Broken Promises, Shattered Lives
An Audit of New Jersey’s Community Mental Health System
I disappear a little each day drowning, fading into the night

My life broken my hope shattered

I reach for help your hand slips away
In the early 1970s, the State of New Jersey embarked on an effort to reduce the State’s reliance on state and county psychiatric hospitals. Over the past 30 years, the number of public psychiatric hospital beds decreased by 87 percent, down from 15,000 in 1970 to under 2,300 in 2003. Although, as this audit will document, the State has succeeded in saving the taxpayer more than $1 billion annually as a result of this initiative, it has created numerous problems for the consumers, families and communities who require a mental health system that will keep people healthy and safe, not just save money.

The State has organized mental health services to reduce hospital admissions, but has not invested enough in the community system to provide the services necessary to fill the void. This underfunding and improper management has manifested itself in numerous problems, including:

- Inadequate salaries and raises
- Insufficient Medicaid rates
- Onerous contract and documentation requirements
- Retaining an institutionalized driven system over a community system
- High turnover and vacancy rates

The consequences for those with serious mental illness are grave and lead to crumbling lives. The State’s failure to invest in mental health services that keep people healthy rather than just save tax dollars has led to:

- Increased admissions to correctional facilities
- Increased homelessness.
- Increased substance abuse
- Self-destructive actions

The State has not provided adequate community support to those with serious mental illness to prevent crises consistently. When a tragedy occurs, as it does often in New Jersey, it is not just the person with mental illness who suffers, but also their family and others in the community who have been adversely affected by untreated symptoms. When the State finally intervenes, it is often after the tragedy has occurred, leaving others to deal with the consequences of the State’s underinvestment and limited focus.

The state must live up to its promises and make the following critical changes to ensure the hundreds of thousands of New Jersey residents with mental illness receive the services they desperately need. The solution includes:

- Providing an adequate cost of living increase
- Providing reasonable Medicaid rates
- Revising contract rules and reducing excessive documentation requirements to allow for innovation, efficiency and investment in services

With change, the community mental health system can avoid the crises that are sure to ensue when mental illness goes untreated and instead can foster the positive life changes that are possible when individuals live up to their full potential.
This fictionalized account is based upon a 2002 incident in New Jersey in which the woman spent eight months in jail. Jails and state prisons have replaced psychiatric institutions as the primary location to house individuals with mental illness. Nearly a fifth of New Jersey’s prison population (14 to 21 percent) is diagnosed with mental illness or serious emotional disorders, with substantially more individuals with mental illness in state prisons than in state psychiatric facilities. In fact, there are 50 percent more adults diagnosed with mental illness in prison than are in state psychiatric institutions. The number of children with emotional and behavioral disorders in juvenile detention facilities is a staggering 300 percent higher than the number in state psychiatric institutions.

While New Jersey’s prisons have dramatically improved their mental health care services as a result of the 1999 settlement of the Terhune vs CF court case, prisons still serve as a terrifying and dangerous place ill-suited for individuals with mental illness. Prisoners with mental illness often are victimized by other inmates and are unable to follow prison rules, according to Human Rights Watch, which issued a report in October 2003 that was cited in the New York Times.

The report states, “The high rate of incarceration of the mentally ill is a consequence of underfunded, disorganized and fragmented community mental health services. State and local governments have shut down mental health hospitals across the United States, but failed to provide adequate alternatives.”

The cost to society of these individuals’ incarceration must be taken into account when evaluating the failure to provide adequate community services. The average cost of incarcerating a juvenile is $62,500 per year, while mental health services provided to adult prisoners averages in excess of $5,000 annually. Adequately funded community services would be significantly less costly than incarceration, keep individuals with mental illness out of the prison system and enhance the communities in which they live.
Drug abuse and mental illness often go hand in hand, as illustrated in the narrative based on the real case of a New Jersey man who was in a coma for a month. While some individuals may develop a mental illness after abusing narcotics, many others who already have a mental illness turn to drugs as a means of dealing with the pain of the disease, particularly anxiety or depression.

