified as eligible for charity care because they lack the required documentation. In addition, the cost of the labor-intensive follow-up to attempt to establish eligibility often surpasses the fiscal capability of providers. Therefore, the number of individuals being served who are assumed under bad debt needs to be identified and factored into the number of persons requiring mental health and substance abuse services. An expedited ability to make people eligible for charity care funding is also necessary.

Further expanding the ranks of those eligible for charity care are people not being covered adequately or at all by employers. With corporate, government and nonprofit downsizing, there is increased reliance on part-time employees and outsourcing personnel, who receive no benefits. There are also frequent reductions in benefits to full-time employees and an upswing in the discontinuation of pension plans and the health care coverage they offer, at retirement. In addition, many low-income workers are young adults no longer covered by parental plans or college-based insurance and not yet in any permanent job situation.

A public policy must be established to cover the needs of those who fall outside the parameters of charity care who will require mental health and substance abuse services. Moreover, controls must be put in place to ensure that employers cannot abandon their benefit programs because of the availability of publicly provided charity care, further exacerbating the issue of "crowd-out."

NJAMHA strongly advocates for the continuation and expansion of New Jersey's FamilyCare Program that provides health coverage to children whose family's income is up to 350 percent of the federal poverty level. This program provides mental health services, both inpatient and outpatient, necessary to keep families together and out of more costly services. The FamilyCare Program serves to reduce the uncompensated care burden of hospitals.

It is imperative that the charity care funds that support mental health and substance abuse treatment be preserved and increased in relation to the ever-escalating need. By recognizing and establishing that charity care is a broad social responsibility of the State and its people, New Jersey's policy

As the number of persons who will need and present themselves for mental health and substance abuse services will indeed increase, it is NJAMHA's position that it is unrealistic to hold providers at risk if current demand for services grows beyond funding.

Charity Care

makers and legislators must not use a short-sighted “band aid” approach, unfairly shifting the burden onto health care providers who remain ethically and legally obligated to provide services to the uninsured, despite the fact that the cost of service delivery often vastly surpasses the dollar amounts that are reimbursed. If the uncompensated costs of meeting the State’s mandate, to treat all regardless of ability to pay, continue to be absorbed by health care providers, ultimately the public will assume higher costs for care and coverage. Charity care for the un- and underinsured must more closely approximate actual cost of care.

As the number of persons who will need and present themselves for mental health and substance abuse services will indeed increase, it is NJAMHA’s position that it is unrealistic to hold providers at risk if current demand for services grows be-

yond funding. As a starting point, providers should receive no less than the amounts evidenced through historical utilization. Then, a mechanism needs to be instituted to serve the expanded population—such as adopting universal health care, as other states have done, while protecting the charity care funds that support mental health treatment. A system must be in place that allows for the projection of anticipated new consumers and the funding required to meet the behavioral health needs of individuals who are un- or underinsured.

In addition, NJAMHA applauds essential expansions of health care coverage such as Public Law 2005, c. 375 – Chapter 375, which was approved on January 12, 2006 by the New Jersey Legislature, that gives certain adults the opportunity to continue coverage as a dependent on their parents’ group health coverage, up to the age of 30.

NJAMHA opposes commercial insurance/managed care benefit plans that offer exceptionally deficient coverage of mental health services, particularly in comparison to the medical benefits these plans provide. Because community mental health providers and emergency and screening services are legally bound to not refuse services to persons who present themselves, costs for treating persons with commercial insurance coverage who quickly exhaust their allowable service limits imposed by commercial carriers, are being passed on to the public non-profit mental health system of care.

This further exacerbates the uncompensated care issue and presents untenable pressure on the underfunded non-profit sector of care while adding to the profit margin of private insurance plans. This cost shifting is a public policy issue that must be addressed by the State as part of any plan to meet the needs of underinsured persons.

Psych Screening & Emergency

NJAMHA asserts that there must be a substantial increase in State appropriations to the community-based psychiatric screening and emergency service network to more effectively

protect New Jersey’s most vulnerable consumers. NJAMHA appreciates increases to these providers that were included in the previous State budget, thanks to the Governor’s Men-

tal Health Task Force. However, more is needed to handle increased referrals to the psychiatric crisis network.

Psychiatric Screening Centers are routinely barraged by individuals in all types of crises. Even in terms of those they were established to evaluate and treat, adults with mental illnesses, they are overextended.

Psych Screening & Emergency

By way of background, New Jersey's Mental Health Screening and Commitment Law (N.J.S.A.30:4-27.1) charges the State with the responsibility to provide care, treatment and rehabilitation services to adults with mental illnesses who cannot provide basic care for themselves or who are dangerous to themselves, to others or to property.

State law provides for the voluntary admission and the involuntary commitment of these individuals, as well as for the public services and facilities necessary to meet the State's responsibilities.

