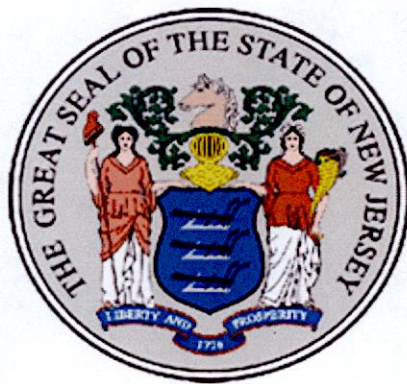


**New Jersey  
Department of Human Services  
Division of Mental Health Services**

**Wellness and Recovery  
Transformation Action Plan  
January 1, 2008 – December 31, 2010**



**October 2007**

## Forward

**By Kevin Martone, Assistant Commissioner  
New Jersey Division of Mental Health Services**

Having served on former Governor Codey's Task Force on Mental Health, I had come to believe that we needed to have a champion to advance reforms in New Jersey's mental health system. Certainly former Governor Codey championed mental health issues and was the springboard for new resources and a positive shift in attitudes and beliefs about persons living with mental illness. The challenge, however, was to prevent the Task Force Report, issued on March 31, 2005, from becoming another shelved document. To the contrary, it has become the foundation of New Jersey's on-going commitment to transforming the state mental health system.

Now, entering my 3<sup>rd</sup> year as Assistant Commissioner for the DMHS, and having spoken with thousands of NJ citizens over the past several years, I have come to learn that NJ doesn't need *A* champion. In fact, this system is comprised of many *champions* who have maintained the hope, optimism and momentum beyond that generated during the work of the task force. These are the consumers, family members, friends, providers and elected officials who have a shared vision for unprecedented change and have made a commitment of leadership towards transforming the system. As mental health becomes more widely known as the public health issue that it is, the State's *champions* continue to set higher expectations and provide welcomed influence. By listening and working in collaboration with the multitude of stakeholders, we are collectively promoting wellness, recovery, and a promise for a better way of life.

With transformation, however, come significant challenges. There are still many people who cannot access services, and who live in poverty or are homeless every day. There are people right now who have been waiting in an emergency room for hours; people sitting idle in a hospital because no decent, affordable housing exists; people told they need to go to program or else face eviction from their housing; people disenfranchised due to stigma.

Despite transparency, dialogue and communication, upheaval and reorganization will occur as new sources of power emerge, as the State develops greater accountability for its limited resources, and as the landscape of services become better able to facilitate recovery. While transformation can be frightening, it offers exciting challenges that will serve to positively influence the inherent inertia that exists in systems.

The following *Wellness and Recovery Transformation Action* Plan is a result of a collaborative process that actively sought and incorporated recommendations from consumers and their families, providers, and governmental and non-governmental agencies. Though additional resources are beyond its scope, this three year plan puts into action transformational activities in three key areas that will result in greater opportunities for wellness and recovery. These are *System Enhancements*, *Data Driven Decision Making*, and *Workforce Development*. The Division recognizes that it will not resolve all of our systemic challenges upon completion of this plan. However, it will result in systematic improvements to the mental health service delivery system, and create an unprecedented culture of caring that fundamentally seeks to evolve with the scientific, scholarly, economic and political environments.

## New Jersey Fast Facts

- As of 2006, NJ's population stood at 8.7 million, an increase of 6.15% since 1997.
- The state's population is growing more diverse. In 2005, non Hispanic whites made up 62%; African Americans 13%; Hispanics 15%; Asians 7% and 3% of the population reported falling into two or more racial categories.
- Despite having the highest median household income in the nation, NJ's poverty level of 8.7% is below the national average. Average unemployment rates rose from 3.7% in 2000 to 4.6% in 2006.
- There are approximately 358,302 people with serious mental illness living in NJ (5.4% of the adult state population)
- Between 1997 and 2006, NJ's state hospital population has remained essentially flat (0.17%) despite the overall population growth. Factored against the population growth, this is a net decrease in overall population to state hospital census.
- Admissions into all five state psychiatric hospitals have steadily decreased over the last 10 years. From a total of 3630 admissions in FY 1997 to 3311 in FY 2007, a decrease of 319 or 8.79%. The most significant decrease in admissions however, has occurred within the past several years. In FY 2004 there were a total of 3803 admissions, down to 3311 in FY 2007, a decrease of 492 or 12.94%.
- Readmission rates within 30 days of discharge, for the non forensic state hospitals, have decreased from 5.47% in FY 2003 to 4.93% in FY 2006. Readmissions within 180 days of discharge have decreased in number from 526 readmissions in FY 2003 to 488 readmissions in FY 2007. Although there has been a slight decrease in the number of readmissions, the overall recidivism rate for 180 days has not decreased, primarily due to the reduction in the number of discharges which can be attributed to the reduction in the number of admissions.
- NJ has continued to increase access to services in the community. The number of adult consumers served in the community increased from 251,190 in FY 2004 to 261,826 in FY 2006, or 4.24%. The units of service that were provided to the consumers in the community programs increased from 3,863,768 in FY 2004 to 5,399,974 in FY 2006, or 39.76%.
- Consumers are accessing more non-emergency care than emergency care. In FY 2000, 165,271 consumers accessed non emergency services. In FY 2007, there were 234,157 consumers accessing non emergency services. This is an increase of 41.68%. In just the past several years from FY 2003 to FY 2007, the increase has been 14.52%.
- The length of stay on Conditional Extension Pending Placement (CEPP) status in the state hospitals has decreased. In FY 2007 there were 3248 consumers on CEPP status. Of the 3248 consumers, 2482 or 76.42% of the consumers on CEPP status that had a length of stay of 1 year or less. In addition, there were 682 consumers or 21% with a length of stay of 1-5 years and 84 consumers or 3% with a length of stay greater than 5 years.
- NJ ranks 8<sup>th</sup> in the nation spending \$139.91 dollars per capita on total mental health expenditures.
- The average Fair Market Rent in NJ for a one-bedroom apartment is \$ 859.
- The vacancy rate in the NJ rental market averages less than 5%, making it one of the strongest more competitive markets according to the Department of Commerce, and thus allowing more landlords to charge more than the area Fair Market Rent.
- Since 2005, DMHS has received approximately \$56M of new funding for community services, included those linked to housing. Support services have been funded for 1033 consumers accessing new housing opportunities, of which 850 are new units either occupied or under development. The remaining housing opportunities stem from rental subsidies funded primarily by DMHS, and also the Dept. of Community Affairs, HUD or local public housing authorities.

## Recovery as the Overall Goal of the Mental Health System

### **Background:**

Why move towards a recovery oriented system now? The answer to this question begins with the vision statement at the beginning of the President's New Freedom Commission Report of 2003: *"We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports – essentials for living, working, learning, and participating fully in the community."*

Upon release, this report clearly called for a fundamental transformation of the mental health service delivery system in the United States. In fact, remarks delivered by A. Kathryn Power, Director of the Center for Mental Health Services (CMHS), clearly supported this new vision, stating: "The New Freedom Commission chose the word transformation to reflect its belief that mere reforms to the existing mental health system are insufficient. Transformation is a powerful word with consequences for policy, funding, and practice, as well as for attitudes and beliefs."

Her message emphasizes that *transformation* of any system is a huge undertaking, one that is all-encompassing, and permeates all aspects of the mental health delivery system. It requires an enthusiasm and momentum that is self-sustaining and that does not decrease with system resistance but rather accelerates so as not to give apathy and sabotaging behaviors a chance to undermine the transformational process. In her Transformation Update in March 2006, she quoted Vice Admiral Cebrowski who headed up the Pentagon's Office of Force Transformation saying, *"Be bold....Pick up the things that look really hard. Other people will have done everything else. Be fast, he added, No transformational leader ever looks back and regrets moving too fast."*

Additional support for a mental health transformation to a recovery oriented system can be found in current research. It indicates that people with mental illness *can* and *do* become productive members of their families and communities—which is contrary to the widely accepted notion that psychiatric disabilities are lifelong, debilitating conditions. There is also a growing body of empirical evidence describing *what is* and *is not* effective in the treatment and rehabilitation fields of mental illness. New treatments, medications, evidence-based or promising practices, and natural supports are proving to be effective. In addition, there is growing support for services that expand beyond the mental health system that impact recovery of individuals such as housing, employment, education, physical health care and substance abuse treatment. As succinctly stated by A. Kathryn Power, "The key messages of transformation are that treatment works, evidence-based practices yield better results, and recovery is not only possible, but is the expected outcome of treatment."