According to the US Substance Abuse and Mental Health Services Administration, nearly 60 percent of individuals with a long history of drug abuse have a lifetime mental disorder. The use of illegal substances exacerbates the mental illness, while the combination of these problems can make recovery more difficult and incarceration, hospitalization, suicide, and homelessness much more likely. Among juveniles, the problem can be even more severe. Nearly two-thirds of incarcerated youth who abuse drugs have a mental health disorder.

A recent report issued by the Washington-based Drug Policy Alliance noted New Jersey leads the nation in the proportion of prison inmates jailed for nonviolent drug offenses, with 36 percent of the state’s prison population — or 10,000 individuals — serving sentences for drug violations. The cost in dollars and wasted lives is astronomical.

Despite the enormity of the problem of co-occurring disorders, New Jersey is woefully unprepared to meet the demand. The federal Center for Substance Abuse Treatment in a 2002 report found that in New Jersey “the substantial proportion of clients… having a co-occurring disorder argues for … greater systems integration and/or expansion of specialized treatment services.”

Because of the complexity in treating co-occurring disorders, it is critical that adequately trained staff can be hired to meet the need. However, because of low wages and insufficient salary increases, filling vacancies in these critical programs is a constant struggle. A recent report listed substance abuse counselors as one of the 10 most underpaid professions for the valuable work performed. Additionally, the need for residential placements for individuals with both mental illness and drug addiction is critical.
Family Reunited with Homeless Woman Found in Park

By MARKUS BROWN
NEW JERSEY STATE TIMES STAFF

The family of a 36-year-old woman found in Mason Park on Friday was reunited with their beloved sister yesterday. The family was brought together after reading an article about a confused woman found sleeping underneath park bushes despite the freezing temperatures.

Sharon Belus of Elmwood Park said her sister has schizophrenia and had been missing for three days. Belus was unsure how her sister had made the 25-mile trip from their home to the park and expressed gratitude to the police who had found and cared for her.

“It’s just so difficult to look after Marie all the time, especially since I work and have three children. Marie gets very confused when she doesn’t take her medication,” said Belus. “I’m just thankful she was found before she was hurt.”

The New Jersey Division of Mental Health Services estimates that there are as many as 9,000 individuals with mental illness who are homeless in New Jersey. Tens of thousands more live with family members who are overwhelmed by their caretaking responsibilities or live in substandard housing. The above narrative is based on the real life of a New Jersey woman and her sister.

Despite the desperate need for affordable, safe housing for individuals with mental illness in New Jersey, there is a severe shortage of residential facilities for these individuals and no statewide waiting list. Instead, the state forces a community housing facility with an open bed to turn away individuals who seek residential placement, saying they must first deteriorate to the point of requiring hospitalization in an institution before qualifying for placement.

Meanwhile, hundreds of other individuals with mental illness wait for discharge from state psychiatric institutions, because adequate facilities to meet their specific needs do not exist.

While the cost of the highest level of residential placement is only half of the cost of state hospitalization — $60,000 versus $120,000 annually – the state still balks at making the necessary investment in the community, leaving thousands of New Jersey residents scrambling for safe, affordable community housing with the supports to meet their mental health needs.

The Facts:

- As many as 8,969 mentally ill individuals were homeless in New Jersey in 2003, according to state estimates.
- Of those, only 560—or about 6 percent—were placed in long-term housing.
- Some individuals have waited on Bergen County’s housing waiting list for two years.
- The average age of parents caring for an individual with a mental illness is 65 years old, according to a survey conducted by NAMI NEW JERSEY.
- The average fair market rent for a two-bedroom apartment in New Jersey is $1,026, according to the National Low Income Housing Coalition.
At least 20 percent—and often times as many as 30 percent—of patients discharged from a state psychiatric institution are readmitted. While the state has made a commitment to reduce the number of individuals in state psychiatric institutions, it has failed to ensure adequate funding to maintain the services that are needed to keep individuals with mental illness safe in the community.