Each county has a designated Psychiatric Screening Center with 24-hour, 365 day per year access. Screening centers are the legally mandated gatekeepers for involuntary inpatient treatment into the public psychiatric hospital system (State and county psychiatric hospitals) and into involuntary psychiatric units - Short Term Care Facilities (STCFs) - located in community acute care hospitals. Adults involuntarily admitted to any of these

facilities must meet the State's commitment standard.

Psychiatric Screening Centers are routinely barraged by individuals in all types of crises. Even in terms of those they were established to evaluate and treat, adults with mental illnesses, they are over-extended. In 2005, the number of hospital emergency department visits in New Jersey rose 4.5 percent to 3.36 million from 2004, and up 25 percent since 1998. Since 1995, 17 acute care hospitals have closed in New Jersey. A 2007 report by the Rutgers Center for State Health Policy found that crowding in hospital emergency departments is so bad that the State would have a difficult time responding to a major health disaster. Without a doubt, the stress on hospital emergency departments would be far greater if Psychiatric Screening Centers did not exist. However, the same stress is being felt also in the psychiatric crisis sector of care.

There is currently an increasing number of persons with men-

tal health crises waiting excessive amounts of time for disposition in Psychiatric Screening Centers due to the lack of psychiatric outpatient services and the shrinking capacity in psychiatric partial hospitalization and partial care (day treatment) programs in the State, which has resulted from inadequate reimbursement rates, cuts in reimbursement rates, and difficulties in the non-profit sector to recruit and retain a sufficient cadre of mental health staff due to stagnating funding to meet increasing demand.

The issue of psychiatric screening is even more acute for children in New Jersey, since the State has no screening and commitment law for children. There is no legal basis to hold a child in screening against the consent of the consumer or the parents. However, screening centers remain committed to serving youth in crisis, but NJAMHA is deeply concerned about children in emergency services. Legal and regulatory issues concerning children and psychiatric screening must be addressed.

Pharmaceutical

NJAMHA supports the preservation of open access to mental health treatment medications by individuals with serious mental illnesses. NJAMHA also supports the continuation of managed care mental to preserve access to medications and mental health treatment by vulnerable individuals with serious mental illnesses.

Research consistently shows that unrestricted access to medically necessary pharmaceuticals and mental health treatment contains costs in all sectors of the health care system. Fortunately, the New Jersey Legislature has protected open access to medications, also known as an "open formulary." However, in every State budget fiscal year, we fear that the open formulary, so

beneficial to New Jersey Medicaid beneficiaries with mental illnesses, will be sacrificed to address budget shortfalls the State has encountered over several annual budget cycles. NJAMHA remains steadfast in working with the Legislature to continue to preserve the open formulary.

Pharmaceutical

The Centers for Medicare and Medicaid Services (CMS) reviewed drug expenditures over an 11-year period and although CMS found that drug expenditures increased 200 percent during this period of time, when drug expenditures were apportioned by total health care costs, the increase accounted for only about 12 percent. Even so, State Medicaid policies continue to ignore the fact that decreasing access to medications actually increases health care costs in other components of the entire continuum of health care.

Many states across the nation continue to focus on cost-containment mechanisms to reduce costs in their Medicaid programs. NJAMHA believes such cost-containment strategies, such as closed formularies (restricted access to certain medications), thresholds on the number of monthly prescriptions and increased prior authorizations (where physicians must obtain approval from a third party before they can prescribe certain medications), all in relation to medications that are medically required to treat serious mental illnesses and addiction disorders, are pound-foolish. This position has been strongly supported by a wide array of scientifically conducted studies over the years.

Extensive research has found that reducing pharmaceutical costs to reduce drug expenditures, particularly for serious disorders such as severe mental illnesses, actually drives up total health care costs. When New Hampshire tried restricting access by implementing limits on the number of prescription fills per month,

drug expenditures dropped among the elderly and persons with mental illnesses; however, spending on hospitalizations, partial care programs, and emergency mental health services increased. Experiences such as this in New Hampshire as well as in numerous other states, demonstrate that "Vulnerable populations are most likely to experience adverse effects from hastily-applied drug cost-containment policies, and resulting compensatory measures may create more expenses than the policy removes." (Journal of Clinical Psychiatry 2003;64[supplement 17]:19-22)

In addition, restrictions on access to medications can increase costs in other systems because if adults with mental illnesses and children with serious emotional disturbances and behavioral disorders do not receive the right medications in a timely manner, they may experience longer recovery times, which also increases health care costs, such as doctor visits, emergency room services, extended hospital stays, and raises the possibility of out-of-home placements.

NJAMHA supports legislation that prohibits restrictive mechanisms, such as prior authorizations and preferred drug lists, from being placed on any drugs prescribed by physicians treating adults with mental illnesses or children with serious emotional and behavioral disorders and supports exemptions for populations who rely on medications such as atypical antipsychotics, which have dramatically

improved the quality of life for many children and adults, and their families.

