

NEW HAMPSHIRE'S PRESCRIPTION FOR MENTAL HEALTH CARE

COMPREHENSIVE, INTEGRATED,
AND COORDINATED HEALTH CARE

**Documenting New Hampshire's need to fundamentally revise
its approach for treating mental and physical health and
substance use disorders**

Written by:
Peter Antal, Ph.D.
October 2009

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EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

The life span for persons with serious mental illnesses is 25 years shorter than the general population (Lutterman, 2003).

In New Hampshire, the provision of mental health care is far from ideal. Many of those living with mental illness report a lack of coordination among those providing mental health, physical health, and substance use services. Many physicians in our state report a lack of mental health expertise, and yet are responsible for prescribing psychotropic medications for thousands of New Hampshire residents. Many New Hampshire hospitals, particularly in rural areas, do not have on-site trained mental health personnel or have inadequate access to mental health specialists, but are making determinations regarding appropriate care and services for individuals with serious mental illness. New Hampshire mental health providers report that the state lacks the capacity for meeting the mental health needs of its residents; in particular, the very young and transition age youth often have difficulty accessing treatment. While inpatient hospitalizations for mental illness continue to rise with population growth, the utilization of hospital emergency departments by those with a primary mental illness diagnosis is increasing at a much faster rate. Additionally, New Hampshire's Community Mental Health Centers are projecting significant increases in the demand for their services at the same time that their operating budgets are being severely cut.

To effectively care for those with mental illness we need to better understand the interactions between physical and mental health, as well as the impact that socio-economic factors have on individuals' ability to manage their illness. As compared to the general population, individuals with severe mental illness have poorer physical health, including a higher likelihood of co-occurring conditions. They are prescribed psychotropic medications that frequently have

side effects that can cause secondary health problems. Those with mental illness also are more likely to experience significant socio-economic challenges—poverty, homelessness, incarceration, victimization, illiteracy, unemployment, and lack of insurance—that affect their ability to access health care.

New Hampshire residents living with mental illness have traditionally been served through distinctly separate programs. This "silo" approach to services is often counterproductive and makes it difficult to provide optimum care and treatment. Those with mental illness need a consistent and effective screening process, open and frequent communication between their mental health and physical health providers, greater access to behavioral health services, and improved coordination of care. The nationally recognized IMPACT and PRISM-E projects have demonstrated that models utilizing a more comprehensive and integrated approach to health care can have significant and lasting positive impacts on the life and well being of individuals living with mental illness (Hunkeler, Katon, Tang, Williams, Kroenke, Lin, Harpole, Arean, Levine, Grypma, Hargreaves, Unutzer, 2006) (Krahn, D; Bartels, S.; Coakley, E.; Oslin, D; Chen, H.; McIntyre, J.; Chung, H.; Maxwell, J.; Ware, J.; & Levkoff, S., 2006).

To reform New Hampshire's approach to care, a number of challenges will need to be addressed. These include:

1. A lack of mental health expertise among health care providers and substance abuse services,
2. A lack of statewide parity for health care coverage of all mental illnesses,
3. A lack of systematic coordination and communication of services among various types of health care providers,

4. A lack of professionals trained in evidence based practices for integrated care,
5. A need for better outreach to the uninsured,
6. The need to reconcile differences in the interpretation of public financing rules and incentives for providers to work together,
7. The absence of the technical and legal infrastructure to electronically share health records, and
8. A statewide need for increased training in integrated care practice.

New Hampshire's failure to develop a comprehensive, integrated, and coordinated health care system has resulted in inefficiencies in service delivery and substantially increased costs. There also are significant societal impacts for individuals living with mental illness when health care services are insufficient or fragmented. These include a higher utilization of hospital emergency departments, shifting the cost of care for disadvantaged populations through higher rates for the privately insured, missed school among youth, missed work days and loss of employment for adults, and increased stress and financial hardship for families.



WHY REFORM IS NEEDED

CURRENT SERVICES ARE NOT REFLECTIVE OF RESIDENTS' COMBINED PHYSICAL AND MENTAL HEALTH NEED

The Connection Between Mental and Physical Health

The quality of a person's life and the ability to successfully engage in the world are influenced by a number of factors including physical and mental health and the individual's socio-economic situation. A person who seeks medical services typically presents with a seemingly overt health problem. However, in determining a course of action, the person's full range of physical and mental health conditions, as well as personal circumstances, must be considered, as these all influence whether or not treatment, illness management, and recovery are likely to be successful.

In 2008 the Institute on Disability (IOD) at UNH released a study of New Hampshire residents hospitalized with a primary diagnosis of mental illness. The IOD found that at the time of inpatient admission at least one in four of these patients had co-occurring conditions of endocrine, nutritional and metabolic diseases, immunity disorders, and diseases of the circulatory system, as well as other ill-defined conditions. Over one in ten had co-occurring conditions related to diseases of the respiratory system, musculoskeletal system and connective tissue, diseases of the digestive system, injury and poisoning, and diseases of the nervous system. Over one in twenty presented with co-occurring diseases of the genitourinary system, or infectious and parasitic diseases (Antal & Mandrell, 2008). Of those with a primary mental illness diagnosis, 83% percent also had an additional secondary mental illness diagnoses.

