

**NAMI New Hampshire National Alliance On Mental Illness
Written Comments on the proposed NH 10 year Mental Health Plan
December 10, 2018**

Thank you for the opportunity to again provide feedback regarding this plan. NAMI NH is pleased with the overall process of the development of the plan and the multiple opportunities to engage key stakeholders and constituents as well as the general public.

With each passing year the challenges faced by individuals with serious mental health conditions and severe emotional disorders grow more complex and often involve multiple diagnoses or co morbid conditions, as well as the individual receiving (or needing services) from multiple systems. At both the micro and macro levels this requires a level of collaboration and interface which is unprecedented as we move to an integrated model of care. While we have made significant progress, we still have a long way to go.

NAMI NH welcomes that the proposed plan continues to lead us toward a more community based integrated model of care across the lifespan. There are way too many positive aspects of this plan to comment on each of them individually though we are especially pleased to see the plan address expanding services to children expanding peer supports, and addressing Medicaid rates and workforce shortage issues. As with any plan, the devil is in the details and while this plan offers many aspirational themes and goals, there are many places where there is little detail offered as to what specifically is being recommended and to how the plan will be implemented.

Based on feedback we have received as well as our own review of the plan, we did feel it was important to offer feedback on the following areas:

Emergency Department Boarding:

As has repeatedly been stated, the situation in our emergency rooms with people in a mental health crisis waiting days and weeks to access services is wrong medically, legally, ethically, morally and economically. The Chief of Security at one of our regional hospitals noted the difficulties they have had managing individuals being boarded including aggressiveness and assaultiveness. However he summed up the inhumanity of this practice succinctly by stating, "...from a security standpoint the biggest challenge we face is that when we bring people to the toilet they refuse to go back into the room...." There is a clear consensus among key stakeholders that this is the most visible symptom of the break down and failures of our mental health system and the one which needs to be fixed immediately. Despite this, the proposed plan lacks any specificity for how or when this will be addressed. There are only vague recommendations regarding this on page 27. If this plan is truly a plan and not an aspirational document it needs to clearly articulate specific plans and timelines for resolving this situation ASAP. An emergency legislative bill to address those specific recommendations should also be considered.

Find Help, Find Hope.

Inpatient Capacity

- **Inpatient Capacity:** There is no doubt that we need more capacity for inpatient psychiatric services. This is true across the lifespan from children to transition age youth, to adults to older adults. It is also true for special populations including individuals with co-occurring: serious medical conditions; head injuries/neurological issues, substance use disorders, intellectual disabilities, and dementia.
- **Institutional Mental Disorders (IMD) Exclusion.** Although the formal announcement regarding CMS's decision to waive the IMD exclusion was relatively recent it had been anticipated for some time and therefore somewhat surprising that it received no mention in the plan. Lifting this prohibition has the potential to bring significant financial support to New Hampshire Hospital as well as for private hospitals looking to expand their current units beyond 15 beds or open a new unit. It is critical that the final plan provide some clear direction for this including anticipated costs and where those state Medicaid dollars will come from as well as anticipated revenue and how that might contribute to funding specific aspects of the 10 year plan.
- **Role of Private Hospitals:** For mental illness it includes both voluntary and involuntary capacity. Our hospitals need to be more engaged in providing services to the whole person including mental illness and/or substance use disorders. We must have them own their mission statements which generally talk about promoting health and wellness for people in their regions, yet over the past two decades many have moved away from a clear commitment to people with mental illness
- **Philbrook/Children's Inpatient Unit** – NAMI NH continues to strongly believe that the current inpatient unit(s) for children is inappropriate – both physically in how it is set up, and therapeutically being located within the larger New Hampshire Hospital Acute Psychiatric Service for adults. While there was a pretty clear consensus about this among the provider and advocacy community, there has not been any clear consensus about *what* to do about it. As required by HB 400, the Department of Health and Human Services made a good faith effort to study the issue and make recommendations to the legislature. Given that this is a 10 year plan, it is disappointing to see that there is no mention the need to change the current status of inpatient psychiatric care for children in the proposed plan.
- **Accountability for NHH Bed Usage:** Leading to NH being named number one in the country for our community mental health system was an aggressive management of bed days at New Hampshire Hospital. This included an allocation of bed days as part of the contracting process between DHHS and Community Mental Health Centers. Allocation was based on a ratio of numbers of certified (meeting state eligibility criteria for services) individuals and overall population of the catchment area. Financial penalties were built into the contracts for excessive use and there may have been a couple of years where financial incentives for underutilization were also included. Monthly reports were issued by DHHS/NHH with calls and/or meetings scheduled to discuss over utilization and at times proposed corrective action plans. There was also an appeal process for particular situations like an individual found to be Not Guilty By Reason of Insanity, or a guardian refusing to allow discharge. This accountability process also resulted in aggressive liaison work from each mental health center to work closely with NHH on admission and discharge planning with most sending a designated liaison at least once per week to meet with patients and the NHH teams. This had very positive clinical benefits as well through the relationships established with the patient while they were at NHH, maintain a strong community presence, smoothing transitions back to the community by having the Liaison there to meet them when they came for a visit or their first follow up appointments etc. It is unclear why NHH bed usage was dropped as a key performance indicator but there is little doubt that it has contributed the ED Boarding situation. The Liaison roles seemed to have dissipated because