In addition, programs for prior authorization and preferred drug lists of prescription medication in the public sector are costly to states and taxpayers because an expanded bureaucracy is necessary to handle prior authorization requests, and the paperwork that accompanies such programs. Plus, physicians frequently resent the intrusive oversight of non-medical personnel or physicians unfamiliar with their patients' histories - basically second-guessing their medical opinions. Moreover, additional costs are incurred to hire personnel to handle the requests. These administrative costs far exceed any savings a state can hope to achieve by limiting access to prescription drugs.

In addition, and with the same concerns in mind, NJAMHA opposes policies that require a person to first "fail" with older, less expensive psychotropic drugs, before gaining access to newer medications. Without a doubt, this approach contradicts sound evidence-based clinical practice.

NJAMHA believes that it is vital for mental health providers and their prescribers to have unrestricted access to all supporting therapies, including medication. NJAMHA believes that open access is imperative. Simply stated, restrictions on medications are ill advised. Not all medications for serious mental illnesses are interchangeable

Pharmaceutical

and, therefore, cannot be selected based on cost. Open access to drugs is cost-effective, and in the long run, will save lives and money.

Open and timely access is critical in effectively treating persons who have mental illnesses in the community, as their functioning and quality of life can be maintained, and recovery realized, with timely and open access to medication. Full access to all drugs prescribed by physicians treating adults with mental illnesses and children with serious emotional disturbances and behavioral disorders is absolutely critical. Without open access to medication

and sufficient funding, non-profit mental health organizations cannot effectively manage a person's total health or the costs of total care. To reemphasize... *restrictions on the mental health category of drugs could result in the risk of cost shifting by increasing utilization of other health care services. Conversely, physical health prescribers must have full access to mental health drugs, as many less severe mental illnesses are often managed by physical health providers.*

In addition, NJAMHA strongly urges policy makers and legislators to address the severely limited formularies in many New Jersey's county jails and to en-

sure that no one with mental illness will be released from a prison or a jail without assured continuity of treatment and supports, including medication.

Stephen Soumerai, Sc.D., Harvard Medical School, echoes these stated concerns and cautions policy makers to rigorously assess the potential risks to vulnerable beneficiaries before adopting drug policies that entail material changes to reimbursement that "...may create greater expenses than the cost-containment policy saves." (*Unintended Outcomes of Medicaid Drug Cost Containment Policies on the Chronically Mentally Ill*)

Universal Health

Recognizing the need to control our country's health care costs—which are a much higher percentage of the gross domestic product than that of any other country—mental health, addictions and children's community providers and policy makers alike cannot afford to ignore the far greater burden to our State's and nation's budgets that is caused by problems stemming from mental health and emotional and behavioral problems left untreated or insufficiently addressed: Chronic health problems and illnesses demanding constant care; unnecessary emergency room visits that drive up health insurance premiums; re/hospitalizations to State and county psychiatric hospitals, all at high cost to taxpayers; inappropriate and costly incarcerations; absenteeism and lost productivity in the work-

force costing companies billions of dollars annually. Concerned about controlling costs, we must, nonetheless, make sure that savings do not come at the expense of persons suffering the stigma associated with mental illnesses and whose lives are often further complicated by homelessness, lack of healthcare coverage and financial instability.

NJAMHA supports universal health coverage to expand health care coverage to the hundreds of thousands of persons in New Jersey, at low- and middle-income levels.

A major goal of providing universal health coverage is to encourage people to seek preventive care, thereby avoiding use of emergency departments for non-emergent

health care services. The accomplishment of this goal, alone, would benefit hospitals in New Jersey in terms of reducing the amount of uncompensated emergency care they provide. Emergency care is among the costliest.

Universal health coverage has the potential to relieve the burden of uncompensated care on acute care hospitals (*Refer to NJAMHA's Public Policy Platform section on Charity Care.*). Under New Jersey Senator Joseph Vitale's leadership, there was momentum gained in 2007 to actively consider developing a universal health coverage plan in New Jersey.

NJAMHA favors several elements of the universal health plan advanced to-date. NJAMHA supports State

Universal Health

subsidies for people who are un-or underinsured and those with inadequate financial means to purchase health insurance. Other positive aspects under consideration are the automatic enrollment of the uninsured visiting hospital emergency rooms and the innovative concept of setting up a network of clinics that would serve the estimated 447,000 uninsured illegal immigrants and homeless throughout New Jersey.

While NJAMHA supports universal health care legislation, it has concerns that must be addressed before implementation. NJAMHA had the opportunity to raise these concerns with Senator Joseph Vitale and Dave Knowlton, President and Chief Executive Officer, New Jersey Health Care Quality Institute and Chair of the Commission for Universal Health Coverage. This was one in a series of meetings conducted by Senator Vitale and Mr. Knowlton. Following are NJAMHA's qualifiers:

- The plan must not discriminate against those who have mental
- The burden of paying for the coverage must not be transferred

illnesses. The insurance must provide equivalent coverage for mental, behavioral and addiction disorders for adults and children.

