NJACMHA
New Jersey Association of County Mental Health Administrators

February 5, 2013

Hon. Peter G. Verniero, Co-Chair
Hon. John J. Degnan, Co-Chair
New Jersey SAFE Task Force
NJ-SAFETaskForce@njdcj.org

Subject: NJ Association of County Mental Health Administrator SAFE Task Force Input

Dear Hon. Peter G. Verniero and Hon. John J. Degnan:

County Mental Health Administrators have a statutorily mandated responsibility (N.J.A.C. 10:37-3.7) to ensure that appropriate treatment is provided to citizens living with mental illness. The New Jersey Association of County Mental Health Administrators (NJACMHA) takes this duty very seriously.

Despite the best efforts of NJACMHA, the Division of Mental Health and Addiction Services, mental health providers, consumers, family members, educators and advocates, this responsibility has been an uphill fight. Along with the rest of the nation, New Jersey juggles with the competing demands of population growth, infrastructure inadequacies, deinstitutionalization, and an increasing demand for specialized services. Service barriers include waiting lists, inadequate insurance coverage and payment rates, as well as the lack of expertise for some very complex problems contribute to the hardships our system faces. A primary barrier to mental health treatment and a primary concern of NJACMHA is stigma. As noted by the Governor's Council on Mental Health Stigma, "Stigma appears as distrust, fear, stereotyping, and discrimination"[1].

NJACMHA writes to the NJ SAFE Task Force today, to express our collective thoughts on mental illness, substance abuse and the relationship to violence.

- ***Criminalizing mental illness perpetuates stigma and hurts those who need help.***

  We know, unfortunately, that "mental illness has traditionally been considered one of the key exemplars of stigmatizing conditions from both theoretical and empirical perspectives", and as such, research shows a significant increase in the association of violent acts, tendencies, or impulses when thinking of or describing a mentally ill person[2].

  Increased negative perceptions are linked to: exposure to negative images of the mental illnesses in mass media; the perception of dangerous to self or others, as defined in commitment criteria, as the publicly perceived standard for diagnosable mental illnesses; and the increase in perceived fear when exposed to mental illness as a result of deinstitutionalization.

  What we need to be cautious of is our role, here and now, in perpetuating stigma. Stigma associated with mental illness will only be decreased when the general population accepts and recognizes mental illness for what it truly is, a chronic disease. A disease, like most others, that differs in range of recovery.

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[1] 2012, About stigma: The basics, NJ GCMHS.
[2] Phelan, J.C. & Link, B.G. (1998) The growing belief that people with mental illnesses are violent: The role of the dangerousness criterion for civil commitment. Soc Psychiatry, 33.

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Some who are affected will go on and fully recover to lead full and productive lives, while others will be dependent upon services and treatment for the rest of their lives. We, as a community, need to model the behavior we'd like the public to adopt.

Conceptualizing, planning and carrying out social interventions almost always yield intended and unintended consequences. We can't allow for individuals with a mental health care need to feel as if they are in a no-win situation in that if they seek mental health treatment, they will be stigmatized as a potentially dangerous person. Nor can we allow for the mental health consumer advocating against stigma to be discriminated against as a result of self-identification that they are in fact a member of a stigmatized group[2].

SAMHSA has clearly documented stigma as a leading obstacle for individuals in need of mental health services[3]. The same applies to family members of persons seeking treatment for mental health concerns. Families fear stigma as do the consumers themselves.

We, as a community, are in a position to strengthen our support of those in need by steadying our course against stigma.

- ***The mental health system of care is neither an adequate nor appropriate safety net to prevent and predict criminal behavior.***

Not all criminals have a diagnosable mental illness and not all individuals living with a mental illness will become criminals. In fact, SAMHSA notes the perception that people with mental illnesses are violent and unpredictable is a falsehood as "the vast majority of people with mental health conditions are no more violent than anyone else" and "people with mental illnesses are much more likely to be the victims of crime". Sadly, family members are the most likely targets of violence from untreated mental illness[4].

While the mental health system is well partnered with law enforcement, courts, and forensic specialties, the fact remains that the community mental health system is not law enforcement. Placing unrealistic demands and expectations in regard to the prevention and prediction of criminal behavior will undoubtedly negatively impact our system's ability to address the clinical mental health needs of our residents as a whole.