Information gathered over the past two years through the New Hampshire Community Mental Health Center (CMHC) Consumer Survey sheds further light on the health challenges faced by individuals who have more severe or chronic mental illness. Half (52%) of adults surveyed stated that they were not in good physical health (Antal & Burbank, 2008), and 38% reported that their physical health had not been good for 15 or more of the past 30 days (Antal, 2009). In comparison, New Hampshire data from the 2008 Behavioral Risk Factor Surveillance System (BRFSS) for the general population found only 11% of all respondents were in fair or poor health and only 10% were in poor physical health for 15 or more of the past 30 days.

In New Hampshire there are an estimated 264,480 adults with a diagnosable mental illness and 59,720 children with a serious emotional disturbance.¹ It can be critical—and indeed life saving—for these individuals to have access to health care providers who understand the interactions among physical, mental, or substance use conditions and how these affect the person's ability to manage their illness and move towards recovery. The national Substance Abuse and Mental Health Services Administration (SAMHSA) has developed nine core principles for reform for treatment of mental and substance use disorders and recommends a whole health approach to care. This includes implementing prevention efforts that "promote healthy environments, norms, and behaviors rather than waiting for the development of full-blown acute or chronic diseases." In this context, mental and substance use disorders are considered "chronic diseases that are preventable, treatable, and often co-occurring with other physical illnesses" (Hutchings

¹ Based on 2007 American Community Survey population data of 1,017,230 adults and 298,598 children and national prevalence estimates for diagnosable mental illness of 26% among adults and 20% among children (Kessler, Berglund, Demler, Jim, Merikangas, and Walters, 2005).

& King, 2009, p.2). In addressing these conditions, emphasis is placed on fully utilizing a range of services and resources, including engaging families, to successfully treat and manage illness.

Growing Demand for Services

New Hampshire can expect to see a steady growth in demand for both acute care hospitalizations and community care for persons who have a mental illness or substance use condition. Among the factors influencing the demand for services are a faltering economy that makes it difficult for people to access and pay for care, improved ability by health care providers to accurately diagnose mental illness-related conditions, and a shift away from specialized and dedicated facilities to the provision of care in more community-based settings.

Data on hospital discharges in New Hampshire documents an average growth of 3%² in patients with a primary diagnosis of mental illness who have sought some form of hospital care (Antal & Mandrell, 2008b). Between the time periods of 1997-1999 and 2004-2006, the average yearly count for this patient group increased from 10,718 to 13,202. Rates for patients with mental illness held relatively stable among inpatient settings (averaging 29.7 per 10,000 residents) and dropped in specialty settings (from 22 to 17 per 10,000). Within ambulatory settings, however, the prevalence rate increased substantially, from 55 to 76 per 10,000 people (Antal & Mandrell, 2008).The number of

individuals served by Community Mental Health Centers also has been increasing, from 34,103 in FY98 to 47,463 in FY07, an increase of 13,360 (39%) or averaging 3.3% across 10 years³ (Riera, 2009). Based on current projections by the CMHCs, the demand for community-based services to treat those with severe mental illness is anticipated to grow by 8% in future years.

The Challenge

Over the last 20 years there have been substantial shifts in the continuum of care for patients with mental illness and substance use disorders. One of the most notable has been the move away from institutionalized care to home and community-based services. For example, in the 1950s, the patient population of New Hampshire Hospital was 2,700. In June 2009, the average daily census for New Hampshire Hospital was 185. In the past decade, multiple inpatient care facilities for mental illness have closed throughout the state, leaving those with more severe mental illness conditions with limited options for specialized care.

When the appropriate community services are available, they have the potential of providing a far more affordable option for care and reducing the number of hospitalizations. When effective supports for mental health care are not available in the community, many of those needing treatment may delay seeking care until they are in crisis and then turn to their hospital emergency departments, often repeatedly.

² The 3% growth estimate for hospitalizations is likely very conservative as these concern only those hospital visits with a primary diagnosis of mental illness. No drops in patient utilization were observed over the years studied.

³ Note that increases in the number of persons served by Community Mental Health Centers were not consistent over time. There was a jump in enrollment between FY1999 and FY2000 of 3,134. Total enrolled held fairly consistent (around 38,000) until FY2005. Between 2005 and 2007 enrollment increased by 22% (from 38,749 to 47,463). Between FY 2007 and FY 2009, the number has increased by 700. During two fiscal years, the number of consumers served dropped slightly.

Unfortunately, expertise in mental health or substance use disorders, particularly for conditions that are non-responsive to traditional treatments, is lacking among many providers and can have dire consequences for patient health. Based on a 2009 survey by the NH Infant Mental Health Association of health care providers, only 19% felt they had expertise in challenging behaviors or abuse and neglect, and only 15% had expertise in emotional / mental health. This would be less of a challenge if there were sufficient resources to support health care providers. However, even among mental health care providers, expertise to treat specific areas has its limits. For example, while close to three quarters had expertise in addressing challenging behaviors, 65% had expertise in child abuse and neglect, 54% with trauma, 53% with caregiver issues, and 35% with grief and loss. Of note, 50% of mental health providers indicated that one of the major barriers to providing mental health services was the fact that there were not enough services to refer people to (Ableman, Antal, Oldham, Printz, Brallier, Nelson, Schreiber, Brandt, 2009).

If we are to support recovery for individuals with mental illness, we need to provide a comprehensive, integrated, and coordinated system of care. It will be important for care providers to develop a common understanding about the physical health conditions that are often co-occurring with mental illness and how these can interact with various licit and illicit substances. It also is critical to understand and address the influences that socio-economic factors have on recovery, particularly for those with severe mental illness. All of these issues will need to be addressed in order for New Hampshire to develop an effective and efficient health care system.

