new jersey department of human services

The Division of Mental Health Services and the Division of Addiction Services Merger

CONSUMER FORUMS

Introduction

Developing the Consumer and Family Forums

In FY 2011 The Governor's Budget merged the Division of Mental Health Services (DMHS) and the Division of Addiction Services (DAS) into the Division of Mental Health and Addiction Services (DMHAS). The first Phase of the merger - listening to stakeholders to develop priorities and direction for the new division - began almost immediately.

The first available opportunity for stakeholder involvement was the Merger Advisory Committee. The MAC was developed by the Department of Human Services with two goals in mind: First, as a body intended to participate in the development of the new division. It was also intended as a means to distribute information regarding the merger progress.

The MAC is a committee comprised of 19 members of the stakeholder community; each member, part of an association or organization of stakeholders. As such, the committee represents and interacts with a large and varied constituency. Outreach for membership resulted in a balance of consumers, families and other stakeholders.

Consumer Forums were suggested by the MAC as a means to inform the merger. A subcommittee, consisting of six members, was formed to develop and staff these forums. The committee also was assisted by staff from the Deputy Commissioner's office, the DAS and the DMHS. The MAC members were active in the development of the forums, including the choice of venues, the development of the format for each meeting and the key questions designed to structure each discussion. The committee and the staff who attended the forums were integral in organizing the consumer feedback received and developing this report.

Forum Participation

Eight forums were scheduled and seven forums were held. One forum was cancelled due to inclement weather. The remaining seven forums were held at locations across the state. They were well attended with approximately 215 total participants, including about 195 consumers and their family members.

The forums were advertised through the new division's website, and distributed to the stakeholder mailing lists of both DAS and DMHS. Two of the forums were held during regularly scheduled meetings of consumers involved with one or more of the 21 Self Help Centers funded by DMHS. One forum was held at the New Jersey Recovery Center, the state's addiction self help center. The other four forums were held regionally.

Participants were not asked to be specific about their personal recovery stories when introducing themselves. But most did share whether they were mental health, addictions or co-occurring consumers. Most also identified themselves as family members or consumers. Based on these introductions, participation represented a wide continuum of individuals involved with mental health and addiction services. Although staff was concerned that consumers with addictive disorders would not attend because of the value they place on anonymity, there were significant numbers at each meeting – many of whom identified themselves as having a co-occurring disorder.

Some attendees indicated they were struggling with the symptoms of their illness and receiving treatment, others were further along in their recovery and there were consumers that represented themselves as having 20 to 30 years of recovery from addiction or since the last hospitalization for mental illness.

Forum Structure

Each forum began with a 10 to 15 minute presentation describing each division, the merger, and the role that these government agencies play in the delivery of services. The intent was to help consumers understand the significant impact that the existing and proposed structures have on their access to services, the type of services available and the quality of these services. Following the presentation attendees were asked to answer five questions, in a group setting, that related to their experiences in service and their recommendations for changes. Answers to the questions were recorded on large flip charts that were visible to all.

The questions developed were:

- What are the barriers that make it difficult to get services? And what would help eliminate those barriers?
- Are fees a barrier to service?
- When you have received services did the agency and staff understand both addiction and mental health issues? How did it impact upon your care? How could the merger of addiction and mental health services create a system that would better serve you in the future?
- Did you receive peer delivered services? What was your experience with peer services?
- What do you want from services?

Structure of the Report
While the committee members have decades of combined experience in the field and a firm understanding of the issues, the group felt strongly that the report should reflect only the consumers' voices and not the interpretation of the professionals attending. When the committee felt it important to interpret or add information to consumer input, it identified the content, accordingly.

There were some themes that pervaded all or most of the forums. Additionally, there was feedback uncommon to most forums that the committee felt to be important or noteworthy contributions.

A few of the themes can be found in the Merger Survey Narrative (hyperlink) while others can be found below, among the recommendations.

Recommendations

The following recommendations were made by the Forum subcommittee in response to the information collected at the Consumer and Family Forums. Citations are made where the recommendations that result from the consumer forums is supported by research. This report includes a list of these articles with a brief description or abstract.

ACCESS: (President's New Freedom Commission on Mental Health Report, 2003)

1) Simplify the service and funding eligibility criteria.
2) Increase support services such as transportation, child care and housing.
3) Increase insurance and funding for the working poor. As Medicaid is expanded and Health Insurance Exchanges are developed as part of the Affordable Care Act, it is critical that the services package includes strong behavioral health benefits.
4) Increase capacity to reduce waiting times and allow for access.
5) Improve access to services to consumers before they reach the need for crisis related services.

SERVICE:

6) Continue to develop and maintain person centered treatment.
7) Create more case management and care coordination services. (McLellan, T., Hagan, T., 1999), (Carey, K.B., 1996)
8) Expand capacity for less intensive treatment modalities.
9) Create a system in which screening/assessment/treatment planning includes both mental health and addictive disorders. (Mueser, K., et al, 2003), (Graeber, D., Moyers, T., et al, 2003)
10) Expand Family Services . (Friesen, B.J. and Koroloff, N. M., 1990)
11) Support the integration of medical and behavioral health care (Druss, B. G., & Esenwein, S. a von., 2006), (Zeiss, A.M. and Karlin, B.E., 2008)

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WORKFORCE:

12) Improve and support training and supervision for the staffing? workforce. (Graeber, D., Moyers, T., et al, 2003)
13) Expand the use of trained and supervised peer services in mental health and addiction services.
14) For agency line staff: Training to improve competency, improve options for self care, train in cultural competence and other steps to improve ability to provide respectful and empathetic care (Hoge, M., Paris, M., et al, 2005), (Carey, K.B., 1996)

MARKETING: (Jacobson, N., & Curtis, L., 2000)

15) Improve the availability of information that enables individuals to find and access the right treatment.
16) Continue to fight stigma (Sirey, J.A., Bruce, M. L., 2001), (Luoma, J.B., Twohig, M.P., et al, 2007)

DMHAS intends to utilize this report and its recommendations as it advances the merger.