In an effort to support the federal transformation challenge, SAMHSA's national panel met to clearly define a recovery system. They developed a consensus statement that outlined 10 fundamental components: self-direction, empowerment, hope, respect, responsibility, holistic, individualized and person-centered, peer support, strength-based, and non-linear. It describes

what they mean and how they will actually impact service delivery, but more significant is that it speaks of changing the attitudes, values and beliefs of consumers as well as of program administrators and providers. SAMHSA has set forth an agenda for states undertaking mental health transformation and demands unprecedented collaboration, accountability, and leadership from everyone involved. This message is further driven home by the US Supreme Court's *Olmstead v. L.C.* decision which asserts the right of people with mental illness to live, fully integrated into the community, and coincides with SAMHSA's 'vision' of "*A life in the community for everyone*".

The time is right for New Jersey to subscribe to the transformation challenge. To many, it may appear as if the state is going to be moving too fast, and to others, such as consumers and families, we may not be moving fast enough. Rest assured, New Jersey will move forward willfully with its action plan for transforming the mental health system.

### **What is a recovery oriented system?**

First and foremost, a recovery oriented system is one based on the belief that recovery is in fact possible. A recovery oriented system recognizes the potential inherent in all consumers. It values and seeks to build upon individuals' strengths. The system ensures access to effective and timely treatment, rehabilitation, crisis intervention, on-going peer and other natural support services that promote meaningful lives, the attainment of valued roles, and true empowerment. A recovery oriented system offers hope, is culturally competent, accountable, and is sagacious in its use of resources. Consumers experience transformation on a personal level and take personal responsibility for their lives.

There is also the recognition that recovery is a non-linear process. Consumers will need and want different services at different times in their lives. Many consumers have needs that cross systems such as those with co-occurring substance abuse issues or developmental disabilities. A recovery oriented system recognizes that people don't stay frozen in time, but rather assists them as they move through this very personal process of growth and development. The system is welcoming, and there is no wrong door. Being 'maintained' is no longer an acceptable outcome. "Some people will never" is no longer an acceptable prognosis.

Services emphasize a life in the community and true community inclusion. Services and supports are abundant, offering a wide variety of opportunities to explore and achieve in domains such as employment, education, interpersonal/social, and housing. Services focus and build upon individual strengths and potential. Services promote growth, competence, and resiliency. Services and systems are integrated. And lastly, resources are efficient and cost effective; resources must also yield observable results for consumers and their families.

Stigma must also be addressed in a recovery-oriented system to ensure treatment is sought and received; opportunities for housing, employment and education are provided; and community inclusion occurs. The stigma surrounding mental illness must be combated on all fronts: within the mental health and primary healthcare systems; from professionals, the general public, and mental health consumers themselves. Good mental health care is primary to overall wellbeing and the establishment of a rich, meaningful life.

### **What might be some outcomes in a recovery oriented system?**

One way to conceptualize outcomes is to look at things from a system, program or service, and consumer perspective. These are the different levels within a system that will change through the transformation process. The President's New Freedom Commission on Mental Health laid out six clear goals of a transformed system: 1) Americans understand that mental health is essential to overall health, 2) Mental health care is consumer and family driven, 3) Disparities in mental health services are eliminated, 4) Early mental health screening, assessment, and referral to services are common practice, 5) Excellent mental health care is delivered and research is accelerated, and 6) Technology is used to access mental health care and information.

From a system's perspective, there is easeful access to, and continuity of care among services. Cross cutting service systems are integrated for those with multiple needs and issues are not bounced between systems or denied entry to one system and forced into another deemed 'more primary'. Consumers and their families are actively engaged and present at all levels of service design, delivery and evaluation. The system facilitates ready access to social, recreational, and relationship opportunities, as well as, to affordable housing, employment, education and other meaningful activity opportunities. And most importantly, the system both generally and at every service level is welcoming and understands its' role in promoting the consumer's recovery and wellbeing.

Programs offer effective, evidence based and best practices to ensure consumer goals are attained. Resources are used efficiently. Person-centered, individualized recovery planning is the standard form of 'treatment planning'. A competent workforce is employed and sustained. Services are culturally responsive, become co-occurring capable to meet this vast need and emphasize life in the community. This includes recognizing its' role in promoting employment, building competencies, encouraging healthy lifestyles and offering choices.

Consumers routinely voice the desire to live in affordable housing of their choosing. Establishing or reconnecting with previous goals of work and/or education are the next most commonly voiced needs by consumers. The devastating impact of living in poverty is countered as incomes, assets, and financial literacy increases.

Consumers experience empowerment and ownership of their recovery, while at the same time are encouraged to take risks, sometimes fail, all the while learning from their decision-making. Consumers increase personal responsibility for their own lives and learn to make more informed choices about their own care, treatment services, where and how they live, and about all aspects of their own existence. They regain a lost sense of control and personal dignity that typically accompanies psychiatric disorders and hinders recovery. And of critical importance, people living with a serious mental illness experience improved health and lifespan.



## New Jersey's Mental Health System Transformation

In New Jersey, the initial charge towards system transformation came in response to Governor Codey's Mental Health Task Force's Final Report in 2005. The Division of Mental Health Services' (DMHS) current transformation efforts, and the plan to achieve a recovery oriented system, are not distinct from the work and findings of the Mental Health Task Force (MHTF) but rather the implementation of its findings.

The MHTF Final Report describes a vision for New Jersey's mental health system that is consistent with a statement articulated by the President's New Freedom Commission, *"We envision a mental health system where every New Jersey citizen with a mental illness will recover and thrive; a system that is consumer driven and family involved, a system where mental illnesses are prevented or detected early; and a New Jersey where all citizens with mental illness, at any stage of life, have access to effective treatments and supports – essentials for wellness, recovery, working, learning and participating fully in the community. We envision a New Jersey that welcomes as full members of society, persons with mental illness."*

### **Guiding Principles**

The Mental Health Task Force delineated values for improving New Jersey's mental health system, and prescribed many actionable recommendations for the State to follow. These guiding values and principles shape New Jersey's mental health system and guide our system as we move forward with our transformation efforts.

- The system is grounded in a *Recovery orientation*.
- All services are *Welcoming*, there is no wrong door.
- *Consumers and their families drive the service needs* based on wellness and recovery.
- *Access* to services promote *Continuity of Care*.
- Services are *Culturally Competent*.
- Services are *Integrated and Collaborative*.
- Services are held *Accountable, Cost Effective and Monitored* at the local level.
- *Stigma will no longer be tolerated* and education and awareness regarding mental illness and mental health will be increased and at the forefront of our mental health system.
- The system emphasizes *Evidence Based and Best Practices, Quality of Care, and Outcomes*.

### **The Transformation Challenge**

In February 2006, Assistant Commissioner Kevin Martone issued his Transformation Statement. In it he wrote, *"The process for moving to a recovery-oriented system must be inclusive and collaborative. Each of the participants in the mental health system – consumers, families, hospitals, and our community providers – hold distinct and valuable knowledge and experience. The Division will incorporate the recovery model into every policy, regulation, contract and expectation, but the effort will only succeed if the entire mental health community helps to shape the system"*.

He then initiated an extensive six month stakeholder input process in June 2006 (See [http://www.state.nj.us/humanservices/dmhs/Wellness%20&%20Recovery\\_%20Stakeholder%20Plan.pdf](http://www.state.nj.us/humanservices/dmhs/Wellness%20&%20Recovery_%20Stakeholder%20Plan.pdf)), convening nine subcommittees comprised of over 120 stakeholders. Subcommittees also held focus groups to ensure widespread participation.

Each of the subcommittees was challenged by Division leadership to come up with “actionable” recommendations. The intent for this Transformation Plan has always been for it to be realistic, impactful and do-able. It is actually more of a work plan for DMHS.

The Division convened all of the subcommittee participants at Mercer Community College on March 2, 2007 to present the summary report. At the conclusion of the event, a survey was distributed to participants about the process. Overall, the results suggested that participants felt positive about the direction the Division is heading.