INDIVIDUALS WITH MENTAL ILLNESS EXPERIENCE MORE COMPLEX HEALTH ISSUES AND FACE HIGHER HEALTH CARE COSTS

Nationally, it has been well documented that those living with mental illness have substantially greater health problems than their peers without mental illness. In addition to having a life span that is 25 years shorter than the general population (Lutterman, 2003), those with severe mental illness also have a significantly higher prevalence of major medical conditions such as diabetes, metabolic syndrome, lung and liver diseases, hypertension, cardiovascular disease, infectious diseases, and dental disorders (Freeman & Yoe, 2006). In their research, Freeman and Yoe documented that 70% of those who use Medicaid funded mental health services had at least one of these chronic health conditions, 45% had two, and almost 30% had three or more. The prevalence of substance use disorders, particularly among those with mental illness also is significant. Among the 2,310 New Hampshire patients with a primary diagnosis of mental illness who were hospitalized at least ten times over a ten-year period, 75% had co-occurring diagnoses for substance use (Antal & Mandrel, 2008).

For individuals with severe mental illness, the additional complications and challenges associated with greater health care also result in significantly increased health care

costs. The data cited in this section is from the *Comprehensive Health Care Information System (CHIS)*⁴ and is posted on-line by the Maine Health Information Center at <https://secure.mhic.org/nhracs/index.html>. These are standard reports drawing on claims data submitted by health care providers for individuals with either private insurance or Medicaid. It should be noted that the additional costs for mental illness documented in this section reflect not only costs for treating an individual's mental illness, but also the costs associated with any health conditions that may have contributed to the person's need to seek medical care.

Based on New Hampshire data from the CHIS Commercial Mental Illness Utilization and Cost tables for 2007, the average claim⁵ payment for a privately insured individual who does not have a diagnosed mental illness or substance use condition is \$2,407. The average claim payment per member for those with a mental illness rises to \$6,840, a 184% increase. If the insured member also has a substance use diagnosis, the average claim per member is \$15,587 (128% above those who have a mental illness and no substance use condition and 548% greater than those with no mental illness or substance use diagnoses). With a substance

⁴ The CHIS represents the most comprehensive set of data on health claims filed for individuals with private insurance and Medicaid living in New Hampshire. Any claim filed for medical care for individuals with these insurance types (though it does not include residents with insurance policies based outside of New Hampshire) is included in the data set, providing researchers with a fairly comprehensive view of the utilization and costs of health care in New Hampshire. The data set provides reliable information on those individuals, under 65, with New Hampshire-based private or Medicaid insurance. Persons seeking care must have gone to a provider who can file a claim for reimbursement of services provided. Of note, the CHIS data does not capture basic utilization and cost information for 56% of the highest users of hospital level services for mental illness (those on Medicare, Government-sponsored insurance, or those who self pay or who are uninsured) (Antal & Mandrell, 2008b).

⁵ Claim payments refer to money paid out by both the insurer as well as the insured

use diagnosis, hospital emergency department and inpatient claims for mental illness increase dramatically, about five and ten times higher, respectively, and requests for long-term care and housing supports more than doubles. It is important to note that these numbers only reflect the amount billed and processed by private insurers. Anecdotal evidence suggests that those with private insurance may be more likely to pay

for mental health care out of pocket. Possible reasons for this include: lack of managed care coverage for mental health, except for severe conditions; concerns that a diagnosis of mental illness will result in an increase in the individual's health insurance rates; and fears that employers will be able to access health information and will discriminate against employees who are diagnosed with a mental illness.

Table 1: FY 2007 Private Insurance Claims

| | No Mental Illness or Subst. (A) | Mental Illness (No Subst.) (B) | Mental Illness & Subst. (C) | Percent Diff. (B-A)/A | Percent Diff. (C-A)/A | Percent Diff. (C-B)/B |
|-------------------------------|---------------------------------|--------------------------------|-----------------------------|-----------------------|-----------------------|-----------------------|
| Members | 353,770 | 55,443 | 2,728 | -84% | -99% | -95% |
| Percent of All Members | 85.5% | 13.4% | 0.7% | -84% | -99% | -95% |
| Claim Amount Filed | \$851,363,683 | \$379,257,791 | \$42,522,650 | -55% | -95% | -89% |
| Claim Payment PMPM* | \$262 | \$659 | \$1,509 | 152% | 476% | 129% |
| Claim Payment PM** | \$2,407 | \$6,840 | \$15,587 | 184% | 548% | 128% |
| Claim Rate Per 1,000 Members | | | | | | |
| Office Clinic Any Mental | 0 | 1,238 | 1,453 | | | 17% |
| Office Clinic MH Specialist | 0 | 3,205 | 5,389 | | | 68% |
| Psychotropic Medications | 759.3 | 7,589 | 12,011 | 899% | 1482% | 58% |
| ED Visit w/ Mental Diagnosis | 0 | 97 | 574 | | | 489% |
| Inpatient w/ Mental Diagnosis | 0 | 35 | 375 | | | 974% |
| Long-Term Care and Housing | 70.1 | 562 | 1,255 | 702% | 1690% | 123% |

*PM = Per Member **PMPM = Per Member Per Month ED = Emergency Department

* Total number of members in 2007 is 413,700; 1,759 were for substance use only.

