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STATE OF NEW HAMPSHIRE

MENTAL HEALTH SERVICES SYSTEM

PERFORMANCE AUDIT
JANUARY 1990

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Office of Legislative Budget Assistant
Room 102, State House
Concord, New Hampshire 03301
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TO THE FISCAL COMMITTEE OF THE GENERAL COURT:

We have conducted a program results audit of the mental health system in the state of New Hampshire in accordance with recommendations made to the Fiscal Committee by the Joint Legislative Performance Audit and Oversight Committee. Our audit was conducted in accordance with generally accepted governmental auditing standards and accordingly included such procedures as we considered necessary in the circumstances.

The primary objective of our audit centered on an evaluation of the efficiency and effectiveness of state-provided services for persons with serious and chronic mental illness within the state's policy of offering these services in the least restrictive environment appropriate for each individual. Thus our audit included an extensive examination of the services necessary to move from treating mental illness in long-term, custodial, centralized, institutionally-based environments to less restrictive, decentralized, community-based environments.

Our audit entailed consultation and interviews with the Division of Mental Health and Developmental Services, the Department of Education, the Department of Corrections, the Division of Children and Youth Services, community mental health centers, representatives of consumer advocacy groups, general hospital administrators, members of local police departments, administrators of homeless shelters, and several elected officials. We extend our thanks and appreciation for the cooperation we received throughout the engagement.

This report results from the evaluation of information obtained from the sources noted above and is intended solely to inform the Legislative Fiscal Committee of our findings and should not be used for any other purpose. This restriction in not intended to limit the distribution of this report, which, upon acceptance by the Fiscal Committee, is a matter of public record.

Office of Legislative Budget Assistant

OFFICE OF LEGISLATIVE BUDGET ASSISTANT

January 1990

STATE OF NEW HAMPSHIRE
MENTAL HEALTH SERVICES SYSTEM

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ABBREVIATIONS

CMHC - Community Mental Health Center
DCYS - Division of Children and Youth Services
DMHDS - Division of Mental Health and Developmental Services
DRF - Designated Receiving Facility
NHH - New Hampshire Hospital

OFFICE OF LEGISLATIVE BUDGET ASSISTANT

EXECUTIVE SUMMARY

MENTAL HEALTH SERVICES SYSTEM

INTRODUCTION

Our audit of New Hampshire's mental health services system began as a study of "deinstitutionalization." States throughout the country generally implemented deinstitutionalization as a policy to varying degrees during the 1960s and 1970s.

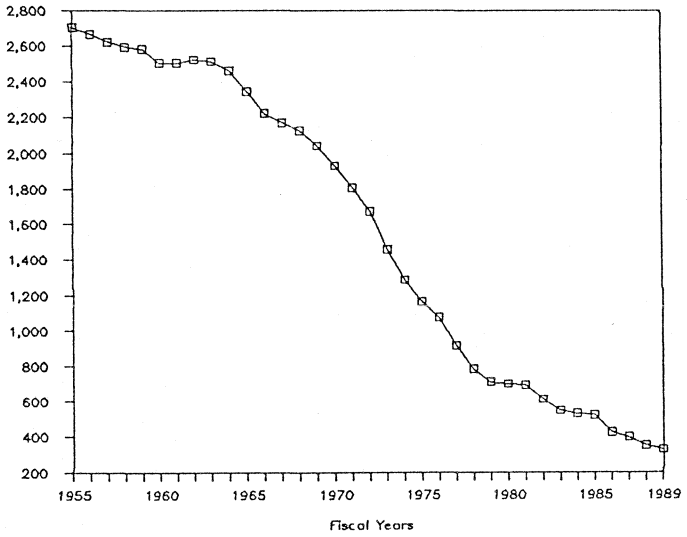
Deinstitutionalization is based on a philosophy that more efficient, effective, and humane mental health care can be provided to the majority of individuals with serious and chronic mental illness in less restrictive, community-based environments than in large, centralized, psychiatric hospitals.

At the state's only public psychiatric hospital, New Hampshire Hospital, the average client census reached an all-time high in 1955 of about 2,700, and it has decreased steadily since then. Federal legislation passed in 1963 created a community mental health center program, and New Hampshire first authorized state funds to help local governments or non-profit corporations establish community mental health centers in 1965. However, it was 1983 when the state legislature passed Chapter 407, mandating that people with mental illness be served in the least restrictive environment appropriate to their needs and authorizing plans to restructure the mental health system.

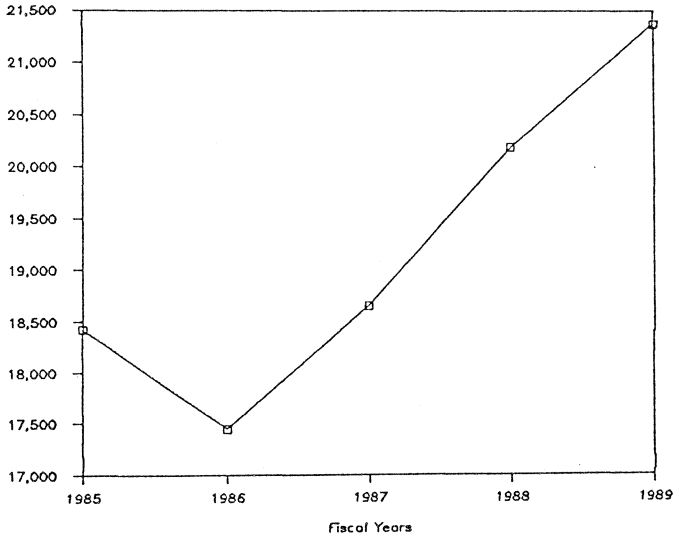
Restructuring focused on reducing the system's reliance on institutional care and creating stronger and more comprehensive community care options. The chart on page eleven illustrates the mental health service system existing today.

The graphs below show client trends for both New Hampshire Hospital and the community mental health centers.

NHH AVERAGE CLIENT CENSUS



CMHC CLIENTS SERVED



Source: DMHDS.

Restructuring of the mental health services system in New Hampshire is largely complete. In many ways, the Division of Mental Health and Developmental Services' accomplishments have led to its national recognition as an innovative leader in the field of mental health services, placing New Hampshire's system among the best in the country.

Some of the exemplary accomplishments include:

- the development of broad based community services in ten CMHCs enabling the transition from institutional care to community-based care for the majority of the seriously mentally ill population, with well defined systems of accountability in place,
- the completion of a fully accredited state-of-the-art acute care psychiatric facility for the most seriously impaired clients,
- the development of the first affiliation of a private medical school (Dartmouth Medical School) with a state psychiatric hospital to provide psychiatric services and to staff an office of applied research to evaluate the quality of services,
- the establishment of continuous treatment teams, funded in part by private grants, which are seen as highly effective mechanisms for achieving continuity of care and sharply reduced hospitalization rates,
- the funding of model programs, notably, a job training and employment program in Keene, and
- the establishment of innovative training programs with the New Hampshire Vocational Technical system to train residential staff and improve the quality of services.

SYSTEM PROVIDERS

Our audit focused on the restructured mental health system in place today, with primary emphasis given to community services. The Division of Mental Health and Developmental Services administers the system, which includes two institutions: New Hampshire Hospital and Glencliff Home for the Elderly. Ten community mental health centers plus two additional housing providers provide services contracted by the division. Mental health services are also provided by general community hospitals through agreements with the mental health centers. The division has designated three hospital units as special receiving facilities, allowing them to accept involuntary emergency admissions and serve as alternatives to New Hampshire Hospital.

Community Mental Health Centers

All the mental health centers that the division contracts with annually are private, non-profit organizations and offer additional services not contracted by the division. The division monitors and assesses the centers' provision of contracted services including emergency, brief and partial hospitalization, children's, elderly, case management, housing, vocational, and other services. Several division-contracted services are limited to those clients certified as severely or chronically mentally ill, based on division criteria.

New Hampshire Hospital

Almost all persons admitted to New Hampshire Hospital today are first screened by staff of the mental health centers. Because clients' average length of stay at the hospital has been decreasing, the average hospital census continues to decline, despite increasing admissions in recent years. In fiscal year 1989, admissions totaled about 900.

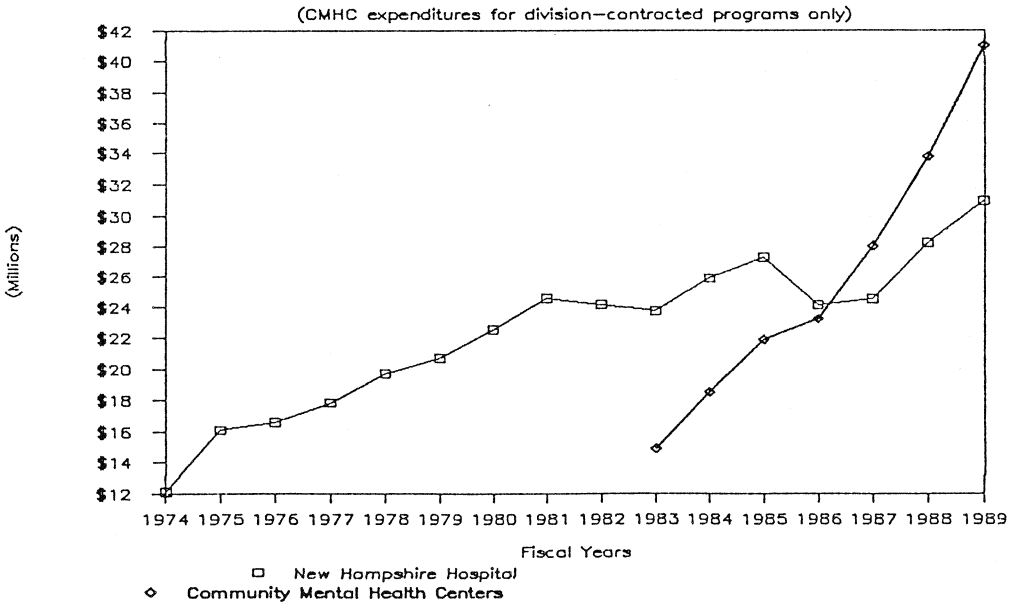
The hospital consists of three different service units. The acute psychiatric unit receives all admissions and provides treatment with the goal of discharging clients back to the communities as soon as possible; transitional housing provides long-term clients who are not ready for community placement a non-hospital environment to further develop adaptive skills; and the long-term nursing care unit serves the elderly with mental illness diagnoses. Glencliff Home also provides care to elderly mentally ill clients.

FUNDING AND EXPENDITURES

The shift from institutional to community-based services within New Hampshire's mental health system is reflected in significant changes in the state's allocation of financial resources. The overall mental health budget increased 180 percent between 1980 and 1990, with the portion allocated to community services growing from about 17 percent to 45 percent of the total budget.

Mental health center expenditures for division-contracted programs have increased from $15 to $41 million since 1983 and have exceeded New Hampshire Hospital expenditures since 1987, as shown in the graph below. Hospital operating expenditures were $31 million in fiscal year 1989. About 64 percent of the centers' costs for contracted programs were funded by state funds compared to 76 percent of the hospital's costs in 1989.

CMHC AND NHH EXPENDITURES



Sources: Community mental health center financial audits, 1983-89, and Statement of Appropriation, 1974-89.

EXECUTIVE SUMMARY

Our observations relating to the division's implementation and control of the restructured community-based mental health system are summarized on the following pages. They are organized according to management objectives related to financial and administrative controls over mental health services, and the level of coordination, effectiveness, and adequacy and accessibility of these services. Each observation is parenthetically referenced to the detailed discussion in the body of the report.

The observations summarized here, and discussed in further detail with recommendations in the body of the report, are offered in the spirit of providing suggestions to enhance the current service system. The division has already made good faith efforts in many areas. The division's comments on this report appear in Appendix A.

FINANCIAL AND ADMINISTRATIVE CONTROLS OVER MENTAL HEALTH SERVICES

COST CONTROLS SHOULD ENSURE THE HIGHEST QUALITY SERVICE AT THE LEAST POSSIBLE COST.

Sound managerial controls that encourage and define systems to maximize productivity and set standards for cost-per-unit of service are instrumental in procuring cost efficient mental health services in a decentralized service delivery system.

Our analysis of division controls in this section focuses primarily on cost containment and cost effectiveness controls over contracted services provided by the ten community mental health centers. We also discuss system controls of New Hampshire Hospital utilization and program data reported by the mental health centers. Our observations are summarized below.