- Reimbursement rates must be realistic to ensure adequate access to care and services must be carefully monitored to ensure they are effective and responsive.
- The system must provide the full continuum of care for both physical and mental health and should be fully integrated to ensure the promotion of health, not just the treatment of illnesses.
- There must be an accurate assessment of what services the Charity Care Program supports, and steps must be taken to ensure funding remains available for those services, particularly mental health and substance abuse treatment.

to overburdened employers, especially nonprofit employers who are already struggling to keep pace with double digit increases in insurance costs and are unable to offer competitive benefits packages to their employees.

- The plan must be responsive to the unique aspects of New Jersey's population and health care needs, recognizing the impact of a large and diverse immigrant population and a much larger pool of uninsured individuals than those living in other states that have enacted universal coverage.

NJAMHA is also concerned with the lack of parity in commercial insurance coverage benefits between physical health diagnoses and mental illnesses or addiction disorders. Any universal health care plan must take this issue into consideration. (*Refer to NJAMHA's Public Policy Platform section on Mental Health Parity.*)

Recognizing the need to control our country's health care costs—which are a much higher percentage of the gross domestic product than that of any other country—mental health, addictions and children's community providers and policy makers alike cannot afford to ignore the far greater burden to our State's and nation's budgets that is caused by problems stemming from mental health and emotional and behavioral problems left untreated or insufficiently addressed.

Diversion from Corrections

NJAMHA supports alternatives to the criminalization of persons with serious mental illnesses.

It is widely recognized that mental illness is overrepresented in the incarcerated population.

A 2005 study by H. Richard Lamb, M.D., and Linda Weinberger, Ph.D., found that, on a national level, severe mental illness may be found in as much as 24 percent of the prison population. While in New Jersey, approximately 16 percent of jail inmates were reported to have a mental illness and approximately 17 percent of inmates in New Jersey State prisons were assessed as needing or receiving some type of mental health treatment. (*Investing in Health and Justice Outcomes: An Investment Strategy for Offenders with Mental Health Problems*, Nancy Wolff, Ph.D., January 2003)

Richard Nakamura, Ph.D., of the National Institute of Mental Health, found jail-diversion programs for individuals, with serious mental illnesses and co-occurring substance use conditions, reduce the time they spend incarcerated without increasing the risk to public-safety. Studies have also found that "...the costs for jail diversion are no higher than those for imprisonment of those with mental illness, who often languish in jail on minor charges ..." (*Psychiatric News*, Volume 41, American Psychiatric Association, Number 20, October 20, 2006)

It is critically important to link inmates with mental illnesses to community-based services. A significant portion of inmates housed

in county jails in New Jersey has a mental illness that is treated with psychotropic medications during incarceration. "However, most of these inmates are released without effective linkages to medications or psychiatric services, both of which are essential for maintaining their mental health." (*Release Planning for Inmates With Mental Illness Compared with Those Who Have Other Chronic Illnesses*, Nancy Wolff, Ph.D., Dena Plemmons, Ph.D., Bonita Veysey, Ph.D. and Angela Brandli, Psychiatric Services, 53:1469-1471, November 2002). The report concludes, "Bridging gaps between the jail and community, state, and local funding streams is necessary if continuity is to be realized."

Recognizing the alarming trend that jails and prisons have increasingly become de facto psychiatric treatment facilities, which is underscored by numerous federal reports, including the 1999 "Mental Health and Treatment of Inmates and Probationers" report issued by the U.S. Department of Justice, *NJAMHA calls for alternatives to incarceration for non-violent offenders who have a severe mental illness and co-occurring disorders through innovative programs and increased access to state-of-the-art treatment for these individuals*. Pre- and post booking programs and reentry programs that continue to be funded by the Division of Mental Health Services (DMHS) are worthwhile programs that assist persons with mental illnesses to reintegrate into the community.

NJAMHA supports initiatives that provide alternatives, such as jail di-

version and mental health courts, to the criminalization of persons who have mental illnesses, and that redirect persons with mental illnesses convicted of misdemeanors away from jails and prisons, and into settings conducive to their stabilization and recovery.

A blueprint to create and implement jail diversion projects throughout the State was developed by the Governor's Task Force on Mental Health in 2004. This blueprint recommended performance measures and benchmarks that would assess programs' effectiveness in reducing recidivism while improving the treatment outcomes of New Jersey's non-violent, mentally ill incarcerated population.

With funding allocated in the FY 2006 State budget, DMHS awarded contracts to three counties (Atlantic, Essex, and Union) to develop three pilot programs to "...coordinate a mental health service component to interface with law enforcement and the courts to address the needs of those individuals who have come into contact with the criminal justice system as a result of behaviors related to their mental illness." (DMHS, 2007).