Over 93% of participants felt that DMHS was both receptive to their input as stakeholders and sensitive to their perspectives regarding wellness and recovery. Most of the participants were confident that DMHS will achieve its wellness and recovery goals. Interestingly, 86% of stakeholders indicated that their knowledge, attitudes and beliefs about wellness and recovery were substantially or moderately effected by involvement in the process. The stakeholder’s overall satisfaction with the wellness and recovery planning process was very positive – 93% of participants indicated they were at least satisfied with the process.

A complete summary of the stakeholder planning process, in both narrative and PowerPoint format, can be viewed at:

[http://www.state.nj.us/humanservices/dmhs/Stakeholder%20Summ\\_cover\\_03\\_07.doc](http://www.state.nj.us/humanservices/dmhs/Stakeholder%20Summ_cover_03_07.doc).

### **Achievements Toward Transformation**

There is much of which to be proud, both prior to, and since the issuance of the Task Force Final Report. Our system has developed much strength upon which to build and move forward. Some of these recent achievements are listed below and indicate the transformational activity occurring in New Jersey.

#### System Wide Achievements:

- Implementation of Executive Order 78 to review and revise relevant regulations to align with Wellness and Recovery.
  - Partial Care regulations revised to include W&R principles, practices and interventions (adopted 11/06)
  - Medicaid Partial Hospitalization regulations (adopted 2/06)
  - Screening (in process, 5/07)
  - ICMS (in process, 5/07)
  - PACT (in process, 10/07)
  - STCF (in process, 10/07)
- Psychiatric Advance Directive regulations implemented. Trainings have begun.



- Regional Cultural Competence Training Centers implemented.
- Jail Diversion pilots implemented in three counties with expansion beginning in FY08.
- Home to Recovery housing initiative to meet the affordable, supportive housing needs of consumers who are in hospitals (Olmstead), homeless, or living in substandard housing settings. Pending application to the federal Centers for Medicare and Medicaid Services to secure additional federal financial participation Supportive Housing services.

#### Hospital and Community Provider Level:

- Illness Management and Recovery now implemented in **all** of our State Hospitals and a growing number of community agencies.
- Building of, and scheduled transition to new, smaller “state of the art” Greystone Park Psychiatric Hospital (November 2007).
- Decreased patient census at Trenton and Greystone Park Psychiatric Hospitals.
- Peer-run Self Help Centers in every county; enhanced Self-Help Centers in Sussex and Hudson County; new centers in southern Ocean, Camden and Paterson.
- Evidence based and Promising Practices in every county: PACT, Supported Employment, Family Education through Intensive Family Support Services (IFSS) programs, Supportive Housing.
- State hospital system-wide revision of crisis prevention training to further efforts to reduce seclusion and restraint use. Seclusion and restraints below national average.
- Tobacco cessation activities in each state hospital.

#### Consumer and Family Level:

- Consumers and families participating in DMHS planning.
- Psychiatric Advance Directives now being exercised by consumers
- Designated Peer staff positions on all PACT teams; Peer position piloted in several screening centers. Peers and family members incorporated into multiple service modalities.
- Peer delivered Recovery Groups in state hospitals. Peers participating in new staff orientation at state hospitals.

### **Overview of Action Plan for Achieving a Recovery-Oriented System**

The Stakeholder Input process resulted in a total of 184 recommendations that ranged from general suggestions for more respectful treatment of consumers to sweeping contract reform based on performance instead of under-informative units of service. Not every single recommendation from this process could be included in this Action Plan, but the Division thoughtfully considered the context of all of the recommendations in order to create an actionable and manageable plan. The attached chart, the *Action Plan for Achieving a Recovery-oriented System*, details the specific plans that the division will focus on over the next three years.

Many common themes emerged from the nine subcommittees' recommendations. All expressed the need for systems wide workforce development to ensure that staff in both the hospital and provider community is current and proficient in core competencies. Consumers were very vocal in both their criticisms as well as hopes for a transformed system. Most of the subcommittees also discussed the need to address inconsistencies or inadequate data collection and contract monitoring structures that currently prohibit accurate assessment of service delivery or contract commitments.

The attached matrix details an Action Plan derived from the Stakeholder's recommendations. It describes actions to be taken over three years, and is comprised of the following three main areas:

- Systems Enhancements,
- Data-Driven Decision Making, and
- Workforce Development.

Within each area are specific actions that are currently underway or projected for implementation during the three year project. The actions within each phase are to be initiated in that year. However, many of these actions require follow up in subsequent years. For example, Phase I of the Action Plan includes recommendations that are expected to be completed within fiscal year 2008. Phase II actions will be initiated in fiscal year 2009 but may require 12-24 months to complete. And lastly, Phase III actions begin in fiscal year 2010.

Many recommendations overlap areas and build upon each other. For example, system, service and consumer outcomes and measures need to be identified and defined before performance based contracting can be fully implemented. Identified outcomes will also form the basis for creating Centers of Exemplary Practice, since these centers will need to model best practices to achieve the outcomes desired. They will also inform what evidence based, best or promising practices may be funded.

Certain recommendations will also require reconvening of stakeholders as part of their implementation. Involved stakeholders will have input into identifying the system, service and consumer outcomes; and finalizing which core competencies with which to move forward. An on-going advisory committee will be established to oversee the multiple recommendations of the workforce development initiative.

The plan will be reviewed annually and updated as necessary as the system evolves. Budgetary constraints or systemic circumstances may require modifications or revisions to be made. As the DMHS implements this plan, progress on the different recommendations will be posted quarterly.

### **System Enhancements**

We now know more about what works. Research, practice and consumer experience are demonstrating that certain approaches, when applied with consistency and competence, are beneficial. Evidence based, promising and best practices, such as Supported Employment,

Assertive Community Treatment, Supportive Housing, and Illness Management and Recovery are implemented in every county in New Jersey. Yet, more than one subcommittee noted a need for more of such practices, and recognized that inconsistencies currently exist in the implementation, monitoring, resource allocation, quality and staff competencies in regard to them.

Consumer participants issued a mandate for more respectful and active treatment from the entire system, noting their often demeaning and devaluing experiences in both community based and hospital systems of care. Meaningful, real life goals, true community inclusion, and a vast increase in opportunities for housing of their choice, work, education, peer support, and real world socialization (not just through program attendance) were routinely cited. Consumers also want a stronger voice and role in the design, delivery and evaluation of services. A nationally recognized hallmark of a Recovery Oriented System is one in which consumer operated and delivered services permeate the system and are not relegated to a second class service modality.

Recommendations that fall within Systems Enhancements that promote wellness and recovery are those that were shared across all subcommittees and relate to service delivery. They are as follows:

- Increase consumer and family role in system.
  - Among roles to be considered expanding existing roles of consumers and families in screening centers and peer delivered alternate screening services. An Advisory Committee will be established to monitor the implementation of this plan and any plan related to resolution of the Olmstead suit.
- Emphasize and instill tools for consumer empowerment.
  - Psychiatric Advance Directives (PAD), Illness Management & Recovery (IMR), and an Individual Integrated Recovery Plan (IRP). The intent is for the IRP to ultimately be shared among all involved service providers to promote coordination and focus on consumer goals and reduce multiple plans driven by individual providers or service modalities.
- Improve integration between primary care and mental health treatment.
  - This objective involves the convening of a Task Force to examine this issue and put forth recommendations on how best to achieve greater integration.
- Improve integration of services for consumers that cross systems.
  - Key actions under this objective include identifying and implementing strategies that result in seamless coordination between Dept. of Human Service divisions, as well as between the DHS and other state agencies. Additionally, a Task Force will be convened with the charge of issuing recommendations to ensure a co-occurring capable system by 2010 to better serve those consumers who experience both mental illness and a substance use disorder.
- Create a culture of Wellness and Recovery and an emphasis on active treatment facilitating life in the community within the state psychiatric hospitals.
  - Actions under this objective relate to Olmstead, actions that will support active treatment and a wellness and recovery orientation within each of the hospitals, and training.
- Emphasize evidence-based, best and promising practices within the mental health system.

- This area recognizes the existing wealth of such services currently within the system while acknowledging the need for better evaluation, expansion of services and improved consistency in service delivery and outcomes achieved.

In addition to recommending new and expanded or additional services, the stakeholders felt that there are numerous system enhancements that can potentially foster recovery. These include but are not limited to the following: improved information sharing, better workforce training and development, more data-driven decision making, implementation of evidence-based and promising practices, and reform of regulatory and contractual mechanisms in order to ensure accountability.