1. Wide cost-per-unit variances for program services exist among community mental health centers. Review of the division's quality assurance evaluations of specific services shows no apparent correlation between unit costs and service quality, although differences in program models may account for some of the unit cost variances. (p. 58)

2. The division's use of performance measures in allocating funds to the community mental health centers is not widely standardized, although new procedures implemented during the most recent contract negotiations suggest the division is moving toward greater standardization. (p. 60)

3. The division has not consistently used financial penalties and incentives to enforce the quotas for utilization of New Hampshire Hospital beds by the mental health centers. (p. 61)

4. The division's existing controls over community mental health center administrative costs should be strengthened to ensure that state dollars are being used most effectively for client services. The division's primary control of these costs is a "rule-of-thumb" 15 percent cap on total administrative expenses. In the centers' fiscal year 1990 budgets, 72 percent of administrative costs were for personnel. Audit guidelines developed by the division for independent financial auditors of the mental health centers do not include specific procedures for testing administrative expenses. (p. 63)

5. The division's financial and program data on community mental health centers is provided to the division through quarterly reports prepared by the mental health centers. Currently, the division does not systematically verify the accuracy and consistency of the program data. (p. 64)

6. The division's review of the independent audits of community mental health centers does not include a standard review of management letters that may accompany the audited financial statements. (p. 65)

COORDINATION OF MENTAL HEALTH SERVICES

MEETING THE NEEDS OF THE MENTALLY ILL IN A COMMUNITY-BASED SERVICE SYSTEM IS COMPLEX BECAUSE OF THE DIVERSITY OF PROVIDERS AND RANGE OF SERVICES REQUIRED.

Coordination of services within the state's mental health system is especially important since deinstitutionalization and restructuring have reduced the system's reliance on institutions like New Hampshire Hospital. While community-based services are generally closer to clients' homes and provide less restrictive environments, they also make meeting the needs of clients more complex. Not all services needed by clients at any given time are provided in one location or necessarily by one provider, and thus require more coordination to effectively meet clients' needs. Clients' needs over a long period may require not only services offered within the community, but also those offered by a designated receiving facility or New Hampshire Hospital. With different levels of service provided by a variety of providers throughout the system, coordination becomes even more important to ensure clients the easiest and smoothest access to services and movement between service levels. Coordination is also necessary to ensure that the individual services available are integrated and function as a true system of care. Our observations related to the coordination of services are summarized below.

7. The role and level of development of designated receiving facilities (DRFs) have changed from what the 1985 mental health restructuring plan originally outlined. Although a majority of community mental health centers indicate some need for more designated receiving facility beds, the division appears to be shifting its emphasis away from the current model of inpatient DRF beds. Data indicate that a DRF can help a region reduce its use of New Hampshire Hospital beds, but that the impact of DRFs may not be long-lasting. (p. 66)

8. Communication and coordination between New Hampshire Hospital and the community mental health centers and designated receiving facilities do not appear to be as strong and consistent as they could be. Gaps in communication and coordination between the different levels of service providers, especially concerning discharges from New Hampshire Hospital, reduce the effectiveness of each service level and prevent service providers from functioning efficiently as part of a unified system of services. (p. 68)

9. The division's ability to compile, coordinate, process, and analyze a wide variety of program and client service data as efficiently and effectively as possible is hampered by its lack of an adequate computerized management information system. (p. 69)

10. The lack of a clear legislative mandate for any one state agency to be responsible for comprehensive mental health services for all children and the involvement of at least three separate agencies in providing public mental health services for children indicate a strong need for continuing efforts by all relevant agencies to coordinate and improve childrens' services. (p. 70)

EFFECTIVENESS OF MENTAL HEALTH SERVICES

EFFECTIVENESS SUGGESTS THAT AS A RESULT OF HABILITATION OR TREATMENT, QUALITY OF LIFE WILL IMPROVE TO THE EXTENT POSSIBLE.

Effectiveness, in the context of performance auditing, is measured by comparing actual performance against an ideal or standard. Analysis of program effectiveness can help to determine whether programs achieve their objectives and also to generate recommendations for improvement.

To maintain our focus on the overall system of mental health services, we chose not to evaluate the effectiveness of specific community mental health services. Instead, we reviewed findings of the division's Office of Evaluation and Quality Assurance, which assesses and strives to ensure the effectiveness of mental health center policies, procedures and performance. Our observations are summarized below.

11. Program standards are the principal basis for monitoring the quality of community mental health services in New Hampshire. Although program standards are necessary to define basic guidelines for service provision, other outcome-oriented measures of program effectiveness need to be developed that tie delivery of mental health services to changes in client conditions and behavior. In the absence of outcome effectiveness measures, the division cannot evaluate which service models and which providers are delivering the most effective programs to mentally ill clients. The division recognizes the importance of these measures and should continue to develop them aggressively as methodology and knowledge evolve within the mental health field. (p. 73)

12. The division does not conduct quality assurance site reviews at all community mental health centers annually, despite their usefulness in identifying problems at the centers. (p. 75)

13. Beyond the site survey/corrective action process, the division has not developed stronger actions to ensure compliance in survey areas that are not program-specific, such as deficiencies related to client rights. (p. 76)

14. Despite extensive documentation, the quality assurance office lacks a listing or index of each mental health center's status in correcting deficiencies cited in division site reviews. (p. 77)

ADEQUACY AND ACCESSIBILITY OF MENTAL HEALTH SERVICES

LEAST RESTRICTIVE ENVIRONMENT IMPLIES PEOPLE SHOULD BE SERVED IN WAYS THAT ARE AS CLOSE TO NORMAL LIVING PATTERNS AS POSSIBLE AND IN A MANNER WHICH LEAST DEPRIVES INDIVIDUAL LIBERTY AND FREEDOM OF CHOICE.

The adequacy and accessibility of community mental health services are measured by the degree to which people needing services receive them when required. In providing services that are adequate and accessible, the division faces a variety of diagnoses and degrees of mental illness demanding individual service plans. This mandate for personalized care drives the division's efforts to coordinate, monitor, and provide community mental health services.

To determine the adequacy and accessibility of state-funded mental health services in New Hampshire, we concentrated on several areas directed or monitored by the division: housing services, the homeless mentally ill, unmet needs/waiting lists and client eligibility (certification). Our observations are summarized below.

15. Housing for the mentally ill is insufficient to meet the needs of clients currently receiving state mental health services, as the demand for community-based housing continues to outpace the supply. (p. 78)

16. The division is presently very active in assisting the state's homeless population. Its efforts include the administration of federal funds available through the Stewart B. McKinney Homeless Assistance Act and oversight of two Housing and Urban Development grants. The division also oversees the Mental Health Services to Homeless Block Grant, specifically addressing the homeless mentally ill, and the Emergency Shelter Grant-in-Aid program. In addition, the division participated in a 1988 study by the New Hampshire Task Force on Homelessness, which estimated that 30 percent, or about 4,300, of the state's homeless are mentally ill. Other studies reviewed by the LBA confirm that the majority of homeless people are not mentally ill. However, the division could improve targeting of services to the homeless mentally ill through expanded data collection efforts directed at identifying the unmet needs of the homeless mentally ill and linking them to available mental health services. (p. 80)

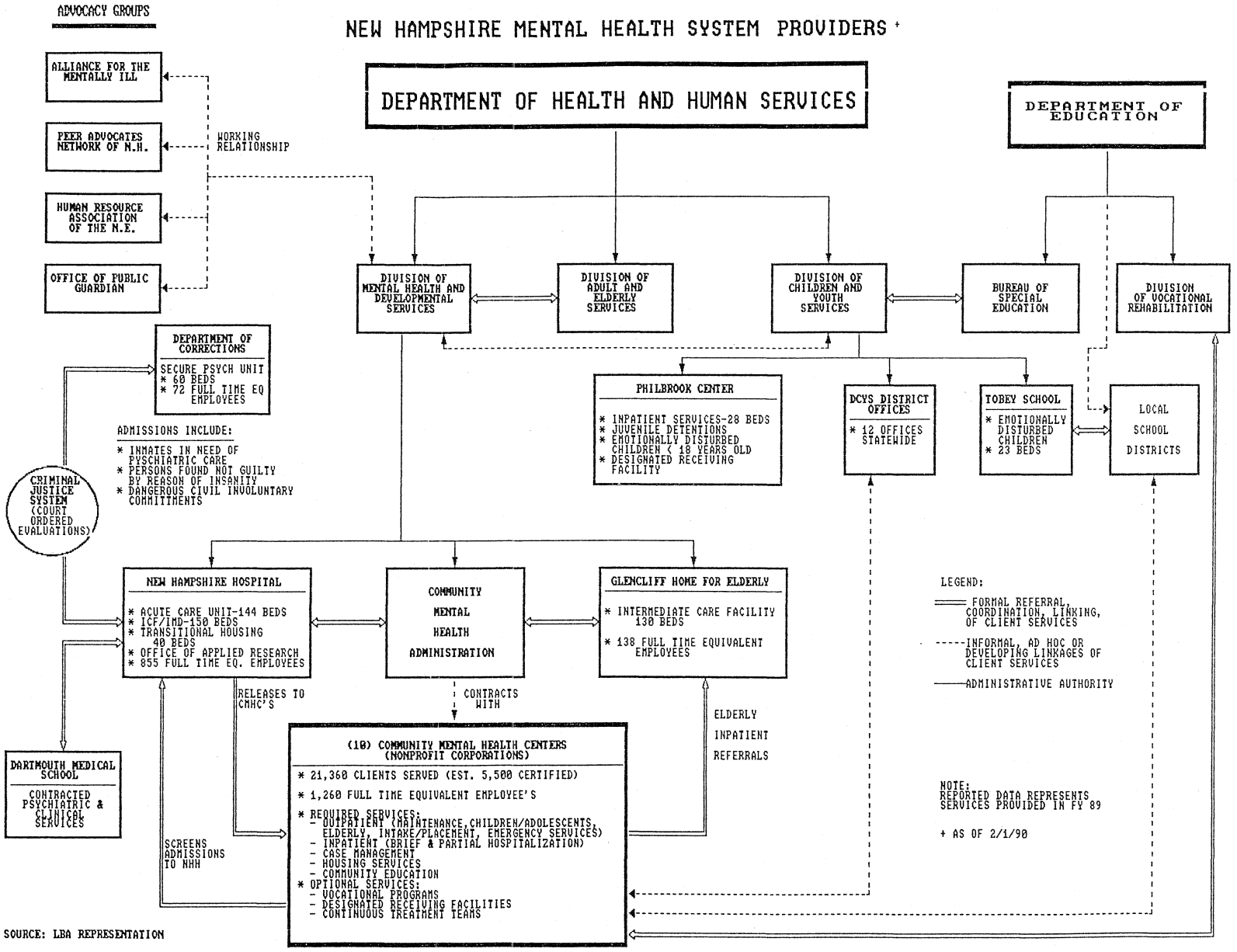
17. The division does not regularly collect data on the number of clients on mental health center waiting lists and thus cannot fully document trends in the number of clients needing services that are unavailable. However, the division does collect comprehensive data on services needed by New Hampshire Hospital clients in order to return to their communities. The division also does not maintain a "needed services database," as required by its rules. (p. 82)

18. The division has not conducted annual certification reviews of all mental health centers during the last two fiscal years. Certification reviews test the eligibility of clients served in state-contracted programs. In 1989, the four certification reviews conducted covered clients certified as chronically mentally ill only and excluded those certified as seriously mentally ill. (p. 83)

OTHER ISSUES

Other issues of importance are discussed beginning on page eighty-five. These issues include comments on involuntary emergency admissions criteria, incompetency rulings, outpatient commitments, client issues and miscellaneous results of our community mental health center surveys not discussed elsewhere in the report.

NEW HAMPSHIRE MENTAL HEALTH SYSTEM PROVIDERS +



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STATE OF NEW HAMPSHIRE
MENTAL HEALTH SERVICES SYSTEM

SCOPE AND OBJECTIVES

We performed our audit of New Hampshire's mental health services system in accordance with recommendations made to the Fiscal Committee by the Joint Legislative Performance Audit and Oversight Committee. Directed to study "deinstitutionalization," we sought first to define this term. We determined that deinstitutionalization, perhaps generally understood to refer to the depopulation of state mental hospitals since the 1960s, was a much broader concept that included the development of a full range of mental health services provided in the community. Thus the report's title, "Mental Health Services," and its content reflect a broad view of deinstitutionalization in New Hampshire, with an emphasis on the state's current service provision in a "deinstitutionalized" environment.

Our audit evaluates the efficiency and effectiveness of state-provided services for persons with serious and chronic mental illness within the state's policies of offering such services in the least restrictive environment appropriate for each individual and within each person's own community. Our audit did not evaluate the policies themselves, which are based on certain philosophies of treating persons with mental illness. Instead, we looked at how services had been developed and changed to implement those policies. Because most persons receiving mental health services today receive them in the community, we focused our efforts on the efficiency and effectiveness of community-based services. Our audit addressed the following objectives:

1. Determine the basis for the concept of deinstitutionalization and how it was implemented as policy, both nationally and in New Hampshire.

2. Identify key goals and objectives in shifting the treatment for persons with serious mental illness from long-term, centralized, institutionally-based services to less restrictive, decentralized, community-based services, and determine the extent to which such goals and objectives have been achieved.

3. Determine and compare current and historical trends in the funding, costs, staffing, services, and client base of New Hampshire Hospital and the community mental health centers.

4. Determine the type and range of mental health services provided through the state and the extent to which they are:

    a. adequate and accessible for persons needing services,

SCOPE AND OBJECTIVES (CONTINUED)

b. effective in providing appropriate placement and treatment that helps persons cope with their illness and reduces their dependence on services over time,

c. coordinated among different levels and providers, and

d. controlled by the Division of Mental Health and Developmental Services to ensure their cost efficiency.

