New Jersey Behavioral Health Planning Council
Meeting Minutes,
March 8, 2017 10:00 A.M.

Attendees:

Bruce Blumenthal	Harry Coe	Pamela Taylor
Joseph Gutstein (P)	John Calabria	Patricia Matthews
Thomas Pyle (P)	John D. Pellicane	Robin Weiss
Barbara Johnston	Judy Banes	Rocky Schwartz
Cheri Thompson	Maryanne Evanko	Winifred Chain
Christopher Lucca	Michael Litterer	Jim Romer
Darlema Bey	Shauna Moses	Connie Greene (P)

DMHAS, CSOC & DDD Staff:

Irina Stuchinsky (P)	Roger Borichewski	Jan Rudder
Donna Migliorino	Morris Friedman	Mark Kruszczynski
Geri Dietrich	Steve Fishbein	Domenica Nicosia

Guests:

Alric Warren (P) Roderick Bell (P) Louann Lukens
Rachel Morgan

I. Administrative

A. Introduction
B. Revised minutes accepted from the February 2017 meeting.

II. Subcommittee reports

A. Data & Outcomes – Substance Abuse (C. Lucca)
   1. August 2016 – White Paper submitted, but no steps or recommendations put forth.
   2.

B. Housing (C. Lucca)
   1. Conference call of Housing Subcommittee on 3/12/17.
   2. Looking at increasing housing resources and expand knowledge of existing housing resource opportunities (via a publishable "Roadmap").
   3. Request made by subcommittee chair to have CSOC participate in proceedings.
      a. Suggestion of M. Litterer for possible relevant speakers/agenda items for subsequent Planning Council meetings
         i. DCF's Family Success Centers (58 across the state); Antonio Lopez DCF
         ii. DCF's Recovery Schools (P. Capaci, Prevention Links)

III. Budget Briefing (Morris Friedman, DMHAS)

A. Impact to DMHAS
   1. $1.1M Olmstead funding for 200 new beds. (Some funded by SRAP vouchers)
   2. $4M to annualize the cost of SFY 2017 beds (220)
   3. $987k for Opioid Overdose Recovery Program, currently in 11 counties.

a. $Another 1.8M from the Alcohol Treatment Funds will be allowed to be used for this program.

4. State Targeted Opioid Response Initiative (STORI) grant, NJ's response to the federal CURES Act is expected to provide additional support for this program.
5. $1M from the Drug Abuse Education Fund will be available in FY18 only for the Recovery Dorm program.
6. Transition to Fee for Service (FFS)
   a. Phase I began mid-January 2017 (16 providers)
   b. Phase II begins 7/1/17
   c. Medication Monitoring rates were recently increased significantly.
   d. New rates may be available for hospital in-reach services.

B. Question and Answers
1. Q: Is the SFY 2018 Budget Ready? A: Not yet, but the NJ Office of Management and Budgets (OMB) has some general information available on the SFY 2018 budget [see http://www.nj.gov/treasury/omb/publications/18bib/BIB.pdf] (MJF).
2. Q: Housing (SRW). A: DMHAS will try to use DCA State-Rental Assistance Program (S-RAP) to partially offset State costs (MJF).
3. Q: Do vouchers that aren't used (due to DCA Funding) get recycled back to DMHAS? A: Yes, I believe so. We will be able to "backfill" clients into vouchers that are no longer needed due to clients moving to SRAP vouchers. (MJF)

IV. Behavioral Health Overview for Veterans and Military Families (Steven Fishbein, DMHAS)

A. Veterans comprise a significant subset of individuals involved in the criminal Justice system; about 9% in correctional facilities. Therefore responding to Criminal Justice Issues as it involves veterans. Programs such as Crisis Intervention Team training (CIT) is important to divert folks from becoming entangled with the system.

B. Choice of words is important: "veterans" (often considered by some vets as only those members of the armed services who served in armed conflict), vs. "people with a background of military service". It is important for providers to ask individuals about their possible military service background so these populations are not excluded from service nor identification.

C. Available Information:

1. According to USTF data, in SFY2015, 6,890 vets were served by DMHAS (mental health). In SFY 2016, 6,556 vets were served. However due to the inconsistency of how USTF data is collected and reported by providers, it is reasonable that the actual numbers served is likely more than double what is reported here.

2. The most utilized programs accessed by vets are Outpatient (68.3% of all SFY15 service episodes for vets), Partial Care (9%), and Case Management (8%).

3. Over time there may have been an increase in trust among veterans with utilizing the VA Healthcare systems for mental health services.

4. The numbers of vets served in SFY 2016 in Screening (83) appears very low [this was commented on by J. Romer, and agreed by S.Fishbein].
5. The counties that reported to have served the largest numbers of veterans in SFY 2016 were Middlesex, Bergen, Monmouth, Essex, and Atlantic.
6. Question of how many vets served are Medicaid covered.

D. There are Three Veterans' Health Care Networks that serve NJ.
   1. NJ VA HealthCare Network (includes locations in the northern region such as Lyons VA Center, & East Orange VA Center), Philadelphia and Delaware.
      a. Lyons VA Center no longer has Long term psychiatric beds.
   2. DMHAS has worked out a good protocol with the NJ VA Healthcare Network to improve access to emergency services and acute care.
   3. DMHAS continues to collaborate with Veterans Administration/ NJ Department of Military and Veterans Affairs (NJ DMVA) such as the "NJ VA Healthcare Summit"

E. Veterans Administration (VA) Justice Outreach Workers are included in the JIS quarterly meetings.

F. Justice Involved Services (JIS), there are 15 providers across NJ.
   1. Available to many county jails.
   2. A Diversion Program in Atlantic County in collaboration with the Attorney General's Office focuses on veterans.