### **Data Driven Decision Making**

Most of the Stakeholder committees acknowledged the need for some uniform system, service element and consumer related outcomes by which to measure our system. Even prior to the process of data driven decision making is the need to identify meaningful, measurable consumer, service element and systemic outcomes. By December 2007, the Division will identify several outcomes toward which the system will work. The list will not be exhaustive, but realistic so that systemic improvements can be measured. Where there are generally accepted outcomes, for example in PACT, the Division has recently begun incorporating outcome measures into contracts. The process of identifying consumer, provider and systemic outcomes will include stakeholders.

Means are needed to consistently collect data, measure performance and analyze outcomes. These will become the building blocks of contract reform, emphasizing performance while allowing for innovation and reasonable flexibility. Much of the transformation efforts will be driven by the redistribution or validation of resource allocation that results from the tracking of performance of agencies towards a recovery-oriented system.

Most of the subcommittees also discussed the need to address inconsistencies or inadequate data collection and contract monitoring structures that currently prohibit accurate assessment of service delivery or contract commitments.

The area of Data Driven Decision Making covers those recommendations aimed at addressing the current lack of uniform or meaningful outcomes, data collection, definitions or use of units of service for contracting. The key objectives in this area focus on:

- Establishing system wide outcomes and measures; and
- Implementing Performance based contracting.
  - Specific actions related to this are related to Olmstead, recovery-oriented activity and contract reform.
- Conduct a systems wide needs assessment.
  - This is envisioned to occur at the county level to provide a clear picture of the unique strengths, weaknesses, opportunities and needs faced by each county.



## **Workforce Development**

The Stakeholder Input Process had two Workforce Development subcommittees, one looking specifically at the state hospital system and the other at the community based system. However, both subcommittees stressed the need for training around wellness, recovery, and how staff can best support consumers in these areas. And while training needs and approaches for each system were discussed, a mutual recommendation was that much of the training should intermingle with state hospital and community provider staff to integrate and bring these two systems together around the common goal of assisting the consumer to live successfully in the community.

The need for promising and best practices in terms of interventions and approaches was also uniformly discussed. These include motivational interviewing, person centered planning, applied stages of change theory, cognitive behavioral interventions and facilitated skill development. Much of the services delivered are by bachelor's degree level staff. No degree program currently teaches what we increasingly know to be effective. Training alone will not increase the competency of the workforce. Sustaining knowledge, skills and attitudes learned will require a supervisory structure that will support the ongoing learning process and the implementation of these practices. In addition, a stronger workforce must also be supported by successful recruitment and retention strategies. Most noteworthy, staff must be adequately compensated for the expertise required. This remains as one of the biggest challenges faced by our transformation efforts, one that will require on-going advocacy efforts.

The recommendations under Workforce Development address the common concerns voiced in every single subcommittee about the necessity of system-wide workforce development to achieve a recovery oriented system. The primary objective will be to:

- Develop and implement a competency based Workforce Development Plan.
  - Create a Workforce Development Committee that is led by DMHS and made up of involved stakeholders. This committee will be charged with creating the Workforce Development Plan, that considers and incorporates:
    - Adopt core competencies that the entire workforce should be skilled in
    - Design and dissemination of training result in measurable gains in knowledge, skills and attitudes that promote wellness and recovery and that can occur both at an agency level, as well as, regionally and statewide
    - Establish Certification program and include competency based standards in regulations and licensing standards
    - Create Centers of Exemplary Practice as both training sites and models of service delivery that will be developed through a Request for Proposals (RFP) process.

## **Olmstead related activity**

The extensive stakeholder input process undertaken also serves to inform the Division as it addresses issues related to Olmstead. Special focus groups were conducted in all of the state psychiatric hospitals to engage consumers and staff in the process. This Plan includes specific

Olmstead related actions under both the Systems Enhancements and Data Driven Decision Making sections.

The Systems Enhancement objective to create a culture of Wellness and Recovery and an emphasis on active treatment facilitating life in the community within the state psychiatric hospitals includes the following actions:

- Implement census reduction strategies in each state hospital to coordinate discharge planning for those consumers on CEPP status.
- Implement Regional Residential Committees to facilitate coordinated, timely assessment, transition and discharge of CEPP patients. This committee will identify and address:
  - Systemic barriers to a timely and easeful transition process
  - Significant and/or unique consumer-specific barriers to transition and community living
  - Community mental health system needs to support consumers transitioning into the community
- Establish and begin to implement a Utilization Review process to safeguard against unnecessary hospitalization and ensure prompt treatment and discharge planning for consumers committed to the state psychiatric hospitals.
- Reduce length of time that a hospital patient remains on CEPP status by establishing benchmarks.
- Develop an Intensive Case Review Committee, with DMHS Central Office staff oversight, to review consumers on CEPP status for a specified duration for whom no suitable or available discharge destination has been identified. This committee will address individual barriers to discharge and community placement.

Within the section on Data Driven Decision Making objectives of establishing system wide outcomes and measures and implementing performance based contracting, the following actions are included:

- Create a residential/housing data system to inform Olmstead-related discharge planning, including but not limited to:
- Tracking of residential/housing vacancies and timeframes from vacancy to referral and admission statewide
- Patient database, including, but not limited to name, key dates, service and housing needs, and the county of residence.

### **Resource Availability and Management**

As a result of the work of the Mental Health Task Force, our system has seen an infusion of \$56M in new funds in the past three fiscal years. These have primarily gone to increase and enhance supportive housing opportunities statewide. Since 2006, support services have been funded for 1033 new consumers living in new affordable housing opportunities. Of these, approximately 300 consumers have been, or will be discharged from one of our state hospitals into their own apartments or shared living settings. We have been able to increase psychiatric services in our CMHC's, enhance screening services, pilot jail diversion and re-entry programs, establish multicultural training centers, expand self-help centers, and strengthen PACT infrastructure.

As the overall population of New Jersey has grown, so have the number of people seeking mental health services. The system faces infrastructure deficits that make it more difficult to maintain an adequate and well-trained workforce, particularly for outpatient treatment services. The challenge will be to balance emerging priorities with the need to create as an accessible system as possible. The caution is to not be perceived as funding one service at the expense of something that is equally important. Statewide, we are also facing impressive budgetary constraints that threaten the availability of new annualized appropriations in the coming year. Therefore, the Division's transformation efforts come at a pivotal time in regard to resource availability.

In addition, the State of N.J. is currently facing an Olmstead lawsuit predicated on inappropriate lengths of stays for many consumers in its state hospitals. The common values of a recovery oriented system are inherent in the U.S. Supreme Court Olmstead decision, including self-directed services, community inclusion, employment and educational goal attainment. The future conclusion of the Olmstead lawsuit will require that hospitalized consumers will have access to housing opportunities within reasonable timeframes. These will need to be developed using a combination of strategies and resources.

The Deficit Reduction Act and new Medicaid Rehabilitation Option regulations offer possible opportunities to draw in additional federal funds, especially in the Supportive Housing programs which are currently 100% state funded. This would allow for expansion of this critical service. DMHS is working closely with our community partners to find areas where additional federal funds can be accessed. The new Medicaid Partial Hospitalization regulations in 2007 established fixed rates for this service. DMHS will be able to redirect targeted savings from this initiative back into our community mental health system.

We have begun a hard, critical examination of existing resource allocation to ensure that consumers are receiving the best of what they both deserve and want, with the limited resources available. What we as a system must do, is closely examine what is already in place and find those places where services can be transformed with little to no new funding, replaced or removed. This will require all of us to collectively and collaboratively work together.

In a recovery model, consumers progress through the system, relying less on services. With this expectation, a bottle neck effect is replaced by an hour glass effect. The current paradigm of getting stuck in the system is transformed into one that encourages people to experience growth beyond the system. As the workforce gains expertise in facilitating consumers to develop competencies, readiness to increase personal responsibility, engage in work and educational activities, learn to better self-manage their illness and establish more non-paid support networks, many will be less reliant on the system for the majority of their non-treatment related needs. This will make space in existing supervised residential, partial care and partial hospital programs for those not currently accessing such services.

In spite of the numerous demands, the State of New Jersey remains committed to moving forward with our system's transformation efforts because we believe that these multiple agendas dovetail, rather than compete with each other. As system, agency and consumer outcomes are

identified, defined, and measured services will become more effective and efficient. Systems' mapping will allow us to identify strengths, areas of need, opportunities and potential threats. Funding and resource allocation decisions will be based on accurate data.

