Addressing the Critical Mental Health Needs of NH's Citizens

A Strategy for Restoration

AUGUST 2008

State's mental health services need attention
By Monitor Staff
Concord Monitor - August 10, 2008

UNH study: N.H. mental health system broken
By ADAM D. KRAUSS
Fosters Daily Democrat - Thursday, May 22, 2008

Six to lose jobs at counseling center
MFS $500,000 short; more trouble expected
By Casey Farrar
Keene Sentinel – June 12, 2008

City moves fast to aid suicide prevention
Portsmouth Herald
July 31, 2008

Increasing demand for mental health care in NH
By Lauren Collins
New England Cable News
May 21, 2008

Mental health feels the pain
Gretyl Macalaster
Foster's

State Officials: Mental health reform needed
By Adam D. Krauss - Foster's Sunday Citizen - January 13, 2007

Some New Hampshire Residents Turn to Massachusetts for Psychiatric Crises
By Dianne Finch
NH Public Radio - July 2, 2008

Authorities receive five suicide calls in 24 hours
By Elizabeth Dinan
Portsmouth Herald – August 09, 2008

Mental health court to open Treatment will replace jail sentences
ELIZABETH DINAN
Portsmouth Herald
August 06, 2008

Family of slain children raise awareness of mental illness
WMUR, August 22, 2008

A collaboration between:
NH Department of Health & Human Services, New Hampshire Hospital Bureau of Behavioral Health and The Community Behavioral Health Association

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Executive Summary

Commissioner of New Hampshire's Department of Health and Human Services, Nicholas A. Toumpas, supported the convening of a taskforce to assess the current status of publicly funded mental health services and to make recommendations regarding additional services and supports that are critical to meeting the needs of New Hampshire's citizens. This was a collaborative effort, with representatives from the Department of Health and Human Services and the New Hampshire Community Behavioral Health Association.

By reviewing previous studies and developing forecasts for future system needs, the taskforce identified recommended services that were never implemented, the erosion of mental health services over the last fifteen years and a growing state population with related rising demands for mental health care.

As described in detail within this report and summarized below, the taskforce makes recommendations including those to be implemented through a combination of federal and state general funds within a comprehensive ten-year plan.

<u>Increase the Availability of Community Residential Supports</u>

- Formal supported housing programs to improve access to housing subsidies while providing intensive targeted case management
- A bridging rental subsidy for individuals eligible for Section 8 vouchers who are on the waiting list for that voucher
- Residential treatment programs with 132 new beds to provide crisis support and specialized housing for persons who are otherwise unable to live independently

<u>Increase Capacity for Community-Based Inpatient Psychiatric Care</u>

- Four additional Designated Receiving Facility units across the state providing an additional 48-64 involuntary beds
- A taskforce of stakeholders to find ways to expand the availability of voluntary inpatient psychiatric care in community hospitals across the state

<u>Develop Assertive Community Treatment Teams</u>

- Twelve new intensive outpatient service teams allowing individuals to recover while reducing repeated use of hospitalization, emergency rooms and jail/prisons

<u>Community Mental Health Workforce Retention and Development</u>

- Adequate resources to pay and maintain qualified staff for the delivery of mandated and necessary services to persons with serious mental illness
- A collaborative to develop a strategy for increasing the number of available residents and experienced psychiatrists in the state
- Investments in updated academic education and ongoing training for our mental health system workforce

<u>Department of Corrections Study Committee Planning Considerations</u>

- The State of New Hampshire needs to consider any necessary plans for mental health housing, training, and specialized services as related to master planning from House Bill 25-FN-A, Chapter 264:1, Section V. (H) for prison units, secure psychiatric care and the housing of non-violent offenders

Introduction

A 1985 report, Planning for Progress: Restructuring the Mental Health/Developmental Services System outlined a framework and rationale for types of recommended community services. This report – referred to as "The 407 Report" – was precipitated by a 1981 federal court decision that required New Hampshire to eliminate unnecessary institutionalization and develop a community-based system.

The plan included the closing of the Laconia State School; the downsizing of New Hampshire Hospital; the development of community-based programs, group homes and individual placements for persons with developmental disabilities; and the support of the ten regional outpatient community mental health centers and the development of ten regional inpatient units (Designated Receiving Facilities, DRF) to serve people with mental illness. New Hampshire Hospital would transform into a state of the art 100 bed facility: 60 of which to serve patients who did not respond to regional treatment, 15 for people with severe violent behavior, 5 for adolescents, and 20 for special diagnostic and evaluation services for people with developmental disability. Nineteen group homes were to be built for people discharged from New Hampshire Hospital. The Secure Psychiatric Unit (SPU) at the State Prison was to be completed. This envisioned system of care for people with serious mental illnesses provided an array of services from low to high intensity that could be easily accessed based on need.

New Hampshire took great strides to further develop a statewide system of care, including the ten community mental health centers; several regional designated receiving facilities, the SPU, and New Hampshire Hospital. This system has worked well and featured a number of nationally renowned services, but was never implemented to the degree initially envisioned in the 407 Report.

Services for individuals with mental illness in New Hampshire (NH) are developed and funded through the Department of Health and Human Services (DHHS), Bureau of Behavioral Health, and provided through a comprehensive network of Community Mental Health Programs, and Providers, as well as a provider network of consumer run Peer Support Agencies. NH prides itself in utilizing an inclusive model to engage active participation and input from Divisions within DHHS, the Community Mental Health Centers, the NH State Planning Council, the National Alliance on Mental Illness (NAMI), the NH Legislature and the Governor's Office, and, most importantly, consumers and their families members who receive services through this system.