Acknowledgements

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References and Literature Synopsis
Consumer Merger Forums

Carey, K. B. (1996). Substance use reduction in the context of outpatient psychiatric treatment: a collaborative, motivational, harm reduction approach. *Community mental health journal*, *32*(3), 291-306; discussion 307-10.

incorporates four themes from the psychological treatment literature: treatment intensity, stages of change, motivational interventions, and harm reduction.

Druss, B. G., & Esenwein, S. a von. (2006). Improving general medical care for persons with mental and addictive disorders: systematic review. *General hospital psychiatry*, *28*(2), 145-53.

'A small but growing body of research suggests that a range of models may hold potential for improving these patients' health and health care, at a relatively modest cost.' This is an earlier article but has some interesting information on their results and a variety of partnerships.

Friesen, B. J., & Koroloff, N. M. (1990). Family-centered services: implications for mental health administration and research. *Journal of mental health administration*, *17*(1), 13-25.

This article examines four barriers to implementing family centered systems of care. Describes consumers working as partners and not just recipients.

Graeber, D., Moyers, T., Griffith, G., Guajardo, E., Tonigan, S. (2003). ADDICTIONS SERVICES A Pilot Study Comparing Motivational Interviewing and an Educational Intervention in Patients with Schizophrenia and Alcohol Use Disorders. *Health (San Francisco)*, *39*(3).

Using motivational interventions can decrease use of alcohol/drugs and increase treatment adherence.

Hoge, M., Paris, M., Adger, H., Collins, F. L., Finn, C. V., Fricks, L., et al. (2005). Workforce Competencies in Behavioral Health: An Overview. *Administration and Policy in Mental Health and Mental Health Services Research*, *32*(5-6), 593-631.

Good resource for looking at what the competencies might be for our field of behavioral health.

Jacobson, N., & Curtis, L. (2000). Recovery as Policy in Mental Health Services: Strategies Emerging from the States. *Psychosocial Rehabilitation Journal*.

"States that have moved beyond such cosmetic efforts tend to focus on several specific strategies for operationalizing and implementing recovery. These strategies include education, consumer and family involvement, support for consumer-operated services, emphasis on relapse prevention and management, incorporation of crisis planning and advance directives, innovations in contracting and financing mechanisms, definition and measurement of outcomes, review and revision of key policies, and stigma reduction initiatives."

Luoma, J. B., Twohig, M. P., Waltz, T., Hayes, S. C., Roget, N., Padilla, M., et al. (2007). An investigation of stigma in individuals receiving treatment for substance abuse. *Addictive behaviors*, *32*(7), 1331-46.

Looks at the impact of stigma on people in substance use treatment: "Data supported the idea that the current treatment system may actually stigmatize people in recovery in that people with more prior episodes of treatment reported a greater frequency of stigma-related rejection, even after controlling for current functioning and demographic variables. Intravenous drug users, compared to non-IV users, reported more perceived stigma as well as more often using secrecy as a method of coping. Those who were involved with the legal system reported less stigma than those without legal troubles. Higher levels of secrecy coping were associated with a number of indicators of poor functioning as well as recent employment problems. Finally, the patterns of findings supported the idea that perceived stigma, enacted stigma, and self-stigma are conceptually distinct dimensions."

McLellan, T., Hagan, T., Levine, M., Meyers, K., Gould, F., Bencivengo, M., et al. (1999). Does clinical case management improve outpatient addiction treatment. *Drug and alcohol dependence*, *55*(1-2), 91-103.

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Case management in addictions has been shown to decrease use and increase medical status, family relations, and improve legal status.

Mueser, K., Noordsy, D. L., Drake, R. E., Fox, L. (2003). *Integrated treatment for dual disorders.* New York, NY: Guilford Express

This manual describes the effectiveness of treating both illnesses together as well as a blue print for assessment, use of interventions, working with

families, both individual and group approaches, as well as housing programs, vocational opportunities and psychopharmacology issues. This manual also discusses the issues of involuntary or coerced treatment approaches

President's New Freedom Commission on Mental Health Report, 2003

Sirey, J. A., D, P., Bruce, M. L., D, P., Alexopoulos, G. S., Perlick, D. A., et al. (2001). Perceived Stigma as a Predictor of Treatment With Depression. *Journal of Clinical Epidemiology*, (March), 479-481.

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Patients' perceptions of stigma at the start of treatment influence their subsequent treatment behavior. Stigma is an appropriate target for intervention aimed at improving treatment adherence and outcomes.

Zeiss, A. M., & Karlin, B. E. (2008). Integrating mental health and primary care services in the Department of Veterans Affairs health care system. *Journal of clinical psychology in medical settings*, *15*(1), 73-8.

This looks at the VA system and the implementations they have used that are evidenced based.