

MENTAL HEALTH

Scope of the Problem and Indicators of Need

Mental health is a basic human need that impacts not only quality of life, but also the ability to engage with and function in society. The lack of mental health, categorized according to mental disorders,¹ covers a broad range of severity and can range in presentation from mood disorders like depressive and bipolar disorders, to psychiatric disorders like schizophrenia, to anxiety disorders like posttraumatic stress disorder. The common characteristic of any mental disorder, as described by the American Psychiatric Association, is “a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.”² Essentially, when an individual’s mental health diminishes to the degree that it substantially impacts their lives they may be diagnosed as having a mental disorder and require appropriate treatment and services. In order to evaluate the state’s provision of such treatment and services, particularly for its most vulnerable residents, we must examine a number of factors. This overview of the problem and needs in terms of mental health will therefore explore both the prevalence of mental disorders in the state as well as the correlations between mental illness and particular vulnerable populations, including people with low-incomes, welfare recipients and children. It also looks at issues of access to care and the impacts of co-occurring problems, including physical health concerns and development disabilities. Data relating to each of these factors provides important context for an examination of the services provided through or by the state of New Jersey.

Mental disorders impact a substantial portion of New Jersey’s population. According to U.S. Department of Health and Human Services estimates, 348,997 New Jersey adults ages 18 and over experienced serious mental illness during 2002.³ By definition these estimates exclude individuals with mental disorders that do not rank as serious,⁴ and because mental illness can often be accompanied by fears of stigma that discourage persons living with mental illness from disclosing their conditions, these estimates may under-report the prevalence of even severe mental illness. According to the 2005 American Community Survey, an estimated 178,000 people between the ages of

¹ The terms mental disorder and mental illness are used interchangeably to indicate a diagnosable mental health problem.

² *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision, American Psychiatric Association, 2000, p.xxxi. The DSMIV-TR is the standard manual used in the United States for the categorical diagnosis of mental illness.

³ State Data, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, http://www.mentalhealth.samhsa.gov/databases/databases_exe.asp?d1=NJ&type=ASMI.

⁴ Serious mental illness, as defined by federal regulation, is restricted to mental disorders that interfere with some area of social functioning and exclude a number of mental disorders that nevertheless involve significant functional impairment. See chapter 2 of *Mental Health: A Report of the Surgeon General*, Substance Abuse and Mental Health Services Administration.

16 to 64 years old living outside of institutions had a mental disability,⁵ based on self-reports of physical, mental or emotional conditions that made it difficult to learn, remember or concentrate. Approximately 30% of these people were employed during the year. Data from the same survey estimates prevalence among other ages groups and indicates that 50,893 children ages 5 to 15; 23,124 children ages 16 to 20, 30,072 seniors ages 65 to 74, and 72,595 elderly ages 75 and older experienced mental disabilities.⁹²

When a person with mental illness also faces the problems associated with low income, these two experiences can have a magnifying affect. Research indicates that economic stress increases the likelihood of a severe mental illness, particularly among individuals with a low socioeconomic status.⁶ Internationally, individuals who are poor, and have low levels of education tend to be more vulnerable to mental disorders.⁷ According to a study of poverty and common mental disorders, the factors that cause people who are poor to be susceptible to a mental illness include a lack of confidence, feelings of hopelessness or physical ill health.⁸ While economic stress has not been found to be a cause of mental disorders,⁹ the experiences of poverty or unemployment can exacerbates the common mental disorders by increasing the length of time that the impacted individual experiences the disorder. Among individuals who have a severe mental illness, awareness of economic problems may also contribute to future mental health problems. Given the higher rates of poverty among persons with mental illness when compared with the general population, this interaction of poverty and mental disorders has a significant impact.¹⁰

Studies of welfare clients have found that rates of specific mental illnesses are higher among those receiving public assistance than among the general population. In 1999, 42 percent of individuals who had been enrolled in Work First New Jersey/TANF for two or more years were likely suffering from major depression.¹¹ Surveys from six New Jersey counties found 14 percent of long-term TANF participants reported taking doctor-prescribed anti-depressant medication and an additional 28 percent met assessment criteria for depression.¹² Additional qualitative information revealed that, among these individuals, only 30 percent told a doctor of their feelings, only 24 percent told another professional such as a social worker, psychologist or clergy and only 19 percent said that they had taken medication other than prescribed medication or used

⁵ Note, the data reported by the American Community Survey in 2005 includes individuals aged 16-20 for whom disability and work status had not previously been reported

⁶ C. Hudson, "Socioeconomic Status and Mental Illness: Tests of the Social Causation and Selection Hypothesis," *American Journal of Orthopsychiatry*, 81(8), 2005.

⁷ V. Patel and A. Kleinman, "Poverty and Common Mental Disorders in Developing Counties," *Bulletin of the World Health Organization*, 81, 2003.

⁸ Patel & Kelinman.

⁹ Scott Weich, "Poverty, Unemployment and Common Mental Disorders: Population Based Cohort Study," *British Medical Journal*, 317, 1998.

¹⁰ N. Ware and S. Goldfinger, "Poverty and Rehabilitation in Severe Psychiatric Disorders," *Psychiatric Rehabilitation Journal*, 21, 1997.

¹¹ *Assessing Work First Challenges Facing Long-Term Welfare Recipients in New Jersey*, Work, Poverty and Welfare Evaluation Project, Poverty Research Institute, Legal Services of New Jersey, 2000.

¹² The study incorporated assessment criteria for Major Depression from the Composite International Diagnostic Interview.

drugs or alcohol because of these feelings.¹³ Welfare recipients and other low-income residents may also require treatment for other serious mental illnesses besides depression, including schizophrenia and bipolar disorder, as documented by qualitative research, but treatment options are impacted by income.¹⁴

The cost of mental health care, and the inability to afford it, is not the only factor that restrains access to appropriate care and treatment; the mental health needs of children are also a cause for significant concern, due to the limited availability of treatment and services for children in New Jersey. New Jersey is one of several states studied in 2001, where state and county workers reported children entering the child welfare and juvenile justice system solely to obtain mental health services. These children are from families of all economic levels. Lack of available services and misunderstandings within and among agencies contributed to the misplacement of these children, mostly adolescent males.¹⁵

Obtaining care is also complicated by the co-occurrence of mental illness and other problems.¹⁶ According to research in the mental health field, persons with mental illness generally have poorer access to quality care when compared to people who do not have a mental illness. Currently, the general health care sector and the mental health sector are not sufficiently integrated; therefore, the complex needs of the mentally ill have not been adequately met.¹⁷ As a result, persons with severe mental illness have higher rates of mortality as well as prevalence of general health conditions, and chronic diseases such as HIV/AIDS, diabetes or hypertension. It has also been specifically found that people who have schizophrenia have a higher risk of contracting HIV.¹⁸ These higher rates of general health problems are not only concerning because of the physical consequences, but also because these conditions tend to have deleterious consequences on the mental health condition of affected individuals.¹⁹

Quality of care issues can also arise when mental disorders co-occur with developmental disabilities. People who have both a mental illness and a developmental disability are underserved and also receive insufficient care due to a lack of an integrated health care system.²⁰ This population often experiences unnecessary hospitalizations and treatment options are often limited to institutional settings or group homes, which may be

¹³ *Assessing Work First Challenges*.