Even for the small percentage of mental health consumers that come to the attention of law enforcement, the community mental health professional cannot, and should not, be expected to serve as the safety net in preventing and predicting criminal behavior. Instead, the State should look to strengthen the collaboration between community mental health and law enforcement, courts, and forensic specialists. An example of this is enhancing Justice Involved Service's programming, drug court proceedings, and integrating more mental health training in the courts, law enforcement and other notable areas.

Importantly, the discontinuation of program funding for fiscally driven motives negatively impacts our system's capacity. An example is found in the discontinuation of the federal grant supporting Mental Health Probation Officers across NJ as of June 2012. While outcomes were reportedly positive, this critical component of the legal system was discontinued. Restoration or alternative funding is ideal as these positions must remain accessible in our community.

Additionally, NJ must not allow the law enforcement system to become the de-facto mental health alternative just because needed mental health resources are unfunded, underfunded and unavailable.

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[3] 2005 National Survey on Drug Use & Health (NSDUH) Data, SAMHSA.
[4] Arboleda-Florez, J., Holley, H., & Crisanti, A. (1998). Understanding causal paths between mental illness and violence. Soc Psychiatry, 33.

Clarity regarding the role of Involuntary Outpatient Commitment (IOC) is essential. Inappropriate and unrealistic expectations that IOC will serve as a community safety net in preventing and predicting criminal behavior will set this program up for failure. IOC is not a crime prevention program, but a program incentivizing treatment.

Mental health providers are not law and public safety specialists. Nevertheless, it can't be overlooked that the mental health system of care has a duty in upholding consumer and community safety as it is possible within a treatment purview. Early screenings, public education and a responsive, accessible treatment system are essential. The advent of forensic behavioral health homes, and integration with adequate forensic psychiatry, forensic case management, and forensic housing would ideally meet the needs of the justice involved consumer.

- ***Maximize existing insight and specializations. Avoid making a damaging and unfair link between mental illness and dangerousness.***

The mental health experts can provide the SAFE Task Force with recommendations related to the diagnosis and treatment of mental illness. It makes sense to rely on a task force of mental health experts to focus on the issues related to mental health, to include assessment and treatment options for people with violent thoughts or behaviors.

Similarly, rely on law enforcement and violence prevention experts to develop a set of recommendations related to gun violence. Providing even the best mental health diagnostic and treatment services will not solve gun violence, take illegal guns off the street or ensure the safe use of legally obtained firearms. Gun safety and violence is a separate issue.

The intersection of behavioral health and law enforcement is a complex one, and one that can't be tackled hastily. NJACMHA implores the Task Force to seek out input from current organizations and steering committees like the State's Justice Involved Services Task Force to better understand how behavioral health and law enforcement can intersect more appropriately to meet the needs of the community.

Specifically, attention must be directed to adequate behavioral health assessments, adequate treatment, and adequate options for individuals who are justice involved. Moreover, a realistic conversation must be had as to what treatment options do, or do not exist, for individuals within the community mental health system that are or may become justice involved. Safety is always a priority, but we must not overestimate what the community mental health system is capable of, and how that reality impacts law and public safety.

- ***The mental health system is underfunded, struggling for innovation, and homogeneous in care. NJ must acknowledge and address structural inadequacies and rigidity.***

New Jersey's population growth is exponential, and our system has struggled to cultivate the proper infrastructure to support both the basic and complex mental health and substance abuse needs of our residents. This is especially true for individuals with complex behavioral, medical and social needs.

Some areas of the State experience twelve (12) week waiting periods for basic outpatient mental health services. These are the basic assessment and treatment services that must be available immediately to people when they make that difficult call and request assistance. Turning away people who want outpatient mental health services is potentially a very costly error. And while some counties benefit from specialized programming and therapeutic interventions, others do not.

The system is severely lacking in its capacity to achieve wellness, recovery and safety for persons with mental illness by providing evidence based practices, innovative therapeutic interventions and strong clinically appropriate care. And because the system is operating in a crisis driven model, when

consumers or family members identify a concern, our system is often perplexed and unable to address the situation in an individualized and effective manner. To compensate for our lack of individualized and innovative programming, services are often offered to consumers and families that don't quite meet their need. Trauma informed care, forensic behavioral health homes, and early intervention behavioral health assessments that include multi-disciplinary inclusion are examples of much needed solutions.

