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Psychiatric Rehabilitation: A Cornerstone of Behavioral & Integrated Health Care at a Breaking Point March 22, 2022

Since the 1962 passage and implementation of President John F. Kennedy’s Community Mental Health Center Act the United States has depended on trained professionals to treat, support and care for those affected by mental health conditions. Always reliable, yet under-resourced and under-compensated, this workforce is under tremendous stress. Solutions are available and it is imperative that they are acted on to meet the needs of our state’s residents.

The psychiatric rehabilitation practitioners of NJPRA’s member agencies are an integral part of the system of agencies delivering community-based rehabilitative and recovery-oriented support and clinical services to over 270,000 New Jersey residents diagnosed with mental health conditions such as schizophrenia, schizoaffective disorder, bipolar disorder, and major depression.

Psychiatric Rehabilitation (PsyR) practitioners are a key element of our New Jersey’s mental health provider workforce. They work in community mental health centers, clinics, private offices, residences and on the street in nearly every municipality and every County, delivering wide-ranging, comprehensive psychiatric rehabilitation services twenty-four hours a day, seven days a week. They facilitate discharges from State Psychiatric Hospitals and enable individuals to live, learn and work outside of those institutional settings. They have been vital to the fulfillment of New Jersey’s Olmstead mandate.¹ We prevent unnecessary long-term custodial and institutional care, alleviating a significant financial burden to the State by providing services to people in community based programs. NJPRA has a long history of coordinating across systems and employing innovation to deliver high-quality, low-cost services through our contractual relationships with the Division of Mental Health and Addiction Services (DMHAS).

The services provided by the psychiatric rehabilitation workforce, made up of peers (persons with lived experience), paraprofessionals, professional counselors, rehabilitation counselors, and social workers, are broad, they include:

Certified Community Behavioral Health Clinics (CCBHC)	Peer Support Services & Wellness Centers
Community Support Services (CSS),	Programs in Assertive Community Treatment (PACT),
Day Treatment/Partial Care,	Projects for Ass’t. in Transition fr. Homelessness (PATH)
Early Intervention Support Services (EISS),	Psychiatric Emergency Screening Services (PESS)
Integrated Case Management Services (ICMS),	Outpatient Therapy
Medication Management	Supported Employment and Supported Education

¹ <https://www.state.nj.us/humanservices/dmhas/initiatives/olmstead/Home%20to%20Recovery%202%20cover%20ltr..pdf>



Across these settings PsyR practitioners utilize evidence-based practices to provide treatment and support. These include, but not limited to; Illness Management & Recovery (IMR), Integrated Co-occurring Treatment (IDDT), and Cognitive Behavioral Therapy & techniques (CBT) are utilized by trained professionals to meet the needs of the individuals and families served every day.

PsyR practitioners and the organizations that employ them are a critical element of the safety-net services across New Jersey that meet the rehabilitation, care, and support needs of our most vulnerable residents.

The Practice of Psychiatric Rehabilitation and Challenges Facing Providers:

The practice of PsyR occurs in evidence-based services that treat and collaborate with individuals recovering from serious mental illness. PsyR practitioners are professionally prepared to utilize a wide range of skills to deliver expert services that assist the individual, family, and community. The expertise in PsyR is wide ranging and includes rehabilitation sciences, psychology, sociology, skills teaching, crisis de-escalation, cognitive restructuring, and a range of evidence-based practices.

Psychiatric Rehabilitation is specifically designed to be flexible and creative so that services provided conform to the needs of the individual. As such, the PsyR practitioner quickly shifts and adapts interventions and activities to wrap the most beneficial and impactful services when and how they are needed. This may be in an inpatient or outpatient treatment facility, in the home, at work, at school, a housing program or on the street.²

The agencies who employ these professionals and para-professionals are faced with wide-reaching and cumbersome contracts and regulations that constrict their operations.