¹⁴ Zippay, Allison and Anu Rangarajan, *In Their Own Words: WFNJ Clients Speak About Family, Work, and Welfare*, Mathematica Policy Research, Inc., March 2005.

¹⁵ *Child Welfare and Juvenile Justice: Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services*, United States General Accounting Office, April 2003.

¹⁶ Note – The co-occurrence of mental illness and substance abuse is discussed in the Substance Abuse Treatment chapter of this report.

¹⁷ M. Horvitz-Lennon, A.M. Kilbourne, and H.A. Pincus, "From Silos to Bridges: Meeting the General Health Care Needs of Adults with Severe Mental Illnesses," *Health Affairs*, 25(3), 2006.

¹⁸ A. Bagchi, U. Sambamoorthi, E. McSpiritt, P. Yanos, J. Walkup, and S. Crystal, "Use of Antipsychotic Medications among HIV-infected Individuals with Schizophrenia," *Schizophrenia Research*, 71(2,3), 2004.

¹⁹ Horvitz-Lennon, et al.

²⁰ T. Patterson, M. Higgins, and D.G. Dyck, "A Collaborative Approach to Reduce Hospitalizations of Developmentally Disabled Clients with Mental Illness," *American Psychiatric Association*, 46, 1995.

inappropriate.²¹ A collaborative effort is needed among community agencies and respite services to reduce the number of admissions of persons with this dual diagnosis. Currently, there are approximately 200,000 people in New Jersey with developmental disabilities and when they need regular medications for mental disorders the costs of co-payments can be burdensome.²² There is also a need for communities to have residential settings that would adequately meet the needs of persons with a mental illness and a developmental disability.²³

In assessing the state's response to the mental health needs of its residents, we must understand its prevalence and the general impact of mental disorders on those who experience them. We must also consider the particular vulnerabilities to mental disorders among certain groups and the challenges posed by inadequate access to appropriate treatment and services.

²¹ Patterson, et al; N. Meisler, C.D. McKay, and R. Benasutti, "An ACT Program for Co-occurring Disorders," *Psychiatric Services*, 50, 1999.

²² The Arc of New Jersey, 2006.

²³ The Arc of New Jersey, 2006.

Mental Health Programs

The state provides critical services for persons with mental illness in New Jersey through many different programs. The programs serve individuals who are hospitalized and those who are living in the community. Some are only accessed for emergencies and others provide on-going support for people living and working in their communities. Many of the state's programs, which are funded by either federal or state monies or both, are accessed by individuals through community providers. The following pages describe only a few of the important mental health programs and initiatives that provide necessary care. These are some of the key state-funded programs that are integral to a coordinated mental health care system.

The New Jersey Department of Human Services, Division of Mental Health Services (DMHS) oversees the state's public system of mental health services, comprised of a range of programs and support services. This includes in-patient hospital care at five state-run psychiatric hospitals, oversight of six county hospitals delivering in-patient psychiatric care, and services provided through several short-term care facilities that serve designated geographic areas.

Designated Screening Centers with mobile outreach and 24-hour access in each county are the legally-mandated gatekeepers for involuntary inpatient treatment and the public psychiatric hospital system, referring consumers for services in the least restrictive setting. Although legislative proposals have been put forward, New Jersey does not have a mandated form of outpatient involuntary commitment.

Access to short-term inpatient care is available at psychiatric inpatient units in local community hospitals throughout the state. Admission to county or state psychiatric hospitals is guaranteed only to persons who meet the commitment standard and for whom local inpatient treatment is unavailable or inappropriate. The county-based Screening Centers, not the hospitals themselves, generally determine need for inpatient treatment within the public system.

As in other states, mental health services in New Jersey continue to evolve from primarily hospital-based treatment to more community-based treatment and support services. Mental Health services are available in every county, through over 120 state-funded, non-profit, community mental health agencies, operating over 700 programs of service to more than 200,000 adults annually. Each county also has a Mental Health Advisory Board composed of county residents appointed by the county's board of chosen freeholders. The community mental health system of services provides for three levels of care in each county: (1) acute care programs and crisis stabilization; (2) intermediate care and rehabilitation; and (3) extended/ongoing support programs. Services include consumer managed self-help centers, Integrated Case Management programs, Supported Employment Programs, Supportive Housing and Intensive Family Support Services. There are also 28 programs in Assertive Community Treatment (PACT) teams, some

covering multiple counties. PACT services continue to expand to alleviate the strain on multi-county PACT teams.

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Note: Some services related to Mental Health and also related to other need areas are addressed under other chapters, including services for mentally ill chemically addicted (MICA) clients (discussed in recommendations for Substance Abuse) and Mental Health services for corrections and post-corrections populations (discussed in Crime, Corrections & Re-entry).

Detailed Program Information

Residential Care (State and County Psychiatric Hospitals & Community Residential Care)

Program Purpose and Description:

The Division of Mental Health Services, under the Department of Human Services, operates six psychiatric hospitals that serve people with persistent and severe mental illnesses who are in need of intensive, inpatient care and treatment. These hospitals and the populations they serve are:

- The Arthur Brisbane Child Treatment Center in Farmingdale serves children ages 11 through 18.²⁴
- The Senator Garrett W. Hagedorn Psychiatric Hospital in Glen Gardner serves the general and the elderly populations.
- The Ann Klein Forensic Center in Trenton serves people who have been determined by the courts to be Not Guilty by Reason of Insanity or Incompetent to Stand Trial or who require special security measures due to the nature of their illness.
- Ancora Psychiatric Hospital in Winslow Township serves not only a general adult population but also has units that serve elderly forensic patients and people who have been diagnosed to have both a developmental disability and a mental illness.
- Greystone Park Psychiatric Hospital in Parsippany serves adults.
- Trenton Psychiatric Hospital in Trenton serves adults.²⁵

Each year, DMHS serves approximately 6,200 people who, for some period of time, require intensive inpatient treatment in state psychiatric hospitals. In addition, DMHS has oversight responsibility for six county hospitals delivering in-patient psychiatric care and provides funding support.

