

New Hampshire

In 2006, New Hampshire's mental health care system received a grade of D. This came as a surprise to many, who had long considered the state a frontrunner nationally. Three years later, the state receives a C, but budget shortfalls threaten to undo this modest advance.

In 2005, New Hampshire's legislature created a commission that brought together the Bureau of Behavioral Health (BBH), legislators, providers, consumers, and families. The BBH and Commission's process restored lines of communication between stakeholders and advocates, who now feel they are included in addressing concerns. This sense of renewal, combined with BBH's commitment to gathering and using data to drive decision-making, are hopeful signs.

New Hampshire also is doing well with involving consumers in its mental health service system. There are peer support sites located in each of the 10 mental health regions in the state. In December 2008, the University of New Hampshire published results from a Public Mental Health Consumer Survey Project, which reflects the changing culture and consumer involvement (see www.iod.unh.edu/pmhs.html).

Overall, New Hampshire is aligning its Medicaid system to support evidence-based practices. Access to modern services has improved since 2006, but much more is needed. For example, illness management and recovery programs developed locally at Dartmouth University served 591 individuals in 2007 and 1,416 in 2008—an improvement to be sure, but a long way from universal access. Supported employment, also developed at Dartmouth, reached only 697 people. Such cost-effective models deserve better funding.

Hospital beds are a central concern in New Hampshire. The state population is increasing, and the number of psychiatric beds is decreasing. The state hospital in Concord is overtaxed. Admissions have increased 69 percent since 2000. Shortages of community resources add to the pressure—from 1990 to 2008, the state reports that the number of community voluntary beds declined from 236 to 186 (21 percent). For involuntary admissions, the number of available community beds declined from over 100 to just eight during the same period. In spite of this pressure, the state hospital has been successful in reducing use of restraints and seclusion.

Ten non-profit community mental health agencies funded by the state provide treatment and services and are facing the same demographic and financial pressures.

Innovations

- Telemedicine
- Statewide planning process based on collaboration and inclusion
- "In Shape" proactive, preventative self-care model

Urgent Needs

- Inpatient beds
- Housing
- Reduce mental health workforce shortage
- Jail diversion programs

Consumer and Family Comments

- *"My daughter was released from a psychiatric hospital—it was six weeks before she could begin her community-based appointments with psychiatrists and talk therapists. A lot of ground was lost."*
- *"We don't feel that a person should have to become 'homeless' to receive a higher level of care."*
- *"Peer Support Agencies have 'warm lines' that you can use to keep a situation from becoming a crisis, and I use it all the time."*

They will not receive rate increases in 2009. All aspects of the system face chronic workforce shortages.

Rising housing costs make affordable housing difficult for consumers to find. As people go without adequate shelter or treatment, criminalization of mental illness becomes more of a concern. To address this, jail diversion requires more attention. But to succeed, community mental health services must be available.

New Hampshire is fostering a culture of consumer- and family-centered services. It is using a federal grant to implement a person-centered treatment planning approach in delivery of services that increases consumer and family involvement in preparing treatment plans. Wellness also is emerging as part of the culture. Monadnock Family Services in Keene has pioneered "In Shape," a proactive, preventive self-care model that could significantly address the mortality and morbidity crisis among people with serious mental illnesses. Another federal grant is allowing the state to add physical health to illness management and recovery. New Hampshire is poised to become a leader on preventable cardiac deaths but is not there yet.

New Hampshire's grade C this year could be a new beginning, but it depends on whether state leaders have the political resolve to invest in building a modern, cost-effective system. If not, then recent progress may be no more than a brief respite from a much longer fall in status.

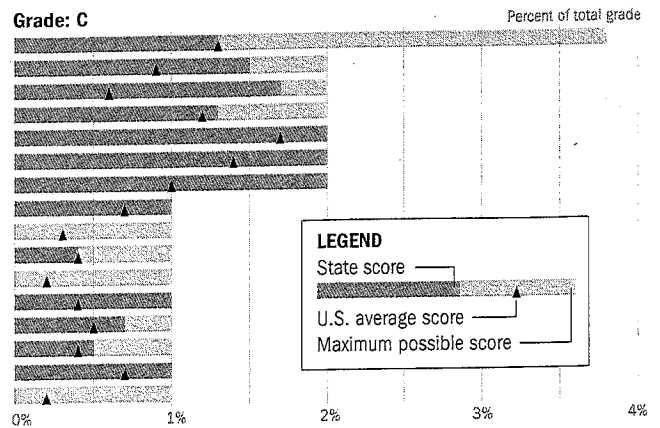
NAMI Score Card: NEW HAMPSHIRE

Grade: C

Category I: Health Promotion & Measurement

- Workforce Development Plan
- State Mental Health Insurance Parity Law
- Mental Health Coverage in Programs for Uninsured
- Quality of Evidence-Based Practices Data
- Quality of Race/Ethnicity Data
- Have Data on Psychiatric Beds by Setting
- Integrate Mental and Primary Health Care
- Joint Commission Hospital Accreditation
- Have Data on ER Wait-times for Admission
- Reductions in Use of Seclusion & Restraint
- Public Reporting of Seclusion & Restraint Data
- Wellness Promotion/Mortality Reduction Plan
- State Studies Cause of Death
- Performance Measure for Suicide Prevention
- Smoking Cessation Programs
- Workforce Development Plan - Diversity Components