To meet the regulations of various stakeholders in the system, PsyR staff may encounter rigid standards that restrict their scope of practice, creating the need to have multiple people with different credentials to deliver the same service in different program settings. For example, a recovery plan (eg treatment plan) may be written by a bachelor's level employee and be approved by an unlicensed masters' level supervisor in a program for assertive community treatment (PACT), but the same plan in a community support services program must be written by a licensed masters' level employee. Same service, similar setting, different requirements. This prevents utilization of staff across department as one might see in other healthcare settings.

The practices restrict the flexibility needed to address emergent and urgent needs; currently impeding the response PsyR professionals and organizations can lend to the pandemic related increased demand for help. Psychiatric Rehabilitation relies on the ability to change course based on the need of the individual and the environment they are living in. It is the foundation of the field and differentiator from other services.

² https://d1wqtxts1xzle7.cloudfront.net/56726349/2010_Recovery_Orientation_of_treatment-libre.pdf?1528144702=&response-content-disposition=inline%3B+filename%3DRecovery_Orientation_of_Treatment_Consum.pdf



COVID-19 as a Breaking Point:

The impacts of the COVID-19 pandemic have been broad, affecting life across the globe. Much attention has been paid to the pandemic's effect on our Nation's physical health care system (hospitals), its impact on schools, youth, and across society. The COVID-19 pandemic and the resulting economic hardships have negatively affected many people's mental health and created new barriers for people who have mental health conditions and substance use disorders. During the pandemic, about 4 in 10 adults in the U.S. have reported symptoms of anxiety or depressive disorder, a share that has been largely consistent, up from one in ten adults who reported these symptoms from January to June 2019.³

A seasoned staff person on a NJ PACT team described the pandemic in these words: "We saw an increase in the need for our services as many other services either went fully remote or simply stopped. Our clients desperately needed in person social interaction, and we were the only service that could provide it for a long time. The one service that was particularly worrisome was the in-home care of our senior clients. We took on the role of providing services that were homemaker related- cooking, cleaning, and even cleaning and disinfecting commodes while continuing our usual mental health treatment, medication delivery, and psychoeducation. We often had an inadequate supply of PPE while doing this. We also had an increase in responsibility such as doing grocery shopping for our clients so that they would not go into stores and be exposed to the COVID-19 virus. We had clients who did not understand the need for PPE and/ or could not afford it. We were tasked with providing this education and PPE. We were also tasked with taking on increased trainings and utilization of assessments such the PHQ-9 and C-SSRS. All while staffing and salary did not increase. ...there were many students who were graduating during this time who were more than capable of filling these community-based roles based on their education that they received in the psychology and psychiatric rehabilitation program at Kean University and Rutgers School of Health Professions, but they could not be hired due to strict hiring criteria (regulations).

I was part of the "great resignation". Increased amounts of tasks each day and ongoing lack of supplies such as PPE and vehicles contributed to my decision. The mental and emotional toll was also a factor. Many services had discontinued or went fully remote while we had continued to outreach clients in the community. Interactions with my own providers were restricted to phone calls and tele-health. The expectation to continue to show up every day and take on increased tasks, responsibilities, and risks without any increase made to salary was not only an unrealistic expectation, but quite frankly a slap in the face to all of us."

Coupled with the stress of daily exposure to headlines about the wide-ranging effects of the pandemic on mental health, is the "great resignation"⁴ referenced above. It has had a hobbling effect on a system of care that has been plagued by some of the lowest reimbursement rates in the Country. State contract reimbursement has lagged woefully behind inflation and increases in operating costs. Operating under funding and rates that were set in 2016, and the budget shortfalls that arose across programs when they were

³ <https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/>

⁴ <https://www.cengagegroup.com/news/press-releases/2022/great-resigners-research-report/>



implemented in 2017 (more than half of which are lower than they were in 2020) there is no fat to cut, no savings to realize. PsyR provider agencies are being squeezed from all sides.⁵

All of New Jersey's PsyR agencies have experienced decreased staffing due to the pandemic. This has been especially severe for the credentialed professionals who have been drawn away from their agencies by significant salary and rate increases that the public mental health system can't match. These include salary increases upwards of 30% for licensed clinicians to transition to a telehealth provision, bachelor's level frontline staff who accept jobs managing convenience stores for better pay, benefits and hours, and of course, "less stress".