While the development of multiple, effective medications and evidence-based outpatient psychosocial treatments has enhanced the ability of the statewide system to improve symptoms and the quality of life for adults and children, as well as reduce the need for inpatient care, other factors have eroded the current and future capacity of New Hampshire's system of care.

Over the past 15 years, New Hampshire Hospital has experienced more than a doubling of admissions and more than a 50% increase in census. These changes have occurred as a number of individuals have stayed longer at New Hampshire Hospital, and as community-based options for intensive treatment have declined. In other words, care remains reasonably available for basic outpatient treatment.

…community-based options for intensive treatment have declined

However, care in the middle and at the higher intensity end of the spectrum of treatment, including intensive outpatient care, residential care, and inpatient care, is not easily available to many individuals with severe mental illness, resulting in an overburden on New Hampshire Hospital and poor outcomes for individuals who are unable to access sufficient treatment choices to remain in the community or to be discharged from the hospital when ready.

Additionally, New Hampshire Hospital is currently functioning at the limits of its capacity, while at the same time the state's population is growing and the need for intensive psychiatric care capacity is rising.

Why is New Hampshire Hospital increasingly challenged in serving the population of NH?

There are multiple factors and challenges that New Hampshire Hospital and the Community Mental Health System are facing today.

First, as previously mentioned, the population of New Hampshire is growing, resulting in more people needing psychiatric care. According to the 2005 Interim State Population Projections by the U.S. Census Bureau, NH's population will continue to rise.

7/1/2005	7/1/2010	7/1/2015	7/1/2020
1,314,821	1,385,560	1,456,679	1,524,751

Second, funding for Medicaid services, the primary insurance for people with serious and persistent mental illness, has been restricted as NH, like every state in the country, has struggled with the increasing costs of providing care to the Medicaid population. For the past ten years, Medicaid spending (a combination of federal and state dollars) for individuals with severe and persistent mental illness has been reduced (on two measures: a per-capita basis, as well as adjusting for inflation) as the cost of providing the services (rent, heat, staff health insurance, etc) has gone up. The end result is less capacity to build additional service options for a growing population, and a population that has more challenging needs. Research demonstrates that decreasing appropriate outpatient services may contribute to disengagement from treatment, and an increase in symptoms and ability to do everyday tasks like caring for oneself or working, which results in increased frequency of visits to expensive emergency departments and often the need for hospitalizations.

Third, inpatient and residential alternatives to New Hampshire Hospital have diminished over the last 15 years. According to the NH Hospital Association, there were 236 voluntary inpatient beds in 1990; currently there are 186 beds across the state. The number has declined over the last fifteen years despite the continuing rise in the state's population. The number of community DRF beds has decreased dramatically over the last eight years from 101 to 8, as have the number of Acute Psychiatric Residential Treatment Program (APRTP's) beds (from 52 to 16). Three psychiatric units recently closed: the psychiatric unit in the North Country in June of 2007, followed by the unit at the Valley Regional Hospital in Claremont, in November 2007, and in June of 2008, Manchester's Catholic Medical Center closed its unit, highlighting the current crisis. Additionally, the numbers of group home beds, which provide consumers with a safe, supportive living environment, have diminished as treatment providers have focused on independent living programs. BBH has identified only 203 residential group home beds available to serve the approximately 7000 adults with serious and persistent mental illness in New Hampshire. These trends have occurred in New Hampshire and nationally due to a combination of factors, including changes in Medicare and Medicaid funding, managed care restrictions, reimbursement rates that have not kept up with costs, and a growing uninsured segment of the population.

Fourth, increasing housing instability and homelessness contribute to the increased use of New Hampshire Hospital. The cost of housing in New Hampshire has skyrocketed as income from Social Security Disability has risen more slowly. People who are disabled due to a severe mental illness who also rely on Social Security for their sole support receive a total of approximately $630/month, whereas the average cost of a modest studio apartment without utilities is $682 (O'Hara, Cooper et al. 2005; 2007). People living on this extremely low income are priced out of the market: they simply

cannot afford to pay for housing leading in some cases to housing instability and homelessness. Housing for any of New Hampshire's citizens is a basic need, for the individual struggling with the daily challenges of a severe mental illness, a lack of housing leads to greater levels of impairment, more difficulty in accessing services and supports, and a loss of stability which leads to subsequent hospitalizations (Corrigan, Mueser et al. 2008). Federally funded housing assistance, when available, helps individuals with severe mental illness maintain housing by paying for a substantial portion of the rent. However, the wait for eligible persons with serious mental illness in New Hampshire is now six years, and of those who finally get vouchers many have difficulty finding a willing landlord and an apartment that is reasonably priced.

Fifth, once admitted to the Hospital, almost a third of the individuals remain longer than necessary. These individuals, involuntarily committed for treatment by the courts, have severe and chronic illnesses and experience multiple barriers to discharge due to their high level of treatment needs, the social and/or legal risks involved in living in less supervised settings, and the scarcity of high intensity community resources, including supervised residences and intensive community treatment. Some of these individuals have significant co-occurring disorders and problems that require specialized treatment, including developmental disabilities, substance abuse disorders, violent behavior, and serious medical illnesses. A challenging small core has serious legal involvement with a history of high-risk behavior (including assault, fire setting and sex offender histories). Additionally, many of these patients have lost their housing while being hospitalized and have no home to which to return.