The FY 2008 State budget enabled the continuation of jail diversion programs that will divert persons with mental illnesses from the criminal justice system and into the mental health treatment system of care. Recent awards went to four community mental health agencies in four counties, totaling \$885,000 in contracts, to divert people with

Diversion from Corrections

mental illnesses at risk of being incarcerated into treatment services rather than jail. The award recipients are all NJAMHA members: Greater Trenton Behavioral Healthcare; Preferred Behavioral Healthcare of New Jersey representing a collaborative which also includes St. Barnabas at Kimball Medical Center and Ocean Mental Health Services; Steinger Behavioral Healthcare representing a consortium of organizations in Camden County; and Cumberland County Guidance Center in cooperation with the County Jail Diversion Task Force.

The counties will use the funding for basically pre-booking, post-booking and reentry programs that will prevent people with mental illnesses from entering the criminal justice system; identify and divert individuals with mental illness after they have been arrested; and reintegrate people with mental illnesses into the community following their release from jail.

NJAMHA also endorses programs that provide discharge planning, case management services and treatment to offenders with men-

tal illnesses leaving jails and prisons. These services focus on safe discharge and treatment of ex-offenders who have mental illnesses and will help combat the high occurrence of recidivism among this population. NJAMHA supports a well-coordinated treatment and pre-release discharge planning process between prison officials and community mental health providers for offenders with mental illnesses leaving state prisons and county jails.

The integration of services among the correctional, court, mental health, substance abuse, and social services systems is essential to adequately address the needs of persons who have mental illnesses who are housed in the correctional system or who face incarceration. NJAMHA staunchly supports jail diversion and pre-booking programs prior to the entrenchment of vulnerable, non-violent persons in the criminal justice system, where often treatment of their mental illnesses is inadequate and clinical conditions may deteriorate.

When an individual who has a mental illness is brought before a judge,

there must be communication and open dialogue among the courts, the prosecutors, prison officials and community mental health providers as to the most appropriate setting and sentence given the convicted individual's health status and severity of the crime. NJAMHA supports programs, such as the one that exists in Gloucester County, which educate and train police officers, prosecutors and judges on identifying and handling persons who come into contact with the correctional system as a result of behaviors resulting from their mental illness. Adequate training and education will help prevent unnecessary incarcerations, which are detrimental to a person's health and further contribute to the stigma of mental illness.

With open lines of communication, and a high level of accountability at both ends, the mental health and correctional systems can avoid unnecessary and costly incarcerations, as people who have mental illnesses are sent to programs designed to aid them in their recovery, rather than to prison, where they may clinically decompensate.

...in New Jersey, approximately 16 percent of jail inmates were reported to have a mental illness and approximately 17 percent of inmates in New Jersey State prisons were assessed as needing or receiving some type of mental health treatment. (Investing in Health and Justice Outcomes: An Investment Strategy for Offenders with Mental Health Problems, Nancy Wolff, Ph.D., January 2003)

Cultural Competence

NJAMHA supports a culturally competent mental health, addictions and children's system in order to ensure the greatest access possible to services and effective care.

"Cultural competence is the process of communicating with audiences from diverse geographic, ethnic, racial, cultural, economic, social, and linguistic backgrounds. Becoming culturally competent is a dynamic process that requires cultural knowledge and skill development at all service levels, including policymaking, administration, and practice." (U.S. Center for Substance Abuse Prevention)

As the world around us changes, so do the needs of the individuals to whom we provide services. It is estimated that the minority population in the United States will increase by 60 percent between now and the year 2010.

More and more, provider agencies are recognizing that in order to adequately meet the needs of the children and adults walking through their doors, they need to ensure the cultural and linguistic competency of their clinical professionals, as well as that of the rest of their staff.

New Jersey, like the rest of the nation, has been experiencing a significant change in its demographics over the past decade. Professionals, parents, families and policymakers are focusing on which cultural and social changes and trends have occurred, including ethnic, linguistic, racial and religious diversification, an aging population, and a prolif-

eration of community resources, which can be tapped to build an effective support system.

As the population increases in numbers and diversity, organizations – both professional and community – need to educate staff and adapt programs to ensure quality and effective care for all individuals regardless of age, race, sexual orientation, cultural, ethnic and linguistic background. As of 2006, New Jersey had an estimated population of 8,724,560 residents, with an estimated 2,163,691 children and adolescents under the age of 18. Studies have shown that at any given time, at least one in five adults and one in five children and adolescents will experience a mental health problem.

In specific relationship to culturally diverse populations, based on census statistics, the foreign-born population of New Jersey was about 1,768,350 residents in July 2006. This meant a foreign-born population share of 20.3 percent. The amount of change since the 2000 census indicates an average annual rate of increase in the foreign-born population of about 46,355 people, which is 94.1 percent of the state's annual average population increase.

In order to provide appropriate services and supports, the target population must first be reached out to in terms and values to which they can relate. The demographic face of New Jersey has changed drastically in the past 20 years, with more than 70 linguistic and

cultural groups within larger population categories consisting of African Americans, Latino or Hispanic Americans, Asians and Caucasians. Subgroups consist of Haitians, Puerto Ricans, Dominicans, Russians, Polish, Pakistanis, Indians and many other groups, which each have their own values. Within these groups are further subcultures, including those related to gender, age, income level, geographic region and physical disability.