5. Determine the extent to which persons with mental illness are represented in the homeless population.

METHODOLOGY

To develop background information on deinstitutionalization policies, we reviewed a variety of national and state reports and professional journal articles. To identify New Hampshire's goals and objectives in implementing those policies, we reviewed various plans and documents from the Division of Mental Health and Developmental Services. We paid particular attention to the state's plan for restructuring mental health services, which was developed beginning in 1983. We also interviewed legislators, division staff, New Hampshire Hospital and community mental health center staff, and representatives of other mental health service and advocacy groups. Data on the hospital's and mental health centers' staffing, clients, costs, and funding were compiled from division statistics, state financial records, and independent audit reports of the community mental health centers.

In assessing the adequacy, accessibility, effectiveness, control, and coordination of services, as well as in determining the extent to which planned service goals and objectives were met, we reviewed and analyzed a wide variety of division reports, files, and documents, and information from other states, federal agencies, and private organizations. We interviewed staff of the division, New Hampshire Hospital, designated receiving facilities, community mental health centers, and other state agencies, as well as staff of selected police departments, homeless shelters, and advocacy agencies. We used a written questionnaire to obtain additional information from the mental health centers.

To determine the extent of mental illness among the homeless, we reviewed research reports from a variety of cities and states, including New Hampshire.

Throughout the audit, we reviewed applicable state and federal laws, regulations, and policies. Most of the reported data has not been independently verified. This audit was conducted in accordance with generally accepted governmental auditing standards.

STATE OF NEW HAMPSHIRE
MENTAL HEALTH SERVICES SYSTEM

INTRODUCTION

STATE AND FEDERAL HISTORY OF MENTAL HEALTH CARE

BACKGROUND

States first became involved in the care of mentally ill persons in the 19th century when state mental hospitals were constructed. The New Hampshire Asylum for the Insane, the forerunner of today's New Hampshire Hospital, was established in Concord in 1842. This marked a shift in responsibility for those with mental illness from families and local communities to the state. In 1903, the New Hampshire legislature assigned responsibility for the care, control, and treatment of all indigent mentally ill persons to the state.

The federal government first became involved in mental health care after World War II, in response to the large numbers of people rejected or discharged from active duty because of mental problems. In 1946, Congress passed the National Mental Health Act, creating the National Institute of Mental Health (NIMH) to help states and communities develop and provide mental health services, to support research on mental illness, and to help train mental health professionals.

MOVEMENT TOWARD DEINSTITUTIONALIZATION

In 1955, the federal Mental Health Study Act was passed, creating the Joint Commission on Mental Illness and Health. The recommendations made by the joint commission in its 1961 report, Action for Mental Health, were the start of the movement toward deinstitutionalization and community care. The act was passed at the same time that the numbers of inpatients in state mental hospitals, both nationally and in New Hampshire, were at all time highs: half a million patients nationally and 2,700 in the state.

From a wide variety of interviews and a review of mental health literature, it appears that deinstitutionalization means very different things to different people. The public policies commonly labeled "deinstitutionalization" were based on the treatment philosophy that persons with mental illness could receive more effective and humanitarian treatment in smaller,less restrictive, community settings that were closer to home than in large, restrictive, centralized state hospitals. Growing concern for the individual liberties and humane care of persons with mental illness as well as greater knowledge about mental illness and its treatment contributed to this philosophy.

The push to apply this treatment philosophy in the provision of public mental health services came from several directions. New antipsychotic, psychoactive drugs under development in the 1950s became widely available, allowing greater control of symptoms. Strong advocacy for civil rights in many areas during the 1960s spilled over into mental health care as well, raising such issues as hospital patients' consent to their treatment and rights of non-dangerous people to retain their liberty. States began to tighten their commitment laws, making commitments to state hospitals more difficult, and the idea that persons seeking treatment for mental illness should be placed in the least restrictive environment possible gained popularity. States' desires to reduce the fiscal burden of increasing mental health care costs also added impetus to the movement to "deinstitutionalize."

Two federal actions in 1963 added momentum to the movement. First, Congress passed the Community Mental Health Centers Construction Act, amended in 1965, to provide grants for the initial costs of staffing the new mental health centers. Second, federal aid to those with mental illness became available under provisions of the Aid to Disabled (ATD) program, now known as Supplemental Security Income (SSI). This change allowed many of those with mental illness to live outside of state institutions without significant cost to the state. As federal Medicaid and Medicare programs and Social Security Disability Income (SSDI) were developed as funding sources for the care and support of those with serious mental illness, states had stronger incentives to discharge patients from state mental hospitals, where the state paid most of the cost, into the community, where patients became eligible for federal aid.

DEINSTITUTIONALIZATION - DEFINED

Deinstitutionalization has been defined many ways. A few selected definitions from the mental health literature follow.

Deinstitutionalization refers to the movement of individuals who cannot function independently and need continuing mental health care from large, long-term, public institutions, to smaller, more flexible, and less restrictive settings in the community.[1]

Deinstitutionalization is a 25-year transition from a mental health system that relies on long-term hospitalization of patients in large state institutions to one that emphasizes cost-efficient care in the community.[2]

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[1] Plum, Kathleen C., "Moving Forward with Deinstitutionalization: Lessons of an Ethical Policy Analysis," American Journal of Orthopsychiatry, October 1987, p. 508.

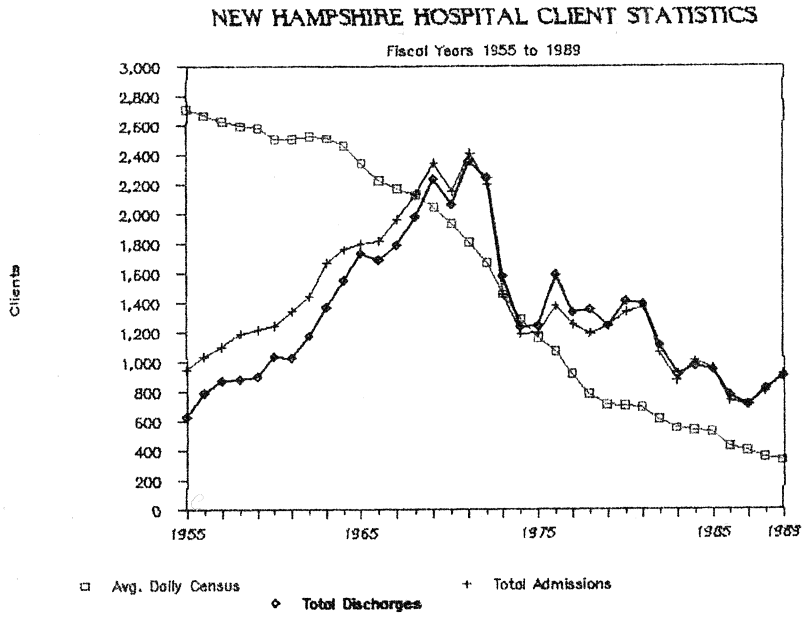
[2] Adapted from Craig, Rebecca T. and Wright, Barbara, Mental Health Financing and Programming: A Legislator's Guide, National Conference of State Legislatures, May 1988, p. ix.

Deinstitutionalization is a process involving the [avoidance] of traditional, institutional settings, particularly state hospitals, for persons with chronic mental disabilities, and the concurrent development and expansion of community-based facilities for the care of this population.[3]

EFFECTS OF DEINSTITUTIONALIZATION

During the main thrust of deinstitutionalization, roughly during the 1960s and 1970s, three basic changes took place affecting state mental hospitals' client populations: (1) clients were discharged from hospitals who might not have been otherwise, (2) people who were admitted to hospitals did not stay as long, and (3) many people who traditionally would have been admitted to hospitals received care in the community and were never admitted.

Large numbers of hospital discharges are probably the most commonly perceived effect of deinstitutionalization. In the 20 years from 1955 to 1975, the number of mental hospital patients declined 57 percent in New Hampshire and 65 percent nationally.[4] Shorter hospital stays are evident from statistics that show the average client census declining while the number of admissions continued to increase. (See the graph below.) The median length of stay for New Hampshire Hospital clients was about 25 days in 1979 but had dropped to seven days by 1989.



Source: DMHDS.

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[3] Bachrach, Leona L., and Lamb, H. Richard, "Conceptual Issues in the Evaluation of the Deinstitutionalization Movement," Chapter 6 from Innovative Approaches to Mental Health Evaluation, eds., Stahler, Gerald J. and Tash, William R., 1982, p. 141.

[4] DMHDS data and Craig, p.8.

The diversion of people with mental illness from admission to mental hospitals is probably the most significant change in client populations that is still occurring today. Although an estimated 5,500 chronic and severe mentally ill persons were served by the community mental health centers in fiscal year 1989, only about 330 new patients were admitted to New Hampshire Hospital for acute psychiatric services, just under six percent of those served in the community. Before deinstitutionalization, it is likely that many certified chronically mentally ill and at least some severely mentally ill persons would have been admitted to psychiatric hospitals rather than served in the community.

The policy of deinstitutionalization has faced much criticism within the past decade. One of the more common criticisms has been that only half of the philosophy behind deinstitutionalization was ever implemented as policy. The theory that persons with mental illness receive more effective treatment in the community than in state hospitals was often put into practice by focusing primarily on the reduction of hospital populations, and paying less attention to the development and funding of community services for the seriously mentally ill population. In New Hampshire, state support of community mental health centers lagged significantly behind support of New Hampshire Hospital until the mid-1980s, when the state began shifting more resources from the hospital to community services.

DEINSTITUTIONALIZATION AND THE DEVELOPMENT OF COMMUNITY MENTAL HEALTH CENTERS

The 1963 federal legislation first authorizing community mental health centers was originally intended to direct community services to those with the most serious mental health problems. However, the federal regulations implementing the law did not ensure that mental health centers would provide services to the seriously mentally ill. In New Hampshire, the legislature authorized state funds to assist cities, towns, counties, or non-profit corporations in establishing mental health programs in 1965. State dollars were a match for the federal dollars going to community mental health centers. According to division staff, the federal government exercised most of the control in evaluating and funding center services.

States found political, service delivery, and other barriers to closing their mental hospitals and continued to fund them, diverting resources away from community-based services. A cycle developed in which inadequate funding for community services meant the continued need for more hospital care and funding which often meant less funding for the community services. The federal government tried to improve the availability of community services through new initiatives such as the 1977 Community Support Program (CSP), designed to address the needs of people with long-term or chronic mental illness. By 1980, only about half of the expected 1500 community mental health centers had been established nationally.

STATE AND FEDERAL HISTORY OF MENTAL HEALTH CARE (CONTINUED)

In 1981, New Hampshire passed Chapter Law 492 stating that the community mental health centers' priority emphasis was to be on the "severely mentally disabled," who were former patients of New Hampshire Hospital or persons at risk of being institutionalized. The division established certification criteria in 1983 to assure state-funded community services were going to those that were the most seriously ill.

A major shift in funding for the community mental health centers occurred in 1981 when a new federal block grant for all mental health, alcohol, and drug abuse programs was created, consolidating various federal categorical grants into a single block grant that went directly to the states. This change gave the states much greater discretion to control how federal mental health funds were spent.

RESTRUCTURING THE MENTAL HEALTH SYSTEM IN NEW HAMPSHIRE

About 1982, the division began pushing community mental health centers to give higher priority to serving the seriously mentally ill. In its plans for fiscal years 1983 to 1985, the division outlined expanded services and development of a full array of each region's community services to the seriously mentally ill.

NARDI AND WHEELOCK REPORTS

At the end of 1982, legislative and executive branch study reports on the state's mental health services were released, known as the Nardi and Wheelock reports. The reports' recommendations for improving mental health services centered on funding and developing community programs to serve a large majority of clients and on reducing reliance on institutional care. A new, smaller central facility was proposed to replace the existing adult psychiatric units at New Hampshire Hospital. The new facility would serve primarily as a back-up for the services offered through the mental health centers, but would also treat a small, special needs group that could not be served in the community.

In response to the recommendations in the Nardi and Wheelock reports, the New Hampshire legislature passed Chapter 407, an Act Restructuring the Mental Health System, in 1983. In this statute, the legislature mandated that the state's policy would be to serve the mentally ill in the least restrictive environment that was appropriate for the individual. It also established a committee, known as the "407 Committee," to plan for stronger community-based programs, a new central psychiatric facility, treatment models for children and the elderly, and redeployment of New Hampshire Hospital staff as the emphasis of state mental health services shifted to the communities.

RESTRUCTURING THE MENTAL HEALTH SYSTEM IN NEW HAMPSHIRE (CONTINUED)

PLANNING FOR PROGRESS - "407 COMMITTEE"

In March 1985, the "407 Committee" released its final report, Planning for Progress, on the plan for restructuring New Hampshire's mental health system. The plan was to decrease reliance on institutional services and increase reliance on community-based services, as well as expand community services from traditional outpatient psychotherapy to include supports such as case management, housing, vocational, and resocialization services. The plan was based on a five-level system of services as follows:

Level 1 Community Mental Health Services
For those with severe mental illness or need for long-term services; services include crisis response, case management, community support services, outpatient and vocational services provided by community mental health centers under contract to the division.