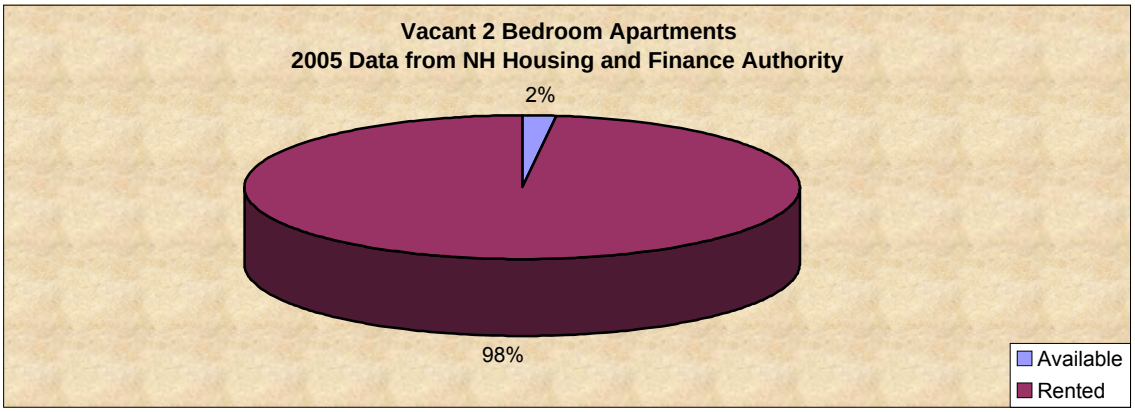
Sixth, New Hampshire is experiencing shortages of psychiatrists and other treatment staff. Over one third of NH is designated a "mental health professional shortage area" by the Health Resources Services Administration [www.bhpr.hrsa.gov/shortage/hpsacritmental.htm]. The availability of adequately trained staff, the ability to pay a fair market wage, and high rates of staff turnover are all significant challenges that directly affect service quality in both inpatient and outpatient settings.

The primary finding of the taskforce is that many individuals are admitted to New Hampshire Hospital because they have not been able to access sufficient services in a timely manner (a "front door problem") and remain there, unable to be discharged, because of a lack of viable community based alternatives (a "back-door" problem).

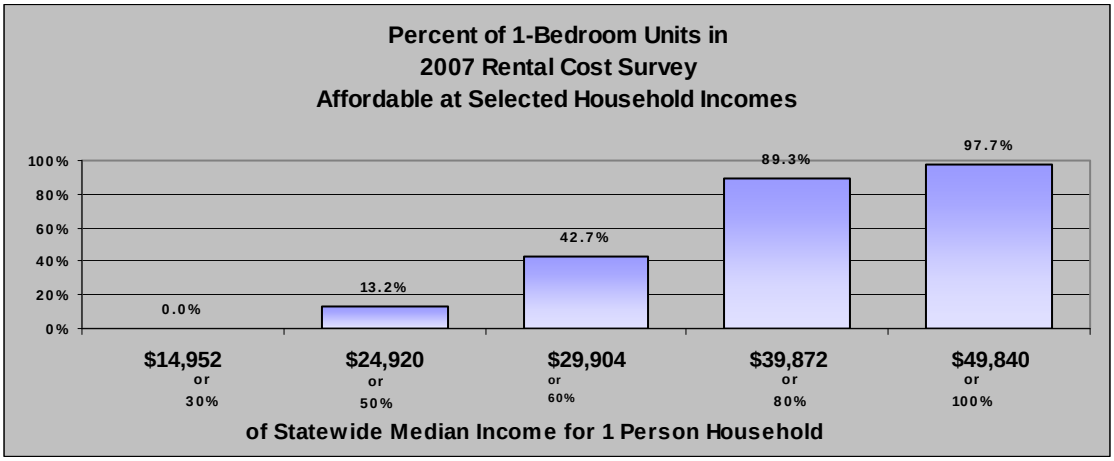
Recommendation I: Increase the Availability of Residential Supports

As previously discussed, lack of safe, affordable and stable housing is an increasing problem for individuals with serious mental illness in New Hampshire. Unstable housing and homelessness leads to greater levels of impairment, more difficulty in accessing services and supports, and a loss of stability, which leads to hospitalization or in some cases incarceration and then difficulties with discharge from the hospital or other institutional settings. Currently, many people at New Hampshire Hospital or the adjacent "Transitional Housing" (eight group homes serving 49 residents) have lived there for prolonged periods of time because adequate community housing and treatment alternatives are not available.

The first barrier to housing is lack of affordable rentals. According to 2005 NH Housing and Finance Authority data, the housing vacancy rate for rental apartments in NH is only 2% at any given time.



Access to housing is also dependent on income - what an individual can afford to pay for an apartment. According to 2007 data compiled by the NH Housing Finance Authority, those whose income equals 50% of the state median income only have access to 13% of the available rental units (13% of 2%). Once an individual's income drops to 30% of the state median income level, no apartments are available. Individuals with a severe mental illness, who live on state and federal assistance, have a median income averaging 10 to 15% of the state median (see figure). New Hampshire 2006 SSI benefits ($630/month) were lower than the average cost of a modest studio apartment (O'Hara, Cooper et al. 2005). Therefore, without assistance, people with severe mental illness do not have access to housing. They are priced out of the market.



Research suggests that several interventions dramatically improve housing stability for people with mental illness. The simplest is the provision of housing vouchers. The Housing Choice Voucher Program, (from Section 8 of the U.S. Housing Act) is the largest federal low-income housing assistance program. Established in 1974, the program is administered by the Department of Housing and Urban Development (HUD). Section 8 vouchers, the housing subsidy available to qualifying NH residents, can assist by paying a portion of "local fair market rent," the average rent of modest housing in a particular community. The subsidy requires that the participant pays 30% of his or her income for rent, and then HUD pays the rest of the

…without assistance, people with severe mental illness do not have access to housing.

"local fair market value" through the voucher. The average voucher value for NH individuals in the Section 8 program is $614 a month.

For many of our citizens, the Section 8 subsidy program is their only way to access affordable housing. The vouchers are of enormous benefit to persons with severe mental illness.