State funding is also distributed to a number of private community residential care settings. These community programs operate on sliding fee scales, with state funding supplementing the payments of residents, calculated according to their ability to pay. Community residences include group homes, supervised apartments and family care homes where people can both live and receive psychiatric care and treatment.²⁶

²⁴ The settlement with Children's Rights, Inc., and the Child Welfare Reform Plan which is part of the settlement, require the Arthur Brisbane Child Treatment Center to be closed by December 31, 2005. The Child Welfare Reform Plan establishes interim milestones for terminating admissions. The Plan also requires the development of community programs to provide an appropriate level of care required by the population groups who otherwise would have been treated by Arthur Brisbane Child Treatment Center. The community programs must be operational prior to each target date. This is required because uninterrupted treatment for the affected populations must be assured. After the Center is closed, the facility will continue to be used to provide children's services.

²⁵ <http://www.state.nj.us/humanservices/dmhs/psych-hospitals.html>.

²⁶ <http://www.state.nj.us/humanservices/dmhs/receivingmhservices.html>;
<http://www.state.nj.us/humanservices/dmhs/community-services.html>.

Budget and Performance Trends:

State Psychiatric Hospitals (Mental Health Services – Residential) Evaluation Data				
Average daily population for each of the following hospitals	Actual FY04	Actual FY05	Revised FY06	Estimated FY07
Arthur Brisbane Child Treatment Center*	46	26	12*	---
Senator Garrett W. Hagedorn Psychiatric Hospital	281	289	282	280
Ann Klein Forensic Center	194	196	199	200
Ancora Psychiatric Hospital	728	727	740	722
Greystone Park Psychiatric Hospital	550	563	566	531**
Trenton Psychiatric Hospital	489	510	497	485
Source: State FY07 Budget Book (p. D-192- D-198)				

*Note: The operating data reflects the period July -- December, 2005 when the facility was ultimately closed. Annual and daily per capita figures and filled position data are an anomaly due to the transition of staff to other facilities. (SFY07 Budget Book p. D-198)

**Note: Census expected to decline in anticipation of a new, smaller Greystone Park Psychiatric Hospital opening in fiscal year 2008. ((SFY07 Budget Book p. D-192)

**State Psychiatric Hospitals (Mental Health Services – Residential)
Direct State Services
Appropriations Data**

	Orig. & --Supple. FY05	Total FY05 Available	Expended FY05	FY06 Adjusted Approp.	Request/Recomm. FY07	Actual Approp. FY07
Arthur Brisbane Child Treatment Center	\$10,604,000	\$10,604,000	\$10,601,000	\$5,542,000	---	---
Senator Garrett W. Hagedorn Gero-Psychiatric Hospital	\$32,459,000	\$35,355,000	\$34,812,000	\$34,837,000	\$35,270,000	\$35,270,000
Ann Klein Forensic Center	\$19,477,000	\$24,834,000	\$24,834,000	\$21,544,000	\$21,382,000	\$21,382,000
Ancora Psychiatric Hospital	\$67,889,000	\$77,358,000	\$76,997,000	\$74,630,000	\$77,589,000	\$77,589,000
Greystone Park Psychiatric Hospital	\$60,445,000	\$68,327,000	\$68,327,000	\$62,760,000	\$63,911,000	\$63,911,000
Trenton Psychiatric Hospital	\$55,484,000	\$61,588,000	\$61,576,000	\$59,691,000	\$61,685,000	\$61,685,000

Source: State FY07 Budget Book (p. D-184) & Appropriations Handbook 2006-07 (p. B-94-B-96)

**County Psychiatric Hospitals
Average Daily Population
Program Evaluation Data**

	Actual FY04	Actual-FY05	Revised FY06	Estimated FY07
Bergen	169	177	177	161
Burlington	24	26	26	27
Camden	148	150	150	147
Essex	195	152	137	142
Hudson	71	72	72	75
Union	33	31	33	34
Total	640	608	595	586

Source: State FY07 Budget Book (p. D-189)

**Support of Patients in County Psychiatric Hospitals
State Aid
Appropriations Data**

Orig. & --Supple. FY05	Total FY05 Available	Expended FY05	FY06 Adjusted Approp.	Request/ Recomm. FY07	Actual Approp. FY07
\$93,510,000	\$99,444,000	\$99,444,000	\$104,575,000	\$116,575,000	\$108,175,000

Source: State FY07 Budget Book (p. D-190) & State FY07 Appropriations Bill S2007 (p. 102)

Additional Analysis:

New Jersey continues to reduce the number of individuals in residential care placements in favor of community-based treatment and services (see Redirection II information in this chapter for more details).

Emergency Services

Program Purpose and Description:

The Division of Mental Health Services provides emergency mental health services through contracts with community-based, not-for-profit service providers. Trained psychiatric personnel working in local screening centers treat people in crisis and determine if they need to be committed involuntarily to a hospital for psychiatric treatment. Screening centers initiate two out of three admissions to state and county hospitals. Services are provided as part of the larger program of Mental Health Services in the Community, which provides a number of state-funded mental health services through more than [120 community-based organizations](#).²⁷

Budget and Performance Trends:

Community Services (Specifically Emergency Services) Program Evaluation Data				
Emergency Services	Actual FY04	Actual FY05	Revised FY06	Estimated FY07
Episodes of care	104,851	101,575	108,325	108,325
Cost to state*	\$30,035,000	\$30,602,000	\$41,809,000	\$44,878,000
Source: State FY07 Budget Book (p. D-188)				

*Note: “‘Cost to State’ refers only to the State portion of the costs in each program incurred by the Community Care account. Additional funds for these programs are available from other divisions and funding sources.” (FY07 Budget Book, p. D-189).

Community Services (Including but not at all limited to Emergency Services) Appropriations Data						
	Orig. & --Supple. FY05	Total FY05 Available	Expended FY05	FY06 Adjusted Approp.	Request/ Recomm. FY07	Actual Approp. FY07
Grants-In-Aid	\$242,029,000	\$253,263,000	\$253,263,000	\$289,872,000	\$276,133,000	\$276,133,000
State Aid	\$93,510,000	\$99,444,000	\$99,444,000	\$104,575,000	\$104,575,000	\$108,175,000
Federal funds	\$15,262,000	\$26,135,000	\$12,608,000	\$14,114,000	\$14,332,000	\$14,077,000
Source: State FY07 Budget Book (p. D-190) & State FY07 Appropriations Bill (p. 101, 102 & 249)						

Note: The above appropriations for “community services” also fund PACT, Partial Care, Integrated Case Management, Out-Patient Services, System Advocacy, Family Support/Support Employment and, as of this year, Redirection II Initiative.