When staffing is inadequate, it drives the system of care to focus primarily on urgent issues; not treatment and services that facilitate and enable recovery. This limits the efficacy and value of services, and it drains the morale of the practitioner and colleagues. The provider system is pushed to its limits and is then also contending with pandemic-related expenses (eg: PPE, increased recruitment costs), revenue decreases driven by limitations to service delivery capacity, and inflation.

This is not the case for all of New Jersey's funded systems of care. In other systems of care; those serving Children, Adults with Intellectual Disabilities and Adults with Substance Use Disorders support has been provided in the form of budgetary boosts, and new systems of support through legislation. For example, direct support professional's wages increase by \$3.50 hour since 2019 and an additional \$1.25 an hour will be added in 2023.

There is an important case to be made for the State's mental health service system to receive consideration, and psychiatric rehabilitation providers, who are at the core of this system, to receive compensation commensurate with their education, credentials, skills and experience. They are at the core of the New Jersey system of care for behavioral and integrated health care, particularly for our most vulnerable residents.

Solutions for the Future

Throughout his tenure, Governor Murphy has touted a "fairer" New Jersey and the inclusion of a \$1 per hour increase for all behavioral health service system providers is a first step. Our "fairer New Jersey" needs to include the behavioral health service system and its providers through a fair, market-based rate structure. This first solution will go far to address the above-referenced shortfalls and challenges.

Our second solution is to implement supports for other credentialed professionals as has been done for psychiatry. In 2021 funding for an additional ten (10) psychiatric residencies was announced at a cost of \$4 million⁶ as a means to address the psychiatric shortage across the State. Tuition forgiveness for undergraduate and graduate degree expenses, the fee "holiday" described in the Governor's 2023 Budget address for licensure of professional counselors, rehabilitation counselors and social workers, and for the certification of peer

⁵ Appendix I, pg. 9

⁶ <https://www.state.nj.us/humanservices/providers/grants/rfprfi/RFPfiles/RLI-CommunityPsychiatricResidence10.29.21.pdf>

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professionals would be a welcome support. Additionally, a financially supported initiative to have all peer providers renew, obtain, and maintain active certifications is strongly recommended.

Trained peer providers have a unique approach and value by using their lived experience to provide hope and a model of care that provides empowerment and self-direction. Please be reminded that programs such as the recently funded Opioid Overdose Recovery Program has its roots in psychiatric rehabilitation's peer-driven service models and that New Jersey's peer providers play an essential role in the delivery of recovery services for both mental health and substance use disorders in New Jersey. Managed care requires active certifications or licenses to reimburse peers. The promotion and support that has been extended to the substance use community peer providers needs be extended to the mental health peers, since many in the peer mental health workforce do not have current, active certifications. This is largely due lack of affordability and a lack of livable wages.

Returning to Governor Murphy's March 2023 Budget Address and efforts to turn New Jersey into a "State of Opportunity"⁷, it is important to remember that most of the college educated professionals in psychiatric rehabilitation jobs are not middle class professionals, but aspiring middle class professionals. Despite their degrees, additional training and certification, many are living below New Jersey's low income threshold for affordable housing⁸. Loan forgiveness, educational grants, and waiving of licensing exam and renewal fees would deliver critically needed relief to these professionals. Without finding ways to hire and retain staff at a livable wage, the system cannot do what it is designed to.