Using similar data from the 2007 CHIS reports for New Hampshire residents covered by Medicaid, the average claim payments for those without mental illness was \$3,485. Those living with mental illness, but with no substance use condition had an average claim of \$13,804 (a 296% increase). For individuals who have both a mental illness and substance use condition, the average claim per member was \$16,036 (16% above those Medicaid recipients who have a mental illness and no substance use condition;

and 360% greater than those without mental illness or substance use diagnoses). Again, with a substance use diagnosis, hospital emergency department and inpatient claims for mental illness increase by close to 400%. Requests for long-term care and housing support drops by 36% for those with mental illness and substance use conditions (in comparison to those with just mental illness diagnoses); note however that the rate of these claims is still ten times higher than those with private insurance.

Table 2: FY 2007 Medicaid Insurance Claims

| | No Mental Illness or Subst. (A) | Mental Illness (No Subst.) (B) | Mental Illness & Subst. (C) | Percent Diff. (B-A)/A | Percent Diff. (C-A)/A | Percent Diff. (C-B)/B |
|-------------------------------|---------------------------------|--------------------------------|-----------------------------|-----------------------|-----------------------|-----------------------|
| Members | 98,846 | 34,743 | 3,643 | -65% | -96% | -90% |
| Percent of All Members | 71.3% | 25.1% | 2.6% | -65% | -96% | -90% |
| Claim Amount Filed | \$344,433,276 | \$479,599,586 | \$58,419,274 | 39% | -83% | -88% |
| Claim Payment PMPM* | \$396 | \$1,310 | \$1,534 | 231% | 287% | 17% |
| Claim Payment PM** | 3,485 | \$13,804 | \$16,036 | 296% | 360% | 16% |
| Claim Rate Per 1,000 Members | | | | | | |
| Office Clinic Any Mental | 0 | 1,409 | 2,268 | | | 61% |
| Office Clinic MH Specialist | 0 | 15,147 | 20,566 | | | 36% |
| Psychotropic Medications | 706 | 6,475 | 10,686 | 818% | 1415% | 65% |
| ED Visit w/ Mental Diagnosis | 0 | 300 | 1,415 | | | 372% |
| Inpatient w/ Mental Diagnosis | 0 | 110 | 575 | | | 425% |
| Long-Term Care and Housing | 8,405 | 20,502 | 13,086 | 144% | 56% | -36% |

*PM = Per Member **PMPM = Per Member Per Month ED = Emergency Department

* Total number of members in 2007 is 138,613; 5,024 were for substance use only.

In comparing individuals with mental illness who have private insurance to those with Medicaid, there are some important differences:

Table 3: FY 2007 Private vs. Medicaid Insurance Claims for Mental Illness Only

| | Private | Medicaid | Percent Diff. |
|-------------------------------|---------------|---------------|---------------|
| Members | 55,443 | 34,743 | -37.3% |
| Percent of All Members | 13.4% | 25.1% | 87.0% |
| Claim Amount Filed | \$379,257,791 | \$479,599,586 | 26.5% |
| Claim Payment PMPM* | \$659 | \$1,310 | 98.8% |
| Claim Payment PM** | \$6,840 | \$13,804 | 101.8% |
| Claim Rate Per 1,000 Members | | | |
| Office Clinic Any Mental | 1,238 | 1,409 | 13.8% |
| Office Clinic MH Specialist | 3,205 | 15,147 | 372.7% |
| Psychotropic Medications | 7,589 | 6,475 | -14.7% |
| ED Visit w/ Mental Diagnosis | 97 | 300 | 207.9% |
| Inpatient w/ Mental Diagnosis | 35 | 110 | 213.8% |
| Long-Term Care and Housing | 562 | 20,502 | 3545.4% |

As shown above, even though there are fewer individuals with mental illness on Medicaid, the total amount of claim payments filed for this group is 26% higher than for those with private insurance. This group had higher payments per member, per month, and overall higher claim payments per member. As illustrated in the tables, these costs are reflected by a higher rate of claims for mental health specialists, increased ambulatory and inpatient hospitalizations, and substantially higher filings for long-term care

and housing supports. These findings are not surprising as adults covered by Medicaid are likely to receive Aid to the Permanently Disabled (APTD) and children are likely to be covered through the Katie Beckett Medicaid waiver. Individuals who meet eligibility criteria for either APTD or Katie Beckett have significantly greater health challenges than the general population.

INDIVIDUALS WITH SEVERE MENTAL ILLNESS ARE DISPROPORTIONATELY IMPACTED BY SOCIO-ECONOMIC CHALLENGES

A comprehensive, integrated, and coordinated health approach to recovery takes into account aspects of an individual's physical and mental health and how these interact. Additionally, this approach needs to consider how socio-economic factors influence an individual's ability to access, utilize, and benefit from services.

For example:

- ◆ **Those who have low incomes are often forced to choose between providing necessities for themselves or their families or filling expensive prescriptions.** Among adults ever diagnosed with depression, 18% indicated they could not afford needed medical care in the past year. Not surprisingly, those with incomes below \$35,000 reported the greatest difficulty in paying for medical care (33%) . For those with family incomes over \$50,000, only 3.5% reported this was a challenge (Analysis of BRFSS Data for 2006).
- ◆ **Individuals who do not have access to transportation frequently miss appointments and are unable to follow up on needed care.** Based on a 2005 survey of public transportation needs, 6.5% of New Hampshire's general population had missed or chosen not to schedule a medical appointment because they didn't know if they could get a ride (Antal, Dornblut, & McIver, 2005).
- ◆ **Individuals who are homeless typically have significant health problems.** In her review of the national literature, Zerger notes that "overall rates of prevalence of chronic health conditions seem to range from one-third to one-half of the homeless population, compared with less than one-quarter of the housed population." (2002, p.8)
- ◆ **Many of those who are incarcerated miss mental health treatments.** For adults with serious mental illness served by CMHCs, 9% had experienced a break in mental health services during their arrest period (Antal, 2009).
- ◆ **Compared to the general population, individuals with current depression are significantly more likely to smoke (44% vs. 16%) and not exercise (43% vs. 16%).** Of note, they were not more likely to be heavy drinkers (NH Bureau of Disease Control and Health Statistics, 2008).
- ◆ **Individuals with severe mental illness are far more likely to be the victims of violent crime than they are to be perpetrators.** Based on a study of violent crime among individuals with severe mental illness and comparing this to data on the general population, researchers found that people with mental illness were four times more likely to be the victims of a property crime, eight times more likely to be robbed, 15 times more likely to be assaulted, and 22 times more likely to be raped. Theft of personal property was 140 times greater. Among those with severe mental illness, victimization rates were higher for women than men (Teplin, McClelland, Abram, & Weiner, 2005).

Based on data from the 2008 and 2009 CMHC surveys, it is clear that New Hampshire residents with severe mental illness face a number of significant challenges. Compared to the general population, adults served by the CMHCs tend to have a much lower income (84% of adults and 53% of families make less than \$30,000 per year), are less likely to be employed (only 20% of adults were employed), and are far more likely to rely on Medicaid or Medicare for their insurance (82% of adults and 50% of families).

One in twenty of adults (5%) served by CMHCs indicated that they did not have a regular primary care physician and 12% of youth ages 14-17 had not seen a medical doctor or nurse in the past year (Antal, 2009).

Over half (53%) of adults surveyed stated that they needed some form of staffing support at home; 12% of those needing home supports reported that they did not receive the housing and case management supports that they needed. Only 59% of adults reported that they had the supports they needed to function in the roles they wanted in their community and approximately one in four (23%) reported that they did not feel they belonged in their community (Antal, 2009). For youth ages 14-17 who were surveyed, 31% had been suspended or expelled from school in the past two years. Twelve percent of adults and 13% of youth ages 14-17 had been arrested in the past two years (Antal, 2009).

In addition to information obtained through the CMHC Consumer Survey, the New Hampshire Bureau of Behavioral Health has worked with the Bristol Observatory, a Vermont-based research center, to develop a better understanding of service needs for individuals with severe mental illness. Their research, published across a range of policy reports, underlines the importance of services provided by the state's CMHCs for New Hampshire's residents with serious mental health needs. The Bristol Observatory estimates that in New Hampshire, the CMHCs serve:

- ◆ 11% of the state's incarcerated adults in 2007 (Bristol Observatory, Apr. 2008)
- ◆ 19% of the state's population living below the poverty line in 2007 (Bristol Observatory, Apr. 2008b)
- ◆ 29% of youth involved in the juvenile justice system in 2007 (Bristol Observatory, Oct. 2007)
- ◆ 31% of the state's known homeless population in 2006 (Bristol Observatory, Jul. 2008)

- ◆ 50% of youth involved in the Youth Treatment Center in 2007 (Bristol Observatory, May 2008)
- ◆ 64% of those hospitalized for behavioral health conditions in 2006 (Bristol Observatory, May 2008b).
- ◆ 86% of those on the New Hampshire Hospital caseload in 2006 (Bristol Observatory, Oct. 2007b)

It should be noted that there are many more individuals living with mental illness with similar challenges who do not meet criteria for severe mental illness or who may meet the criteria, but who have not been seen in a mental health care facility. For example, a 2007 survey by the New Hampshire County Association found that 46% of prisoners in the county jails had a major mental illness and 75% had a substance use problem (cited in Fulfilling the Promise, 2008). Among the state's homeless population, 50% of those in homeless shelters are estimated to have mental health issues (cited in Wierwille Norton, 2009).

The worsening economy and rising unemployment are likely to increase growing demands for mental health services. A recently released national study by Gallup-Healthyways compared how changes in the nation's daily economic health have corresponded with the status of individual mental health. Researchers found that personal stress levels increased rapidly throughout 2008 with the overall well being of Americans plunging on days when there was a substantial drop in the DOW (cited in Blass, 2009). In addition, America's involvement in world conflicts directly impacts the mental health of armed service personnel and veterans. Reservists and National Guard made up 53% of veteran suicides between 2001 and 2005 (Associated Press, 2008) and anticipated increases in deployments over the next two years will impact New Hampshire service personnel and their families and is expected to increase the need for mental health services both now and in the future. New

Hampshire's Medicaid program also is likely to see an increased enrollment as individuals whose mental illnesses go untreated become ill enough to meet Medicaid requirements for services.



**CHALLENGES TO CARE REFORM
IN NEW HAMPSHIRE**

CHALLENGES TO CARE REFORM IN NEW HAMPSHIRE

For individuals with severe mental illness, just managing day-to-day life can be a challenge; trying to access needed supports and services can be overwhelming. Inconsistent parity in health care coverage, lack of expertise among providers, lack of coordinated supports, limited outreach to the uninsured, confusing public financing rules, and the absence of electronic health records all pose barriers to New Hampshire residents with serious mental illness.

Lack of Expertise In Mental Health

One of the major challenges identified by the New Hampshire Association for Infant Mental Health survey of health care providers⁶ was the lack of expertise among general health care providers on mental health topics. Less than one in three health care providers reported having expertise in any of the following areas: challenging behaviors, child abuse and neglect, impact of caregiver's issues, emotional/mental health, grief and loss, trauma, or attachment issues (Ableman, et al, 2009).