²⁷ <http://www.state.nj.us/humanservices/dmhs/community-services.html>.

Redirection II Initiative

Program Purpose and Description:

This initiative is the result of an effort to revise the state's mental health system through reorganization of both the state psychiatric hospital system and the larger community context for mental health services. The Finalized Plan for the initiative states that the purpose is "to ensure the provision of high quality mental health care in the least restrictive setting possible." The components of the plan were developed as a result of comprehensive clinical assessments concerning the needs of hospital patients as well as careful review of outcomes associated with existing service programs and previous initiatives, with input from focus groups and advisory committees. The Finalized Plan outlines a number of separate but related components, including:

- The community placement of 388 patients from state psychiatric hospitals who have been assessed as appropriate for discharge but for whom development of suitable residential settings coupled with necessary supportive mental health services is required;
- The expansion and strengthening of community mental health services;
- Construction of a new, smaller hospital to replace Greystone Hospital;
- Improved quality of care and patient supervision at all adult state psychiatric hospitals as a result of a higher staff-to-patient ratio; improved staff recruitment and retention efforts; improved new employee orientation and strengthened in-service training programs; and increased flexibility for clinical programming resulting from freed-up physical space in good repair; and
- A reduction of 44 positions over a two-year period, through attrition. All state hospitals would continue to be operated by state employees.²⁸

Community placements for people experiencing mental illness are provided through a variety of settings. The Division of Mental Health Services contracts with community residences such as group homes, supervised apartments and family care homes where people can both live and receive psychiatric care and treatment. These services are provided as part of the larger program of Mental Health Services in the Community.²⁹

²⁸ <http://www.state.nj.us/humanservices/dmhs/redirection%20plan2002.html#i>.

²⁹ <http://www.state.nj.us/humanservices/dmhs/community-services.html>.

Budget and Performance Trends:

Redirection II Initiative* Program Evaluation Data				
	Actual FY03	Actual FY04	Revised FY05	Estimated FY06
Community Placements	304	511	591	---
Redirection II Initiative	\$22,159,000	\$30,125,000	\$32,725,000	---

Source: State FY07 Budget Book (p. D-189)

*Note: Funding for this initiative was consolidated into the Community Care account appropriation in fiscal 2007. (FY07 Budget Book p. D-189)

Community Services (Including but not at all limited to Redirection II) Appropriations Data						
	Orig. & --Supple. FY05	Total FY05 Available	Expended FY05	FY06 Adjusted Approp.	Request/ Recomm. FY07	Actual Approp. FY07
Grants-In-Aid	\$242,029,000	\$253,263,000	\$253,263,000	\$289,872,000	\$276,133,000	\$276,133,000
State Aid	\$93,510,000	\$99,444,000	\$99,444,000	\$104,575,000	\$104,575,000	\$108,175,000
Federal funds	\$15,262,000	\$26,135,000	\$12,608,000	\$14,114,000	\$14,332,000	\$14,077,000

Source: State FY07 Budget Book (p. D-190) & State FY07 Appropriations Bill (p. 101, 102 & 249)

Note: The above appropriations for “community services” also fund PACT, Emergency Services, Partial Care, Integrated Case Management, Out-Patient Services, System Advocacy, Family Support/Support Employment and, as of this year, Redirection II Initiative.

Additional Analysis:

Funding for this initiative is partially based on a redirection of a portion of state hospital dollars to produce benefits across the entire mental health system. However, the Governor’s Task Force on Mental Health reported that the average daily population of New Jersey’s state hospitals is actually 5% higher than it was when the initiative began. Language in the FY05 Appropriations Bill S2005 (p.89) indicates that the Commissioner of Human Services may submit for a transfer of funds from the Greystone Park Psychiatric Hospital Bridge Fund (totaling \$29,975,000) as part of the phase-in plan for Redirection II, but does not indicate the extent of this redirection. The Redirection II Initiative plan also required an increased annual investment of additional funding and the appropriation of bridge funding during FY02 and FY03 to build the capacity of

community programs before the discharge of patients and redirection of available hospital dollars.³⁰

³⁰ <http://www.state.nj.us/humanservices/dmhs/redirection%20plan2002.html#i>.

Programs of Assertive Community Treatment (PACT)

Program Purpose and Description:

The PACT program was designed to redirect clients from more restrictive settings into community-based services. The initiative’s mission is to provide intense services for adults with severe mental illness so that they may live successfully in normal community settings. Thus, the initiative is re-directing services and funding, where appropriate, from inpatient psychiatric to community-based care. The program is designed for the most severely challenged segment of people with mental illness who will need services throughout their lives. According to program information, these individuals will have a history of repeated hospitalizations despite enrollment in treatment or refusal to participate in treatment.³¹ The program involves a multi-disciplinary team of providers who make sure that comprehensive rehabilitation, treatment, and support services are integrated into a treatment plan for individuals with the most serious and persistent mental illnesses.³² There are 31 PACT teams in the state.

To be eligible for PACT services, an individual must meet significant inclusion criteria, including a primary Axis I psychiatric diagnosis (such as schizophrenia or other psychotic disorder, major depressive disorder, bipolar disorder, delusional disorder, etc.), impaired functioning in at least one significant domain (such as personal self-care, interpersonal relationships, or shelter), and high risk of hospitalization. Exclusion criteria for PACT include diagnosis with a developmental disability (unless co-occurring with an Axis I disorder), delirium/dementia/amnesic and other cognitive disorders, and substance-related disorders (unless co-occurring with an Axis I disorder).³³

Budget and Performance Trends:

Community Services (Specifically PACT)				
Evaluation Data				
PACT	Actual FY04	Actual FY05	Revised FY06	Estimated FY07
Episodes of care	1,840	2,005	2,039	2,039
Cost to state*	\$14,320,000	\$14,591,000	\$15,188,000	\$16,303,000
Source: State FY07 Budget Book (p. D-189)				

*Note: “‘Cost to State’ refers only to the State portion of the costs in each program incurred by the Community Care account. Additional funds for these programs are available from other divisions and funding sources.” (FY07 Budget Book, p. D-189).

³¹ “Introduction to Program for Assertive Community Treatment (PACT).”

³² <http://www.state.nj.us/humanservices/dmhs/community-services.html>.

³³ “Introduction to Program for Assertive Community Treatment (PACT).”