### Conclusion

It is widely believed and fully accepted that no single plan/policy initiative can independently achieve the fundamental restructuring that is needed to transform the mental health care delivery system. In February 2006, following the work of the Governor's Task Force on Mental Health, the Division of Mental Health Services launched its state mental health system transformation initiative. All transformation efforts are consistent with the spirit and legal mandates embodied in the *Olmstead* decision, the New Freedom Commission goals, and with the statutorily prescribed funding and planning requirements of the Mental Health Block Grant. Continuous monitoring of national outcomes measures and state-specific performance indicators data will help determine whether our system of care is functioning in accordance with New Jersey's stated priorities and needs as part of the overall planning, implementation, evaluation of New Jersey's Wellness and Recovery Transformation Action Plan.

The Division consciously decided to follow a two-pronged approach to transformation, one of planning and one of action, while remembering that "The perfect is the enemy of the good." Though discussion and assessment are important, this approach was based upon the belief that the system as a whole can paralyze itself into inaction unless action is a conscious part of the plan. Frankly, we are motivated for action as directed by federal initiatives (i.e., New Freedom Commission Report, *Olmstead* lawsuit) and of equal importance by the voice of our own consumer constituents who are challenging the status quo on a daily basis by incorporating the language and values of recovery into their own lives.

Despite modest resources considering the scope of this public health issue, the Division has assumed a leadership role in building a community-based and hospital system that is built upon the principles of wellness and recovery. There is no cure for mental illness at this time, and people will continue to experience the challenges and triumphs associated with living with a psychiatric disorder in the recovery process. Therefore, the Division is committed to ensuring that no matter what point a person finds themselves along that continuum, people shall receive the range of services and supports they need.

This Transformation Action Plan has been designed to include a time-table so that New Jersey residents will benefit from concrete, yet transformative improvements to the mental health system. Though we will likely encounter numerous challenges as we move forward, it is clear that action is at the forefront. The entire mental health community is embracing these fundamental changes that will lead to an improved quality of life for those who we are committed to serve.



## References

Barger: Barger, D. G. (2004). It is time to transform, not reform, U.S intelligence. [Electronic version]. *S AIS Review*, 24, No. 1, Retrieved January 3, 2005, from <http://www.saisreview.org/PDF/24.1barger.pdf>

Cebrowski, A. (2002) Fateful lightning: Perspectives on IT in defense transformation: An interview with the director, (Electronic version] Information Technology Association of America interview, August 2002. Retrieved January 3, 2005, from [http://www.oft.osd.mil/library/library\\_files/trends\\_164\\_transformation\\_trends\\_28\\_october\\_issue.pdf](http://www.oft.osd.mil/library/library_files/trends_164_transformation_trends_28_october_issue.pdf)

Haines, S., Aller-Stead, G. & McKinlay, J. (2004) *Enterprise-wide change*. NY:Wiley.

Mazade, N.A. (2004) Concepts of "transformation." Manuscript submitted for publication.

New Freedom Commission on Mental Health  
<http://www.mentalhealthcommission.gov/reports/reports.htm>

New Jersey Mental Health Task Force Report:  
<http://www.state.nj.us/humanservices/dmhs/Governor%20final%20report.pdf>

SAMHSA [http://www.samhsa.gov/Matrix/MHST\\_report\\_def.aspx](http://www.samhsa.gov/Matrix/MHST_report_def.aspx)

Morbidity and Mortality in People with Serious Mental Illness  
Integrating Behavioral Health and Primary Care Services: Opportunities and Challenges for State  
Mental Health Authorities

NASMHPD <http://www.nasmhpd.org/publications.cfm#techpap>

## NEW JERSEY DIVISION OF MENTAL HEALTH SERVICES ACTION PLAN FOR ACHIEVING A RECOVERY-ORIENTED SYSTEM

### Systems Enhancements that Promote Wellness and Recovery

Common concerns and recommendations shared across all subcommittees included the need to increase the role, opportunities and involvement of consumers, both in the types of services to be provided (real life outcome orientation, Evidence Based, Best and Promising practices) and in the design, delivery and evaluation of services. Improving treatment and conditions in the state hospitals to ensure a recovery and 'life in the community' emphasis was stressed. Better coordination among Department of Human Services (DHS) divisions and other related state agencies such as Labor, Education, and Corrections was discussed in most subcommittees.

Year 1 (0-12 months) 2008	Year 2 (12-24 months) 2009	Year 3 (24-36 months) 2010
<b>Objective: Increase Consumer and Family Role in the System</b>		
<p><b>New roles for consumers and families within the mental health system</b></p> <p>Create mechanisms for the active engagement of consumers and families that will include new roles in service design, delivery and evaluation. Roles to be designed and implemented in Year 1 include:</p> <ul style="list-style-type: none"> <li>• Peer Specialists in State Hospitals and Screening Centers</li> <li>• Consumer Advisory Committee</li> <li>• Family Advisory Committee</li> </ul> <p><b>Training</b></p> <p>Training needs for participants of Advisory committees are identified and delivered.</p> <p>Implement training on <i>Supporting a Consumer Workforce</i> for agencies, consumers, providers and families, starting with a statewide conference in Spring 2008.</p> <p>Note: this differs from supporting consumers in working as is covered in Supported Employment programs.</p>	<p>Continue to expand the role of consumers and families in designated screening centers, and conduct evaluations.</p> <p>Design and implement additional roles for Peer Specialists as identified by stakeholder input, the Consumer Advisory Committee or needs of the system (example, Peer Navigator or Educator).</p> <p>Ongoing training for Advisory Committee participants delivered.</p> <p>Training on <i>Supporting a Consumer Workforce</i> available on an ongoing basis.</p>	<p>Integrate and support Peer Specialist roles throughout the workforce and ensure that these roles are valued and equivalent to related staff roles.</p> <p>Evaluate effectiveness of consumer and family roles in designated screening centers.</p>

Year 1 (0-12 months)  
2008

Year 2 (12-24 months)  
2009

Year 3 (24-36 months)  
2010

**Objective: Emphasize and Integrate Tools to Promote Consumer Empowerment**

**Psychiatric Advance Directives**

- Assure statewide implementation of Psychiatric Advance Directives (PADs). Activities to include:
- Statewide training session to be available on DMHS website and CDs made
  - Train staff on intervention to facilitate PADs (F-PADs) (able to be offered on a regional basis, if requested by interested agencies)
  - Draft regulations on development and execution of PADs.
  - Establish benchmarks for completion of PADs.
  - Develop capacity for electronic access to PAD registry on DMHS website.

Assure Year 1 benchmark is achieved.

**Individual Integrated Recovery Plan (IRP)**

Establish a workgroup to make recommendations for developing and mandating uniform documentation requirements that would be wellness and recovery-oriented, strength-based and program specific. This is to include the recommendation of a person-centered, standardized IRP to be adopted and used among all service providers.

Assure that DMHS contracted service providers document that consumers received education and were offered the opportunity to complete PADs.

Assure that consumers' completed PADs are available electronically.

Assure that consumers who do not have completed PADs receive F-PAD intervention.

Assure Year 2 benchmark is achieved.

Begin to pilot individual IRPs incorporating WRAP (Wellness Recovery Action Plan), if available. The IRP would become the primary service/treatment plan that is shared among all involved service providers.

Assure that completing an IRP becomes part of the Core Competency (see "Workforce Development Plan").

Assure that IRPs are incorporated into relevant licensing standards and regulations as these come up for review and re-adoption.

Evaluate feasibility of an electronic IRP that could be shared among involved providers. An example would be the VIEW (Virtual Integrated Electronic WRAP) as discussed in one of the subcommittees.

All completed PADs are available electronically via protected website link.  
F-PAD interventions will continue as needed.  
Assure Year 3 benchmark is achieved.

All DMHS contracted service providers use the IRP as the primary service/treatment plan.  
Implement electronic IRP, if feasible.

Year 1 (0-12 months)  
2008

Year 2 (12-24 months)  
2009

Year 3 (24-36 months)  
2010

**Objective: Emphasize and Integrate Tools to Promote Consumer Empowerment (cont.)**

**Illness Management and Recovery (IMR) Training**

Actions related to IMR are addressed in "Objective: "Emphasize Evidence-Based, Best and Promising Practices Throughout the Mental Health System".