In an effort to keep recently discharged individuals with mental illness safe in the community, the state created the Programs for Assertive Community Treatment (PACT) and Intensive Case Management Services (ICMS) programs to provide intensive services to those persons most at risk of hospitalization. However, because of inadequate funding, these programs cannot retain the personnel needed to fill these difficult, yet critical, positions.

The tale of individuals cycling through the hospitals, languishing while they await discharge or leading self-destructive lives when released to inappropriate settings is a three-fold tragedy. Individuals trapped in institutionalized settings are missing out on the opportunity for more complete, productive lives in the community.

For many others who are in the community, but whose illness remains untreated, the emotional pain they experience sometimes leads them to take their own lives. In the United States, more than 30,000 people lose their lives to suicide each year. Suicide is the second leading cause of death among college students, with 90 percent of all adolescent suicide victims having at least one diagnosable, active psychiatric illness at the time of death. The vast majority, however, were not in treatment at the time of their death.

Providing adequate services in the community is critical to enabling individuals with serious mental illness to lead productive, safe lives.

Suicide took the lives of 29,350 Americans in 2000.

More people die from suicide than from homicide.

Suicide is the third leading cause of death among 15–24 year olds and its incidence is rising dramatically in young Americans.

Twenty (20) percent of all high school students have seriously considered suicide at some time.

The suicide rate for the elderly has been rising dramatically.
Take a look at the needs of mental health consumers and the services available to them. You will see a clear snapshot of the failures of the mental health system in New Jersey and the impact on those it serves. This analysis will demonstrate that the State of New Jersey has failed to live up to its promises to individuals with mental illness, leading to crumbling lives and devastated families. The community mental health system is stretched to the breaking point and in danger of collapse.

This audit demonstrates that the historically inadequate funding of the community mental health system has created unmanageable burdens for consumers, their families and the providers of their supports and treatment services. Today, the system is seriously understaffed and unable to meet the demands of the growing population in need of mental health care services.

The state, while maintaining its desire to move away from an institutionalization centered mental health care system, has continued to focus its funding and energy on state institutions at the costly expense of undermining and underfunding community mental health care providers. Because of higher salaries paid in the institutions, skilled and experienced community care workers are drawn away from their positions in the community to work in state facilities or other higher paying fields, leaving community agencies struggling to fill vacancies and understaffed, particularly in demanding and high-risk programs.

The state continues to exacerbate the situation by not allotting the same adequate Cost-of-Living increases that it provides to state employees each year to contracted agencies, thereby further widening the gap between salaries in the community mental health system and in state psychiatric institutions. Additionally, because the state does not provide the non-profit organizations which face other increased costs, such as insurance, gas and heating prices, with the same type of increases it provides to fund its own operations, mental health care providers are forced to make additional cutbacks.

The vacancy and high turnover rate, coupled with onerous regulations, difficult work conditions and inadequate resources – such as a lack of housing for consumers, are bringing the community mental health system to the edge of a crisis. The strained system, long underfunded and taken for granted, is cracking under the weight of increased demand and inflexible constraints.

As a result, mental health consumers released from state and county psychiatric institutions with the promise of a better life in the community often cannot obtain the level of service and supports they deserve and therefore often cannot reach their potential. Worse yet, there are consumers who are lost to the system or decompensate so greatly they reach crisis levels and return to the hospital, end up in prison or living on the street.