their services were not billable. Bringing back both bed day accountability and Liaisons would provide incentive to shorten hospital stays and even avoid hospitalization altogether. Active liaisons would undoubtedly improve patient experience. An additional consideration would be having designated liaisons from the Peer Support Agencies, similar to peer navigator roles mentioned in the plan

- **North Country:** We especially need to prioritize improving inpatient capacity in the North Country. This is an imperative.

Mobile Crisis Response:

Directly related to Emergency Department Boarding is the need for *statewide* mobile crisis response (MCR). The three MCR teams operating now were required under the mental health settlement agreement with the number being a *compromise* and with all parties recognizing this was a starting point from which we could plan further expansion. The three MCR's, have replicated the evidence base built elsewhere in the country for their effectiveness at diverting people from Emergency Departments and contacts with law enforcement and the criminal justice system. The current plan calling for expansion of one team in the biennium is unacceptable. NAMI NH strongly encourages the final plan to include specific plans and timelines for making mobile crisis a statewide service and commit to the funding required to make it sustainable ASAP. Other states, which are significantly larger and have far more rural areas have successfully accomplished this, and there are both non-profit and for profit providers who specialize in providing these services who should be considered if the current array of service providers in NH decide they are not willing/able to do so.

Restraints During Transport:

Multiple people offered heart wrenching personal testimony about the trauma and indignity of being restrained with handcuffs, wrist to waist restraints and/or leg shackles. These included people who were transported as well as their family members. NAMI NH specifically requested that Antioch include this issue in the plan, and toward that end forwarded the recommendations of the 2016 SB 427 Legislative study committee. Antioch declined stating that it was too "detailed and proscriptive" While the proposed 10 year plan focuses on building a comprehensive community based system of care, a key underlying value and principle needs to be focused on preventing and reducing trauma as well as restoring the dignity and worth of individuals with mental health conditions. Allowing this inhumane practice to continue undermines all of the other aspirational goals of this plan. The plan identifies the need for prevention and early intervention and moving further upstream in our efforts the severity of mental health conditions. Eliminating the indiscriminate use of restraints during transport, together with ending emergency department boarding is critical to reducing trauma and restoring dignity.

Suicide

- As noted in the draft 10 year plan. Suicide is on the rise in NH as well as elsewhere in the country. Given that NH was identified as having the 3rd largest increase in suicide rates in the CDC report issued in June 2018, NAMI NH expected to see suicide prevention efforts play a more prominent role in the proposed 10 year plan.
- While the Zero Suicide model is mentioned several times, it lacks any clear plan about how mental health centers, hospitals, managed care companies, private insurers, community health centers and other providers and key stakeholders will be engaged with this. With 6 of the 7 proposed substance misuse HUBs being Hospitals, and presumably similar selections for the mental health hub and spoke model, this could be a great opportunity to leverage hospitals, and their larger health care systems, to adopt a zero suicide model.