"When it was time for my son to leave the hospital, I was surprised that they were going to release him to the streets. There was no transitional home for him to go in. There was a five year wait for housing."
–Client's mother

Some individuals with serious mental illness have complex needs and are unable to maintain an independent room or apartment even with intensive professional supports.

According to data from the Housing Finance Authority the average wait period for a person with severe mental illness to obtain a voucher in NH is six years. Additionally, once the voucher is obtained, some participants are unable to use it because they are unable to find housing within their price range and/or a willing landlord (2007). Once a rental is found, landlords are under no obligation to rent to families with vouchers, although those who receive low-income housing tax credits are forbidden to discriminate.

Research shows that "supported housing," (the provision of vouchers in combination with access to targeted case management and community based supports to help persons with mental illness and or other disabilities manage their symptoms and maintain their housing), improves housing outcomes. Recent studies have documented, for example, that participants of supported housing programs experienced half the number of psychiatric hospital admissions (Martinez and Burt 2006) and reduced their use of other expensive emergency services (Martinez and Burt 2006; Seigel, Samuels et al. 2006) compared to individuals who did not receive supported housing. Formal supported housing of this type, however, is not available to most NH residents with mental illness disabilities, in part because DHHS has no control over how quickly a person with a mental illness disability gets a voucher and the wait is so long, but also because home-based services need to be further developed to meet the current need.

Some individuals with serious mental illness have complex needs and are unable to maintain an independent room or apartment even with intensive professional supports. For these individuals, group home settings that offer services for their complex needs can be an effective alternative that increases stability and reduces the need for hospitalization. Care within a group home setting is provided on a 24-hour basis, and providers are reimbursed for staff that provides a range of services to the individual within the residence.

Group home settings are ideal for people with complex psychiatric needs and co-occurring physical health problems, developmental disabilities, high risk behaviors, and/or substance use disorders, as these co-occurring problems require more intensive treatment, monitoring and support that may be difficult to provide in community settings.

The numbers of group home beds have dramatically declined over the past ten years as the cost of running these programs has increased while Medicaid reimbursements remained steady until recently (2007). Currently only 203 group home beds are available to serve the more than 7000 individuals with severe mental illness in the entire state.

Residential Supports Recommendations

Supported Housing

Supported housing services will be expanded through the Community Mental Health Centers service system, with additional funding from BBH. The provision of supported housing, however, will require improved access to affordable housing, which will be addressed with a voucher program (see below). Additionally, this taskforce recommends that some individuals who receive supported housing will utilize the Enhanced Family Care model, in which the individual would have access to a family setting that provides critical day to day supports. This model currently exists within the Developmental Disabilities (DD) system, as well as through the Bureau of Elderly and Adult Services (BEAS). The daily cost for an Enhanced Family Care Home is between $82.00 and $164.00 based on the individual's needs, which is close to the cost of living in a group home setting, but offers a more mainstreamed, natural living setting.

Housing Subsidy Bridge Program

The taskforce is proposing the development of a housing subsidy bridge program that would provide a housing subsidy for individuals with severe mental illness who are eligible and on the waiting list for a Section 8 voucher. This program will establish a revolving fund for individuals with a severe mental illness who are 1) ready for discharge from an institutional care setting including New Hampshire Hospital, Transitional Housing Services, or a general hospital inpatient psychiatric unit, 2) do not have housing, and 3) have applied for the Section 8 housing program. The fund will provide cash assistance equal to the value of a Section 8 housing voucher for a period of time not to exceed the current wait period for Section 8 assistance, or until the individual receives Section 8 assistance, whichever is shorter. The Division of Community Based Care Services will administer the new bridge subsidy program.

The bridge program will leverage other existing programs to create a package of assistance to ensure successful placement into an apartment. Other programs include the DHHS Housing Security Guarantee Program, which provides funding for the initial security deposit, and the NH Homeless Housing and Access Revolving Loan Fund, which provides funding for the first month's rent as well as security deposits for individuals who are homeless.

This program will be linked with clinical services that will teach people the skills to manage their illnesses in order to maintain their housing. This program would mirror the HUD-funded Section 8 vouchers to enable a smooth transition from the NH voucher to the federally funded voucher when it becomes available.

It is anticipated that the demand for this program will be greater than the available resources; therefore a wait list will be established for individuals requesting assistance under the program. Individuals who are eligible for Assertive Community Treatment (ACT) services will be prioritized for this program, as well as individuals receiving services under the housing support program- Projects to Assist Transition from Homelessness (PATH).

The bridge program fund will be established beginning in SFY 10 and the final fund balance will be rolled out over a 3-year period of time. In Year 1, the program will begin with $300,000, in Year 2 $300,000 will be added to the fund, and in Year 3 $300,000 will be added to the fund for a total of $900,000 in available funds for assistance for each of the remaining ten years proposed in this recommendation. As an individual receives a Section 8 voucher, funds previously allocated to that individual will be made available to the next person on the waiting list.

This program is projected to enable access to housing for 41 individuals in Year 1, 82 individuals in Year 2, 123 individuals in Year 3 and in each year thereafter. In Year 7, 41 new individuals will access the program as 41 individuals leave with Section 8 vouchers.

Increase the Number of Group Home Beds

The taskforce is proposing to add additional long-term group home beds to provide community residences with 24-hour services and supports for 132 individuals with severe mental illness and co-occurring disorders who are unable to reside independently in the community. These additional 132 beds will be divided up into four categories:

> **Category 1:** Expansion of existing community residence beds - 88 beds will be utilized for individuals with a severe mental illness utilizing the existing group home model in place currently,
> **Category 2:** Crisis beds - 12 beds will be developed to provide short-term crisis care in the community,
> **Category 3:** 20 beds will be developed for individuals with co-occurring mental illness and substance abuse problems, and
> **Category 4:** 12 beds will be developed for individuals with severe mental illness who have histories of violence or criminal involvement that impair their ability to return to the community.