As funded, the community mental health system cannot live up to the promise created in 1963 or to the legal obligations of the 1999 Olmstead decision. The State of New Jersey must invest a greater portion of the billions of dollars saved by moving individuals with mental illness out of deteriorating psychiatric institutions back into the system to ensure the well-being of these state citizens.
Approximately 50 years ago, more than 20,000 of New Jersey’s citizens were housed in state psychiatric institutions. In 1963, President John F. Kennedy ushered in a new era with the creation of the Mental Retardation Facilities and Community Mental Health Centers Construction Act, which provided the funding for the construction of hundreds of community mental health centers across the nation. Along with the medical community, President Kennedy recognized the need to move mental health consumers away from antiquated institutional settings to productive lives in the community. With the advent of improved treatments in the 1960s and the burgeoning community mental health system, thousands of patients enjoyed improved, productive and more independent lives.

More recently, in the 1999 Olmstead vs. L.C. decision, the U.S. Supreme Court ruled that states are required to take reasonable steps to move individuals with mental illness out of institutions into community settings.

In New Jersey, the exodus from the institutions began in the 1960s, accelerating in the 1970s through the 1990s, when the state moved from a population of 15,000 to 2,330 as of August 2003. Achieving these reductions enabled the state to close Marlboro Psychiatric Hospital and drastically scale back its other facilities.

The closure of Marlboro saved the state $68 million annually in 1995 dollars – which had provided services for 580 patients at a cost of nearly $120,000 per individual annually, all the while promising adequate funding to meet the need in the community. According to the New Jersey Division of Mental Health Service’s 2000 Status Report on the Redirection Plan, the state committed that:

- The dollars saved by the closing of Marlboro Psychiatric Hospital were to be permanently transferred to other mental health needs;
- Only clinically suitable patients were to be relocated to community settings;
- Community residential and clinical services were to be expanded and upgraded to better accommodate future and existing community mental health consumers and to divert unnecessary hospital admissions.

In its Redirection I Plan, the state noted the critical nature of the Integrated Case Management Services (ICMS) system, which offers a minimum of 18 months case management services to every consumer discharged from a state or county psychiatric hospital, and the round-the-clock Programs for Assertive Community Treatment (PACT), which serves mental health consumers most at risk of hospitalization. The success and stability of these programs are essential to meet the needs of discharged consumers.

However, as will be illustrated in the sections that audit salaries and vacancies, these programs are severely underfunded and stretched to the breaking point.
The State of New Jersey has saved billions of dollars by its ability to serve mental health patients in the community rather than in state psychiatric institutions. To illustrate, if the state were to still house 20,000 individuals in institutions at a cost of $120,000 per patient, the state would spend $2.4 billion annually on state psychiatric institutions alone. Instead, the state’s entire community mental health care budget, which provides contract and Medicaid dollars to non-profit facilities that serve approximately 220,000 individuals annually, is $434 million (which also includes a small percentage of client fees).

The chart below dramatically illustrates the bargain the state enjoys in its community mental health services program.

<table>
<thead>
<tr>
<th></th>
<th>STATE INSTITUTIONS</th>
<th>COMMUNITY SERVICES</th>
<th>RESIDENTIAL</th>
</tr>
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<tbody>
<tr>
<td># SERVED</td>
<td>2,280</td>
<td>220,000 (estimate)</td>
<td>4,790</td>
</tr>
<tr>
<td>ANNUAL COST</td>
<td>$244M</td>
<td>$434M (includes client fees)</td>
<td>$96M</td>
</tr>
<tr>
<td>DAILY AVERAGE</td>
<td>$350</td>
<td>$5.35</td>
<td>$54.90</td>
</tr>
</tbody>
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To further demonstrate the inequities in the system, compare the dollars spent in the state-run psychiatric institutions — $244.3 million in 2003 to serve 2,280 patients. Each of the state’s hospitals has a staff ratio of approximately two employees for every client. Of those employees, as many as 20 percent serve as administrative and support staff as opposed to patient care and program staff. However, in the community system, which has experienced a 6 percent increase in demand for state-funded services – from 291,672 episodes of care to 310,732 episodes of care from 2001 to 2003 – there was a 4 percent decline in state contract funding.