Supporting the dire need for culturally competent professionals in New Jersey, given the ethnic diversity of the State's population, in 2005 Governor Richard J. Codey signed into law a requirement that medical professionals be trained in the provision of culturally competent health care as a condition of licensure to practice medicine in New Jersey. The law states, "...providing quality health care to all segments of society dictates the need for a formal requirement."

In order to reach, relate to and provide therapeutically appropriate services and supports to New Jersey adults and children with diverse racial and ethnic backgrounds who are often bi-cultural or multi-cultural, all mental health providers have to recognize and address unique sets of mental health issues, in terms of symptom presentation and clinical interventions. This involves building upon cultural knowledge as well as families' strengths. Cultural knowledge and sensitivity must be incorporated into every aspect of program development, policymaking, administration and services.

Cultural Competence

Natural helping networks, such as neighborhood organizations and community groups, are also valuable sources of support and need to be involved.

Cultural and linguistic competence and a strong knowledge, understanding and inclusion of the community are crucial in order for service providers to appropriately understand and respond to the needs of individuals. This type of attention to the details and specifics of each individual's cultural background will dramatically improve treatment outcomes.

NJAMHA supports additional funding dedicated to training and educating mental health providers on cultural competence and expanding culturally sensitive and competent services.

As state policymakers begin to realize the effectiveness and strengths of culturally competent services, the demand for more training and education will increase. New statewide programs, such as the New Jersey Mental Health Institute's *Changing Minds, Advancing Mental Health for Hispanics* program and its National Resource Center for Hispanic Mental Health, have culturally and linguistically specific components intended to address and overcome the barriers that routinely prohibit mental health providers from treating New Jersey's diverse population. Such programs have shown immensely successful outcomes and promise to revolutionize the method in which mental health services are delivered in the state. The State of New Jersey, through the Division of Mental Health Services (DMHS), has made important strides in the right direction, teaming up with commu-

nity partners to develop statewide cultural competency trainings and education seminars. The State of New Jersey must be committed to providing culturally competent services through routine and timely training of staff and employees in State government and the community alike.

Good training alone, provided to agencies by outside entities, does not usually lead to lasting and substantial change. Agency competencies and increased agency staff capacity to grow are the keys. Funding for training should also encompass individualized and ongoing technical assistance to any agency that needs it.

Licensing and Standards

NJAMHA supports the continuation of the exemption of nonprofit mental health providers from the New Jersey Board of Social Work Examiners (at N.J.S.A. 45:15BB-5) and the New Jersey Board of Marriage and Family Therapy Examiners (at N.J.S.A. 45:8B-6) regulations. These boards oversee the practice of professional social workers and therapists and administer the licensing and certification requirements governing these professionals.

The nonprofit exemption gives community mental health agen-

cies the needed flexibility given nonprofits' serious staff retention and recruitment issues.

Largely due to low salaries, inadequate or non-existent benefits, and sizeable pay scale inequities between the nonprofit and for-profit sectors of care, there is a serious shortage of certified and licensed social workers and therapists working in nonprofit mental health agencies throughout New Jersey. In recognition of this, nonprofit mental health programs have long been exempt from the regulations of the State Boards of Social Work and Marriage and Family Therapy

Examiners. Further, exemptions for the nonprofit sector are fairly common across the nation for the very same reasons.

The nonprofit exemption is a very important component to the strength and stability of the community mental health system. Licensed and certified social workers and therapists command salaries that nonprofit providers can ill afford to pay. In addition, retention of this level of professional has been difficult since once certified and licensed, these professionals often migrate out of the nonprofit sector of care to State and private sector

Licensing and Standards

positions with higher compensation and benefits than those of the nonprofit service sector. All too often, nonprofit providers serve as a training ground for students pursuing licensure, only to lose them once licensure and certification are obtained.

There are major considerations uniquely applicable to the nonprofit mental health system of care that demand the continuation of the exemption:

- The number of clinically complex individuals with co-morbid conditions (e.g., mental illness in combination with serious physical conditions, addictions, and/or developmental disabilities) presenting for mental health services continues to increase while funds stay stagnant.
- Nonprofit mental health providers continue to struggle to meet the escalating costs of providing services (e.g., utilities, gas, health insurance, etc.), with no predictable inflation factor or annual cost of living adjustment.
- State oversight already exists in the form of extensive State regulations, incident reporting systems, and on-site monitoring visits by the Division of Mental Health Services, Medicaid, the Department of Health and Senior Services, and the Division of Addiction Services, among others, all with a focus on consumer protection and quality care.