It is expected that the need will be larger than the availability of these services, and individuals who are being discharged from institutional settings will be the priority.

The scheduled SFY 09 Medicaid rate for daily treatment costs for an individual residing in a traditional group home setting is $107/day or $39,055/year, not including room and board. This treatment cost may be compared to the current Medicaid rate for treatment at New Hampshire Hospital of $750/day or $273,570/year, including room and board.

Capital investment will also be necessary to acquire properties to house these individuals, estimated at $300,000 to $700,000 per home (depending on the housing market within each region of the state), or between $30,000 and $70,000 per bed in capital costs. This will total between $3.6M and $8.4M. The taskforce proposes to roll out these residential programs in communities across New Hampshire over ten years, annualizing the capital investment over that period of time.

The following is a proposed breakdown of the community residence expansion:

Category 1: Expansion of existing community residential beds

> The taskforce is recommending the development of 88 additional group home beds for individuals with a severe mental illness, using the current community residence program model. We are recommending the development of 28 beds in FY10, 24 beds in FY11, 12 beds in FY12, 12 beds in FY13, and 12 beds in FY14. Following an analysis of current group home cost data, the taskforce is recommending the rate for the current group homes be increased to $150 a day beginning in the FY 10/11 biennium to reflect the actual cost of operations, and to prevent any further loss of group home beds in the system. Based on the FY09 rate of $107 per day, there will be an annualized deficit exceeding $2.3M on existing group home beds, which creates significant risk for retaining the community residence beds currently available, and is preventing the development of any additional bed capacity in the community. This barrier must be eliminated.

Development of capacity to serve individuals with severe mental illness and complex medical conditions

Similar to other service systems in NH, and due to the changing demographics of the population, more individuals receiving services through the community mental health system have complex medical issues that need to be addressed in their current living situation. These individuals do not meet criteria for a nursing home placement, but require additional services that are beyond the scope of practice for residential staff. The taskforce is recommending that capacity be developed, within the proposed 88-bed expansion outlined above, to provide services to these individuals. This will require an enhanced rate, which will allow additional staffing to be retained to maintain and extend community tenure for this population, and provide the necessary supports to address both issues relating to medical status and severe mental illness. The taskforce is recommending a rate of $170 a day for these beds across the system, based on existing models that serve this population, for an annual per bed cost of $62,050.

Category 2: Development of crisis bed capacity

In addition, the taskforce is recommending the development of 12 crisis beds, where an individual can be placed for short-term enhanced monitoring and supports, within the structure of a community residence, utilizing existing staffing and supports. The daily rate for these crisis bed supports is projected to be $170 a day.

Category 3: Development of specialized community residences for co-occurring disorders

For individuals with complex dual disorders involving substance abuse and a severe mental illness, the taskforce is recommending the development of a 10-bed residential program beginning in FY10 and a second 10-bed residential program in FY12 to address the needs of these individuals. Additionally, the taskforce is recommending a rate of $170.00 a day, for an annual per bed cost of $62,050**.**

Category 4: Development of two specialized community residences for high-risk individuals

For individuals with severe mental illness who have histories of violence or criminal involvement that impair their ability to return to the community, the taskforce is recommending the development of a six-bed residential program in FY11 and a second six-bed program in FY14. The proposed enhanced rate of $260.00 a day, for an annual per bed cost of $95,000 would allow for specialized services and staffing patterns to meet the needs of the residents, as well as ensure the safety of the community.

Recommendation II: Increase Capacity for Community –Based Inpatient Psychiatric Care

The 407 Report planned for a system of care that provided an array of services from low to high intensity that would be easily accessible. Although, great efforts were made to develop this statewide system of care, it was never fully implemented with the array of community services that was initially envisioned**.** Specifically, only three of the ten intended Designated Receiving Facilities were implemented, and, with the closing of units over the past ten years, DRF beds have been reduced from 101 to eight, as only one hospital-based DRF is now in existence.

A DRF is a hospital-based psychiatric inpatient unit or a non-hospital-based residential treatment program designated by the Commissioner of DHHS to provide care, custody, and treatment to persons involuntarily admitted to the state mental health services system. DRFs in local facilities allow people who are in need of emergent psychiatric inpatient care to be treated in their region, which reduces transportation costs and reduces length of stay because discharge planning and coordination are easier to accomplish locally. Providing treatment on a local level also makes it easier for family members and others to provide support and participate in the individual's treatment and discharge planning. Because DRF care is currently only available at the Elliot Hospital, the state is lacking regional capacity for inpatient voluntary and involuntary care. This issue is most prominent in the North Country following the recent closure of Androscoggin Valley Hospital's DRF in June 2007. Changes in Medicare and Medicaid funding, private insurance reimbursement rates that have not kept up with costs, and a growing uninsured segment of the population that cannot pay for care have been responsible for the downsizing or closing of hospital based psychiatric units.

DRFs in local facilities allow people who are in need of emergent psychiatric inpatient care to be treated in their region…

Based on the current need for inpatient care and expected levels of population growth, capacity for both voluntary and involuntary inpatient psychiatric treatment must be expanded. While one option is to build additional central treatment facilities, such as a new wing on New Hampshire Hospital, this is the most expensive option and only addresses the involuntary bed issue. Expanding capacity within local general hospitals would allow people to be treated in their own region makes more sense. Inpatient care has diminished because this care is not financially viable for providers. In order to establish or re-establish inpatient care across NH, viable financial and clinical models with partnerships between state and local health care entities must be developed.