By continuing to shortchange the community mental health system, the State of New Jersey is actually increasing the demand on more expensive state services. Individuals in the community at risk of a crisis may be unable to obtain the services they require and deteriorate to the point of needing hospitalization at a cost of $350 a day.

Compounding the problem, the state has increased burdensome regulations, reduced flexibility, frozen Medicaid rates and hamstrung providers, while providing no incentives for ingenuity or resourcefulness.
Medicaid rates for reimbursement for mental health care services have stagnated for nearly three decades, making it nearly impossible to recruit and retain qualified staff. When some of these rates were instituted nearly 30 years ago, Richard Nixon was president, a stamp cost 8 cents, a gallon of gasoline was 39 cents and the average national income was $8,030.

The $9 allotted for a medication management visit is to pay for 20 to 30 minutes of a psychiatrist’s time, when a mental health consumer discusses the side effects of prescribed medications, new medical conditions and prescriptions and other pressing issues. Only able to recoup between $18 to $27 an hour, mental health care providers must pay approximately $95 an hour, not including benefits, to the physician. The result is long waits — sometimes as long as three months — between appointments for consumers.

The situation is even worse for comprehensive intake, which requires the time of screeners, 90 minutes with a psychiatrist and the cost of transcription. For a service that costs providers at least $200, they receive $45. Such low reimbursement rates leads to a 4-to-6 week wait for an initial meeting, during which time consumers can seriously deteriorate. Agencies are constantly juggling the demands of individuals in crisis, which puts a further strain on the system.

Mental health care providers receiving such unrealistic reimbursement rates and stagnating contract funds still must meet the rising costs of running a business and have little choice but to maintain a hold on employee wages.

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>INADEQUATE REIMBURSEMENT RATE</th>
<th>ACTUAL COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Intake</td>
<td>$45</td>
<td>$200</td>
</tr>
<tr>
<td>Individual Psychotherapy (50 to 60 minutes) Risen only once since 1977</td>
<td>$26</td>
<td>$90</td>
</tr>
<tr>
<td>Group Psychotherapy Has not changed in 25 years.</td>
<td>$8</td>
<td>$55</td>
</tr>
<tr>
<td>Medication Visit</td>
<td>$9</td>
<td>$60</td>
</tr>
<tr>
<td>Injection Visit</td>
<td>$2.50</td>
<td>$30</td>
</tr>
<tr>
<td>Family Conference (50 minutes)</td>
<td>$13</td>
<td>$90</td>
</tr>
<tr>
<td>Partial Care (Full Day)</td>
<td>$77</td>
<td>$145</td>
</tr>
</tbody>
</table>
Employees in the community mental health care system historically have been underpaid and given short shrift. Particularly when compared to state employees with similar experience and job titles in state psychiatric institutions, these devoted community workers receive significantly lower salaries and far fewer benefits.

Imagine the valuable work these individuals perform: Screening individuals in crisis to ensure appropriate placement, monitoring and prescribing appropriate medication to control symptoms, counseling to help individuals cope with the trials of life and mental illness, connecting clients with appropriate community services, providing substance abuse counseling, and helping to find housing, among many other activities. This is not a job for someone who wants an easy 9-to-5 experience. It requires patience, commitment and a wide range of talents.

Many positions that pay approximately $30,000 require a master’s degree. See the attached 2001 salary chart (Table A) that compares wages at state run New Jersey psychiatric institutions and salaries paid at New Jersey community mental health agencies. The state wages were obtained from the National Association of State Mental Health Program Directors Research Institute, while the community wages were compiled from information submitted by a representative sampling of approximately 20 percent of New Jersey’s community mental health agencies.

The severe discrepancy between state and community salaries is striking. In every job category, the entry level state salary is at least 30 percent and sometimes as much as 90 percent higher than the community entry level salary. Additionally, in all instances, the entry level state salary is significantly higher – at least 20 percent — than the average community salary.