Smart investment in the community-based psychiatric rehabilitation workforce that serves and treats individuals with mental health conditions to support them to live as full citizens is a sound companion to housing the housing dollars that Governor Murphy has budgeted for 2023.⁹

Increasing attention is being paid to the importance of social determinants of health (SDOH) and the need for systems of care that are capable of addressing them. They are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.¹⁰ Long before the term became popular, psychiatric rehabilitation practitioners were learning and working in that space. Founded in 1975, the Psychiatric Rehabilitation Association states that "Psychiatric rehabilitation promotes recovery, full community integration, and improved quality of life for persons who have been diagnosed with any mental health condition that seriously impairs their ability to lead meaningful lives. Psychiatric rehabilitation services are collaborative, person-directed and individualized. These services are an essential element of the health care and human services spectrum, and should be evidence-based. They focus on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning, and social environments of their choice".¹¹

⁷ <https://nj.gov/governor/news/news/562022/approved/20220308b.shtml>

⁸ https://ahpnj.org/member_docs/Income_Limits_2021.pdf

⁹ <https://nj.gov/governor/news/news/562022/approved/20220308b.shtml>

¹⁰ <https://health.gov/healthypeople/objectives-and-data/social-determinants-health>

¹¹ <https://www.psychrehabassociation.org/about/who-we-are/about-pra>



Third, the impact of the delivery of psychiatric rehabilitation services to person with mental health conditions has a significant positive impact on the health care system, further supporting investment in this workforce. In a 2020 study published in the National Library of Medicine, collaborative care implementation for mental health teams was associated with significant reductions in mental health hospitalizations, leading to substantial cost savings of about \$1.70 for every dollar spent for implementation.¹²

Thinking towards the future and participating in managed care networks to support the needs of the whole person and meet the triple aim¹³, those managed care organizations will have the responsibility to make sure that scarce dollars are used responsibly and the services being provided are necessary. Small and medium sized agencies that have contracts with DMHAS will be significantly burdened provide the level of infrastructure and additional staff to meet the managed care requirements. Costs of contract compliance, billing, technology, and other support will increase, creating shortfalls in other funding needed to run the programs. The negative impacts to these program is significant for the larger system capacity and their needs must be addressed in a collaborative manner that includes technical assistance and infrastructure development support.

There are also the added expenses of operating community-based psychiatric rehabilitation services: multiple facilities with their repairs and maintenance, billing/fiscal operations, HR, technology (including EHR, computers/laptops/phones all with internet and video capabilities, technology for consumers that don't the ability on their own, vehicles and the maintenance for the vehicles. Operating costs include much than traditional office space.

Lastly, eliminate the budget and regulatory inconsistencies that make it challenging for practitioners and the agencies who employ them to do their work. This includes the regulations that prohibit advance practice nurses from prescribing in PACT programs, that prohibit other than licensed clinicians to write recover plans in CSS programs, and limiting billing to a single practitioner when two are required in a community for safety reasons. Compensate contracted community-based providers' employees on a scale commesurative with State employees and right-size the rates for all community-based services. Existing and proposed regulations that prescribe specific interventions or activities can restrict the practitioner's ability to work with an individual on their recovery. Psychiatric Rehabilitation is specifically designed to be flexible and creative-conforming to worki with the individual's needs. There are different practices that can be employed in the work, but Psychiatric Rehabilitation relies on the ability to change course based on the need of the individual. It is the foundation of the field.

¹² <https://pubmed.ncbi.nlm.nih.gov/32732780/>

¹³ <http://www.ihi.org/Topics/TripleAim/Pages/Overview.aspx>



In closing, always mindful of the fiscal challenges that continue to face New Jersey and the importance of prudent fiduciary decisions we recommend the following:

- 1) correct reimbursement rates in the 2023 Budget to meet the true cost of service delivery,
- 2) comprehensively address workforce compensation needs,
- 3) continue to integrate access to behavioral health care with physical health care for all New Jerseyans, and
- 4) decrease barriers to service through delivery of evidence-based and best practices, utilization of outcomes data for decision-making and sound fiscal policy practices.

The psychiatric rehabilitation workforce in NJ has a long history of supporting and participating in cost-saving initiatives and new programs with other stakeholders. These professionals are dedicated to serving and supporting persons living with psychiatric disabilities to pursue self-managed recoveries, and live, learn and work in their communities.

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ABOUT NJPRA:

Every day NJPRA members live our mission to serve the practice and practitioners of psychiatric rehabilitation in New Jersey, assure the availability of quality wellness and recovery-based services, advance public policy to strengthen behavioral health services, and increase integrated care for consumers in the Garden State. We envision improved wellness and recovery outcomes for persons with the lived experience of a serious mental illness and co-occurring conditions, as promoted by psychiatric rehabilitation practitioners, services and systems.