Level 2 Housing Services
For those meeting level 1 criteria plus a need for supported living; services are same as level 1 plus a range of housing supports and supervision; provided by mental health centers or other housing providers under contract to the division.

Level 3 Brief Hospitalization Services
For those meeting levels 1 or 2 criteria plus acute and moderate symptoms and medical complications or uncertain diagnosis, with willingness to enter hospital; services include psychiatric and medical diagnosis and evaluation, with 24-hour nursing supervision; provided by mental health centers in conjunction with local general hospitals under agreements with the mental health centers.

Level 4 Designated Receiving Facility Services
For those meeting levels 1 or 2 criteria plus acute and severe symptoms, or severe agitation or confusion, plus medical complications or uncertain diagnosis, with or without willingness to enter hospital; services are same as level 3 plus secure management and special legal rights protection; provided by mental health centers and regional general hospitals with legal designation to receive involuntary admissions under agreement with the division.

Level 5 Acute Psychiatric Services
For those meeting level 4 criteria plus highly complicated diagnosis, or symptoms repeatedly unresponsive to treatment at other levels; services are same as level 4 plus specialized diagnostic units and program units organized for specific target populations; provided by the division through New Hampshire Hospital with contracts for medical and some support services.

Services at levels 1, 2, and 3 were to be offered in each region, level 4 services would be offered in about half the regions, and New Hampshire Hospital would offer level 5 services to the entire state.

In addition to expanded community services, the restructuring plan included development of designated receiving facilities (DRFs) to which involuntary, short-term commitments could be made, more coordinated services for children and elderly, and a new, central psychiatric facility to treat the most difficult cases, evaluate clients with developmental disabilities, and provide research and training for the whole mental health system. Plans related to the new central facility included reaccreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), reduction of the adult psychiatric population, and the transfer of forensic mental health services to the state prison.

Restructuring for the community mental health centers involved a major shift from early intervention services and short-term counseling therapies to more comprehensive services for clients with serious mental illnesses. The division used three approaches to help shift the emphasis of the mental health centers:

- revised clinical standards that specified who were to be served and how they were to be served,

- adopted new financial reporting standards with uniform line items and cost centers which the centers were required to use,

- initiated performance contracts that set program standards, recordkeeping and audit procedures, and other requirements for the centers to implement.

In 1986, New Hampshire's mental health laws were consolidated in RSA 135-C, re-emphasizing that the state's first priority was to ensure services to the most seriously mentally ill and that those services, to the extent possible and as appropriate to each person's needs, be provided within each person's own community, be the least restrictive of a person's freedom of movement and ability to function normally, and promote each person's independence.

THE CURRENT SERVICE SYSTEM

Today, restructuring of the state's mental health system appears to be largely completed. Clients in New Hampshire Hospital's old adult psychiatric units were transferred to the new acute care facility in October 1989. All ten community mental health centers provide services to the chronically and severely mentally ill which include housing and vocational services, case management, and partial hospitalization.

(See chart on the following pages.)

DIVISION-CONTRACTED SERVICES OFFERED BY COMMUNITY MENTAL HEALTH CENTERS

	NORTHERN NHCMHC	WEST CENTRAL SERVICES	LAKES REGION CMHC	CENTRAL NHCMHC	MONADNOCK FAMILY SERVICES	COMMUNITY COUNCIL OF NASHUA	GREATER MANCHESTER MHC	SEACOAST MHC	STRAFFORD GUIDANCE CENTER	CENTER FOR LIFE MANAGEMENT
REGION:	1	2	3	4	5	6	7	8	9	10
CLIENT SERVICES										
INTAKE SCREENING AND PLACEMENT Services which provide medical and psychiatric screening and diagnostic services and develop a plan for service system intervention upon an eligible client's application for admission to the service system.	X	X	X	X	X	X	X	X	X	X
MOBILE CRISIS RESPONSE Service which is available 24 hours a day, 7 days a week, to provide rapid expert response to persons experiencing psychiatric emergencies. The service has the capacity to be provided at community locations outside of the agency or hospital emergency rooms.	X	X	X	X	X	X	X	X	X	X
MAINTENANCE Service to maintain the client in the community and reduce the likelihood of a hospital admission, including medication monitoring, administration, education, and counselling.	X	X	X	X	X	X	X	X	X	X
INPATIENT Brief inpatient psychiatric services provided in medical-surgical or in specialized units of general hospitals, offering brief psychiatric treatment close to home.	X	X	X	X	X	X	X	X	X	X
DESIGNATED RECEIVING FACILITY * Facility approved to accept persons who are referred for involuntary emergency admission.	X						X	X		
CASE MANAGEMENT Services consisting of monitoring, brokerage, advocacy, supportive counselling, and outreach in order to assure that the individual receives the services required for successful community adjustment and is provided with continuity of care.	X	X	X	X	X	X	X	X	X	X
INTENSIVE/RESTORATIVE PARTIAL HOSPITALIZATION Structured, active treatment to stabilize and return clients to pre-crisis level functioning or to alleviate the effects of mental disorders through clinical activities.	X	X	X	X	X	X	X	X	X	X

DIVISION-CONTRACTED SERVICES OFFERED BY COMMUNITY MENTAL HEALTH CENTERS (Continued)

	NORTHERN NH CMHC	WEST CENTRAL SERVICES	LAKES REGION CMHC	CENTRAL NH CMHC	MONADNOCK FAMILY SERVICES	COMMUNITY COUNCIL OF NASHUA	GREATER MANCHESTER MHC	SEACOAST MHC	STRAFFORD GUIDANCE CENTER	CENTER FOR LIFE MANAGEMENT
REGION:	1	2	3	4	5	6 **	7	8	9	10
CLIENT SERVICES (Continued)										
CHILDREN AND ADOLESCENT SERVICES Specialized outpatient and in-home services provided by a designated program with specialized expertise in children's mental health services, providing individual, group, and family interventions, and liaison with courts, child welfare agencies, and schools.	X	X	X	X	X	X	X	X	X	X
ELDERLY SERVICES Specialized services for elderly including individual treatment and consultation with nursing homes and senior centers.	X	X	X	X	X	X	X	X	X	X
EMPLOYMENT SERVICES* Services designed to assist clients achieve supported or competitive employment, with emphasis on integrated services, where clients work alongside non-handicapped workers.	X	X	X	X	X	X	X	X	X	X
HOUSING	X	X	X	X	X	X	X	X	X	X
Crisis										
Group Homes	X	X	X	X	X	X	X	X	X	X
Supportive/Supervised	X	X	X	X	X	X	X	X	X	X
CLIENT IDENTIFICATION AND OUTREACH * Services consisting of assertive out-of-office mental health services to persons who have rejected traditional services, including outreach to homeless shelters and soup kitchens, and continuous treatment team services.	X	X	X	X	X	X	X	X	X	X
PEER SUPPORT/CLUBHOUSE Services provided by and for consumers of services, including peer self-help and advocacy, respite care, hot-lines, friendly visiting, food banks, emergency loan accounts, and other similar non-clinical services.	X	X	X	X	X	X	X	X	X	X
COMMUNITY EDUCATION Services designed to educate the general public, landlords, employers, and others regarding serious mental illness, in order to promote community understanding, acceptance, and support for persons with serious mental illness.		X		X	X	X				

* Optional services
** Region 6 housing services provided by an independent provider.
Source: LBA compilation of DMHDS data.

The division's Mental Health Services Plan 1989-1992, prepared in response to the federal Mental Health Planning Act of 1986, builds upon the five-level system of services and focuses on refinements such as improved client outreach, client access, continuity of care, greater family and peer support, integration of services into the community, increased affordable housing, and other services.

The 1988 report Care of the Seriously Mentally Ill was the second rating of state programs for the mentally ill by the National Alliance for Mentally Ill and the Public Citizen Health Research Group. The first rating, done in 1986, rated New Hampshire seventh among the states. The most recent rating placed New Hampshire third. The first rating was based on states' hospital care and outpatient services; the 1988 rating added rehabilitative services and housing. New England states overall did well in the rating, with four of the top five states being in New England. (Rhode Island was rated at the top.) The report ranked New Hampshire as "improving significantly." (Also see page 56)

The division's contract with Dartmouth College Medical School for faculty to provide psychiatric services at New Hampshire Hospital was a significant factor in the high rating. However, the report emphasized that nowhere are services for the seriously mentally ill excellent. High ranked states like New Hampshire are merely doing better than other states, rather than having achieved excellence by any objective measure.

We conducted a survey of all ten community mental health centers in October 1989. In response to a question concerning the structure of the state's mental health system, seven of the ten centers rated the existing system as "somewhat effective;" the other three rated it "very effective."

THE DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL SERVICES

Section 135-C:1 of the New Hampshire Revised Statutes Annotated (RSA) assigns responsibility for the provision and administration of mental health services to the Division of Mental Health and Developmental Services. The purpose of the law is to enable the division:

- to establish, maintain, and coordinate a comprehensive, effective, and efficient system of services for persons with mental illness,
- to reduce the occurrence, severity, and duration of mental, emotional, and behavioral disabilities, and
- to prevent mentally ill persons from harming themselves or others.

RSA 135-C:1 also states that it is New Hampshire's policy to provide persons who are severely mentally disabled with care that is (1) adequate and humane, (2) offered within each person's own community and is the least restrictive of each person's movement and ability to function normally in society, to the extent possible while meeting the person's treatment needs, and (3) directed toward eliminating the need for services and promoting the person's independence.

RESPONSIBILITIES

The division's powers and responsibilities are broad and include the authority to operate, administer and/or contract for any program or facility that provides services to mentally ill persons. The law directs the division to give first priority in providing services to persons who are "severely mentally disabled." The division may also provide mental health services on an optional basis to those who are not seriously mentally ill, but the law states that in providing optional services, the division is to give special emphasis to children and the elderly. The law also allows the division to provide such general services as information, consultation, education, and prevention to all citizens.

MISSION AND SERVICE SYSTEM PRINCIPLES

The division's mission statement and overall policies reflect the legislative directive to promote each person's independence and individual freedom and have focused the delivery of mental health services on the following principles, which among others guide the development and administration of New Hampshire's mental health system.

- o SERVICES ARE CLIENT-CENTERED- New Hampshire's mental health system is responsive to needs, preferences and desires of clients, and includes them in service planning and evaluation.

- o SERVICES FOCUS ON CLIENT STRENGTHS, NORMALIZED SUPPORTS, AND INTEGRATED COMMUNITY ENVIRONMENTS- Services provide supports which enable clients to function in living, learning, and working environments of choice, attend to primary needs of housing and employment, and educate the community to accept and involve persons with mental illness in community life.

- o SERVICES PROMOTE CLIENT INDEPENDENCE AND SELF-DIRECTION- The system encourages consumer decision making,promotes peer support, and assists development of consumer leadership.

- o SERVICES ENCOURAGE FAMILY STRENGTH AND UNITY- The system provides supports to families of persons with serious mental illness, including education, outreach, leadership development, and involvement in planning.

These principles are based, in part, on the following statutes which promote the concept of individual rights and client-driven service plans.

INDIVIDUAL SERVICE PLANS

RSA 135-C:19 requires that each client in the mental health services system have an individual service plan, developed by the service provider with the participation of the client when possible. With the exception of authorized involuntary admissions for those cases where a client's mental condition poses a likelihood of danger to himself or others, all other admissions and placements of persons seeking state mental health services are to be voluntary. RSA 135-C states that mental illness, in and of itself, is insufficient grounds to involuntarily admit someone to the mental health system.

CIVIL RIGHTS

RSA 135-C:57 guarantees the client's right to be informed of and give consent to any treatment, to refuse all forms of medication, treatment, and services except in emergency cases as defined by law, and to be free from seclusion or physical or pharmacological restraint unless the client gives informed consent or in cases of emergency treatment. The law further outlines the rights of those receiving mental health services, stating that those persons shall be treated with dignity and respect, shall not be subjected to abuse or neglect, and shall not be

deemed incompetent or deprived of any civil right solely because of their admission to the mental health services system. All persons receiving mental health services are required to be informed of their rights.

The director of the division is authorized to nominate a guardian, in accordance with legal requirements, for clients in the mental health system when such clients are substantially deprived of their capacity to manage their own affairs and are at risk of substantial harm to person or estate because of mental illness.

MENTAL ILLNESS

PERSONS IN NEED OF MENTAL HEALTH SERVICES

Within the field of mental health, there are two basic groups of people generally identified as needing mental health services. One group comprises people with problems of living, personal growth, coping with crises, or change, as well as those with certain maladaptive behaviors. The services needed by this group include treatment, often in the form of counseling or psychotherapy, and preventive services, to help them avoid more serious problems like child or spouse abuse. The division currently does not provide funding for these services, although it does fund emergency, screening, and other services which are used by this group.