Each year, the gap widens as state workers receive the state-union negotiated increases in addition to built-in anniversary increases within each salary range. Meanwhile, rarely growing far beyond the salary at which they were hired, community workers are only allotted meager increases afforded by the Cost of Living Allowances offered by the state those years when they are fortunate enough to receive one. These increases generally range from 1 to 2 percent and were denied in fiscal year 2004.

The meager increases afforded community facilities not only must cover wage hikes, but also are needed to cover the increased costs of insurance, transportation, rent and other services. As the chart notes, while the salaries provided to state workers just kept pace with the Consumer Price Index, both they and the COLA fall far short of the annual increase in medical costs.

An employee discouraged by such inadequate wages does not have to look far for other employment opportunities, as the unemployment rate for health service workers generally remains 2 to 3 percentage points below that of the general population. Therefore, even the most dedicated and hard-working employees are hard pressed to stay with the jobs they love.
### TABLE 1: SALARY COMPARISON

<table>
<thead>
<tr>
<th>Position</th>
<th>Entry level NJ State Hospitals</th>
<th>Entry level NJ Community Programs</th>
<th>Entry level Community Connecticut</th>
<th>National average state hospitals—entry level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social workers MSW</td>
<td>$40,999</td>
<td>$28,000</td>
<td>$41,655</td>
<td>$30,745</td>
</tr>
<tr>
<td>Psychologists, Ph.D.</td>
<td>$64,969</td>
<td>$35,000</td>
<td>$50,324</td>
<td>$41,610</td>
</tr>
<tr>
<td>Substance Abuse Counselors</td>
<td>$46,389</td>
<td>$30,000 (master’s)</td>
<td>$38,865</td>
<td>$27,927</td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>$142,480</td>
<td>$100,000</td>
<td>$119,025</td>
<td>$96,352</td>
</tr>
</tbody>
</table>

2001 statistics from the National Association of State Mental Health Program Directors Research Institute and a survey of a representative sample of NJAMHA members.

In every category, the entry level salary in NJ state psychiatric institutions was between 45-90 percent higher than the entry level salary in NJ community programs. For example, social workers with a master’s degree in state hospitals earned $40,999 to start, while the starting salary was $29,000 in the community. The gap has continued to widen over the years.

### TABLE 2A: COMPARISON OF COLAS FOR STATE EMPLOYEES VERSES SERVICE PROVIDERS

<table>
<thead>
<tr>
<th>Year</th>
<th>State Employee Wage Increases</th>
<th>Cost of Living Adjustment for Service Providers</th>
<th>Medical Care Consumer Price Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989</td>
<td>4.0% 5.0%</td>
<td>7.7%</td>
<td></td>
</tr>
<tr>
<td>1990</td>
<td>4.5% 4.2%</td>
<td>9.0%</td>
<td></td>
</tr>
<tr>
<td>1991</td>
<td>5.5% 5.0%</td>
<td>8.7%</td>
<td></td>
</tr>
<tr>
<td>1992</td>
<td>5.5% '5.0% - cuts'</td>
<td>7.4%</td>
<td></td>
</tr>
<tr>
<td>1993</td>
<td>6.0% 3.0%</td>
<td>4.8%</td>
<td></td>
</tr>
<tr>
<td>1994</td>
<td>n/a 3.0%</td>
<td>4.5%</td>
<td></td>
</tr>
<tr>
<td>1995</td>
<td>n/a</td>
<td>3.0% - $3.6M in cutbacks</td>
<td>3.50%</td>
</tr>
<tr>
<td>1996</td>
<td>n/a</td>
<td>0%-$5.5M in cutbacks</td>
<td>3%</td>
</tr>
<tr>
<td>1997</td>
<td>2% 2.00%</td>
<td>3.20%</td>
<td></td>
</tr>
<tr>
<td>1999</td>
<td>2% 1.60%</td>
<td>3.50%</td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td>2%+1.5% 0.80%</td>
<td>4.10%</td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td>2%+1.5% 1.60%</td>
<td>4.60%</td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>2%+1.5% 1.60%</td>
<td>4.70%</td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>2%+1.5% 2.00%</td>
<td>4.00%</td>
<td></td>
</tr>
<tr>
<td>2004</td>
<td>2.90% 0.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2004-05</td>
<td>2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2005-06</td>
<td>2%+2.25%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2006-07</td>
<td>2.35%</td>
<td></td>
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Note: A 2% + 1.5% denotes two raises in one fiscal year.
The result of this untenable situation is the inability of many agencies to retain skilled and experienced employees and to recruit to fill vacancies. The turnover rate in some agencies can reach as high as 125 percent – with some positions becoming vacant twice in one year. And in several high-risk programs, such as the Programs for Assertive Community Treatment (PACT), which serves the consumers most at risk for hospitalization, and Intensive Case Management Services (ICMS), which serves individuals released from state institutions, vacancies can last more than 6 months.