This self reported lack of mental health expertise is also of concern given the role of pediatricians and family practice doctors in prescribing medications for those with severe mental illness – pediatricians prescribe 85% of all psychotropic medications taken by youth (Goodwin, Gould, Blanco, Olfson, 2001). Psychotropic medications have many damaging side effects that can be mistaken for a newly emerging mental illness. Of CMHC consumers surveyed, 28% of adults and 19% of youth experience serious side effects from their medication (Antal & Burbank, 2008). Fifty-six percent of youth who were surveyed are on medication for emotional / behavioral

conditions. Of these, 9% indicated that the doctor or nurse did not tell them about potential side effects (Antal, 2009).

Inconsistent Parity in Health Care Coverage

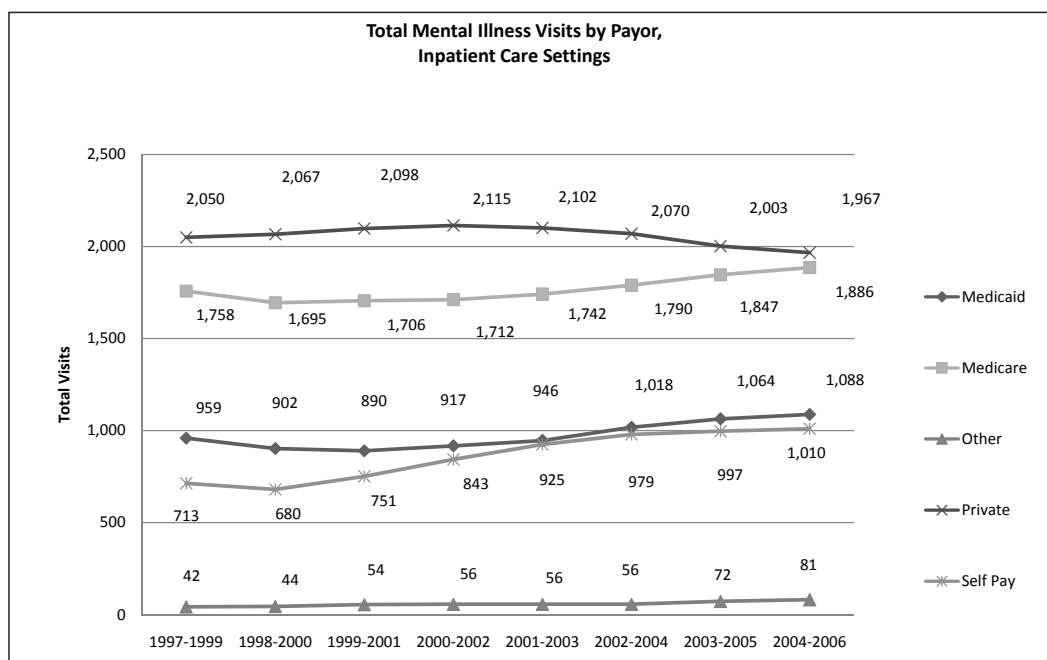
Parity in health care coverage for those with mental illness continues to be a challenge, despite state and federal policies that seek to address inconsistencies. At the state level, RSA 415:18-a Coverage for Mental or Nervous Conditions and Treatment for Chemical Dependency requires that New Hampshire insurance carriers and managed care companies cover mental health and substance use services and further requires that the ratio of benefits not be dissimilar than for other services (e.g. physical health care). At the federal level, in 2008 Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act to ensure that group health plans for 50 or more employees included coverage for mental health and addiction treatment; this expands state-level protection by requiring compliance by companies with self-funded insurance plans. While passage of legislation lends some hope for better access to services by expanding coverage for self-insured companies as well as for a broader range of mental illness and substance use conditions, much work still needs to be done. Effective parity is limited as small businesses are not required to comply (state law covers companies with at least 25 employees, federal law takes effect for companies with 50 or more employees) and those who purchase individual health insurance also are not protected. As presented below, recent New Hampshire-based research on private coverage also raises some broader questions as to the extent to which this federal legislation will address individual and systemic barriers to mental health care.

⁶ Responses gathered from 72 health care providers from across the state, 42 of whom were pediatricians or family practice physicians

The individual burden of cost of care among those with private insurance falls more heavily on those with mental illness conditions. The New Hampshire Center for Public Policy Studies documented that "individuals accessing mental health services through the private sector face cost-sharing that is significantly greater than those seeking traditional medical services. Out of pocket expenditures accounted for 8.4% of total medical services expenditures. Those seeking mental health services experienced out of pocket costs representing almost 17% of total expenditures" (Aug., 2008). We also know that 12% of families with children who have severe emotional disturbance report not having adequate insurance coverage to cover mental health services (Antal, 2009).

Additionally, changes in the demand for health care among those with private insurance are in part driven by what services are covered and whether those with private insurance have to

pay out of pocket for their mental health care. For example, even though the number of New Hampshire residents covered by private insurance increased 2.2% between 2006 and 2007, the number of members with mental illness claims increased by only 0.6% (NH Public Health, 2009a, 2009c). For this same time period, the number of residents covered by Medicaid insurance increased by less than 1%, while the number of people covered by Medicaid with a mental illness diagnosis increased by 4.2%⁷ (NH Public Health, 2009b, 2009d). Findings from the IOD analysis of hospitalization data for mental illness reflects a similar pattern; inpatient visits for mental illness among those with private insurance dropped by 4% between the 1997-1999 and 2004-2006 time periods. During the same periods, inpatient visits increased by 42% for self-pay and uninsured patients and increased by 13% and 7% for Medicaid and Medicare patients, respectively (Antal & Mandrell, 2008b).