**Community Services
(Including but not at all limited to PACT)
Appropriations Data**

	Orig. & --Supple. FY05	Total FY05 Available	Expended FY05	FY06 Adjusted Approp.	Request/Recomm. FY07	Actual Approp. FY07
Grants-In-Aid	\$242,029,000	\$253,263,000	\$253,263,000	\$289,872,000	\$276,133,000	\$276,133,000
State Aid	\$93,510,000	\$99,444,000	\$99,444,000	\$104,575,000	\$104,575,000	\$108,175,000
Federal funds	\$15,262,000	\$26,135,000	\$12,608,000	\$14,114,000	\$14,332,000	\$14,077,000

Source: State FY07 Budget Book (p. D-190) & State FY07 Appropriations Bill (p. 101, 102 & 249)

Note: The above appropriations for “community services” also fund PACT, Emergency Services, Partial Care, Integrated Case Management, Out-Patient Services, System Advocacy, Family Support/Support Employment and, as of this year, Redirection II Initiative.

Partial Care

Program Purpose and Description:

Partial Hospitalization and Partial Care are the most intensive community health services for people who are ambulatory. These services are provided through contracts with community-based, not-for-profit service providers by the Division of Mental Health Services. This type of treatment focuses on improving not only a person's mental health but also a wide range of skills that will help him or her function more independently in the community including personal hygiene, cooking, medication management, understanding mental illness and self-advocacy. Services are provided as part of the larger program of Mental Health Services Community.³⁴

Budget and Performance Trends:

Community Services (Specifically Partial Care)				
Evaluation Data				
Partial Care	Actual FY04	Actual FY05	Revised FY06	Estimated FY07
Episodes of care	15,780	15,518	12,341	12,341
Cost to state*	\$17,743,000	\$18,078,000	\$18,773,000	\$20,151,000
Source: State FY07 Budget Book (p. D-188)				

*Note: "'Cost to State' refers only to the State portion of the costs in each program incurred by the Community Care account. Additional funds for these programs are available from other divisions and funding sources." (FY07 Budget Book, p. D-189).

Community Services						
(Including but not at all limited to Partial Care)						
Appropriations Data						
	Orig. & --Supple. FY05	Total FY05 Available	Expended FY05	FY06 Adjusted Approp.	Request/ Recomm. FY07	Actual Approp. FY07
Grants-In-Aid	\$242,029,000	\$253,263,000	\$253,263,000	\$289,872,000	\$276,133,000	\$276,133,000
State Aid	\$93,510,000	\$99,444,000	\$99,444,000	\$104,575,000	\$104,575,000	\$108,175,000
Federal funds	\$15,262,000	\$26,135,000	\$12,608,000	\$14,114,000	\$14,332,000	\$14,077,000
Source: State FY07 Budget Book (p. D-190) & State FY07 Appropriations Bill (p. 101, 102 & 249)						

Note: The above appropriations for "community services" also fund PACT, Emergency Services, Partial Care, Integrated Case Management, Out-Patient Services, System Advocacy, Family Support/Support Employment and, as of this year, Redirection II Initiative.

³⁴ <http://www.state.nj.us/humanservices/dmhs/community-services.html>.

Integrated Case Management

Program Purpose and Description:

The integrated case management program is another service funded by the Division of Mental Health Services through community contracts. The program is designed to engage, support, and integrate people with serious mental illnesses into their communities and help them connect with resources there that they can use to become as independent as possible. Integrated Case Management services are available for at least 18 months after discharge from a short- or long-term residential care facility. This service is provided as part of the larger program of Mental Health Services in the Community.

Budget and Performance Trends:

Community Services (Specifically Integrated Case Management) Evaluation Data				
Integrated Case Management	Actual FY04	Actual FY05	Revised FY06	Estimated FY07
Episodes of care	14,652	14,449	11,317	11,317
Cost to state*	\$22,399,000	\$22,822,000	\$25,227,000	\$27,079,000
Source: State FY07 Budget Book (p. D-189)				

*Note: “‘Cost to State’ refers only to the State portion of the costs in each program incurred by the Community Care account. Additional funds for these programs are available from other divisions and funding sources.” (FY07 Budget Book, p. D-189).

Community Services (Including but not at all limited to Integrated Case Management) Appropriations Data						
	Orig. & --Supple. FY05	Total FY05 Available	Expended FY05	FY06 Adjusted Approp.	Request/Recomm. FY07	Actual Approp. FY07
Grants-In-Aid	\$242,029,000	\$253,263,000	\$253,263,000	\$289,872,000	\$276,133,000	\$276,133,000
State Aid	\$93,510,000	\$99,444,000	\$99,444,000	\$104,575,000	\$104,575,000	\$108,175,000
Federal funds	\$15,262,000	\$26,135,000	\$12,608,000	\$14,114,000	\$14,332,000	\$14,077,000
Source: State FY07 Budget Book (p. D-190) & State FY07 Appropriations Bill (p. 101, 102 & 249)						

Note: The above appropriations for “community services” also fund PACT, Emergency Services, Partial Care, Integrated Case Management, Out-Patient Services, System Advocacy, Family Support/Support Employment and, as of this year, Redirection II Initiative.

Outpatient Services

Program Purpose and Description:

The Division of Mental Health Services provides outpatient mental health services through contracts with community-based not-for-profit service providers. These services are for ambulatory individuals and include periodic counseling, therapy, and assistance in taking and monitoring medication. These services are provided as part of the larger program of Mental Health Services in the Community.³⁵

Budget and Performance Trends:

Community Services (Specifically Outpatient Services)				
Evaluation Data				
Outpatient Services	Actual FY04	Actual FY05	Revised FY06	Estimated FY07
Episodes of care	161,756	163,397	158,013	158,013
Cost to state*	\$35,689,000	\$36,363,000	\$41,303,000	\$44,335,000
Source: State FY07 Budget Book (p. D-188)				

*Note: “‘Cost to State’ refers only to the State portion of the costs in each program incurred by the Community Care account. Additional funds for these programs are available from other divisions and funding sources.” (FY07 Budget Book, p. D-189).

Community Services						
(Including but not at all limited to Out Patient Services)						
Appropriations Data						
	Orig. & --Supple. FY05	Total FY05 Available	Expended FY05	FY06 Adjusted Approp.	Request/Recomm. FY07	Actual Approp. FY07
Grants-In-Aid	\$242,029,000	\$253,263,000	\$253,263,000	\$289,872,000	\$276,133,000	\$276,133,000
State Aid	\$93,510,000	\$99,444,000	\$99,444,000	\$104,575,000	\$104,575,000	\$108,175,000
Federal funds	\$15,262,000	\$26,135,000	\$12,608,000	\$14,114,000	\$14,332,000	\$14,077,000
Source: State FY07 Budget Book (p. D-190) & State FY07 Appropriations Bill (p. 101, 102 & 249)						

Note: The above appropriations for “community services” also fund PACT, Emergency Services, Partial Care, Integrated Case Management, Out-Patient Services, System Advocacy, Family Support/Support Employment and, as of this year, Redirection II Initiative.