The program, which was designed to avert crises, instead must focus on individuals in the midst of crisis.

In the PACT program, workers must visit the residences of clients, sometimes in dangerous neighborhoods. They are needed at all hours and regularly must address developing crises.

Of the 256 Programs for Assertive Community Treatment (PACT) positions statewide, the vacancy rate was 15.4 percent as of June 30, 2003, and 17.6 percent as of December 31, 2002. Some critical positions have been vacant for more than a year. These individuals serve 1,819 PACT clients, most of who have chronic conditions and have been repeatedly hospitalized.

PACT team members work with consumers to ensure they understand the importance of their medication and take it regularly. In some instances, they must visit daily to ensure compliance. Staff also struggle to help consumers avoid homelessness and re-hospitalization. But because of the high vacancy rate, staff members must carry higher caseloads and often are unable to see individuals as often as necessary. The program, which was designed to avert crises, instead must focus on individuals in the midst of crisis.

The vacancy rate in Individual Intensive Case Management Services (ICMS) programs can range up to 25 percent. ICMS employees serve 6,500 clients in need of comprehensive and a high level of support. The impact on remaining employees, who must do the work of two — and sometimes three — employees, and on the mental health consumers they serve can be devastating.

Because of the inability to fill vacancies, the overburdened staff must carry heavy workloads and are less able to provide the level of service needed for the optimum care of mental health consumers. As a result, clients can decompensate, reaching crisis levels and end up back in state psychiatric institutions or county hospitals. Many end up in prison or living on the street. Consumers, then, are denied the opportunity to reach the highest levels of functioning they may be able to attain.
The Division of Mental Health Services employs a policy of excessive micromanagement of provider agency contracts that makes innovation and efficiencies nearly impossible. The fiscal employees of community mental health care providers spend as much as 20 percent of their time doing budget modifications, which is a $4 million drain on the system. These dollars could be used instead to provide services. The system focuses on revenues without regard to expenditures and includes a highly restrictive budget modification policy that forces agencies to lose money, scrimp on salaries, waste resources and focus on paperwork instead of services. These policies reduce the quality of services provided and increase the opportunity for dramatic and life threatening incidents.

Current state agency documentation requirements necessitate excessive amounts of paperwork that require an inordinate amount of staff time to complete. Even worse, these requirements often have little to no bearing on the quality of care.

The state builds in barriers that prohibit community service providers from responding to the specific needs of consumers. For example, the state will not allow a consumer to utilize the services of a PACT team and an outpatient program, often leading to the individual’s deterioration and rehospitalization or homelessness. Such arbitrary barriers were not designed with the needs of the consumer in mind and ultimately lead to increased costs.

Additionally, if a service provider finds efficiencies in one program or generates additional income through fundraising, it must return the excess to the State Treasury, even if it has severe deficits in another program. Those deficits must lead to cutbacks, although the agencies are prohibited from reducing services, leading to an impossible situation. After years of under funding, the system has been patched together with gum and glue and is ready to burst at the seams.