- Waits-for-service exceed, on average, six weeks.
- In several programs that serve adults and children at high risk of re/hospitalization and out-of-home placement, staff vacancies can last over six months. Staff vacancy rates can span between 15 and 17 percent.
- If required to hire only higher salaried licensed professionals, programs could not afford to maintain current client capacity, thereby leaving needy New Jersey residents unserved, which would result in more costly types of care, such as psychiatric hospitalizations or emergency room services. **Whenever community provider service capacity is compromised by interests of a particular profession, preserving service capacity should win.**

In 2005, a bill was introduced that would have eliminated the nonprofit exemption. With the community mental health system already on the brink of a crisis due to the shortage of employees willing to work for wages that are considerably lower than what the State and for-profit sectors have to offer for similar job responsibilities, this bill would have crippled the existing community mental health system, increasing already excessive waits-for-service and caseload sizes.

The sustainability of the community mental health system relies upon community agencies' non-credentialed staff, and any attempt to

eliminate or remove the nonprofit exemption would have detrimental and irreversible consequences on the viability of the nonprofit mental health system of care.

With regard to overlapping licensing requirements and monitoring visits across departments of the State, NJAMHA supports a full "deemed status" recognition of national accreditations, such as the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Committee for Quality Assurance (NCQA), the Council on Accreditation of Services for Families and Children (COA) and other prestigious national accrediting bodies, as equivalent to State licensure.

In order to streamline operations and to avoid onerous and costly administrative duplications, NJAMHA supports work by the Department of Human Services to unify accreditation by national bodies, and allow for "deemed status" for State licensure and **encourages the Department of Children and Families to follow suit.** This will help to end lengthy and often unnecessary site reviews that redirect staff time away from direct care services to prepare for site visits.

It would also be more efficient to have State site reviews synchronized with accreditation surveys to best utilize staff time devoted to this non-direct care task.

Licensing and Standards

NJAMHA supports the coordination of State facility licensing requirements for mental health and addictions services to eliminate the administrative duplication and the cost involved in multiple licenses.

Mental health programs that are currently certified/licensed by the New Jersey State Division of Mental Health Services and that also offer addictions services should not have to apply for additional licensure

for programs that treat dual mental illnesses/addictions disorders.

Through State coordination of licensure requirements and reciprocal recognition of existing mental health and addictions program licenses, providers will be better able to direct time and dollars toward direct services rather than toward meeting administrative obligations. Given the high prevalence of co-occurring disorders among those with mental health disorders, and in light of the publication of re-

search that supports the effectiveness of coordinated and simultaneous treatment of persons with dual diagnoses (i.e., both mental illness and addictions issues), a uniform licensure standard is needed for programs that provide comprehensive mental health and addictions services to eliminate the time-consuming process of applying for separate licensure and to promote the clinically recognized simultaneous treatment approach for programs treating these dual diagnoses.

Efficiencies

The State's regulatory climate continues to be of tremendous concern to NJAMHA members. We continue to work to restructure and reform the state regulatory system to avoid overlapping and duplicative requirements; to achieve regulatory relief from unfunded mandates; to reduce regulatory barriers; to decrease excessive and unnecessary administration and oversight; to minimize and end unwarranted penalization; to increase coordination among the various divisions and departments of government; to encourage performance based on achievable goals; and to generate greater awareness and responsiveness to members' operations and fiscal realities so that they can best serve the needs of persons with mental illnesses and addictions, children with emotional and behavioral health disorders, and their families. To operate efficiently in the current healthcare environment, the State of New Jersey needs to review and streamline policies, regulatory pro-

cesses and reporting requirements that are overlapping and creating unnecessary duplication and to develop policies and regulations that result in operational, administrative and fiscal efficiencies.

NJAMHA supports the development of a statewide common database; the availability and creation of relevant norms and standard measures for performance; and their utility for the meaningful comparison and finite analysis of data in any combination to meet the needs of constituency groups – community nonprofit providers, payors, adults with mental illnesses and children with emotional disorders, and their families – in the mental health, addictions and children's systems.

Given the pressures from both private and public payors to produce relevant and useful measures of treatment modality/methodology

performance, NJAMHA urges the State to partner with community nonprofit providers to develop an instrument capable of integrating all data collection systems to produce a meaningful information source for all constituency groups and a larger statewide focus on improving and maintaining quality treatment, assuring safety and promoting wellness and recovery for children and adults based on a commonly defined set of objectives and measures. Such capability will serve as a cost-effective mechanism that will enable community nonprofit providers to integrate their data and use these data to more accurately measure outcomes.

NJAMHA supports the identification of increased efficiencies in State operations.

NJAMHA's primary commitment is to strengthen and enhance direct services to adults with mental illnesses and addictions and to chil-

Efficiencies

dren with serious emotional disorders, along with their families, to the maximum degree possible. One area that needs significant attention is the current way government is organized. As the children's, mental health and addictions systems move to new approaches, there must be a simultaneous change in government's role and an increased emphasis on the efficiencies that need to be realized within government.