- NAMI NH was encouraged to see the section on page 24 on supporting transitions as a critical point of intervention. Research has indicated that steps taken to close gaps and promote connectedness during transitions can be an important suicide prevention strategy.
- It was also great to see the proposed plan call to expand New Hampshire Hospital discharge follow up to include adults via the New Hampshire Hospital Discharge Coordinator, who currently does follow up with youth and young adults. Based on the emerging body of research showing the effectiveness of even simple, non-personal follow up, NAMI NH recommends considering expanding this follow up to all designated receiving facilities and perhaps also to anyone assessed in an Emergency Departments for suicide risk.
- While it was encouraging to see funding for suicide prevention specifically broken out in appendix C, given the seriousness of this issue and rising rates, the amount allocated seems like a minimal amount. Specific funding to expand the role of the Suicide Prevention Council, (which currently receives no funding), to support the annual suicide prevention conference as well as expansion of other activities should also be considered
- To offer support for increased suicide prevention activities and funding, NAMI NH also recommends adding the CDC's Wisqars leading cause of death chart (attached) as an appendix item to visually show the burden of suicide death in NH.

Equity and Cultural Effectiveness

Although the plan addresses the importance of these issues in very general terms, it lacks specifics about how to improve capacity for meeting the growing needs of these underserved populations. NAMI NH is has had many discussions related to this; as a small organization how do we be more inclusive of and welcoming of these populations with the services we offer on a statewide basis, especially since so many of our services and supports are volunteer driven? There needs to be more funding specifically dedicated to this purpose across the state – however with services for the general population in short supply, it is very difficult to advocate/prioritize the financial and human investments needed to make this happen

Department of Health and Human Services Capacity:

NAMI NH was happy to see that Appendix C identified the need for rebuilding/increasing capacity within the Bureau of Mental Health Services and Bureau of Children's Behavioral Health. However we feel that the proposed positions did not go far enough. Other areas of need include:

- **Training/Leadership in Evidence Based Practices:** One of the significant factors which led to NH being identified as having the best community based mental health services in the country was the leadership and intensive training efforts in emerging and evidenced based practices which were constantly being brought forward by the then Division of Mental Health Services. Requirements about training were often built into the contracts for Community Mental Health Centers, and the Division of Mental Health sponsored annual conferences as well as specialized ongoing trainings in key areas like Dialectical Behavior Therapy, Dual Diagnosis, and Forensic assessments. Trainings were offered/tailored to all levels of the workforce including residential staff, staff with a Bachelor degree, Masters level clinicians, prescribers and psychiatrists. These trainings served multiple purposes including improving the service delivery system, investing in the workforce through skill development, and building a sense of camaraderie and shared purpose across different organizations (what today we would call communities of practice). It is our recommendation that the 10 year plan also include a training plan which clearly identifies and articulates what specialized training will be needed in what areas, in order to implement this 10 year plan.

- **Contracts Unit:** A significant challenge in operationalizing new mental health initiatives is the inordinate amount of time it takes to move proposals through to contracting. Developing capacity and/or streamlining this process will be essential to efficiently enacting and implementing new initiatives called for in the 10 year plan. This area is also one which creates tension between the Department and advocates, Legislators and Providers. There have been several initiatives approved and funded by the legislature during the last several years including the Clinical Care Coordinator, Crisis Care Unit and additional transitional housing beds which have either been delayed significantly or never made it through the Department/contracting process. Given the influx in funding for Substance Use Disorder services as well as anticipated increased funding for the 10 year plan we hope that DHHS can build capacity now to avoid future delays.
- **Medical Director/Policy Leader:** While the proposed 10 year plan articulates the need for leadership on page 33, it fails to offer clear details about how to achieve this. Again, looking retrospectively at how mental health services were so successful in NH in the past, during that time the Division of Mental Health had significant and effective policy leaders including a Medical Director and policy director embedded in the Mental Health Services unit. Although we have been advocating for a Medical Director with expertise in addressing policy, clinical and contractual issues for several years now, it is imperative that successfully moving this 10 year plan forward will require a high level of DHHS visibility, expertise and leadership at the Legislature as well as interfacing with providers, the general public, advocates and other key constituency groups.

Choice: In the US we value the importance of choice as a basic driver of free markets, competition and enhancing the quality of services. It is hard to think of any health care services where consumers lack any semblance of choice more so than in the area of mental health treatment for individuals with serious mental illness. For many people, their utter lack of choice is both for inpatient as well as outpatient services. Lack of choice often goes beyond these traditional services and also includes an inability to access alternative treatments/services like acupuncture, yoga, mindfulness and other alternative forms of care and/or treatment.. Consumer choice is a powerful tool and can help fuel people in moving forward in their recovery process. Though a difficult topic, it should be addressed in this plan as we look toward the future.