NJPRA has a long history, dating back to our 1980 founding, of legislative advocacy and lobbying on behalf of our workforce at the local, State and Federal levels. Through face to face meetings, written testimony and grass-roots advocacy our membership has made wide array of recommendations to improve New Jersey's mental health system and services.

Over the last five (5) years these have included:

- Increase medication management rate to adequately cover the cost of psychiatry time
- Strengthen the practice of psychiatric rehabilitation in the new service CSS to offset loss projections
- Provide a safety net in reserve to offset losses by providers due to the CSS reimbursement rate.
- Fund Supported Education & Supported Employment with Partial Hospitalization rate adjustment savings
- Address salary inequity between the private, not-for-profit workforce and State employees
- Investment of capital to fund DOH licensing requirements for integrated care services
- Support CCBHC programs through sustainment of funding in New Jersey and nationwide expansion
- Adequately fund Supported Employment, Supported Education, Early Intervention Support Services, & Crisis Living Rooms Statewide.
- Maintain Olmstead Services/Community services appropriations & fund housing vouchers
- Provide a fair market based rate structure
- Address the shortfall of psychiatrists & reimbursement rate inequity across program types.
- Correct NJ Medicaid rates (among lowest in Nation) & fund full, fair market value & cost of services
- Increase service capacity; in 2021 40.9% of all American adults had an "adverse mental consequence", yet 12% received services.
- Increase STCF beds from 83 to 90 to avoid costly state hospitalizations
- Expand emergency services allocation increase to serve 30,000 more people
- Increase outpatient services capacity
- Increase Supportive housing investment by \$10M & add 520 SH beds statewide
- ICMS – restore previously decreased funding
- Provide wage increases for MH staff commensurate with the DDD workforce provision



Appendix I: State-wide Median Rate Changes for Behavioral Health Services in NJ

SERVICE TYPE	FY2010 STATEWIDE MEDIAN	FY 2012 STATEWIDE MEDIAN	FY2016 STATEWIDE MEDIAN	FY2017 STATEWIDE MEDIAN
OUTPATIENT CLINIC	\$93.81	\$86.45	\$35.48	\$84.56
OUTPATIENT HOSPITAL	\$85.29	\$85.01	\$56.25	\$65.36
PARTIAL CARE CLINIC	\$22.03	\$20.47	\$14.55	\$17.92
PARTIAL HOSPITAL	\$25.03	\$34.05	\$33.08	\$17.92
PC / PH OTHER	\$29.43	\$32.39		
A+ GROUP HOME	\$197.09	\$178.22	\$179.23	\$268.85
SPECIALTY A+ GH	\$229.44	\$235.51	\$179.23	\$268.85
A+ APARTMENT	\$146.60	\$161.87	\$179.23	\$268.85
A GROUP HOME	\$171.27	\$180.94	\$143.16	\$214.74
A APARTMENT	\$158.82	\$135.39	\$72.13	\$214.74
B GROUP HOME	\$83.91	\$78.97	\$111.48	\$167.22
B APARTMENT	\$76.01	\$25.16	\$4.10	\$13.33
C APARTMENT	\$35.60	\$35.59		
D FAMILY CARE	\$56.24	\$52.70	\$43.71	\$17.55
SUPPORTED HOUSING	\$43.14	\$40.47	\$24.76	\$29.58
RIST	\$41.71	\$36.81		
AT-RISK SUPP. HOUSING		\$40.47	\$24.76	\$29.58
ENHANCED SUPP. HOUSING		\$37.22	\$24.76	\$29.58
MEDICAL SUPP. HOUSING		\$36.31	\$24.76	\$29.58
CEPP		\$44.73	\$24.76	\$29.58
ICMS	\$58.85	\$54.94	\$19.92	\$38.12
PATH	\$56.63	\$51.10	\$19.92	\$38.12
PACT		\$227.73	\$163.01	\$185.98