³⁵ <http://www.state.nj.us/humanservices/dmhs/community-services.html>.

Child Behavioral Health Services (CBHS) (formerly Children’s System of Care Initiative and Partnership for Children)

Program Purpose and Description:

The Children’s Behavioral Health Services, first known as the Children’s System of Care and later as the Partnership for Children, was first launched in three counties in 2001 as a reform initiative to restructure the state’s system for delivering mental health services, on a single continuum, to children involved in the child welfare, mental health and juvenile justice systems.³⁶ The program was intended to provide a comprehensive, managed system of access and delivery for children who would come into the program from any portal, including schools, medical professionals and self-referrals. As acknowledged in the Division of Youth and Family Services (DYFS) reform plan, this system spent a disproportionate amount of funding on institutional and residential care for children with behavioral problems and did not adequately serve needy children in the DYFS and juvenile justice systems.³⁷ The reform plan states that the Partnership for Children will be reorganized into the Children’s Behavioral Health Services (CBHS) under the Office of Children’s Services, which will incorporate other child mental health services to form a single system to address child behavioral health needs.

The state continues to evaluate the continuum of children’s mental health services and reallocate resources, as necessary, to ensure that the continuum meets the following goals: improved clinical outcomes and emotional/behavioral stability; improved permanency in community placements; reduced inappropriate use of and length of stays in residential care; reduced readmissions to psychiatric facilities; and improved crisis management and stability for families and caregivers. The division’s ultimate goal is to create a system providing a flexible array of mental and behavioral health services to children and their families that includes social support systems as well as the capability to track children’s treatment and the delivery of services.

The organization of the initiative involves four elements. The Contracted Systems Administrator provides the administrative functions of creating a single electronic file and coordinating care across all child-serving systems. Care Management Organizations (CMOs) provide case management for children with the most complex needs and pull together local resources. CMOs are being phased in and currently exist in only ten counties. Unified Screenings establish protocols for a universal screening tool for children in all systems while Family Support Organizations provide peer support for families. Families voluntarily support other parents through Family Support Organizations (FSO). There are currently approximately seven FSOs that support parents with issues surrounding the treatment and coordination of care for their child, especially the development of an appropriate Individual Service Plan (ISP).

³⁶ Child Welfare Plan released Feb. 18, 2004, p. 170.

³⁷ Ibid.

Budget and Performance Trends:

Child Behavioral Health Services (Now under the new Department of Children & Families) Evaluation Data				
	Actual FY04	Actual FY05	Revised FY06	Estimated FY07
Care Management Organizations – Treatment Slots	n/a	1,840	2,520	2,700
Family Support Organizations – Family Slots	n/a	1,022	2,800	3,068
Behavioral Assistance & Intensive In-Home Community Services Hours	n/a	200,982	531,439	703,125
Mobile Response and Stabilization Services – Families Served	n/a	6,160	7,440	7,680
Youth Case Management (YCM): Case Managers	n/a	30	134	244
YCM: Case Managers – Division of Mental Health Services	n/a	53	53	n/a
YCM: Slots Available	n/a	652	2,948	4,774
YCM: Slots Available – Division of Mental Health Services	n/a	1,166	726	n/a
Out of Home Treatment Services Bed Days Available	n/a	699,916	882,818	997,284
Partial Care/Partial Hospitalization Slots	n/a	n/a	n/a	1,907
Outpatient Services Hours Available	n/a	n/a	n/a	143,118
Source: State FY07 Budget Book (p. D-36)				

**Child Behavioral Health Services
Grants-In-Aid
Appropriations Data**

	Orig. & --Supple. '05	Total '05 Available	Expended '05	'06 Adjusted Appropriation	Request/ Recommend '07	Actual Approp. FY07
(From General Fund)	(\$171,424,000)	(\$272,631,000)	(\$251,961,000)	(\$132,319,000)	(\$284,576,000)	(\$284,576,000)
(From Federal Funds)	(\$105,156,000)	(\$95,516,000)	(\$74,846,000)	(\$106,966,000)	(\$135,043,000)	(\$135,043,000)
Child Behavioral Health Services - total	\$276,580,000	\$272,631,000	\$251,961,000	\$332,319,000	\$419,619,000	\$419,619,000

Source: State FY07 Budget Book (p. D-38) & State FY07 Appropriations Bill S2007 (p. 30)

Additional Analysis:

The FY06 budget materials make direct reference to the new location of this program in the following language: "The appropriation for Children's Behavioral Health Services has been moved to the Office of Children's Services" (FY06 Budget Book p. D-189).

System Advocacy

Program Purpose and Description:

The Division of Mental Health Services provides system advocacy through contracts with community-based, not-for-profit service providers. Systems advocates provide legal and companionship services to mental health clients as well as operating self-help centers. These services are provided as part of the larger program of Mental Health Services in the Community.³⁸

Budget and Performance Trends:

Community Services (Specifically System Advocacy) Evaluation Data				
System Advocacy	Actual FY04	Actual FY05	Revised FY06	Estimated FY07
Episodes of care	3,934	3,881	3,994	3,994
Cost to state*	\$5,439,000	\$5,542,000	\$6,354,000	\$6,821,000
Source: State FY07 Budget Book (p. D-189)				

*Note: “‘Cost to State’ refers only to the State portion of the costs in each program incurred by the Community Care account. Additional funds for these programs are available from other divisions and funding sources.” (FY07 Budget Book, p. D-189).

Community Services (Including but not at all limited to System Advocacy) Appropriations Data						
	Orig. & --Supple. FY05	Total FY05 Available	Expended FY05	FY06 Adjusted Approp.	Request/ Recomm. FY07	Actual Approp. FY07
Grants-In-Aid	\$242,029,000	\$253,263,000	\$253,263,000	\$289,872,000	\$276,133,000	\$276,133,000
State Aid	\$93,510,000	\$99,444,000	\$99,444,000	\$104,575,000	\$104,575,000	\$108,175,000
Federal funds	\$15,262,000	\$26,135,000	\$12,608,000	\$14,114,000	\$14,332,000	\$14,077,000
Source: State FY07 Budget Book (p. D-190) & State FY07 Appropriations Bill (p. 101, 102 & 249)						

Note: The above appropriations for “community services” also fund PACT, Emergency Services, Partial Care, Integrated Case Management, Out-Patient Services, System Advocacy, Family Support/Support Employment and, as of this year, Redirection II Initiative.

³⁸ <http://www.state.nj.us/humanservices/dmhs/community-services.html>.