Justice Involved Individuals: There is a plethora of data available nationally to show that one of the serious consequences of attempts at deinstitutionalization is the dramatic rise in the numbers of people with mental illness who have been, or are incarcerated. NAMI NH receives constant calls coming into our information and resource line from family members whose loved one is incarcerated in jail or prison. There were also multiple people who offered testimony at the public hearings who talked about loved ones with known mental health histories being diverted from Emergency Departments to jails. We need to do a better job at preventing people from being incarcerated. Steps mentioned in the proposed plan like CIT training for law enforcement and/or first responders are very positive and necessary, but we need to do more including:

- **Develop statewide capacity for Mental Health Courts:** If justice is supposed to be blind, where you are arrested or incarcerated shouldn't make a difference in what type of sentence or alternative to sentence you are likely to receive or what treatment or supports you receive while incarcerated.
- **Transition Age Youth:** It is great to see the inclusion of expanded supervised housing for Transition age youth in Appendix C and funding for the FY 20/21. However a more comprehensive plan needs to be developed especially to address the high numbers of transition

age youth who end up incarcerated – what is often referred to nationally as the “pipeline from Special Ed to jail....”

- We need to develop some type of oversight mechanism to monitor or better yet to prevent individuals who are being held or assessed for an Involuntary Emergency Admission from being diverted to jail, and for those who do get diverted to expedite the current torturous route they now take to go from jail to NHH.
- County Jails – We need to develop more comprehensive supports to individuals with mental illness in our county jails. Many of them have very high rates of recidivism due to the lack of effective treatment available as well as little or poorly executed transition planning. Because the financial burden for this rests with the counties, there seems to be little incentive to address this area where many people with mental illness and/or co-occurring disorders have their illnesses exacerbated rather than treated. One consideration might be to develop a model of peer supporters who can assist with the transition process.

Accountability regarding plan implementation*: Plans are mere pieces of paper without mechanisms in place for holding individuals, organizations, systems, and elected officials accountable. We need only look at the 2008 ten year plan, which although lacking information about children, has many similar components to the proposed plan. Although like this plan, there was general consensus that the plan offered a good road map for moving us forward, that plan never got off the ground due to an emerging recession and other factors which brought moving the plan forward to a halt. Although this current plan talks about *accountability*, it does so mostly in justification of the role a centralized data system and Hub and Spoke model can play in relation to service accountability. The plan doesn’t really address who or how we can be building overall accountability regarding implementation of the overall plan. A few factors to consider:

- Commissioner Meyer’s term ends in a little over a year. What happens if a year from now we end up with a new Commissioner of DHHS, and that person has other priorities or ideas about mental health system reform and/or less investment in implementation of this specific plan?
- As a 10 year plan we can expect the Legislature to turn over 5 times during the life of this plan. We are fortunate to currently have a Governor and bipartisan leadership committed to mental health reforms. Will the elected leaders of tomorrow or five years from now feel the same level of commitment to this plan?
- We have been in a sustained period of economic growth, we cannot expect this will continue over the next ten years; to wit the volatility in the stock market during the past month combined with a burgeoning federal deficit does not bode well for the future. How will future economic factors impact the plan?
- Although much harder to clearly predict – the current leadership of each of the Community Mental Health Centers are potentially in the window for retiring during the life of this plan. (This may present both a threat and an opportunity to the plan).

Our collective failure to implement the previous plan has had devastating consequences, as evidenced by human suffering from failure to access timely and effective treatments, and likely contributing to our rising suicide rates. In the absence of our ability to hold *anyone* accountable for this, we have abdicated all of the responsibility to the courts with two Federal Class action lawsuits brought against the State of NH since the last plan was published in 2008. To avoid a similar fate this time, NAMI NH recommends establishing some type of independent monitor similar to the Office of the Child Advocate who has the authority to investigate and monitor the implementation process* and provide regular updates to the Governor, Legislature, and Commissioner of Health and Human Services, as well as other key stakeholders and ultimately the people of the State of New Hampshire.

*Implementation: How the plan is implemented will have a significant effect on the success or failure of the plan. Michael Cohen provided lengthy suggestions regarding implementation planning. Rather than offering similar comments, we endorse the comments and suggestions Mike made in his written comments on the 10 year plan.