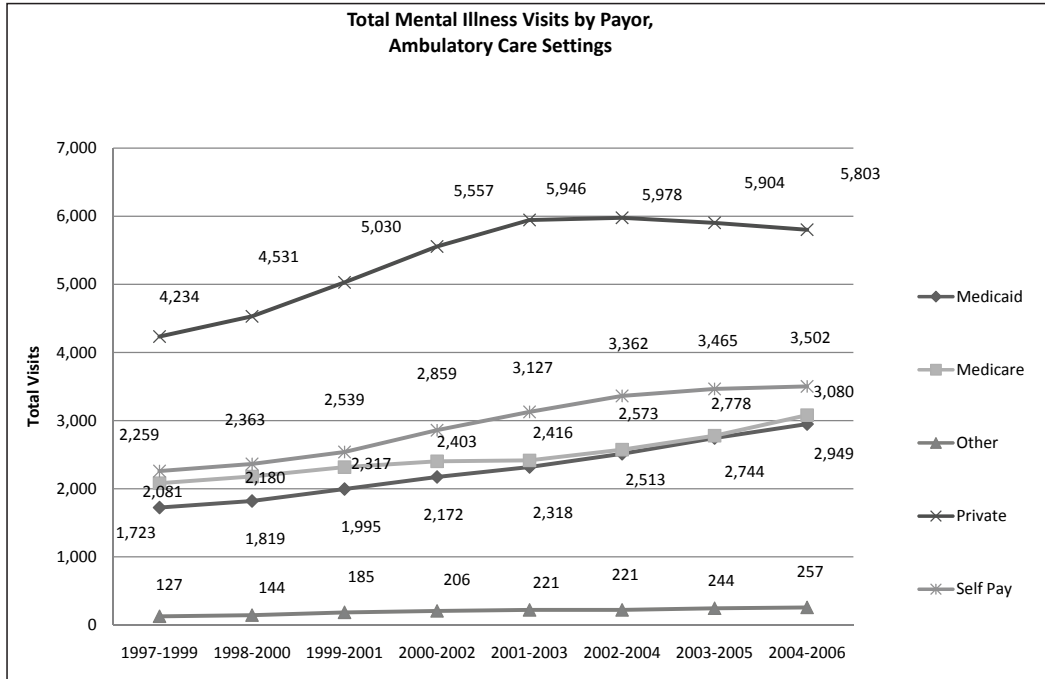


Data Source: Mental Illness and Substance Use Hospitalizations in New Hampshire, 1997-2006

⁷ Based on New Hampshire CHIS data.

Within ambulatory care settings, substantial increases were seen among those privately insured until 2001-2003 after which the number of visits dropped slightly (-2.4%) while other

payer groups continued to see an increase after this time period: Medicare (+27%), Medicaid (+27%), and Self Pay (+12%) (Antal & Mandrell, 2008b).



Data Source: Mental Illness and Substance Use Hospitalizations in New Hampshire, 1997-2006

There is also disparity in what conditions different types of insurance agree to cover and the number of providers who even are willing to take on patients without private insurance (let alone provide them with an effective level of services). This is particularly concerning for individuals who have more critical mental health conditions. In the IOD's review of ten years of hospital discharge data, individuals who had been hospitalized ten or more times over a ten year period for a mental illness were most likely to be covered under Medicare (40%), followed by Medicaid (23%), Private (21%), Self-Pay or Uninsured (11%), and Other (4%) (Antal & Mandrell, 2008b).

Lack of Coordination Among Providers

A third challenge concerns the extent to which personnel trained in either physical or mental health care or substance use disorders are

able to coordinate referrals and services in an effective manner. In the CMHC Consumer Survey conducted by the IOD, 31% of adults reported that their mental health provider does not coordinate services with their primary care provider (Antal, 2009). For youth surveyed, 42% of families with 17 year-olds reported that they were not working with the CMHC to plan for their transition to adulthood, and 11% of youth ages 14-17 thought that mental health services were not well coordinated between their school and service provider (Antal & Burbank, 2008). The NHCPP review of New Hampshire's system of care for children enrolled in school also found "little formal coordination between public systems receiving state and local funding to provide mental health services to children" (New Hampshire Center for Public Policy Studies, 2009, p.2).

Furthermore, while limited coordination exists among adults and youth, the situation is worse for very young children (birth to five). The New Hampshire Association for Infant Mental Health documented that the lack of a consistent and comprehensive statewide screening, eligibility, and referral system was a major barrier for young children needing care (Ableman, et al, 2009).

Lack of coordination can be particularly problematic for those who have an acute emergency episode. In a medical crisis, individuals and families generally end up in their local hospital's emergency department. The ability for emergency departments to effectively respond to the physical and mental health needs of patients will in large part be determined by the extent to which ED doctors have received substantive mental health training and/or have partnerships with local mental health resources.