SERIOUSLY MENTALLY ILL

The second group of people needing mental health services are those with demonstrable or potential major psychiatric disorders. This group is variously referred to as seriously or chronically mentally ill. State law uses the term "severely mentally disabled," defined as having a mental illness that is either so acute or so long-term as to cause a substantial impairment of a person's ability to care for him/herself or to function normally in society. The National Institute of Mental Health, a division of the U.S. Department of Health and Human Services, defines the chronically mentally ill population to include

> persons who suffer from emotional disorders that interfere with their functional capacities in relation to such primary aspects of daily life as self-care, interpersonal relationships, and work or schooling, and that may often necessitate prolonged mental health care.

The kinds of services needed by this group include early intervention to diminish potential illnesses, emergency services for active illnesses, and long-term support services to maintain community living. This is the group for which the division currently funds services. The division targets this population through a certification process, with certification criteria based on psychiatric symptoms, history, diagnosis, ability to function in normal family, work, school, social, and community roles, and need for services. Persons may be certified as either severely mentally ill or in need of long-term services (chronically mentally ill), and certification is reviewed every 6 to 12 months by community mental health center staff.

SERIOUS MENTAL ILLNESS

Serious mental illness has significant costs to society including lost productivity and increased use of social services. A division publication reported studies by a branch of the U.S. Department of Health and Human Services estimating the total economic cost to American society of mental illness as $54.8 billion in 1980. The cost to New Hampshire was computed at $220 million in 1980.[5]

Research during the past decade has provided more evidence that at least some serious mental illnesses are brain diseases, although the precise causes are not known. Both hereditary and environmental factors can play a role in the development of mental illness.

The two most common forms of serious mental illness for adults are schizophrenia and the affective disorders of clinical depression and manic-depressive disease (or bipolar disorder). Affective disorders consist of recurrent periods of severe depression and elation or just depression. Schizophrenia may be the most devastating of the mental illnesses. Hallucinations and delusional or illogical thinking are common symptoms.

The onset of these diseases usually occurs when people are in their late teens or twenties for schizophrenia and twenties and thirties for affective disorders. Although many individuals with mental illness can return to normal functioning within a short time as a result of appropriate medical and psychiatric management, the illnesses can become severe and cause major impairments in an individual's functioning for an extended period of time. Persons with serious mental illness often experience periods of health interspersed with acute episodes of illness. As these persons get older, they often learn to cope with their illness better, and treatment can help to

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[5] New Hampshire Division of Mental Health and Developmental Services Newsletter, July 1982, p. 4.

lengthen the time between episodes and reduce the severity of the episodes. Serious mental illnesses are frequently compared to diabetes; there is currently no cure or way to prevent them, but they can be treated.

PREVALENCE OF MENTAL ILLNESS--POPULATION ESTIMATES

National estimates of adults who are chronically or seriously mentally ill range from 1.7 to 2.4 million, including 70,000 children who suffer from mental illnesses such as autism and childhood schizophrenia.[6] The division estimates that roughly 7,000 to 11,000 adults in New Hampshire will develop serious, chronic mental illness sometime during their lives, based generally on schizophrenia prevalence rates. An estimate of 0.8 percent of the population as severely disabled with mental illness, used in the 1988 report Care of the Seriously Mentally Ill and based on studies for the 1980 National Plan for the Chronically Mentally Ill, would place New Hampshire's seriously mentally ill population at about 8,900.

CLIENT PROFILES

According to our October 1989 survey of New Hampshire's mental health centers, clients in state-contracted programs were more likely to be female (57%), 18 to 34 years old, and have a diagnosis of adjustment disorder, a maladaptive reaction to stress that may imply an underlying major mental disorder. According to division staff, clinicians often use an adjustment disorder diagnosis to avoid "labeling" clients with more serious diagnoses prematurely. Because some contracted programs, like emergency services and intake and placement, are open to all clients regardless of their certification status, diagnostic breakdowns of all clients in contracted programs show smaller percentages of clients with schizophrenia and affective disorders than breakdowns of certified clients only would probably show. The table on the following page compares caseload data from New Hampshire's mental health centers (as reported in survey responses) and data from a 1987 survey by the National Council of Community Mental Health Centers of 335 centers across the country.

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[6] Manderscheid, Ronald W. and Barrett, Sally A., eds., Mental Health, United States, 1987, U.S. Department of Health and Human Services, 1987.

MENTAL ILLNESS (CONTINUED)

	NEW HAMPSHIRE[7]	NATIONAL COUNCIL
Average CMHC Caseload	2,015	2,808
Clients Served:		
Adults	64%	69%
Children	23%	23%
Elderly	13%	8%
Diagnoses:[8]		
Adjustment disorder	32%	DNR
Affective disorder	21%	20%
Schizophrenic disorder	10%	22%
Anxiety disorder	7%	13%
Substance abuse disorder	7%	13%
Personality disorder	5%	DNR
Psychosis not classified	3%	6%
All other disorders	15%	26%
Total	100%	100%

Sources: LBA 1989 and National Council of Community Mental Health Center 1987 survey results.

National figures suggest that about 25 percent of those with serious or chronic mental illness reside in institutions such as state or local mental hospitals, nursing homes, and jails or prisons. Our estimate of New Hampshire's seriously or chronically mentally ill in institutions is about 420, based on the number of clients who have been at New Hampshire Hospital's acute psychiatric unit for more than one year, who are residing at Glencliff Home for the Elderly and the hospital's intermediate care facility, or who are at the state prison's secure psychiatric unit. Assuming a seriously mentally ill statewide population of roughly 8,900, institutionalized clients are about 4.7 percent of the total. Our figures do not include individuals who are receiving services in private mental hospitals or in nursing homes in the state.

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[7] New Hampshire data reported for division-contracted programs only.

[8] New Hampshire diagnoses based on data from only eight of the ten mental health centers. "DNR" indicates the National Council survey did not report rates for the diagnosis.

Division staff estimate that roughly 60 percent of the state's seriously mentally ill live with their families. Most of the rest live in group homes, in supported housing, or on their own. Division statistics indicate that 1,290 persons, or 23 percent of the severely and chronically ill served by mental health centers in fiscal year 1989, were receiving state-supported housing services. (Refer to page seventy-eight for further information related to housing services.)

PROVIDERS OF MENTAL HEALTH SERVICES

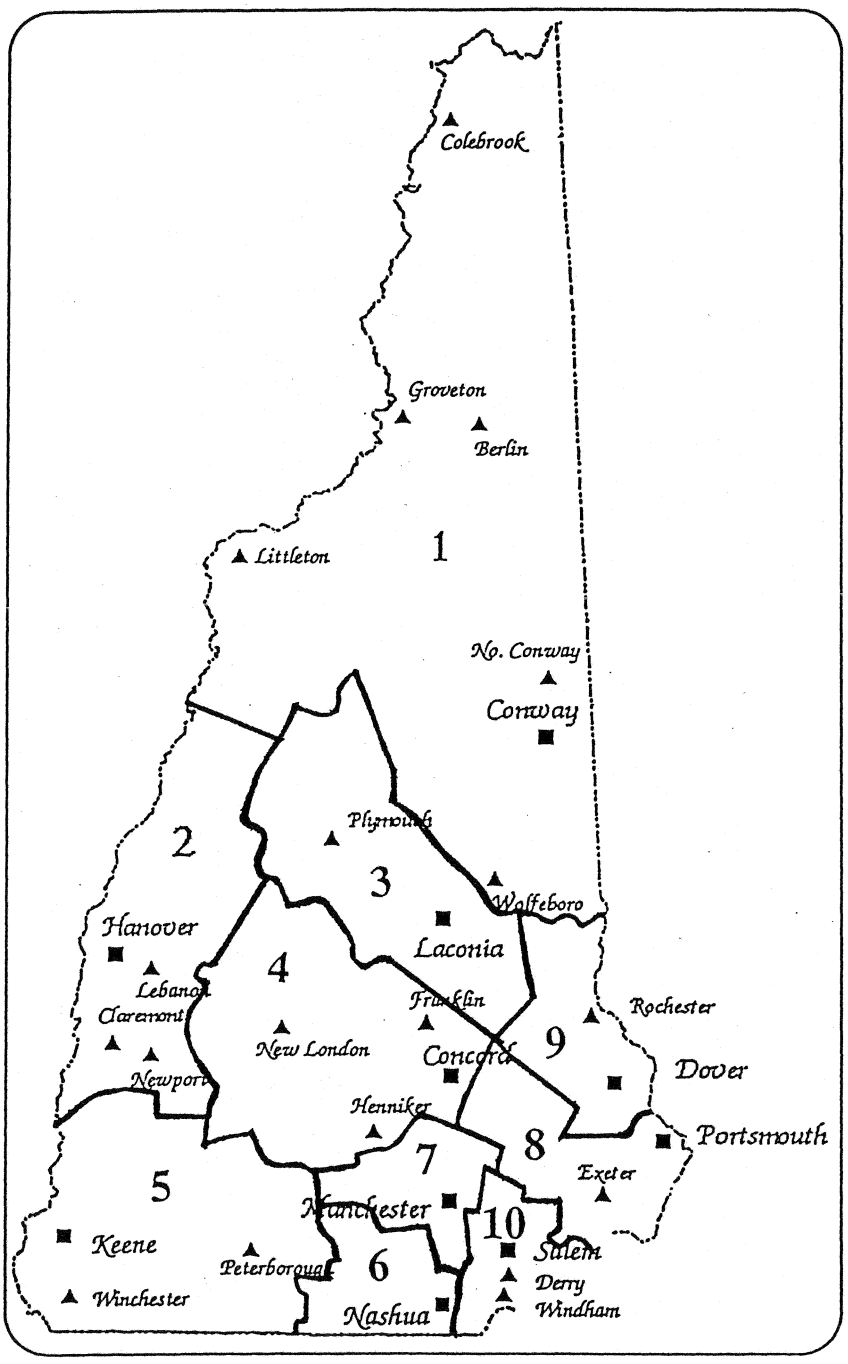
State-funded mental health services in New Hampshire are provided primarily by two state institutions, New Hampshire Hospital and Glencliff Home for the Elderly, and by ten community mental health centers under contract to the division. Services are also provided by the Secure Psychiatric Unit at the state prison (formerly known as the forensic unit). Mental health services for children and adolescents are provided by both the community mental health centers and by other providers, like the Philbrook Center, administered by the Division of Children and Youth Services. The flowchart on page eleven shows how these components relate to each other in the mental health system.

COMMUNITY MENTAL HEALTH CENTERS

Community Mental Health Centers are private, non-profit organizations designated as "community mental health centers" by the Division of Mental Health and Developmental Services according to state statutes and regulations. They comprise the core of the state's community-based service system. Their designation as mental health centers gives them certain advantages in providing mental health services including the ability to collect certain insurance reimbursements. All the centers rated their designation by the division as "very important" to their successful operation. The centers generally administer directly or indirectly all state-supported community mental health services in their region. There are ten regions (or catchment areas) established throughout the state. (See map on the following page.) Each center may have several satellite offices located throughout its region.

The services provided by mental health centers consist of services contracted by the division, as well as non-contracted services. Non-contracted services receive no funding from the Division of Mental Health and Developmental Services, although they may receive funds from other state agencies. They are provided at the mental health centers' option and may include individual and group counseling for children, adults, and families to cope with a wide variety of problems, stress management, parenting skills and child abuse prevention, and various other services.

New Hampshire's State Supported Mental Health Regions



■ = Central office ▲ = Branch office

Region One
Northern N.H. Mental Health and Developmental Services

Region Two
West Central Services, Inc.

Region Three
Lakes Region Mental Health Center

Region Four
Central N.H. Community Mental Health Services, Inc.

Region Five
Monadnock Family & Mental Health Services

Region Six
Community Council of Nashua

Region Seven
Greater Manchester Mental Health Center

Region Eight
Seacoast Regional Mental Health Center

Region Nine
Strafford Guidance Center, Inc.

Region Ten
Center for Life Management

Source: DMHDS.

Mental health centers reported serving about 20,150 clients in their contracted programs during fiscal year 1989. Division-compiled data indicate centers served about 21,360, or an average of 2,136 clients per center. Nine out of ten centers reported clients served in non-contracted programs totaling 10,924, or an average of about 1,214 per center, in the same year.

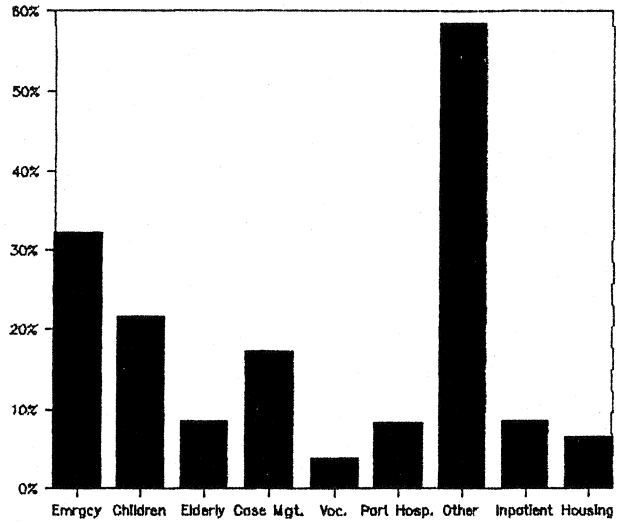
In their contracted programs, the centers serve clients who are certified as chronically or severely mentally ill, those who were formerly certified as severely mentally disabled, and many more who are not certified, but who require contracted services. In fiscal year 1989, certified clients comprised 26 percent of all clients served in contracted programs, and received 87 percent of all services provided. During the past four years certified clients served in division-contracted programs increased about 48 percent while non-certified clients served increased only about 8 percent.