**Objective: Improve Integration Between Primary Care and Mental Health Treatment**

**Primary Care/Mental Health Task Force**

Convene a Task Force to make recommendations for the integration of mental health and primary care. Use NASMHPD technical reports, "Morbidity and Mortality in People with SMI" and "Integrating Behavioral Health and Primary Care Services."  
Refer to [www.nasmhpd.org](http://www.nasmhpd.org)

Task Force puts forth recommendations in final report, including plan and timelines for implementation  
Begin implementing key recommendations.

Continue to implement recommendations.

**Collaborative Models for Co-Existing Medical Conditions**

Develop collaborative models with community healthcare providers, such as FQHC (Federally Qualified Healthcare Center) and VNA (Visiting Nurse Association), to meet primary care needs for services (example, supportive housing for consumers with co-existing medical conditions).

Continue to develop collaborative models with community healthcare providers.

Continue to develop collaborative models with community healthcare providers.



Year 1 (0-12 months)  
2008

Year 2 (12-24 months)  
2009

Year 3 (24-36 months)  
2010

**Objective: Improve Integration of Services for Consumers that Cross Systems**

**Integration within the DHS**

Work with sister divisions (DDD, DAS, DMAHS, DBVI, DDHH, DFD) within DHS to develop a consumer-focused approach to serving those with cross-cutting needs.

Identify areas for partnerships among DHS divisions.

Possible areas include jointly funded housing programs for consumers with multiple service needs and other similar types of collaborations.

Develop a data collection system within the DHS to track consumers heavily involved with multiple systems to research strategies to best serve this population in an effective, cost-efficient manner.

**Integration with other State agencies**

Continue to work with committees formed in FY07 to look at cross-systems issues related to the development of affordable housing for special needs populations (DHS division-wide Special Needs Housing Committee, interdepartmental committee with DHS, DCA and HMFA).

Issue RLI (Request for Letters of Interest) and award up to three (3) new Jail Diversion programs, or two (2) combined Jail Diversion/Re-entry programs.

Define processes, roles and responsibilities for points of access to services needed by those consumers who cross systems, based in part on data collection system to track consumers heavily involved with multiple systems.

Establish agreements between DHS divisions for shared service provision among mutual consumers.

Strengthen existing structures such as System Review Committees, for system coordination to ensure seamless transition between multiple systems for shared consumers.

Establish agreements with the Criminal Justice system, Labor, DCF and DHSS for shared consumers.

Jail diversion pilots expanded to counties with limited Criminal Justice-connected mental health services.

Implement processes as defined.

On-going implementation of established Agreements among DHS divisions.

Jail diversion pilots expanded to counties with limited Criminal Justice-connected mental health services, continued.

**Year 1 (0-12 months)  
2008**

**Year 2 (12-24 months)  
2009**

**Year 3 (24-36 months)  
2010**

**Objective: Improve Integration of Services for Consumers that Cross Systems (cont.)**

**Create a co-occurring competent system to address the needs of consumers with both mental illness and substance abuse issues**

Establish a Task Force to make recommendations that would ensure a co-occurring capable system by 2010. Among issues to be addressed are access to co-occurring capable services; definition of co-occurring capable service; and ensuring service access to all eligible consumers, including those who may be current substance abusers.

Begin to implement recommendations made by Co-occurring Task Force.

Continue implementing recommendations made by Co-occurring Task Force to ensure system wide co-occurring competence by 2010.

**Objective: Create a Culture of Wellness and Recovery and an Emphasis on Active Treatment Facilitating Life in the Community within the State Psychiatric Hospitals**

**Olmstead related activity**

Implement a strategic plan to promote active treatment that emphasizes recovery, life in the community, and meets all requirements of CEPP Plan.

Implement census reduction strategies in each state hospital to coordinate discharge planning for those consumers on CEPP status.

Implement Regional Residential Committees to facilitate coordinated, timely assessment, transition and discharge of CEPP patients. Committee will identify and address:

- Systemic barriers to a timely and easeful transition process
- Significant and/or unique consumer-specific barriers to transition and community living
- Community mental health system needs to support consumers transitioning into the community

Continue to develop enriched supportive housing opportunities for discharge-ready consumers.

- Work with NJHMFA and DCA to ensure, to the extent possible, ongoing capital and operating funds are available for housing development.
- Work in partnership with other state and county entities to bring additional HUD funds into NJ to support housing development.
- Request new service funds annually through the state budget planning process
- Implement Medicaid reimbursable Community Support Services to be paired with Supportive Housing development.

Expand Residential Intensive Support Teams (RIST) in each state hospital catchment area, contingent upon new funds received through the annual state budget appropriations process.

Ongoing development of enriched supportive housing opportunities for discharge-ready consumers. (Note: this action continues throughout designated timeframe of Olmstead/ CEPP Plan through 2013).

Ongoing meetings of established Regional Residential Committees and CEPP Review Committee. (Note: this action continues Throughout designated timeframe of Olmstead/ CEPP Plan through 2013).

Ongoing implementation of the Utilization Review process consistently across all state psychiatric hospitals. (Note: this action continues throughout designated timeframe of Olmstead/ CEPP Plan through 2013).

Year 1 (0-12 months) 2008	Year 2 (12-24 months) 2009	Year 3 (24-36 months) 2010
<p><b>Objective: Create a Culture of Wellness and Recovery and an Emphasis on Active Treatment Facilitating Life in the Community within the State Psychiatric Hospitals (cont.)</b></p>		
<p><b>Olmstead related activity (cont.)</b></p> <p>Establish and begin to implement a Utilization Review process to safeguard against unnecessary hospitalization and ensure prompt treatment and discharge planning for consumers committed to the state psychiatric hospitals.</p> <p>Reduce length of time that a hospital patient remains on CEPP status.</p> <ul style="list-style-type: none"> <li>• Establish benchmarks for CEPP patients.</li> </ul> <p>Assure Year 1 benchmark is achieved.</p> <p>Develop an Intensive Case Review Committee, with DMHS Central Office staff oversight, to review consumers on CEPP status for a specified duration for whom no suitable or available discharge destination has been identified. This committee will address individual barriers to discharge and community placement.</p>	<p>Implement the Utilization Review process consistently across all state psychiatric hospitals.</p> <p>Continue Intensive Case Review Committee activities.</p> <p>Assure Year 2 benchmark is achieved.</p>	<p>Continue Intensive Case Review Committee activities.</p> <p>Assure Year 3 benchmark is achieved.</p>
<p><b>Activities that support active treatment and Wellness and Recovery orientation in the State hospitals</b></p> <p>Implement hospital workgroups to promote Wellness.</p> <p>Analyze staffing patterns with the goal of increasing the amount of active treatment.</p> <p>Conduct assessment to identify and address safety concerns.</p>	<p>Implement pilot programs identified by the workgroup for building wellness culture and healthy habits and evaluate outcomes to recommend expansion or changes.</p>	<p>All hospitals have programs or activities to promote healthy lifestyle and support a culture of wellness within the hospital.</p>

Year 1 (0-12 months)  
2008

Year 2 (12-24 months)  
2009

Year 3 (24-36 months)  
2010

**Objective: Create a Culture of Wellness and Recovery and an Emphasis on Active Treatment Facilitating Life in the Community with in the State Psychiatric Hospitals (cont.)**

**Activities that support active treatment and Wellness and Recovery orientation in the State hospitals (cont.)**

Complete training for medical staff on prescribing practices for nicotine replacement therapies.

With funding from a Federal three-year grant, DMHS will implement its plan to reduce and/or eliminate seclusion and restraints in state hospitals.

Develop assessment and treatment interventions in order to provide trauma informed care in state hospitals.

Implementation of Management Support Team at Ancora Psychiatric Hospital.

**Hospital training activities**

Continue contract to provide ongoing consumer-delivered Recovery Network trainings.

Complete training of direct care staff in implementation of the Learning About Healthy Living manual designed to address smoking in all state psychiatric hospitals.

Continued implementation of Federal three-year grant.

Continued assessment and treatment interventions in order to provide trauma informed care in state hospitals.

Continued implementation of Federal three-year grant.

Continued assessment and treatment interventions in order to provide trauma informed care in state hospitals.

State hospitals establish training units or teams and provide ongoing Wellness and Recovery-related training.