All of New Hampshire's CMHCs have 24 hour/7 days a week emergency service coverage as is required by state and federal regulations. However, how this emergency coverage is provided varies greatly from community to community. The Foundation for Healthy Communities (2007) found considerable differences in how emergency mental health care is delivered in New Hampshire's rural areas. The Foundation identified seven rural hospitals (Cottage, Littleton, Memorial, Speare, Upper Connecticut Valley, Valley Regional, and Weeks) that have no contract in place with their regional CMHC. For Speare, New London, Monadnock, and Franklin Hospitals, the CMHC in their region does not provide on-site ED mental health services (although Franklin Hospital has had televideo mental health services in place for several years). In addition, the Foundation noted

significant variations across hospital sites in the following areas⁸:

- ◆ Who can do involuntary emergency admissions (IEA) [*]
- ◆ How IEA admissions processes are completed [*]
- ◆ How transportation of patients is handled
- ◆ Availability of inpatient options (particularly for specific age groups)
- ◆ Expertise of ED staff to handle mental health issues
- ◆ Availability of on-call services [*]
- ◆ Staff availability on weekends and evenings [*]
- ◆ Community resources and follow up for substance abusers
- ◆ Roles of primary care providers in providing mental health services (e.g. prescribing medications)

The Foundation for Healthy Communities found that in the state's rural areas those who have expertise in mental health care are stretched thin; providing services to several hospitals across substantial geographic distances, resulting in delays in service delivery.

In the area of criminal justice, the New Hampshire Mental Health Commission found that, "for a majority of defendants whose mental illness and substance use is a contributing factor to their unlawful actions, there is a need to develop programs that better assess such individuals to divert them into community-based treatment, preventing incarceration whenever possible and appropriate" (Fulfilling the Promise, 2008, p.20). The Commission also identified the need for

⁸ * Many of these areas are required under state contract. However, there is limited guidance on how services should be provided or the quality of such services.

better assessments and treatments of individuals during incarcerations, as well as more effective supports prior to and during community re-entry. The Commission notes that all of these changes will require collaboration across agencies and disciplines.

At the federal level, changes in the definition for Targeted Case Management Services may help to guide improvements in service coordination. The new definition expands the scope of case management services to include all aspects of the individual's life, not just those relating to mental health needs.

Recommendations for Care Reform for Individuals Living with Mental Illness

In addition to challenges that have already been discussed, New Hampshire faces a number of other challenges to the provision of mental health services for people with serious mental illness. The following recommendations are offered to improve access to services and the quality of care and treatment:

- ◆ Establish better outreach for those with mental illness who are uninsured or who for other reasons may not be receiving mental health services. The need to improve access to mental health services is especially critical for children and older adults.
- ◆ Develop a technical infrastructure for electronic health record data sharing between primary care doctors and mental health providers. While local efforts are currently underway in this area, funding for health information technology among community mental health centers was notably absent from the 2009 American Recovery and Reinvestment Act.
- ◆ Ensure adequacy of health care providers; this should include the provision of additional training in integrated care for mental

health, substance abuse, and physical health providers.

- ◆ Clarify the responsibility for providing services across private and public sectors and create payment structures that will ensure that services are fiscally sustainable. Additionally, incentives are needed to support greater integration between mental and physical health providers.
- ◆ Address the widespread social stigma surrounding mental illness and substance use.

A Final Note on Unmet Need

There is a significant gap between those who need mental health services and those who actually receive care. Nationally, 9% of adults are estimated to have a diagnosable mental disorder with some functional impairment (National Advisory Mental Health Council, 1993). Yet, based on 1998 data from the National Ambulatory Medical Care Survey, only 3% of physician office visits were for mental health care. The United States Surgeon General's Office estimates that less than one-third of adults with a diagnosable mental disorder receives treatment in one year (cited in *Mental Health Care Services by Family Physicians*, 2001). One of the major factors contributing to the gap between the need for care and the utilization of services is the intense social stigma associated with mental illness. When the New Hampshire Association for Infant Mental Health asked parents about the barriers to obtaining mental health care for their young children, 49% of families stated that they did not want their child or family labeled as having a mental illness (Ableman, et al., 2009).



CONCLUSION

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The importance of establishing a comprehensive, integrated, and coordinated approach for the treatment of individuals with mental illness is well documented. The national Substance Abuse and Mental Health Services Administration has developed nine core principles for health reform for mental and substance use disorders that focus on a whole health approach to care (Hutchings & King, 2009). The New Hampshire's Mental Health Commission report, *Fulfilling the Promise: Transforming New Hampshire's Mental Health System*, (Fulfilling the Promise, 2008) and the National Alliance on Mental Illness New Hampshire white paper, *Reclaiming our Future*, (Stearns, Cohen, & Kinsey, 2009) call for a concerted statewide effort to address challenges confronting the state's mental health care system. A review of New Hampshire-based research underlines the need for a statewide approach to health care reform. Ideally, individuals with mental illness or substance use conditions would have access to a continuum of care that is well coordinated, uses evidenced-based treatments, and provides comprehensive support services. Those providing services would work in partnership with individuals to ensure that they have the information and tools they need to effectively manage their illness and move toward recovery.

With an increasing demand for community-based mental health and substance use services, it becomes imperative to identify the most effective and efficient means for providing quality care and treatment. New Hampshire's current silo approach to delivering services makes coordination of care extremely difficult, contributes to poor health outcomes for individuals, and ultimately, increases health care costs. Optimum care for those with mental illness will require a better understanding of the interactions between physical and mental health, as well as an appreciation for the influence that socio-economic factors have on an individual's

ability to access and benefit from services. The challenges to New Hampshire's mental health care system have been well documented and the recommendations for needed reforms are clear. What is needed is the commitment to move forward on all fronts by all stakeholders invested in making New Hampshire's health care system a more effective resource for those living with mental illness or substance use conditions.



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