The graph at the top of the following page shows the percentage of clients receiving different types of contracted services. Because many clients receive multiple services from the mental health centers, the percentages of clients receiving each type of service does not add to 100 percent.

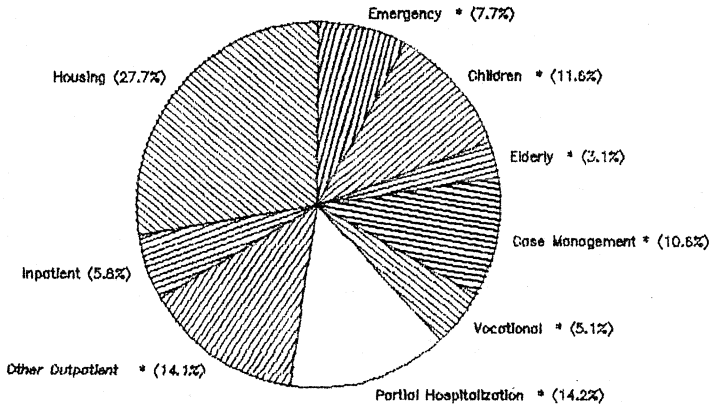
The division measures services provided in units; generally one unit of service is equal to 15 minutes, although vocational services are measured in hourly units and all housing services are measured in one-day units. Of the approximately 2.7 million units of primary services the centers provided in fiscal year 1989, about 51 percent were partial hospitalization service units. The graph on the following page shows the percentage of other service units provided. Overall, centers provided about 128 units of all types of service per client served in fiscal year 1989, but units per client varied greatly among service categories: from an average of 794 units per client in partial hospitalization services to only six units per client in intake and placement.

Comparisons of the graphs at the top and bottom of the next page show several types of services that are provided at levels very different from the levels of clients served. Such differences are due to the severity of illness among the clients being served and the nature of the services themselves. For example, partial hospitalization is an intensive service only open to those more seriously ill clients who meet certification criteria. While relatively few clients received partial hospitalization services, they tend to be the more seriously ill clients, who require the most services. Conversely, while large numbers of clients required emergency and other out-patient services, such as intake and placement, these are less intensive services, requiring fewer units of service per client, and serving many less seriously ill clients.

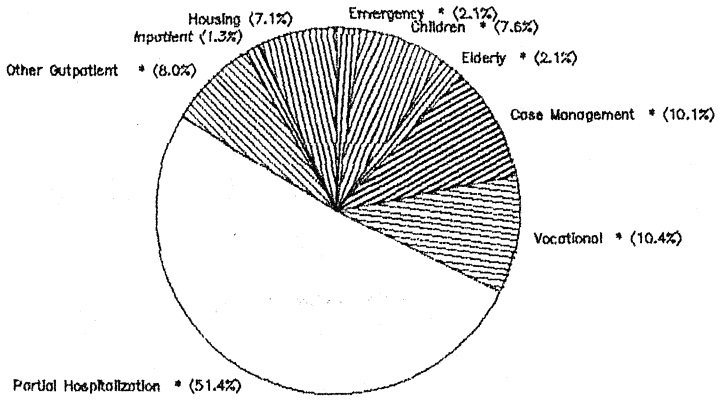
FY '89 CMHC CLIENTS SERVED IN CONTRACTED PROGRAMS



FY 1989 CMHC EXPENDITURES BY CONTRACTED PROGRAMS
(* = Outpatient Services)



FY 1989 CMHC UNITS OF SERVICE BY CONTRACTED PROGRAMS
(* = Outpatient Services)



Source: LBA calculations based on DMHDS program data.

PROVIDERS OF MENTAL HEALTH SERVICES (CONTINUED)

Total costs and division funding for the different services also vary widely. The middle graph on the previous page shows the percent of mental health center expenditures for contracted services. Total expenditures vary among different services according to actual costs of a service as well as the amount of service units provided. The division funds about 62 percent of overall service costs, but that also varies by type of service, according to funding available from federal, Medicaid, private insurance, or other sources that reduce the division's share of costs. For example, the division funded about 93 percent of housing service costs but only about 25 percent of children's services in 1989. The most expensive services, which include inpatient care, housing, and emergency services, receive significantly higher levels of division funding than other services.

Community mental health services are also provided through general hospitals and hospitals approved as "designated receiving facilities" in conjunction with the mental health centers. The hospitals' services and their relationship to the mental health centers are discussed in separate sections below.

GENERAL HOSPITALS

General Community Hospitals across the state have agreements with the mental health centers to help provide emergency care, brief inpatient and partial (day) hospitalization, and maintenance services. There are currently twenty hospitals working with the centers in their regions. Although regions have organized their emergency and inpatient services in different ways, generally hospital staff provide basic round-the-clock emergency and nursing care while mental health center staff conduct screening and evaluations, and provide varying amounts of treatment and therapy. Inpatient care is supposed to be brief, with a goal of clients' quick return to the community.

The hospitals bill clients who are admitted as they would any other hospital patient and do not receive any reimbursement from the mental health centers. The division's funding for contracted emergency, partial and brief hospitalization services primarily covers the centers' cost for staff to provide evaluation, treatment, and therapy services for clients admitted to the hospital.

PROVIDERS OF MENTAL HEALTH SERVICES (CONTINUED)

Designated Receiving Facilities (DRFs) are special units designated by the division to provide secure psychiatric treatment and to serve as regional alternatives to New Hampshire Hospital. The DRFs generally serve only those clients in the DRF's region. Regions without a DRF use New Hampshire Hospital for clients needing involuntary admission. There are three DRFs in operation; all are units in general hospitals, located in Berlin, Portsmouth, and Manchester. The DRFs have contracts, approved by the division, with the mental health centers in their regions.

While close to 90 percent of all DRF admissions in fiscal year 1989 were voluntary, the DRFs have the ability to accept involuntary admissions. They differ from other hospital units that serve clients with psychiatric diagnoses in that they are staffed and equipped to provide more intensive inpatient services and can handle more disruptive clients. (For more detailed discussion of DRFs, refer to page sixty-six.)

STATE INSTITUTIONS

New Hampshire Hospital - Acute Psychiatric Unit provides inpatient, intensive, secure psychiatric services to persons 18 years old or older. In October 1989, this unit moved to a new facility on hospital grounds in Concord. Although the new unit has only a 144-bed capacity, it provides services to significantly more clients because of their generally short length of stay (from three days to a number of weeks).

Although the law allows any board-certified psychiatrist to admit persons to New Hampshire Hospital, most acute psychiatric unit admissions are screened first by community mental health center staff and referred directly by staff from general hospital emergency units, the centers, or later, by a designated receiving facility. Most admissions to the hospital are involuntary emergency admissions; for fiscal years 1985 through 1989, involuntary admissions have comprised an average of about 85 percent of total admissions. About 65 percent of those involuntarily admitted are found by the courts to be dangerous to themselves or others. Other admissions are voluntary, although clients generally still meet the "dangerousness" criteria, and it is not uncommon for persons admitted involuntarily to later switch to a voluntary admission status.

In addition to current admissions, the acute psychiatric unit serves persons needing continuing care in a secure environment and who have generally been at the hospital for several years. The new facility also provides services to a small group of clients with a primary diagnosis of mental retardation who are also mentally ill.

Psychiatric staff, including the hospital's medical director, are primarily faculty at Dartmouth College Medical School, rather than state employees. A five-year, $10.6 million contract between the hospital and Dartmouth, entered into in 1988, provides for hiring a total of 14 psychiatrists. As of October 1989, seven had been hired, including the medical director. The contract requires all psychiatrists at the hospital to be Dartmouth employees by 1991.

The acute psychiatric unit is primarily state-funded, but can receive federal reimbursement through Medicare based on federal determination of clients' needs for hospital services. Funding sources also include client fees (adjusted on ability to pay) and private insurance. (See more detailed discussion of New Hampshire Hospital funding on pages fifty and fifty-one.)

New Hampshire Hospital - Intermediate Care Facility provides long-term, nursing home care for the elderly mentally ill. Currently, this unit is housed in two separate buildings on the New Hampshire Hospital grounds, Dolloff and Thayer. However, as a budget reduction measure, the division is closing Dolloff and transferring clients to the Thayer as vacancies open. Thus, in effect, new admissions to the intermediate care facility have been closed. The two buildings together had an average client population of 242 in fiscal year 1986. The population is being reduced primarily through attrition to the 130 beds certified at Thayer Building. As of November 1989, there were 128 clients at Thayer and 20 remaining at Dolloff.

About 90 percent of the clients receiving services at the intermediate care facility were referred from the hospital's acute psychiatric unit. The others were referred directly from the community mental health centers or from Glencliff. All admissions to this unit are voluntary. About half of the clients are very long-term New Hampshire Hospital clients who have been institutionalized for decades. Others are shorter-term hospital clients, or those who have been receiving services from community mental health centers or nursing homes but can no longer be served adequately by those facilities. Most clients admitted to the intermediate care unit stay for a long time, usually until their death; the discharge rate is minimal.

Officially certified as an Intermediate Care Facility/Institute for Mental Diseases (ICF/IMD) by the Health Care Financing Administration, it is the only facility with this classification in the state. This makes it eligible for Medicaid reimbursement for those clients that are over 65 years old, that meet the financial need criteria, and who have a psychiatric diagnosis with a need for medical monitoring.

New Hampshire Hospital - Transitional Housing is a relatively new component of hospital services, serving its first clients in May 1988, and is funded in part by the federal Department of Housing and Urban Development. Transitional housing provides clients a place to learn community living skills in a residential setting without leaving the security of the hospital campus. Five houses along the outer edges of the campus are being used: three of them have room for 11 clients each; the other two serve three to four clients each.

Transitional housing serves long-term New Hampshire Hospital residents with chronic mental illness and those who are developmentally disabled and have chronic mental illness. While clients in transitional housing are currently counted as clients of the acute psychiatric unit, the hospital plans to separate transitional housing services and let it stand as a semi-independent unit. When this separation occurs, clients will be officially discharged from the acute unit to transitional housing, lowering the census figures for the acute unit.

New Hampshire Hospital-Dartmouth Office of Applied Clinical Research was jointly created in 1988 as part of the hospital's contract with Dartmouth. The purpose of the office is to increase applied research funding and activities within the state's mental health service system and implement an applied research program in order to enhance clinical services for the chronically mentally ill and improve treatment models used in the system. The office is to be staffed by two full-time equivalent staff, and funding over the five-year contract period is about 5 percent of the total contract funds.

Glencliff Home for the Elderly also provides long-term, nursing home care for the elderly mentally ill, but clients generally do not need as intensive care as those at the hospital's Intermediate Care Facility. Glencliff used to accept only long-term residents from New Hampshire Hospital, but since 1984, has received admissions through both the hospital and the ten community mental health centers. It also has some developmentally disabled residents who were admitted from Laconia Developmental Services. Glencliff has recently opened a separate 3-bed group home for former New Hampshire Hospital residents with primary diagnoses of developmentally disabled.

Most clients at Glencliff stay a long time, and there are few discharges. All admissions are voluntary, and admission criteria specify that individuals are to be 60 years old or older, do not require physician or psychiatric care on a daily basis, and are not likely to improve to a point that long-term care will not be needed or that placement in the community will be possible. Glencliff is certified as a general Intermediate Care Facility, and is eligible to receive both Medicaid and Medicare reimbursements for client care costs.

PROVIDERS OF MENTAL HEALTH SERVICES (CONTINUED)

The **Secure Psychiatric Unit** was established at the state prison in Concord in 1985 to replace the old forensic unit at New Hampshire Hospital and is the most restrictive alternative in the state's mental health system. The unit has a capacity for 60 residents and held 48 residents as of January 1990.

The unit conducts inpatient and outpatient evaluations for district, municipal and superior courts to determine individuals' competency to stand trial or to determine sanity. It also conducts the only inpatient sex offender program in the state. Admissions to the unit include (1) persons who, convicted of crimes, are serving sentences in other units of the state prison or in any correctional facility in the state and need psychiatric care, (2) persons involved in serious crimes who are declared not guilty by reason of insanity, (3) persons civilly committed to the mental health system but who are determined to be dangerous to a point requiring additional security, and (4) persons admitted to the mental health system on an involuntary emergency basis whose dangerousness requires additional security. Those admitted under a not guilty by reason of insanity determination are committed to the unit for a minimum five-year period. Others' length of stay at the unit depends on their psychiatric needs or their level of dangerousness, but it is bounded by the term of their sentence or civil commitment.