"WE WANT TO SPEND OUR TIME ENGAGED WITH OUR CLIENTS AND THEIR FAMILY MEMBERS -- NOT WITH REAMS OF MEANINGLESS PAPER. OUTCOMES, NOT PAPER CHASES, SHOULD BE THE PRIORITY."

Joseph Masciandaro, President/CEO, Care Plus New Jersey, Inc.
The result of this underfunded and overly controlled system is marked. Despite the state’s commitment to close outdated state psychiatric institutions, the institutionalized population is rising once again, with many individuals continuing to cycle through the state system.

Additionally, the number of individuals ready to move into the community but remaining in the institutions, called Conditional Extension Pending Placement, (CEPP), are dramatically rising (see graph below). They remain trapped because of the lack of adequate services in the community. The cost to the public is $120,000 per year for each individual hospitalized. But the cost in lives is even more dramatic. These individuals, with adequate services, could be enjoying productive lives in the community.

Instead, many individuals spend years in institutions or end up in prison, living homeless on the street, addicted to drugs or even dead through neglect or suicide. Their stories, which are repeated hundreds of times throughout the state, are found in the front of this audit.

THE PRICE WE ALL PAY

THE COST TO THE PUBLIC IS $120,000 PER YEAR FOR EACH INDIVIDUAL HOSPITALIZED. BUT THE COST IN LIVES IS EVEN MORE DRAMATIC.

IN JUST SIX MONTHS, THERE WAS NEARLY A 20 PERCENT INCREASE IN THE NUMBER OF INDIVIDUALS WHO CANNOT BE DISCHARGED FROM STATE INSTITUTIONS BECAUSE OF A LACK OF APPROPRIATE COMMUNITY SERVICES.

State Psychiatric Hospital Census

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Adult</td>
<td>2,077</td>
<td>2,057</td>
<td>2,065</td>
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<tr>
<td>Forensic</td>
<td>200</td>
<td>197</td>
<td>188</td>
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<tr>
<td>Children</td>
<td>49</td>
<td>45</td>
<td>42</td>
</tr>
<tr>
<td>CEPP</td>
<td>910</td>
<td>765</td>
<td>852</td>
</tr>
</tbody>
</table>

-Adults in State Psychiatric Hospitals as of December 2003

- 1167
- 910
- 44% CEPP Status Awaiting Discharge
What must the state do to remedy this crisis situation?

NEW JERSEY MUST:

- Provide a 4 percent increase in contract dollars to cover the increased cost of doing business and to retain vital staff.
- Eliminate burdensome and unreasonable regulations through real contract reform.
- Revise contracts to focus on service outcomes, best practices and staff training rather than the micromanagement of budgets.
- Allow service providers to retain a percentage of the money they save or raise to be used to help struggling programs.
- Immediately create a panel to review abysmally low Medicaid rates and raise the rates to a realistic level to ensure adequate access to services.
- Implement an office procedures code in Medicaid to cover the full range of services during an outpatient visit.

By continuing to ignore the plight of non-profit community mental health care providers, New Jersey is failing to live up to the promise of its de-institutionalization plan and the Olmstead decision, and threatening hundreds of thousands of individuals with mental illness with shattered lives. New Jersey must live up to its commitment to these individuals.

By doing so, New Jersey will save millions of dollars, avoid needless tragedy, and offer the opportunity for full, productive and promising lives to hundreds of thousands of New Jerseyans and their families.
The New Jersey Association of Mental Health Agencies, Inc. (NJAMHA) is comprised of the leading mental health care providers who treat New Jersey residents with mental illness. Our membership represents top decision-makers from organizations in every county and almost every community statewide - nearly 98 percent of the mental health care market in New Jersey that serves mental health consumers and their families. In aggregate, our members help children and adults with mental health issues more than 1 million times annually and employ 50,000 members of the state’s workforce.

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