Assure that consumers and families are integrated into hospital training activities.

Continue to provide ongoing Wellness and Recovery-related training.

Assure that consumers and families are integrated into hospital training activities.



Year 1 (0-12 months)  
2008

Year 2 (12-24 months)  
2009

Year 3 (24-36 months)  
2010

**Objective: Emphasize Evidence-Based, Best and Promising Practices Within the Mental Health System**

**General strategies**

Identify outcome and fidelity measures for each Evidence-Based, Best and Promising practice that is implemented.  
See "Data Driven Decision Making" section for details.

**Supportive Housing**

Issue RFP and award funds for up to 100 discharge-ready consumers in state psychiatric hospitals. Funding to include services and project-based rental assistance to promote the development of up to 100 new supportive housing units.  
Submit proposal to DMAHS for supportive housing-related Medicaid reimbursable service model, accessing either the new Rehabilitation Option regulations or opportunity under the Deficit Reduction Act.  
Issue funding announcements and award additional supportive housing opportunities, contingent upon resource availability.

All new funding opportunities will require incorporation of relevant Evidence-Based, Promising or Best practices, modalities and interventions.  
Statewide training begins in Evidenced-Based and Promising practices (i.e. Motivational Interviewing, Stages of Change approach, Cognitive-Behavioral Therapy and other psychotherapeutic practices and techniques), and these are implemented via Core Competency training initiative. Refer to section on Workforce Development.  
Conduct assessment of fidelity to model practices and assure consistent and effective implementation.

Medicaid reimbursement for supportive housing (Community Support Services) fully implemented if approved by CMS.  
Issue funding announcements and award additional supportive housing opportunities, contingent upon new funds received through the state budget appropriations process.

Conduct assessment of fidelity to model practices and assure consistent and effective implementation.

Issue funding announcements and award additional new supportive housing opportunities, contingent upon new funds received through the state budget appropriations process.

**Year 1 (0-12 months)  
2008**

**Year 2 (12-24 months)  
2009**

**Year 3 (24-36 months)  
2010**

**Objective: Emphasize Evidence-Based, Best and Promising Practices Within the Mental Health System (cont.)**

**Supported Employment/Education**

Issue RLI and award up to 3 Supported Employment expansion projects targeting consumers currently enrolled in partial care programs; and up to 2 Supported Education components to existing SE programs.

Expand Supported Employment to become Career Development and include Supported Education services, contingent upon new funds received through the state budget appropriations process.

Work and education readiness development services fully incorporated into partial care programs.

Expand Supported Employment and Education services, contingent upon new funds received through the state budget appropriations process.

**Peer-delivered and consumer-operated services**

Fund enhanced Consumer-Operated Self-Help Centers open in Hudson and Sussex Counties.

Fund 3 new Self-Help Centers in Passaic County, southern Ocean County and Camden County.

Strengthen the role of peer support as part of the continuum of services available and offered to all interested consumers.

Evaluate pilot of Self-Help Centers outreaching to patients on CEPP status in Trenton Psychiatric Hospital to determine if engagement with Self-Help Centers occurs after discharge.

Enhance leadership of Self-Help Centers through the FY08- funded Leadership Training Academy to provide training and support to Self-Help Center managers and facilitators.

Evaluate Leadership Training Academy.

Research and evaluate existing pilot programs to determine feasibility for replication (example, peer-delivered transportation service in Burlington County).

Expand Self-Help Center outreach to patients on CEPP status to at least two additional state psychiatric hospitals.

Increase education of, and access to, self-help dual recovery groups available in the community. Activities to do this can include:

- Make available the Self-Help Clearinghouse resource manual and 800 number;
- Providers can invite self-help groups to share about benefits and groups available;
- Provide transportation to meetings.

Based on findings of Leadership Training Academy evaluation, continue to support training to Self-Help Center managers and facilitators.

Expand Consumer-Operated Service modality to include Warm Line services and crisis diversion via RFP/RLI and contracting processes.

Self-Help Centers establish active partnerships with partial care and partial hospitalization programs to educate and invite consumers to engage with the centers.

Have in place an established Self-Help Center outreach program available to all discharged-ready patients in state psychiatric hospitals.

Self-Help Centers are established as fully integrated part of service continuum and provide the long-term social support for consumers who express an interest.

Continue replication of successful programs and continue to monitor outcomes.

Based on Year 2 outcomes, continue to refine and implement peer support model across variety of community-based programs.

Year 1 (0-12 months) 2008	Year 2 (12-24 months) 2009	Year 3 (24-36 months) 2010
<p><b>Objective: Emphasize Evidence-Based, Best and Promising Practices Within the Mental Health System (cont.)</b></p>		
<p><b>Peer-delivered and consumer-operated services (cont.)</b></p> <p>Research and work with Medicaid office to determine feasibility and advisability of implementing Medicaid-reimbursable peer-support services in community-based agencies throughout the state</p>	<p>Begin replication of promising practices in accordance with existing resources and evaluate outcomes.</p> <p>Implement pilot peer support project(s) and evaluate outcomes.</p>	
<p><b>Assertive Community Treatment (PACT)</b></p> <p>Implement PACT outcomes initiative to begin to standardize and incorporate consumer outcomes into PACT service commitments and expectations.</p>	<p>Standard consumer outcomes are fully implemented and integrated into service commitments and all contracts.</p> <p>Research need and, if applicable, pilot specialized PACT services, such as forensic PACT team.</p>	
<p><b>Co-Occurring Services</b></p> <p>Continue to fund training in IDDT (Integrated Dual Disorders Treatment) to targeted agencies.</p> <p>Evaluate effectiveness and implementation of IDDT training.</p> <p>Begin to implement IDDT in state psychiatric hospitals.</p> <p>Continue to distribute, provide training and encourage application of co-occurring manual created and organized by the DMHS as a tool to begin to develop foundational co-occurring capable skills within provider agencies.</p> <p>Create a task force to promote a co-occurring competent system by 2010. See "Improve integration of Services for Consumers that Cross Systems".</p>	<p>Begin to Implement recommendations to promote a co-occurring competent system, as outlined by the Task Force.</p> <p>Continue implementation of IDDT in state psychiatric hospitals.</p>	<p>Continue to implement recommendations to promote a co-occurring competent system, as outlined by the Task Force.</p> <p>Continue implementation of IDDT in state psychiatric hospitals.</p>

Year 1 (0-12 months)  
2008

Year 2 (12-24 months)  
2009

Year 3 (24-36 months)  
2010

**Objective: Emphasize Evidence-Based, Best and Promising Practices Within the Mental Health System (cont.)**

**Family psycho education**

Conduct an inventory of existing family-based services to identify use of family psycho education practices.  
Evaluate existing services to determine their capability of establishing multiple family psycho education groups and monitor fidelity and other outcomes.

Provide incentives and training, where desired and/or necessary, to existing services that are capable of revising their practices so that they can provide multiple family psycho education groups.  
If resources allow, DMHS will make available start up funds to present the multiple family psycho education group model to key and relevant stakeholders, with the goal of stimulating understanding and interest in this model.  
Explore possibility of multiple family psycho education groups as a Medicaid reimbursable service with DMAHS.  
Establish a practice group focused on multiple family psycho education group services.

Continue to evaluate and address on-going family psycho-education needs and services.

**Illness Management and Recovery (IMR)**

Expand IMR pilot project to all state psychiatric hospitals and selected agencies, with emphasis on partial care programs.  
Design and develop plan to evaluation effectiveness of training, fidelity to practice and outcomes of IMR service.  
Begin evaluation of training and implementation of IMR in selected provider agencies and state hospitals.

Continue to offer IMR training to DMHS contracted providers.  
Increase the number of IMR teams per agency who can provide IMR to consumers.  
Fully evaluate fidelity and outcomes of existing IMR activities and assess sustainability of implementation and program model.

IMR training offered to all DMHS contracted providers.  
IMR available to interested consumers in all DMHS contracted services. For consumers who have completed IMR training and have identified goals, these are shared among involved providers.

**Year 1 (0-12 months)  
2008**

**Year 2 (12-24 months)  
2009**

**Year 3 (24-36 months)  
2010**

**Objective: Emphasize Evidence-Based, Best and Promising Practices Within the Mental Health System (cont.)**

**Acute Care Models**

Align the acute care system with Wellness and Recovery principles by working with designated screening centers to ensure a welcoming approach for consumers in time of crisis, and by researching alternative and peer-delivered crisis intervention models, such as the Living Room model for crisis diversion, Crisis respite models, Warm Lines.