1. NJAMHA encourages the State to move to a system of pooled funding across departments to reduce administrative overhead costs, thereby freeing up additional funds for direct services and supports.
2. In addition, NJAMHA urges the State to explore the potential of saving significant funds by streamlining its own licensing operations and by assessing cost vs. benefit analyses related to increased demands on providers. The State should:
 - Move to a system that demands accountability and promotes collaboratively defined outcomes.
 - Integrate licensing oversight into one licensing entity. Community programs are frequently stymied by the fact that they must adhere to multiple licensing authorities, are subjected to multiple division licensing site reviews, and meet standards that often overlap across and conflict between multiple State divisions/departments in terms of oversight and monitoring.

This would also help to address providers' growing staff retention issues and increase face-to-face time with clients.

- Automate the site review process in order to be able to readily identify, by standard, those areas most commonly found as deficient. In this manner, best practices and targeted training interventions could be more easily identified to produce quality improvements across the system of care.
- Modify the Department of Human Services (DHS) regulatory role regarding agencies with "full deemed status"—those accredited by a nationally recognized body such as the Joint Commission, the Council on Accreditation (COA), the Commission on Accreditation of Rehabilitation Facilities (CARF), etc. Although site visits would still be required, the nature of the visits would be less extensive.
- Extend deemed status to providers under contract with the Department of Children and Families (DCF).
- Consider the development of examples of standardized forms and check-off lists that agencies may choose, at their option, to use to demonstrate compliance with particular program standards.
- Consolidate regulations as much as possible to steer away from focusing on separate and distinct program elements, which

is not conducive to a systems approach and further fragments service delivery.

NJAMHA opposes mandates without reimbursement.

NJAMHA members believe that regulations, mandated requirements and legislation that result in increased administrative or service costs should include mechanisms to pay community nonprofit providers for the additional burden. Otherwise, unfair competition is created in the healthcare marketplace.

NJAMHA supports evidence-based treatments as we agree that treatments should be effective and that effectiveness should be objectively assessed by commonly defined measures between the State and providers.

Most of all, NJAMHA believes that children with emotional and behavioral disorders and adults with mental illnesses deserve measurably effective treatments and services that are driven by clinical outcomes.

...But NJAMHA opposes unfunded mandates, e.g., in the form of payment for the creation of infrastructure, training, and measurement tools.

NJAMHA opposes unfunded reporting requirements.

In August 2, 2006 RAND Corporation issued a study that found that work hours spent on compliance

reporting consumed 11 percent of the nonprofit agency in question's annual budget. In fact, the RAND researchers discovered that employees of the agency spent nearly half their time collecting information needed for compliance efforts imposed by funders. These included activities such as writing reports, tracking expenses and attending meetings.

Further, NJAMHA has found that surveys conducted by the State and changes to data collection systems

are costly to providers and take time and attention from direct client care. NJAMHA strongly recommends that the State include providers in the planning and development of surveys and data collection efforts and conduct a cost vs. benefit assessment prior to mandating changes in policy, operational procedures, data collection etc. that will incur costs to providers. Additionally, providers should be given sufficient time to adjust to any new reporting requirements.

NJAMHA supports the State providing funds for creating the necessary information technology infrastructure and training, so staff can meet both compliance requirements and improve clinical outcomes.

The RAND study concluded that if nonprofits could find ways to comply with reporting requirements, such as the use of information technology systems that allow staff to create reports, update records and share files, the cost of reporting



It's **Time** To END The Wait

“It is to be hoped that within a few years the combination of increased mental health insurance coverage, added State and local support, and the redirection of State resources from State mental institutions will help us achieve our goal of having community centered mental health services readily accessible to all.”

These words could be spoken today. But they were part of an address by President John F. Kennedy Jr., delivered to Congress on Feb. 5, 1963. Forty-five years later, millions of adults and children with mental illnesses are *Still Waiting...*



In 1963, President Kennedy recognized the need to move individuals with mental illnesses out of institutions and to return them to their communities with a system of care that would provide diagnostic, emergency, inpatient, outpatient, residential, rehabilitation, and case management services, as well as mental health education and information.

The process began that year with the passage of historic legislation that created mental health centers in communities across the nation. New Jersey and the rest of the country have made tremendous progress during that time, but have fallen far short of the goals set out in 1963. One troubling statistic that demonstrates the failings of the system: Today, the life expectancy of individuals with severe mental illness is 25 years less than that of the general population and the gap is widening.

New Jersey began to address the crumbling system three years ago with the work of former Governor Codey's Mental Health Task Force and the ensuing focus on specific needs, such as housing, screening, and wellness and recovery.

But an architect knows you must not build additions on a house without ensuring that the foundation is strong. The added weight will force the whole structure to crumble. The foundation of New Jersey's mental health system is crumbling.

As a result, more than four decades after President Kennedy's optimistic prediction, millions of adults and children with mental illnesses – your family members, neighbors, co-workers, and friends -- are *Still Waiting* for a system that provides services that are “readily accessible to all”.

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