G. NJ Judiciary – Veterans Assistance Initiative
   1. Consumers can get referrals [to behavioral health services].
   2. Available in all 15 of New Jersey's vicinages.

I. Law Enforcement Training
   1. Crisis Intervention Training (CIT) a 40 hour training program to educate Law enforcement about behavioral health populations—training on the unique needs of veterans is covered.
   2. Currently about 3,000 officers training in CIT in NJ.
   3. CIT trainings do include information about interacting with veterans.

J. Criminal Justice Reform/Bail Reform
   1. Bail is no longer based on finances; it is based on a risk assessment system.
   2. Consumers who are detained in jail now are often quickly released with 24 to 48 hours due to bail reform which is good. However, time needed to arrange for mental health services has correspondently become more difficult because of the rapid turnaround.
   3. NJ Judiciary website has a section devoted to mental health issues http://www.judiciary.state.nj.us/mentalhealth/index.html

V. Olmstead Update (Roger Borichewski, Donna Migliorino, Domenica Nicosia, DMHAS)

A. DMHAS as met substantial compliance with the Olmstead Settlement

1. *Home to Recovery Plan* (2008)
http://www.nj.gov/humanservices/dmhas/initiatives/olmstead/Home_2_Recov_Plan_2008.pdf

2. *Home to Recovery 2, 2017 to 2020: A Vision for the Next Three Years* (2017, draft) was distributed in hard copy to members of the Planning Council. [See that document for details of the plan].

B. New Housing Opportunities Developed

1. Consumers in Supportive Housing/CSS have lease-based /tenant rights.
2. The number of community-based beds for consumers at risk for homelessness and inpatient psychiatric hospitalization has increased.

C. DMHAS has entered an agreement with NJ Bureau of Vital Statistics to obtain birth certificates from those born in NJ who need copies of their birth certificates in order to be discharged from state psychiatric hospitals.

D. Improved tracking of DMHAS contracted community based housing through the development of the Bed Enrollment Data System (BEDS).

E. The assignment process [of consumers on CEPP status being discharged from state psychiatric hospitals into community settings] has been improved so consumers do not have to "interview" with providers.

F. The transition to FFS offers additional choices for consumers.

G. Consumer Support Services (CSS) – Rehabilitation Services

1. 2011 State Plan Amendment that allows the state to run CSS as a Medicaid-reimbursable service.
2. CSS is "'showing how, not doing for'."

H. Separation of Housing from Services; in fidelity to the "housing first" model.

I. Integration of Primary Health and Behavioral Health, through the Behavioral Health Home model; These exist in Bergen, Mercer, Monmouth, Atlantic

J. Expansion of Supportive Employment

K. Selected Quantitative Accomplishments

1. Decrease in hospital admissions from 2,938 in 2006 to 1,884 in 2016 was a decrease of 35.9%.

2. In SFY 2016 hospital discharges exceeded admissions.

3. There was a decrease of 716 (33.7%) in the total average census between 2006 (2,122) and 2016 (1,406).

4. The CEPP census as a proportion of state hospital census has steadily declined from 50% in 2006 to 43.6% in 2009, and to 21.8% in 2016.

5. Between 2010 and 2014 the total number of beds that was created by DMHAS for the discharge of CEPP consumers was 941. This exceeded the settlement target of 695 beds by 246 (35.4%). In addition, DMHAS developed 185 beds in 2015 and 148 beds in 2016 for a total of 1,274 new beds created between 2010 and 2016.

6. There has been an increase in the number served in Supportive Housing from 2006 (2,136) to 2016 (6,301). This represents increase of 4,165 (195%).

7. Since 2011 the percent of CEPP populations discharged to Supportive Housing has steadily increased relative to the percent of all hospital populations discharged to Supportive Housing, indicating that the Division is successfully promoting the use of Supportive Housing, especially for CEPP consumers.
8. There has been a paradigm shift in the delivery of services to NJ's mental health consumers [with regard to the locus of treatment]. In SFY2016 there were 5,205 consumers served in non-forensic state hospitals (or 70% of state hospital and supportive housing populations combined) and 2,136 consumers served in Supportive Hosing (or 30% of the combined populations). By the end of SFY2016, 6,301 consumers were served in Supportive Housing and 3,290 consumers were served in non-forensic state hospitals in NJ. This means that Supportive Housing now comprises 64.6% of the combined populations served, while the state hospital percentage has dropped to 35.4%. This change is illustrated as early as 201 with the increased use of Supportive Housing over state hospital services.

9. From 2019 to 2016, cumulative state spending increased from $40.3M to $104.2M, which is an increase of $63.9M (158.56%).

L. Comment: Concern that if hospitals close [too many beds] there is a risk that more mentally ill populations will go to jails and prison (J. Banes).

M. Targets and Outcome Measures (see page 28 – 29 of *Home to Recovery 2: 2017-2020 a vision for the Next Three Years* (2017)).

VI. Public Comment

A. Apparent lack of housing resources for people in the community (J.Banes).
1. Continuum of Care Committees exist in most counties, and are a good resource for housing concerns (R. Morgan).

B. Question related to Decrease in the use of hospitalizations (J.Guttstein).

VII. Meeting Adjourned.

Next Meeting of the Planning Council,
Wednesday, April 12, 2017, 10:00 am
222 South Warren Street, Trenton NJ 08625, Room CR-1000

12:00 Housing/Data/Advocacy Subcommittee Meeting