Fund demonstration projects for alternative Early Intervention approach to crisis management

**Medication Algorithm**

Reconvene and expand Medication-Related Services Workgroup to expand "DMHS Pharmacological Practice Guidelines for the Treatment of Schizophrenia" to include other behavioral disorders.

Develop a plan to implement these guidelines in psychiatric hospitals and community-based programs.

Begin discussions with Medicaid to develop a mechanism to monitor prescribing practices and provide feedback to promote compliance with the guidelines. Will also explore the possibility of providing medication histories from Medicaid to assist prescribers.

Evaluate funded Early Intervention demonstration projects to determine effectiveness and possibility to replicate in other counties.

Increase staffing resources in the Office of the Medical Director to allow monitoring of prescribing practices and implement a feedback system to encourage more appropriate practices.

Fully implement the monitoring and feedback mechanisms to ensure full compliance with the practice guidelines.

## Data Driven Decision Making

Common concerns and objectives shared across all subcommittees emphasize a current lack of uniform or meaningful outcomes, data collection, definitions or use of units for service for contracting instead of incentives or disincentives, and lack of needs assessment to inform new service funding or development.

Year 1 (0-12 months) 2008	Year 2 (12-24 months) 2009	Year 3 (24-36 months) 2010
<p><b>Objective: Establish System Wide Outcomes and Measures; Implement Performance-Based Contracting</b></p>		
<p><b>Olmstead-related activity</b></p> <p>Create a residential/housing data system to inform Olmstead-related discharge planning, including but not limited to:</p> <ul style="list-style-type: none"> <li>• Data to guide housing and service development (CEPP consumer needs and geographic locations for housing development such as county of origin)</li> <li>• Tracking of residential/housing vacancies statewide</li> <li>• Timeframe from vacancy to referral and admission</li> </ul> <p>Research capability of incorporating above system into existing mechanisms such as the short-term care facility bed tracking done through the 211 system.</p> <p>Create data collection and analysis system to facilitate decision making and action on information obtained through the newly created Utilization Review policy and procedures in the state psychiatric hospitals.</p>	<p>Implement data collection and tracking system to ensure that the requirements and targets of the Olmstead/CEPP Plan are met.</p> <p>Implement Utilization Review data collection and analysis system within the state psychiatric hospitals.</p>	<p>Ongoing use of residential/housing data collection and tracking system to ensure that the requirements and targets of the Olmstead/CEPP Plan are met. (Note: this action continues throughout designated timeframe of Olmstead Settlement Plan, minimally through 2013).</p> <p>Ongoing use of the Utilization Review system. (Note: this action continues throughout designated timeframe of Olmstead CEPP Plan, minimally through 2013).</p>



**Year 1 (0-12 months)**  
2008

**Year 2 (12-24 months)**  
2009

**Year 3 (24-36 months)**  
2010

**Objective: Establish System Wide Outcomes and Measures; Implement Performance-Based Contracting (cont.)**

**Recovery-oriented activity**

Identify Recovery-Oriented system wide benchmarks and outcomes for consumers, services and agencies. This will include:

- Convening stakeholder groups for input
- Consumer-specific outcomes as well as outcomes for each service modality and EBP
- System wide benchmarks that may include improved customer service; access to services; PAD, IMR and IRP completion rates; completion rate for Wellness and Recovery Plan implementation; possible long-term outcomes such as improved health status, etc.

Create and/or identify outcome and service/EBP fidelity measures associated with Recovery-Oriented benchmarks and outcomes. Measures must be consistent with DMHS reporting mechanisms.

**Contract reform**

Initiate contract reform activities, including:

- Redefine units of service commitments for service elements
- Research funding mechanisms, including new Medicaid opportunities, bundled vs. unbundled services, and rate structures
- Require demonstration of service-related outcomes in all issued RFPs/RLIs

Create and implement feedback loop to ensure effective and supportive implementation of contract reform activities.

Conduct ongoing evaluation on Recovery-Oriented benchmarks and implementation of the Wellness and Recovery Plan.

Incorporate Wellness and Recovery outcomes and measures into all QCMR, Annex A and contract commitments.

Conduct ongoing evaluation on Recovery-Oriented benchmarks and implementation of the Wellness and Recovery Plan.

Continue with contract reform activities.

Design and implement resourced data collection and analyses infrastructure.

Integrate identified outcomes and measures into licensing standards and regulations.

Create baseline database based on identified outcomes and measures.

System wide performance-based contracting implemented.

Implement system wide incentive program tied to identified outcomes and measures and redirect resources from lesser valued/lower priority to higher priority services when necessary.

Issue and publish Performance Report Cards based on identified system, service and consumer outcomes.

Year 1 (0-12 months) 2008	Year 2 (12-24 months) 2009	Year 3 (24-36 months) 2010
<p><b>Objective: Conduct System Wide Needs Assessment</b></p>		
<p>DMHS will work with County Mental Health Administrators to design process for system mapping to be conducted in Year 2.</p>	<p>Conduct both statewide and county-specific system mapping to obtain clear picture of strengths, weaknesses, opportunities and problems.</p>	<p>Issuance of RFPs/RLIs will consider findings of county and statewide system mapping and other needs assessments undertaken by DMHS.</p>

## Workforce Development

Common concerns and recommendations across all subcommittees emphasized the need for more consumer-centered service planning, communication and motivational interviewing techniques to ensure respectful treatment. Skill development for all staff, especially direct care positions in interventions such as skill teaching, cognitive-behavioral techniques and assisting consumers using stages of change framework, was also stressed.

Year one focuses on laying the foundation for a long-term workforce development initiative. Then, in Year 2, training activities begin.

Year 1 (0-12 months) 2008	Year 2 (12-24 months) 2009	Year 3 (24-36 months) 2010
<p><b>Objective: Develop and implement a competency based Workforce Development Plan</b></p>		
<p><b>Develop a Workforce Development Plan:</b></p> <p>Convene a Workforce Development Committee, including stakeholder representatives (consumers, families, providers, educators, MH Licensing, practice group and/or Trade Association representatives), to coordinate and advise on a statewide workforce development initiative.</p> <p>Develop a Workforce Development Plan that may include the following tasks:</p> <ul style="list-style-type: none"> <li>• Review and adopt final list of core competencies as outlined by Workforce Development Committees, and ensure these will effect identified outcomes to be achieved by consumers, services and the system.</li> <li>• Conduct inventory of all DMHS-sponsored training initiatives and evaluate efficacy of current training activities based on identified outcomes and core competencies.</li> <li>• Design delivery and dissemination strategies for core competency training, that is flexible; agency and regional based; includes partnerships with university affiliations, Trade Associations, consultants and practice groups;</li> </ul>	<p><b>Implement the Workforce Development Plan:</b></p> <p>Begin to implement the Workforce Development Plan. Core competencies and training become incorporated into agency contracts, licensing standards and regulations.</p> <p>Develop a certificate program to demonstrate acquisition of core competencies.</p> <p>Begin to establish Centers of Exemplary Practice for evidenced-based, promising or best practices sites.</p> <ul style="list-style-type: none"> <li>• Create the application process for Centers of Exemplary Practice within the community which will serve as both model and practice sites for selected evidence-based, promising and best practices.</li> <li>• Identify which evidence-based, promising and best practices will have one or more Centers for Exemplary Practice.</li> </ul> <p><b>Recruitment and Retention Strategies that support a competent workforce:</b></p> <p>Convene focus groups to explore recommendations and identify best practices and strategies for staff</p>	<p><b>Implement the Workforce Development Plan:</b></p> <p>On-going implementation of the Workforce Development Plan.</p> <p>Establish Centers of Exemplary Practice for additional evidence-based, promising or best practices.</p>

<p>is user-friendly; and includes multi-media training packages, training sites, and train-the-trainer model.</p> <ul style="list-style-type: none"> <li>• Delineate process for curriculum/training content approval to ensure effective and consistent training experiences.</li> <li>• Determine methods to evaluate knowledge and skill acquisition.</li> </ul> <p>Create timeline to incorporate core competencies into all contracted services, licensing and regulations.</p>	<p>recruitment and retention.</p> <p>Incorporate training and supervision-related standards into licensing and regulations.</p>	
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