Expanding capacity within local general hospitals would allow people to be treated in their own region …

The taskforce has developed two recommendations to address the need for expansion of community inpatient psychiatric treatment capacity.

First, the number of DRF units and beds be expanded in regions across the state so that no citizen must travel more than an hour and a half to access this type of care. Four 12-16 bed DRF units should be developed in local hospitals, one each in the northern, southern, eastern, and western regions of the state. It is proposed that these units be developed over the course of the next ten years, to be available for use in approximately 2010, 2012, 2014 and 2016.

Second, a taskforce of stakeholders from community hospitals, the insurance industry, DHHS and local communities be convened to find ways to expand the availability of voluntary inpatient psychiatric care in community hospitals across the State.

Inpatient care has diminished because this care is not financially viable for providers.

<u>Recommendation III: Develop Assertive Community Treatment Teams</u>

Assertive Community Treatment (ACT) is an intensive outpatient service that has been shown to be effective at helping individuals with serious mental illness manage their illnesses while living independently in the community. When applied to homeless individuals with serious mental illness, ACT reduces homelessness (Coldwell and Bender 2007). When applied to individuals with frequent hospitalizations, ACT reduces their hospital use and enhances their ability to maintain employment and personal satisfaction (Marshall and Lockwood 2003). Currently, this type of intensive case management-based comprehensive service is available only in Manchester and is being developed in the North Country.

How does ACT work?

ACT is a specialized multidisciplinary team designed to provide intensive community based services for adults with severe mental illness. The team is responsible for either directly providing a full array of services, or ensuring that the individual receives those services from another organization or provider. ACT is effective for individuals who have the most serious and intractable symptoms and who consequently have a history of multiple psychiatric hospitalizations, frequent visits to hospital emergency departments, and incarcerations, as well as difficulty maintaining a safe living situation and basic self care. ACT is well studied and therefore is endorsed by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) as an Evidence Based Practice. When delivered with good fidelity to the model, ACT has been demonstrated to reduce psychiatric hospitalization rates for individuals with severe mental illness and improving other outcomes.

ACT reduces hospital use and enhances the ability to maintain employment and personal satisfaction.

ACT teams include nurses, a psychiatrist, case managers, and master's level clinicians. Team members directly provide individualized, comprehensive and flexible treatment support and rehabilitation services. The team members share responsibility for the provision of services to the client. The clinician-consumer ratio is low (1:10) to ensure that intensive daily services are possible. Most services are delivered in the community as opposed to a traditional office setting. The ACT team provides day and evening services and delivers emergency care to individuals served by the team.

This program can be utilized to engage individuals in services and to help them manage their illness while remaining in the community.

We propose an increase in the availability of ACT to individuals with serious mental illness who are frequent New Hampshire Hospital users. This program can be utilized to engage individuals in services and to help them manage their illness while remaining in the community. Nationally, some experts have suggested that .06% of the adult population is eligible for ACT (Cuddeback, Morrissey et al. 2007). Applied to New Hampshire, this suggests that approximately 800 people would be eligible. We propose to apply more conservative criteria, and focus on a subset of our current and future population that would most benefit from ACT services, which would approximate serving up to 500 individuals per year. We propose to implement ACT over five years, phasing teams in over that time. Individuals with high emergency department utilization, high readmission rates, and unstable living situations would be eligible for the service. The number of eligible individuals served within the region would define the numbers of teams developed. Some re-admitted individuals may not actually meet criteria to benefit from ACT and that others may require more intensive services, such as residential treatment, in order to remain out of the hospital. Additionally, some individuals need ACT based on repeated use of community hospitals, emergency rooms, and jail/prison. Thus the estimate of need is approximate but realistic.

Community Mental Health Centers will require time and financing for training to implement ACT. Teams will be phased in over five years.

Proposed plan for ACT implementation over five years

Year 1: 3 Teams
Year 2: 2 Teams
Year 3: 3 Teams
Year 4: 2 Teams
Year 5: 2 Teams

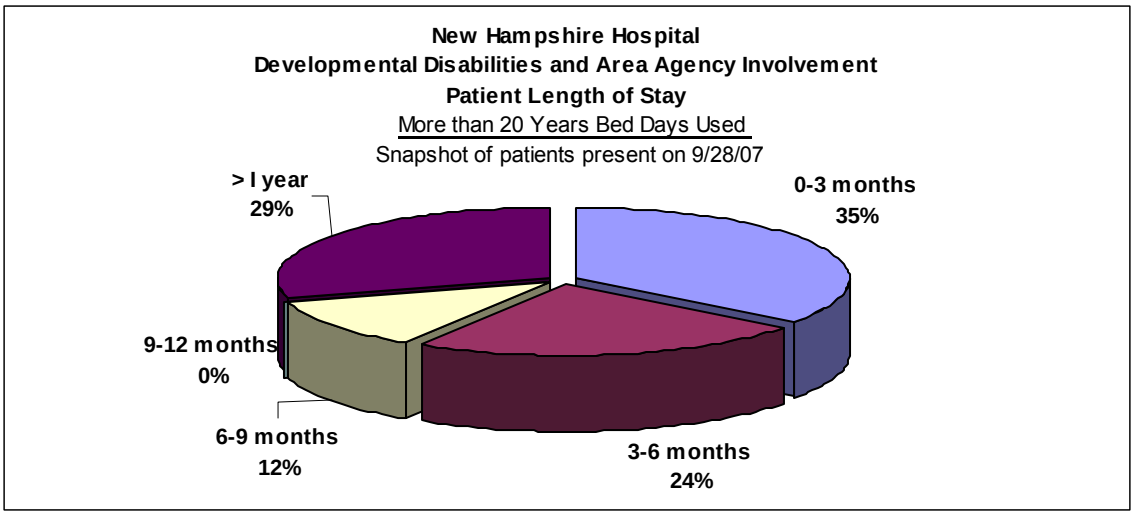
The majority experience behavioral disturbances that require a high level of structure and support currently only available at New Hampshire Hospital, but could be managed in the community with appropriate services.