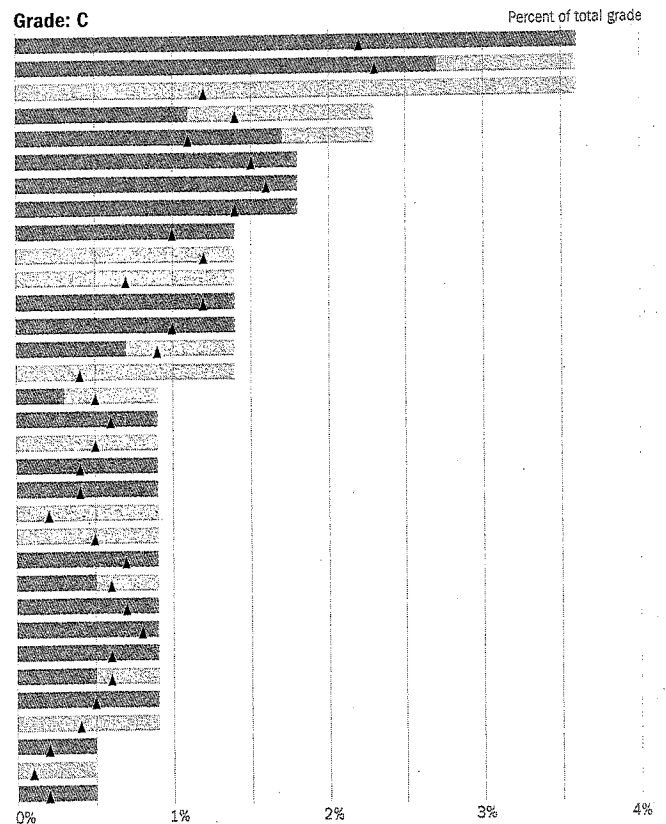
Grade: C



Category II: Financing & Core Treatment/Recovery Services

- Workforce Availability
- Inpatient Psychiatric Bed Capacity
- Cultural Competence - Overall Score
- Share of Adults with Serious Mental Illness Served
- Assertive Community Treatment (ACT) - per capita
- ACT (Medicaid pays part/all)
- Targeted Case Management (Medicaid pays)
- Medicaid Outpatient Co-pays
- Mobile Crisis Services (Medicaid pays)
- Transportation (Medicaid pays)
- Peer Specialist (Medicaid pays)
- State Pays for Benzodiazepines
- No Cap on Monthly Medicaid Prescriptions
- ACT (availability)
- Certified Clubhouse (availability)
- State Supports Co-occurring Disorders Treatment
- Illness Self Management & Recovery (Medicaid pays)
- Family Psychoeducation (Medicaid pays)
- Supported Housing (Medicaid pays part)
- Supported Employment (Medicaid pays part)
- Supported Education (Medicaid pays part)
- Language Interpretation/Translation (Medicaid pays)
- Telemedicine (Medicaid pays)
- Access to Antipsychotic Medications
- Clinically-Informed Prescriber Feedback System
- Same-Day Billing for Mental Health & Primary Care
- Supported Employment (availability)
- Integrated Dual Diagnosis Treatment (availability)
- Permanent Supported Housing (availability)
- Housing First (availability)
- Illness Self Management & Recovery (availability)
- Family Psychoeducation (availability)
- Services for National Guard Members/Families

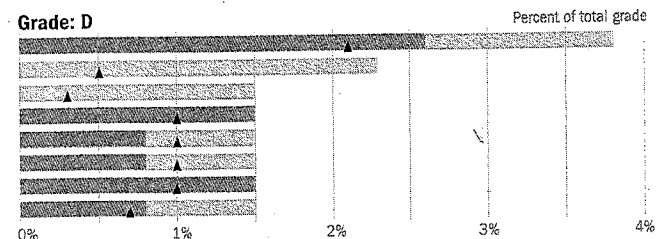
Grade: C



Category III: Consumer & Family Empowerment

- Consumer & Family Test Drive (CFTD)
- Consumer & Family Monitoring Teams
- Consumer/Family on State Pharmacy (P&T) Committee
- Consumer-Run Programs (availability)
- Promote Peer-Run Services
- State Supports Family Education Programs
- State Supports Peer Education Programs
- State Supports Provider Education Programs

Grade: D



Category IV: Community Integration & Social Inclusion

- Housing - Overall Score
- Suspend/Restore Medicaid Post-Incarceration
- Jail Diversion Programs (availability)
- Reentry Programs (availability)
- Mental Illness Public Education Efforts
- State Supports Police Crisis Intervention Teams (CIT)
- Mental Health Courts - Overall Score
- Mental Health Courts - per capita

Grade: D

