NAMI New Hampshire
National Alliance on Mental Illness

January 22, 2019

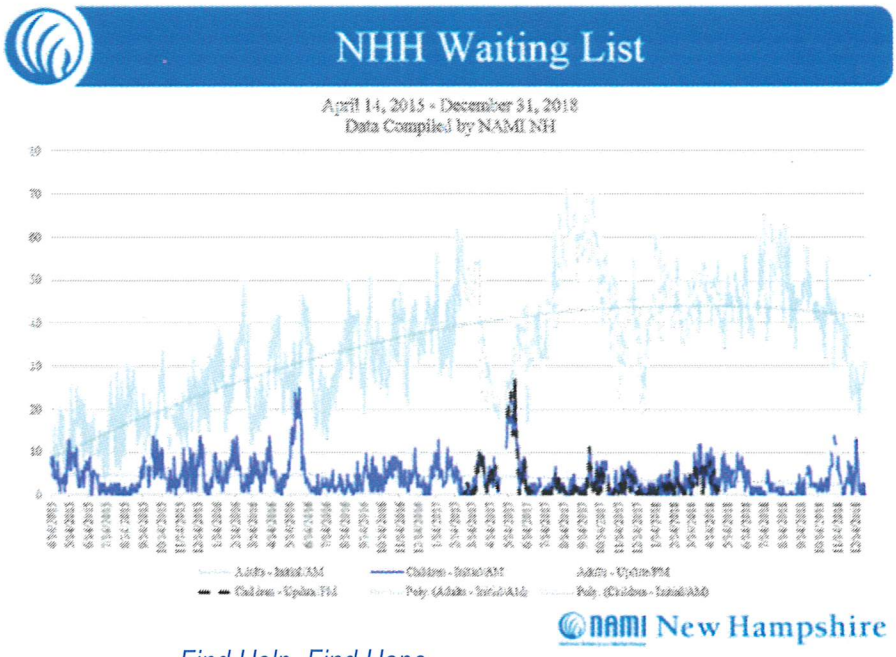
Honorable Chairman Thomas Sherman
Senate Health and Human Services Committee Room 101
36 North State Street
Concord, New Hampshire 03301

Dear Chairman Sherman:

My name is Ken Norton and I serve as the Executive Director of NAMI NH, the National Alliance on Mental Illness. I also have a family member with serious mental illness and co-occurring substance use disorder.

On behalf of NAMI NH, I am here today to offer testimony strongly supporting SB 11 relative to mental health services and appropriations. Governor Sununu has stated on numerous occasions that we are in the midst of a mental health crisis. NAMI NH strongly supports the steps outlined in this bill to expedite funding to address Emergency Department Boarding, hospital reimbursement rates and funding for housing to address this crisis.

In January of 2013, NAMI NH was joined by over 15 other organizations in drawing attention to an emerging crisis in our state regarding the lack of inpatient capacity for individuals in a mental health crisis and the subsequent "boarding" of people in emergency departments around the state while waiting for a bed to open up. We identified this problem as wrong medically, legally, ethically, morally and economically. It is medically wrong because people don't receive timely treatment to reduce their suffering and promote speedy recovery. It is legally wrong because NH law establishes due process and other legal protections under RSA 135-C which are currently being ignored. It is ethically wrong because it places medical providers in the untenable position of failing to uphold the standard of care to "do no harm." It is morally wrong because we don't categorically deny treatment to patients with heart disease, diabetes or any other medical condition. And it is economically wrong because emergency



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departments are one of the most costly hospital services and these people could receive more effective and less costly treatment in other settings.

In the six years that have transpired since, the problem has worsened dramatically with the average number of adults waiting each day quadrupling to over 40 and at several points during that time reaching over 70. While this practice is unacceptable for anyone to endure, it is particularly traumatic for children. Though the average numbers for children has been low, there have been some challenging spikes including a high of 27 children waiting in May of 2017. The accompanying chart tracks the average number of adults (top) and children (bottom) waiting each day since April of 2015.

There are a myriad of complex reasons which have contributed to this situation. However, one significant contributing factor has been the reduction in both designated receiving facility (DRF) hospital beds and voluntary psychiatric inpatient hospital beds. When the New Hampshire legislature and Governor decided to build a new state of the art state psychiatric hospital during the late 1980's, the capacity for the facility was based on the availability of regional designated receiving facilities. Although there are several DRFs available today, the full complement of DRFs originally envisioned was never realized. Having local and regional options available for inpatient psychiatric treatment plays a critical role in the mental health service delivery system. Local treatment keeps people close to their homes, families, communities, and natural support systems. Easy access to inpatient care in local hospitals is much less stigmatizing than being hospitalized at New Hampshire Hospital and may encourage people to seek treatment earlier and ultimately reduce length of stays, as well as improve long term outcomes.

Reimbursement rates for both designated receiving facility beds and voluntary inpatient beds have not been sustainable which has contributed to the reduced availability of both involuntary and voluntary beds. Increasing rates will incentivize local hospitals to increase psychiatric bed capacity and also has the potential to attract private companies interested in developing psychiatric hospital beds in NH.

Section 6 and the appropriation to the Housing Finance Authority is critical to reducing the wait for the "back door" at New Hampshire Hospital where the number of people ready for discharge typically exceed the number who are being boarded in Emergency Departments. However, there appears to be a typo in line 22 as the December 1, 2019 date is out of sync with the November 1, 2019 date in line 25 and the language in the fiscal note infers that this funding is for FY 2019. It is NAMI NH's recommendation that these funds be made available as soon as possible as the lack of affordable housing available is another major factor impacting on the emergency department boarding crisis.

NAMI NH also strongly endorses the section 4, 151-2-h regarding compliance with involuntary admission requirements. Since our press conference in 2013, NAMI NH has repeatedly called on the state of NH to comply with the provisions of RSA 135-C. We want to see people in a mental health crisis receive immediate access to mental health treatment. This includes that people are provided their right to a due process hearing within the 72 hour time frame provided by law and that the state provides sufficient funds for this to occur in Emergency Departments, if necessary.

NAMI NH also supports Section 7, 417-F:4 and the importance of providing reimbursement to hospitals by insurance carriers for individuals who are being boarded in Emergency Departments. It has been NAMI NH's long standing position that a significant contributing factor of the Emergency Department Boarding crisis is the failure of insurance carriers to provide adequate networks for mental health care and inpatient capacity for individuals in a mental health crisis. Further, the proposed credentialing

requirement for community mental health center staff will remove unnecessary barriers, promote collaboration and insure appropriate reimbursement to mental health centers for services rendered. As a final comment, while NAMI NH fully endorses this legislation and is grateful to the sponsors for bringing it forward, we feel it is important to point out that an equally high priority should be to move forward with statewide mobile crisis response. Mobile crisis response has a strong evidence base nationally demonstrating that it is successful in diverting people away from hospitalization and incarceration, and successfully de-escalating a mental health crisis while maintaining the individual in their home, or in a short term non hospital crisis or respite bed. The three mobile crisis teams currently operating in New Hampshire have demonstrated similar results. As we look to develop a strong community based system of mental health care, developing statewide mobile crisis response capacity is an essential element. NAMI NH strongly recommends that this legislation be amended to include a provision directing the Dept of Health and Human Services to issue a Request for Information (RFI) for *statewide* mobile crisis response, including a centralized data system, as soon as possible, so that proposals could be returned and reviewed, and recommendations made to the Legislature regarding statewide mobile crisis response before the end of this legislative session.

Thank you for your consideration and I would be happy to answer any questions which you may have.

Respect fully submitted,

Kenneth Norton, LICSW
Executive Director