Medicaid pays for ACT, but the service is high intensity. In order to support the delivery of this service, the overall spending for outpatient services must be increased to $20,000 per person served. According to BBH, the current average cost for outpatient services is approximately $5,000. When considering overall cost of service, ACT is cost effective for frequently hospitalized individuals, as one month of New Hampshire Hospital care costs about $21,300, somewhat more than the cost for one year of ACT. Many persons served by ACT can be expected to develop better illness management over several years and to be able to "graduate" to less intensive services over time, allowing others who have become ill to access this service. The eventual cost to serve 490 persons per year will be almost $10M per year. The taskforce believes this will be cost-effective because ACT services will cost less than hospital care for eligible individuals. Implementing this recommendation will allow New Hampshire Hospital or the DRF's to have more beds available to serve those needing them.

Recommendation IV: Developmental Disabilities at New Hampshire Hospital

The total number of patients admitted to New Hampshire Hospital with co-occurring mental illness and developmental disability (DD) has continued to present a challenge. These individuals are typically admitted because of difficult to manage, high-risk behaviors such as aggressiveness, inappropriate sexual conduct, and arson. About half have remained at the New Hampshire Hospital longer than required to provide acute evaluation and stabilization of the presenting psychiatric symptoms for reasons outlined below.

A snapshot of individuals with developmental disabilities at New Hampshire Hospital on September 28, 2007 (BBH/New Hampshire Hospital DD/MI Census Management Report), is fairly representative of the Hospital's experience over the past ten years. Seventeen individuals with a developmental disability were in the hospital, two thirds of which had been in the hospital longer than three months. Four of the individuals have been in New Hampshire Hospital for over three years. As shown in the chart below, these patients have experienced the equivalent of more than 20 years of hospital care. Half of the 17 individuals were unable to be discharged due to a lack of residential placement or insufficient specialized community services. The majority experience behavioral disturbances that require a high level of structure and support currently only available at New Hampshire Hospital, but could be managed in the community with appropriate services.



Several options could enhance the State's ability to serve these individuals outside of New Hampshire Hospital. The first is to establish a residential treatment facility for those few who require a "step-down", intensive, long-term treatment setting. This facility would provide highly needed care to a small number of individuals. The second important step is to enhance the treatment skills of community providers (both Area Agency and CMHC) in order to address the unique needs of this population. Additionally, assembling a ACT team with expertise in treatment of co-occurring developmental disability and mental illness should be considered to serve individuals with frequent or lengthy hospitalizations as it may provide a viable clinical capability for safely transitioning some of the more challenging individuals back to their communities.

The taskforce recommends that the Bureau of Developmental Services (BDS) immediately initiate a taskforce with BBH that focuses on the following:

1. Outlining targeted goals to facilitate discharge for current New Hampshire Hospital patients with co-occurring mental illness and developmental disability.
2. Establish regional residential treatment facilities to serve individuals with co-occurring developmental disability and serious and persistent mental illness.
3. Consider the establishment of regional ACT teams for patients with co-occurring mental illness and developmental disability to support individuals living within the community.
4. Establish specialized training for Area Agencies without regional resources to manage individuals with co-occurring developmental disability and serious and persistent mental illness.
5. Review current funding mechanisms and recommend a strategy to blend resources for this population.

Recommendation V: Community Mental Health Workforce Retention and Development

In order to be successful with any plan to provide more community based housing options for New Hampshire's mental health consumers, an adequate workforce must be recruited and retained within each of the CMHCs. The DHHS FY08 Community Mental Health Block Grant Application includes the need for workforce development and the need to reduce professional staff shortages as the highest priorities following the need for available and affordable housing options.

The community mental health workforce includes staff with a broad range of credentials including psychiatrists, nurses, psychologists, social workers, counselors, case managers, outreach workers and housing staff who each perform crucial services within the purview of their credentials as outlined in statute or administrative rules.

According to the CMHCs, the average yearly staff turnover rate ranged from 17.48% to 24.21% with an overall average of 19.85% between years 2000 and 2006. This essentially means that approximately every five years there is a complete turnover of staff. While some turnover is to be expected, the system must do what it can to recognize the impact of staff turnover, identify the reasons for it, and explore strategies to reduce turnover and its negative impact on the mental health system. In FY08 budget submissions the ten community mental health centers reported a statewide direct care vacancy rate of 6.81% with seven out of ten centers reporting more than ten direct care vacancies.

Turnover has a negative impact on the care provided to consumers. "That's the major issue," said Michael Cohen, executive director of the NAMI-NH chapter. "We have people who have to tell their stories two or three times a year to a new face because there is such a high turnover rate. What makes mental health services work is the continuity of care and a significant turnover affects the quality of care." (Associated Press March 2006).

Turnover of staff not only compromises clinical care, but it also leads to increased administrative burden. Each time a direct care staff person gives notice of their plans to leave a position they immediately begin to decrease their direct care services as they work on case transfers and assuring that all of the case paperwork is complete and up to date prior to their exit. New staff joining a center must be trained in areas that are not part of their academic training such as how to use the center's computer system, compliance training, and the specifics relating to the completion of service documentation. Additionally, many colleges and universities simply do not provide training in how to do basic services. Thus inexperienced new staff requires training in the actual provision of services. This wind down and ramp up, which does not address any period of time the position is vacant between staff, decreases the availability of services to clients and increases the likelihood that clients may need a higher level of care during the transition. When the new staff person is assigned, even though there may be a complete history in the medical record, the client needs to begin at ground zero to build a treatment relationship with their new provider.