Family Support / Supported Employment

Program Purpose and Description:

The Division of Mental Health Services provides supported employment services through contracts with community-based, not-for-profit service providers. These services are designed to help clients prepare to enter or re-enter the workforce successfully. Services include job placement and interviewing assistance, supervised work assignments, and follow-up support. These services are provided as part of the larger program of Mental Health Services in the Community.³⁹

Budget and Performance Trends:

Community Services (Specifically Family Support/Supported Employment) Evaluation Data				
Family Support/Supported Employment	Actual FY04	Actual FY05	Revised FY06	Estimated FY07
Episodes of care	19,235	18,551	20,118	20,118
Cost to state*	\$15,755,000	\$16,053,000	\$21,629,000	\$23,217,000
Source: State FY07 Budget Book (p. D-189)				

*Note: “‘Cost to State’ refers only to the State portion of the costs in each program incurred by the Community Care account. Additional funds for these programs are available from other divisions and funding sources.” (FY07 Budget Book, p. D-189).

Community Services (Including but not at all limited to Family Support/Supported Employment) Appropriations Data						
	Orig. & --Supple. FY05	Total FY05 Available	Expended FY05	FY06 Adjusted Approp.	Request/Recomm. FY07	Actual Approp. FY07
Grants-In-Aid	\$242,029,000	\$253,263,000	\$253,263,000	\$289,872,000	\$276,133,000	\$276,133,000
State Aid	\$93,510,000	\$99,444,000	\$99,444,000	\$104,575,000	\$104,575,000	\$108,175,000
Federal funds	\$15,262,000	\$26,135,000	\$12,608,000	\$14,114,000	\$14,332,000	\$14,077,000
Source: State FY07 Budget Book (p. D-190) & State FY07 Appropriations Bill (p. 101, 102 & 249)						

Note: The above appropriations for “community services” also fund PACT, Emergency Services, Partial Care, Integrated Case Management, Out-Patient Services, System Advocacy, Family Support/Support Employment and, as of this year, Redirection II Initiative.

³⁹ <http://www.state.nj.us/humanservices/dmhs/community-services.html>.

Work First New Jersey Mental Health Initiative (MHI)

Program Purposes and Descriptions:

MHI is one of the support and service initiatives associated with Work First New Jersey (WFNJ), Temporary Assistance to Needy Families (TANF). MHI is designed to assist WFNJ recipients to be able to meet WFNJ work requirements and eventually move into self-sufficiency by assessing mental health barriers and providing mental health and job readiness services.⁴⁰

The initiative is jointly sponsored by the Divisions of Mental Health and Family Development of the Department of Human Services, and utilizes contracted intensive case management service agencies who additionally contract with supported employment services and the county welfare agencies (CWA) in the 6 participating counties (Atlantic, Camden, Essex, Hudson, Passaic, and Union). The services employ a team approach with multiple point-of-service contacts, including CWA referrals, assessment and services from trained mental health clinicians, and job placement through supported employment. The program is targeted to WFNJ/TANF recipients who have not been deferred from work requirements and have a demonstrated mental health condition that interferes with employment. It is also available to those deferred recipients who may have mental health conditions. Participation in the program is voluntary, and provides the option of counting mental health activity as the recipient's WFNJ work-activity. In addition to assessment and services that range from full-time mental health services to supported employment, the program involves case management of services to review program participation and progress.⁴¹

⁴⁰ *Addressing Barriers to Employment: Detecting and Treating Health and Behavioral Problems Among New Jersey's TANF Clients*, June 17, 2003, draft report by Mathematica Policy Research, Inc., p. 63.

⁴¹ *Addressing Barriers to Employment*, Mathematica.

Budget and Performance Trends:

The state budget materials contain one grants-in-aid line-item appropriation for the Mental Health Initiative, which reflects the costs of assessments and services to participants, but not the administrative costs. There is no evaluation data in the budget book, but program participation information is available from DFD. The FY06 participation figures are combined for both TANF and GA and provide detail about the sources of referrals, results of assessments, and services provided to participants. Data for early years indicates only the number of clients referred for assessment, cases opened, and clients successfully engaged in work, for both TANF and GA. This year's evaluation data reflects that fewer individuals are being served through the Mental Health Initiative, due in part to the fact that persons with a work deferral are not assisted by the program.⁴²

Mental Health Initiative FY06 Evaluation Data by County								
	Atlantic	Camden	Union	Essex	Passaic	Hudson	Mercer	State Total⁴³
Total referrals	56	70	22	69	10	59	66	352
<i>CWA referrals</i>	52	70	22	69	10	59	66	348
<i>DYFS referrals</i>	4	1	0	0	0	0	0	5
Total assessments	38	70	17	64	5	52	66	312
<i>Accepted for services</i>	30	32	11	29	5	44	62	212
<i>Not enrolled in services</i>	11	38	2	35	1	9	4	100
Provided services ⁴⁴								
<i>Engaged in mental health svcs.</i>	29	22	13	27	2	19	29	141
<i>Receiving AWEPP svcs.</i>	0	0	6	5	1	0	11	23
<i>Employed</i>	4	4	0	3	1	4	1	17
<i>Referred to SSI</i>	18	3	3	3	0	16	1	44
<i>Closed (drop out)</i>	23	44	4	14	0	25	31	141

⁴² Based on a conversation with staff in the DFD, December 18, 2006.

⁴³ Note – The total referrals accept for services that is reported by the source is 212, but the county totals add to 213. Given the inconsistencies in the data listed for Passaic county between total assessments (5) and the sum of assessments accepted for service (5) and not enrolled in services (1), it is likely that the inconsistency relates to a data error for Passaic county.,

⁴⁴ Service numbers add up to more than the number of assessments that lead to service because clients may receive multiple types of services.

Mental Health Initiative Evaluation Data			
	FY03	FY04	FY05⁴⁵
GA			
Referrals	285	387	278
Opened	200	300	228
Working (open & closed)	38	144	114
TANF			
Referrals	549	542	530
Opened	415	372	408
Working (open & closed)	252	229	142
Combined Total			
Referrals	834	929	808
Opened	615	672	632
Working (open & closed)	290	373	256
Source: NJ DHS, Division of Family Development document via e-mail September 1st, 2005			

Mental Health Assessment (Mental Health Initiative) Grants-in-Aid Appropriation Data					
Orig. & --Supple. FY05	Total FY05 Available	Expended FY05	FY06 Adjusted Approp.	Request/Recomm. FY07	Actual Approp. FY07
\$3,200,000	---	---	\$3,345,000	\$3,361,000	\$3,361,000
Source: State FY07 Budget Book (p. D-239) & State FY07 Appropriations Bill S2007 (p. 127)					

Additional Analysis:

MHI began as a pilot in Atlantic County in April 2000 for the WFNJ/TANF population who were experiencing mental health barriers to employment. The Initiative expanded in April 2001 to include Camden, Essex, Hudson, Passaic and Union Counties for eligible TANF recipients. In February 2002, the program expanded to include the

⁴⁵ The FY05 figures include the 4th quarter projected numbers for referrals, open cases and working (open & closed). Estimates for FY06 are not available at this time.