OTHER PROVIDERS

Providers of Child and Adolescent Services include not only the Division of Mental Health and Developmental Services (DMHDS) but also the Division of Children and Youth Services (DCYS) and its district offices, the Department of Education through its special education bureau, and local school systems. DMHDS provides outpatient services through its contracts with community mental health centers to children and youth under age 18.

DCYS, with a legislative mandate to provide comprehensive services to children who have come through the court system due to abuse, neglect, or commission of an offense, provides inpatient and outpatient services directly or through private sector providers. As of February 1990, DCYS was administering Philbrook Center, New Hampshire's only public facility providing secure, inpatient, psychiatric services to children. Philbrook is also a designated receiving facility, allowing it to accept involuntary admissions.

The Department of Education is mandated to ensure a free education to all "educationally handicapped" children, including those with mental or emotional handicaps, from ages 3 to 21. It works with local school systems to provide special education services to children, either in the local school or through special placements.

ANALYSIS OF COSTS AND FUNDING TRENDS

OF NEW HAMPSHIRE HOSPITAL AND COMMUNITY MENTAL HEALTH SERVICES

HISTORY

The plan for restructuring the mental health system, Planning for Progress, stated that the goals of the planned changes were intended to provide for "more cost-effective and decentralized services" for the mentally ill. Using the five-level service typology described on page 20, the plan stressed the need for additional and expanded services at levels two, three, and four — housing services of all kinds in the community, regional hospital services, and designated receiving facilities outside of Concord. The build-up of these services was to reduce the reliance on level five services — acute psychiatric care at New Hampshire Hospital — when it was not required.

The plan outlined several reasons for replacing some portion of hospital services with other service options:

(1) placing people in services that are more restrictive than necessary is contrary to clients' rights and state policy,
(2) centralized services provided away from family and community supports could hinder clients recovery and return to productive lives, and
(3) level five services (acute care) are more costly in the long run than the lower level services.

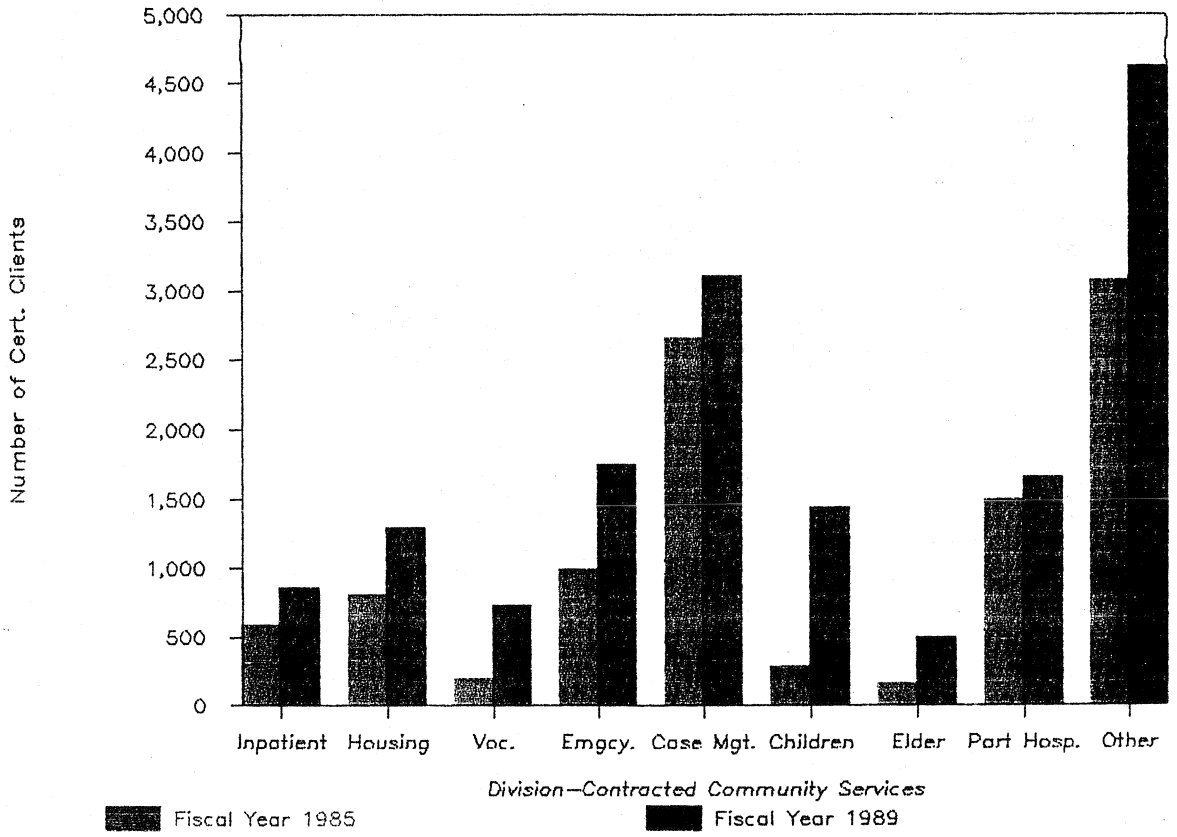
Restructuring included replacing the existing hospital facilities, which were "antiquated, no longer safe or efficient to maintain" with a new, smaller facility that would restrict services to only the most complicated, serious cases and those in need of a secure environment.

The plan indicated that once restructuring was completed and the planned facilities and services were fully established or expanded, the new system would yield "substantial savings" over the costs of the existing system.

The system today largely reflects the restructuring plans laid out in 1985. Housing services have expanded, with a 68 percent increase in beds from 1985 to 1989; the number of regions having service agreements with general community hospitals has grown from eight to ten; designated receiving facilities have been established in three locations; and New Hampshire Hospital clients and staff moved to a new 144-bed acute psychiatric unit in the fall of 1989. More clients with serious or chronic mental illnesses receive services in their community -- avoiding unnecessary trips to New Hampshire Hospital -- and generally receive services in less restrictive environments than they

might without the option of community-based services. The trend of increasing mental health service provision in communities is shown in the graph below, which illustrates the changes in number of certified clients served by community mental health centers since 1985.

CERTIFIED CLIENTS SERVED BY MENTAL HEALTH CENTERS



Source: DMHDS.

Some critics of the state's mental health system say that it may not provide care that is restrictive enough in some cases. It thus appears that the goal of a decentralized service system, providing a range of service environments less restrictive than the state hospital, has basically been met.

The following analysis on pages 42 to 56 examines the changes in mental health expenditures and sources of funding, and changing trends in the allocation of resources resulting from the state's policy to provide mental health services in a decentralized environment.

ANALYSIS OF COSTS AND FUNDING TRENDS (CONTINUED)

COMPARISON OF ACTUAL COSTS TO ESTIMATED COSTS OF RESTRUCTURING

Determining whether the shift in service emphasis as a whole has yielded the substantial savings predicted is difficult since the costs of a "non-restructured" service system can only be estimated. A division summary based on the Wheelock and Nardi reports that compares state cost estimates for the mental health system with and without restructuring, shows that by fiscal year 1987, a bigger shift from institutional care to community care was estimated than actually occurred. (See table below.) Community costs may not have been as high as predicted with restructuring due to fewer designated receiving facility beds having been developed. The actual costs to the state for community and hospital care were lower than what was anticipated from restructuring in 1987, mainly because community care costs had not risen to the expected levels. However, in 1987, hospital costs began rising again. With community care costs also continuing to increase, the system costs today are significantly higher than they were in 1987. Without knowing what the costs of the system would be today without restructuring, it is not clear what net savings restructuring has achieved, if any.

COST COMPARISONS
(in millions)

	FY 1987 Estimates of net state costs - no restructuring	FY 1987 Actual **NET** state costs	FY 1987 Estimates with restructuring-net
Community Services (including DRFs)	$17.7	$19.2	$22.2
NHH	$24.1	$16.7*	$14.6
Total (Does not include Glencliff or Secure Psychiatric Unit)	$41.8	$35.9	$36.8

*Total NHH operating expenditures net of federal revenue, client fees and 3rd party reimbursements.

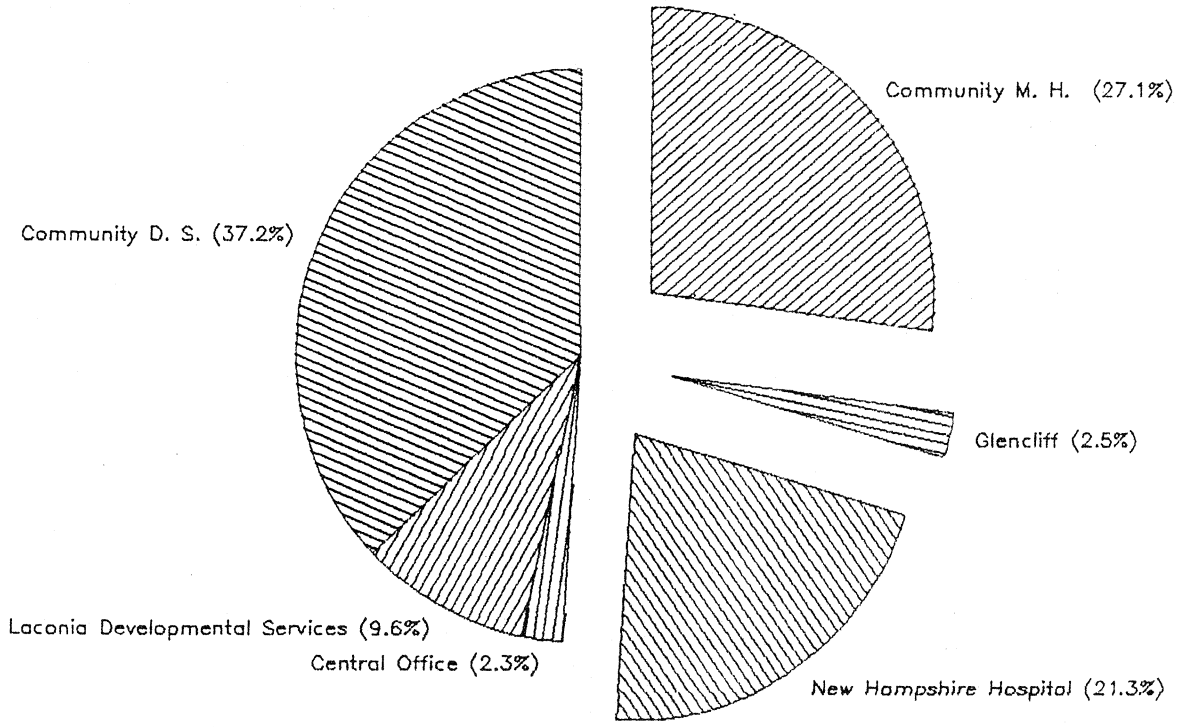
Determining whether the goal of a more cost-effective system has been met is also difficult. System costs have increased since 1985, yet that does not necessarily indicate that the system is less cost-effective today than it was in 1985 or than it would be today without restructuring. If the services provided are more appropriate, effect bigger and more lasting changes in clients' abilities to lead independent and productive lives, and maintain clients' dignity and self-worth to a proportionately greater degree for the dollars spent than less costly services, then they are more cost effective. Although

the people we interviewed throughout the mental health system generally thought that the services provided today were more appropriate and effective than those provided five years ago, the division does not have a comprehensive way to measure this yet. (See page 73 on outcome measures.)

DIVISION EXPENDITURES

In fiscal year 1989 the Division of Mental Health and Developmental Services expended $145.4 million in operating funds and an additional $10.2 million in capital funds. Almost all of the division's capital expenditures (83%) were for the new acute psychiatric facility at New Hampshire Hospital. Of the operating expenditures, 51 percent were for mental health services — Glencliff, New Hampshire Hospital, and community mental health service contracts and administration — as well as emergency shelter services for the homeless, which are administered under mental health programs. (See graph below.) Another 47 percent of operating expenditures were for Laconia Developmental Services (formerly the Laconia State School) and community developmental service contracts and administration. Two percent of expenditures were for central office activities supporting both mental health and developmental services.

DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL SERVICES
Fiscal Year 1989 Expenditures



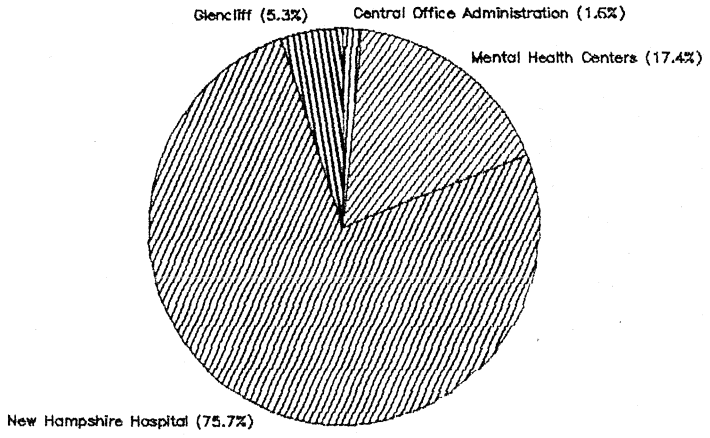
Source: 1989 Statement of Appropriation.