"… people who have to tell their stories two or three times a year to a new face because there is such a high turnover rate. What makes mental health services work is the continuity of care and a significant turnover affects the quality of care."

Exit interviews reveal that some staff turnover is due to reduced wages in the face of the rising cost of living as well as the increased paperwork burdens driven by federal requirements. The Carsey Institute (2007) points out that, while New Hampshire enjoys the lowest unemployment rate in New England, median wage growth of 8% from 2000 to 2006 has not kept pace with the 20% increase in housing payments during the same period. The average 2006 hourly salary for 15 out of 40 CMHC position categories was less than the $16.27 livable wage required to meet basic family needs. Bachelors and masters level staff may be leaving the field simply because they cannot make ends meet.

Community Mental Health Center wages have been below the cost of living because centers are not able to afford to pay higher salaries and benefits while at the same time remain solvent. CMHCs are mandated to provide services to those in crisis or those meeting the eligibility requirements established under State laws and rules-He-M 401 for children, severely and persistently mentally ill adults and older adults regardless of their ability to pay. Uninsured clients who meet eligibility requirements pay on a sliding fee

schedule based on income and family size. Employers who provide self-funded insurance plans are exempt from New Hampshire requirements for parity and coverage of service at CMHCs due to protections afforded under federal Employee Retirement Income Security Act (ERISA). According to FY06 billing data supplied by the CMHCs, they absorbed an estimated $3.5M of services to New Hampshire's uninsured population and approximately $1.8M in mandated case management services to those that were not covered by commercial insurance. Thus, community mental health center services require payments that can support staff salaries.

"…as mental illness and severe emotional disturbances are biologically based brain disorders; however, treatment works and science/evidence-based practice shows us what works best"

--Client's family member

Since the mid-1990's community mental health centers were required to name a Health Insurance Portability and Accountability Act of 1996 (HIPAA) Compliance Officer, develop and implement compliance plans and then later develop and implement changes related to HIPAA. Documentation of each service contact has become more detailed and complex in order to meet the requirements of any and all payers related to a claim. Staff at all credential levels must have a complete understanding of the state administrative rules, statutes and federal regulations that apply to the services they provide. The job of providing and documenting community mental health services has simply become more complex over the past 15 years. Electronic systems offer the ability to manage these more complex documentation tasks while at the same time cuing appropriate clinical care and collecting data. Linked systems can also provide the opportunity for enhanced communication between service providers.

One reason for the shortage in this group of physicians is that fewer medical students are choosing to become trained in psychiatry.

The job of providing and documenting community mental health services has simply become more complex over the past 15 years.

Increasing regulatory demands make an effective and efficient system for organizing, collecting, and sharing behavioral health information essential to leadership planning, staff communication, patient care, performance evaluation and staff retention. An electronic health record, a single centralized application that is used by the CMHCs and New Hampshire Hospital will provide a system to reduce some of the redundancy staff encounter when completing required paperwork. This advance in information management will provide a strengthened position for achieving patient safety, best practices and regulatory compliance; improved clinical documentation, legibility, communication, and collaboration; decreased time documenting, with chart/data access at point of service, and more time providing patient care; enhanced management reporting, outcomes analysis, and decision making; and better billing resulting in improved reimbursement, lower receivable days and improved revenue management.

Electronic systems offer the ability to manage these more complex documentation tasks while at the same time cuing appropriate clinical care and collecting data.

Physicians who specialize in mental health, psychiatrists, are an important resource in community mental health care. Unfortunately, in most regions of New Hampshire, not enough psychiatrists are available to oversee the care of patients in the community mental health centers and to provide the medical management for patients. New Hampshire has less than 200 psychiatrists (approximately 1.3 per 10,000 residents). With an adult prevalence rate for a diagnosable mental illness of 26.2% there is clearly an inadequate number of psychiatrists to meet the needs of our residents. One reason for the shortage in this group of physicians is that fewer medical students are choosing to become trained in psychiatry. Factors influencing choice of residency include lifestyle, income, debt and practice style. The CMHC practice pattern of utilizing physicians predominately for brief medication checks, rather than for a broader array of services, does not allow for the development of treatment relationships that physicians might prefer.

Recommendations to address workforce recruitment and retention issues include

1. Provide adequate fiscal resources to maintain a qualified workforce, who will deliver mandated and necessary services to persons with serious and persistent mental illness.
2. CMHCs should work collaboratively with BBH and academic psychiatry training programs to develop a strategy to increase the number of available residents and experienced psychiatrists in the state.
3. Provide investment in training for staff. This investment needs to begin with academic training programs updating their curriculum to meet workforce requirements; ongoing training and support from BBH and the CMHCs to provide necessary training and support to staff on a regular and ongoing basis.
4. Provide investment and support for development of an electronic health record. Federal matching funds are currently available to assist in the acquisition of electronic health records. Any request for federal matching funds should support the acquisition and implementation of an electronic health record that would be available at the CMHCs and New Hampshire Hospital to provide the best possible level of seamless care for our consumers.

Recommendation VI: Department of Corrections Study Committee

The taskforce acknowledges that effective July 1, 2007, the New Hampshire Legislature passed House Bill 25-FN-A, making appropriations for capital improvements. Within this new law, Chapter 264:1 Section V. (H), $700,000 in capital appropriation funds was allocated to the Department of Corrections. The Department of Corrections currently is preparing a comprehensive master plan addressing the expansion of maximum and/or medium security units and/or a secure psychiatric care unit while considering at the same time how to best house non-violent offenders**.**

The work of the Department of Corrections study committee may have direct implications for the recommendations made herein, which have not yet been accounted for.

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