General Assistance (GA) population in the six counties with TANF MHI programs, and Mercer County.⁴⁶ In December, FY05, the program was expanded to allow for direct referrals from the Division of Youth and Family Services (DYFS) for TANF/DYFS and GA/DYFS clients in the seven counties where the program exists.

⁴⁶ Program history information provided by DHS. This is the most current information available at this time.

Disaster and Terrorism Branch (Division of Mental Health Services)⁴⁷

Program Purpose and Description:

The Division of Mental Health Services (DMHS), within the Department of Human Services, has developed the Disaster and Terrorism Branch to address the psychosocial needs of residents in the wake of disaster. They have recruited a roster of more than 3,500 mental health counselors throughout the state who are highly trained in this area of practice and committed to respond in the event of a disaster. The services that can be accessed include individual and group crisis counseling, psychological first aid, consultation and training, written and oral recorded education materials, and a toll-free help-line.

The Disaster and Terrorism Branch has a part-time staff of five people to provide training and support to mental health providers throughout the state. The state staff also work with counties to assist their efforts and optimize their response plans for mental health services in the time of disaster. The Branch also maintains a website ⁴⁸ and publishes a bimonthly e-newsletter, “New Jersey Crisis Counselor.”

Budget and Performance Trends:

State and county mental health disaster plans are incorporating federal guidelines that will ensure that the state receives federal funding in the event of a disaster. The state is also developing its plan to reflect the planning approaches of the Substance Abuse and Mental Health Services Administration (SAMHSA). The Disaster and Training Branch has conducted at least three trainings each month to develop and sustain a corps of professionals to address disaster-related mental health issues that arise. The state has been supported in these activities by SAMHSA and Health Resources Services Administration (HRSA) grants through the NJ Department of Health and Senior Services.

Medical Emergency Disaster Preparedness for Bioterrorism (Direct State Services) Appropriation Data					
Orig. & --Supple. FY05	Total FY05 Available	Expended FY05	FY06 Adjusted Approp.	Request/ Recomm. FY07	Actual Approp. FY07
\$45,000,000	\$4,000,000	\$4,000,000	\$4,000,000	\$4,000,000	\$4,000,000
Source: State FY07 Budget Book (p. D-158) & State FY07 Appropriations Bill S2007 (p. 80)					

Note: Although not completely clear in the budget, it seems that a portion of this funding is used to fund the Disaster and Terrorism Branch of DMHS. The specific amount of money from the state and the federal

⁴⁷ Replaces the Phoenix Project, which provided public mental health services in the form of crisis counseling, clinical services, information and referral following the September 11, 2001, attacks and the anthrax crisis; Project Phoenix was funded by the Federal Center for Mental Health Services, Disaster Relief Grant (CMHS) and a Federal Emergency Management Agency (FEMA) grant

⁴⁸ www.disastermentalhealthnj.com.

government funding the mental health services under this program can not be extrapolated from the budget materials at this time. A note in the FY07 Budget Book (p. D-161) indicates that up to \$4,722,000 may be appropriated from a surcharge on agency vehicle rentals to fund the Medical Emergency Disaster Preparedness for Bioterrorism program.

Medical Emergency Disaster Preparedness for Bioterrorism Schedule 2 (denotes federal revenue)			
Actual FY05	Estimated FY05	Estimated FY07	Appropriations FY07
---	\$4,722,000	\$4,722,000	---
Source: State FY07 Budget Book (p. C-20)			

Recommendations

Children's Behavioral Health Services

- This program should be expanded, because it can provide a coordinated system of quality mental and behavioral health services for children and young adults, with strong emphasis on support for the creation and maintenance of a sufficient number of appropriate services in the community. Essential to the development of this system, we recommend continued efforts to obtain federal funding for this program.

While continuing to provide for necessary institutional and residential care, the program is expanding access to appropriate community care which is much needed. The program is creating a single, managed system that utilizes a universal screening tool and is funded from multiple sources, such as Medicaid and commercial insurance coverage. As a result, it can provide real access to necessary quality care without families having to turn to welfare programs or the juvenile justice system to find and be able to afford the mental health services that their children need.

- The state should provide funding for prompt evaluation, placement, treatment, and follow-up supportive services for juveniles with mental, emotional or behavioral disorders who become involved with the justice system. This funding should include the cost of special training for all juvenile judges and personnel in the court system.

Juveniles who need treatment for mental health and/or substance abuse should not be warehoused in the State's prison system or juvenile facilities because they are not fully evaluated for their condition or because there are not appropriate juvenile treatment settings available. This has too often been the case for children who enter the justice system in New Jersey. When juveniles must be placed in detention centers because of the seriousness of their crime, appropriate treatment for mental health and/or substance abuse must be provided within the incarceration setting.

Mental Health Initiative

- The link between the Division of Family Development and the Division of Mental Health Services should be strengthened and expanded to all counties.

The Work First New Jersey Mental Health Initiative provides valuable access to mental health care management for welfare recipients, and coordinates these services with the individual's WFNJ obligations and responsibilities. However, because the MHI is only available in seven counties, many people continue to go without case management and have added difficulty in accessing and coordinating treatment.

Supported Employment

- Additional funding should be provided to the Division of Vocational Rehabilitation Services within the Department of Labor and Workforce Development, and to the

Division of Mental Health Services within the Department of Human Services, to adequately cover supported employment services for people with mental illness, which include long term, employment-related, follow-up services.

Supported employment services with continued follow-along services are a proven way for individuals to re-enter the workplace and regain economic stability. This independence decreases reliance on public assistance programs. Community agencies provide focused training for individuals with mental illness, identification of employment opportunities, job-coaching, and support services. However, funding is needed to provide services both for adults re-entering the workforce and for young adults with mental illness who are entering the workforce for the first time.

Least Restrictive Settings (Mental Health Housing)

- A comprehensive plan should be adopted that includes adequate and sustained funding for permanent and affordable supportive housing for persons with mental illness. Success depends not only on a commitment of direct funding but also the provision of builder and landlord incentives, rental subsidies, maximizing federal funding (HUD and Medicaid), and collaboration for creative funding opportunities with other departments and divisions within the state.

The lack of suitable housing continues to be an insurmountable barrier for persons with mental illness who are otherwise able to move back into the community. Funding remains the largest obstacle to creating adequate supplies of affordable housing for individuals experiencing mental illness.

- DMHS should continue to fund initiatives to move persons into the most appropriate and least restrictive settings.