The mental health and substance abuse system of care is in need of funding, plain and clear. Needed are the following: Medicare and Medicaid rate increases; insurance coverage of telemedicine, telepsychiatry and teletherapy; enhanced mobile services; and proper financial infusions to support both infrastructure and the introduction of much needed services. In this regard, our public and private system stakeholders should support, reward and adequately compensate research and research based treatments.

Successful mental health programs do exist, but these programs are often at capacity, with little flexibility to move beyond contracted levels of service due to funding constraints and conflicting regulatory and eligibility requirements. Again, these programs are not always available statewide. Without proper funding, flexibility, and innovation we will continue to dilute the already strained service delivery system.

The need for regulatory flexibility for program eligibility when clinically appropriate is paramount. An example is flexibility in effectively filling vacant state funded residential units through community referrals for aging in youth and other appropriate individuals in our communities. Often, these housing options are available only to those being discharged from state psychiatric hospitals.

Substance abuse, mental illness and co-occurring disorders are complex. Individuals, who ask for substance abuse and mental health treatment, need access to treatment immediately. And access to inpatient rehabilitation should not require one to fail at outpatient treatment first. It is simply too dangerous, in every way, to deny or delay immediate access to substance abuse and mental health treatment services to anyone that requests it.

The system is antiquated in the technology that would allow for seamlessness and interoperability. There is no comprehensive statewide database that effectively tracks treatment needs and outcomes. Without this data, we lack credibility. Sadly, many efforts to capture the information are unsuccessful. Outcome data, related to recovery and wellness, are deficient. We have to track more than just the number of people who are admitted and discharged from state and county hospitals. We must capture data specific to improvements in quality of life and progress made toward wellness and recovery to determine which services should be enhanced.

- ***Workforce development issues, funding and health care reform impact the availability of psychiatry and psychiatric specialties.***

It has been noted within various community needs assessments conducted through the Mental Health Boards and Children's Interagency Coordinating Councils that a shortage of psychiatrists and/or prescribers, within New Jersey, has an increasing negative impact on access to services

One of the most significant contributing factors in access to mental health services is the inability to attract, employ and retain psychiatrists on more than a per diem basis. Providers simply do not possess the financial resources necessary to attract, employ and retain psychiatrists, never mind psychiatrists with a specialty like pediatrics, geriatrics, forensics or complex neurodevelopmental issues.

Now is the time to engage in cutting edge collaborations and incentives to engage medical schools and hospitals to encourage young students to consider psychiatry and specialties like

neuropsychology. The complex behavioral, medical and social needs of our consumers clearly demand that we seek to better integrate and support access to psychiatric specialties.

It is important to communicate that NJ's experience with what seems to be a limited pool of psychiatrists within today's workforce is concurrent with international trends. In fact, the field of psychiatry is struggling to recruit, retain, and employ professionals while simultaneously realizing an exodus of current practitioners as they exit or fade from the system due to retirement[5]. On a continuum, psychiatry as a declining workforce trend is alarming to our system of care[6].

With some counties experiencing volume of approximately 700 consumers per month at psychiatric emergency screening centers, the systems ability to adequately meet the clinical needs of residents without additional psychiatrists is impossible absent of telepsychiatry. Telepsychiatry serves as a mechanism in which efficiency in service delivery is achieved within a system experiencing infrastructure deficits. As demands have continued to severely outweigh the supply of services, it is unfeasible to function without telepsychiatry within a state, like NJ, that is considered fast growing.

- ***System change as a result of the Comprehensive Medicaid Waiver and development of an ASO/MBHO will impact the system.***

  The mental health system is facing major changes with the development of a fee for service system. The new system must include adequate payment rates, timely payments and reasonable administrative requirements. Eligibility for service must be wide enough to ensure that all those seeking services have access and the quality of services must be assured.

NJACMHA strongly urges the NJ SAFE Task Force to consider these initial thoughts. We look forward to following your progress as you take on this enormous challenge. We support you in your efforts and stand ready to help in this process.

If you have any questions, concerns, or if we can be of assistance, feel free to contact me.

Respectfully,

Tracy Maksel, MPA
NJACMHA President

cc: NJACMHA Members
NJ Association of Human Service Directors
County Mental Health Boards

[5] Association of American Medical Colleges, National Physician Workforce Trends, 2009
[6] Rao, N.R. (2003). Recent trends in psychiatry residency workforce. Academic Psychiatry, 27(1), 269-276.