ANALYSIS OF COSTS AND FUNDING TRENDS (CONTINUED)

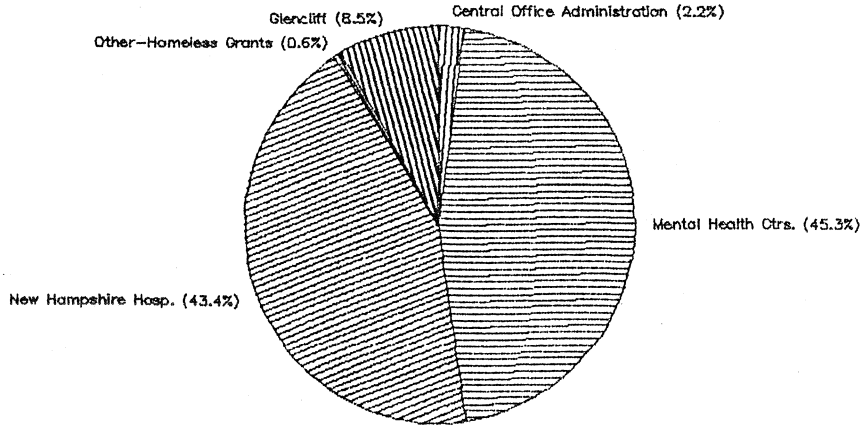
MOVEMENT TOWARD COMMUNITY SERVICES

The decision to move toward community-based services has resulted in a large shift in the allocation of financial resources between institutional providers and community providers. The allocation of state mental health appropriations in 1980 compared to the allocation of mental health appropriations in 1990 is shown below. The budget has increased by 180 percent between fiscal year 1980 and 1990 and the percentage of resources allocated to community mental health centers grew from 17 percent of the budget to 45 percent of the budget.

1980 MENTAL HEALTH APPROPRIATIONS



1990 MENTAL HEALTH APPROPRIATIONS



Sources: 1980 and 1990 State Operating Budgets.

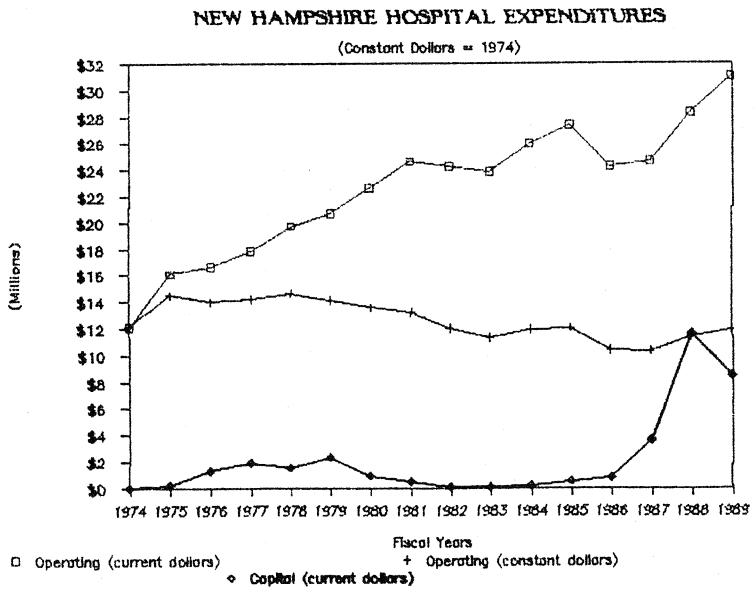
ANALYSIS OF COSTS AND FUNDING TRENDS (CONTINUED)

MENTAL HEALTH EXPENDITURES

Because implementation of deinstitutionalization policy primarily affected state hospitals and community mental health centers, we analyzed funding and expenditure data in further detail for these components of the mental health system. Although comparative statistics on the hospital and mental health centers are presented in this section, it is important to recognize that these two types of service providers offer different kinds of services and generally treat clients with differing types and degrees of illness who may be in various stages of their illness. Cost and funding data for the two types of providers are presented together to illustrate past and continuing shifts in service emphasis. When making comparisons between these two groups, it is important to understand that the care provided by both has changed in ways that tend to increase costs per client. New Hampshire Hospital has gone from custodial care for many clients to active treatment for all clients; mental health centers have gone from fledgling organizations with emphasis on counseling and prevention services to fully-developed organizations providing services to the seriously and chronically mentally ill.

NEW HAMPSHIRE HOSPITAL EXPENDITURES

During the past 15 years, New Hampshire Hospital operating expenditures have increased 156 percent, from $12 to $31 million. (Some hospital expenditures are attributable to other state activities unrelated to mental health services.) After adjusting for inflation, expenditures have decreased a net one percent, illustrated below. Expenditures generally decreased from 1978 to 1987, but have been rising since 1987 as hospital admissions have been increasing.



Sources: Statements of Appropriation, 1974-1989. Constant dollars based on Consumer Price Index.

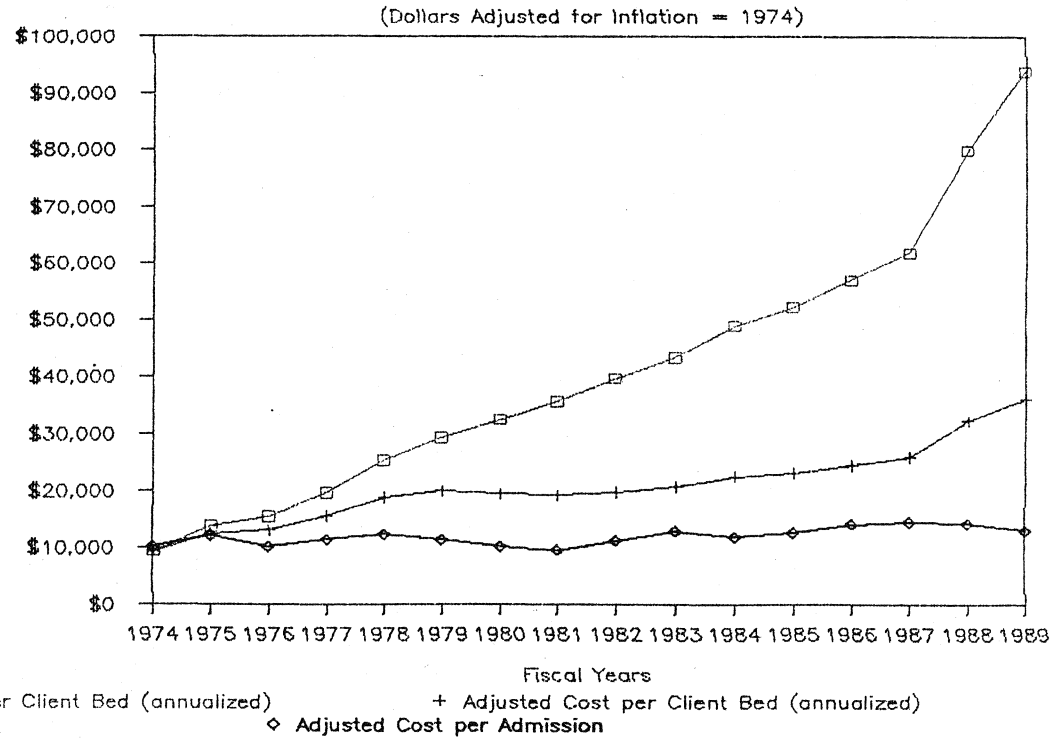
ANALYSIS OF COSTS AND FUNDING TRENDS (CONTINUED)

HOSPITAL COSTS PER CLIENT

The average expenditure per client bed (based on the daily client census) in fiscal year 1989 was $257 a day, or $93,944 a year. Hospital costs per client bed have increased almost 900 percent since 1974, when the average yearly expenditure per bed was $9,408. This increase is due to sharp declines in the average client census and increasing costs, resulting in fewer clients sharing fixed physical plant costs as well as the increased costs involved in shifting from custodial care to active treatment. When adjusted for inflation, the average cost per client bed increased 284 percent, from $9,408 to $36,160 during the same period, illustrated below.

Because the number of hospital admissions has a greater effect on costs than the number of beds filled at any given time -- especially since hospital stays have become shorter -- we also analyzed costs per admission. Average cost per admission in constant dollars shows a net increase of only 28 percent for the past 15 years, from $10,167 to $13,013 per admission. Several years showed declining average costs per admission. From 1987 to 1989, the adjusted cost per admission declined a little more than 10 percent, at the same time the number of admissions increased 29 percent.

NHH AVERAGE COST PER CLIENT BED AND PER ADMISSION



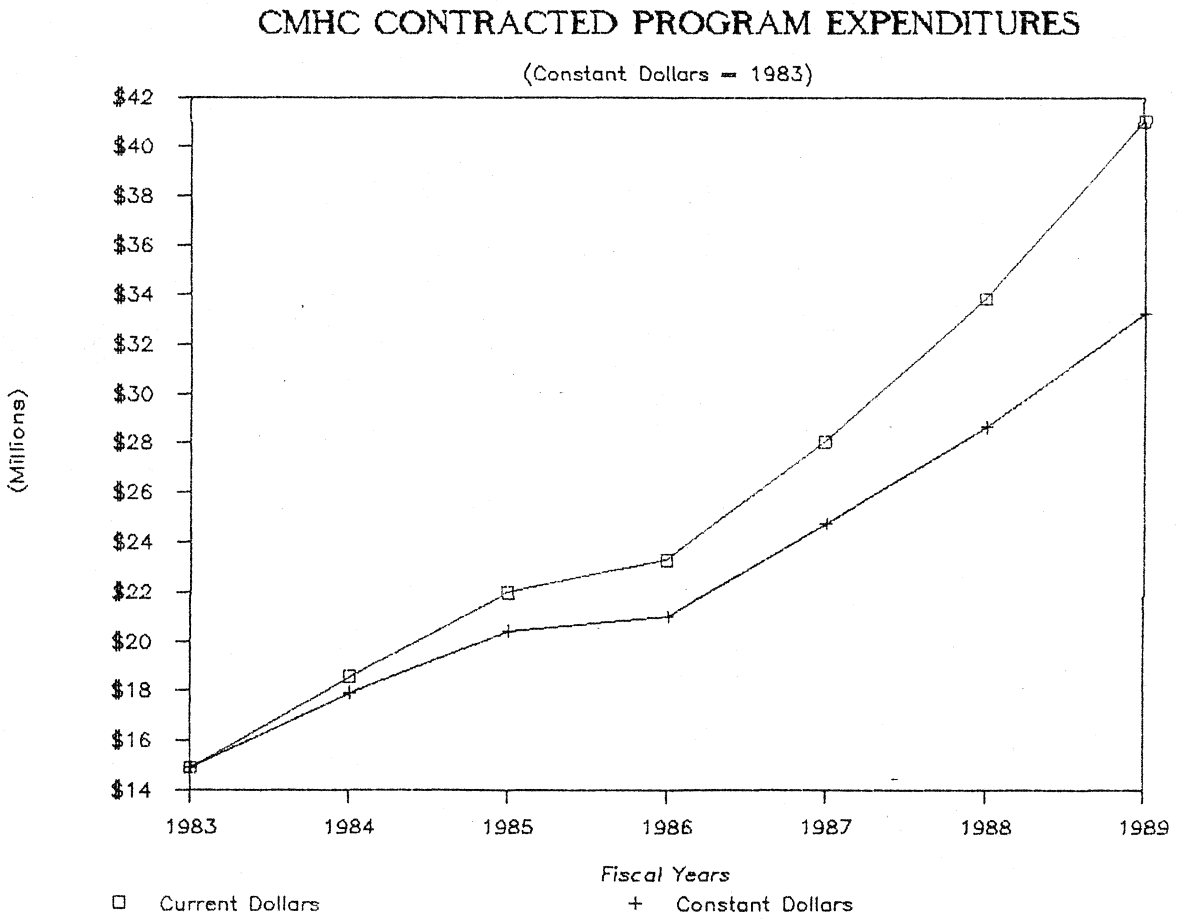
Source: LBA calculations based on Statement of Appropriation and DMHDS data. Constant dollars based on Consumer Price Index.

ANALYSIS OF COSTS AND FUNDING TRENDS (CONTINUED)

COMMUNITY MENTAL HEALTH PROGRAM EXPENDITURES

From 1983 to the present, center expenditures for contracted programs have increased 175 percent, from about $15 to $41 million. When adjusted for inflation, it increased by 122 percent, illustrated in the graph below. The ratio of mental health center dollars spent to hospital dollars spent has steadily increased from 63:100 in fiscal year 1983 to 132:100 in 1989. Mental health center expenditures for division-contracted programs have exceeded hospital expenditures since 1987. (See graph on page 3.)

During the period of mental health restructuring, from 1985 to 1989, mental health center expenditures increased 63 percent (based on constant dollars) compared to a one percent decrease in hospital expenditures. The total number of clients served in mental health centers' contracted programs increased 16 percent during this period. At the same time, the average client census at the hospital declined 37 percent, and total admissions declined by a net 4 percent.



Source: Community mental health center financial audits, 1983-89. Constant dollars based on Consumer Price Index.

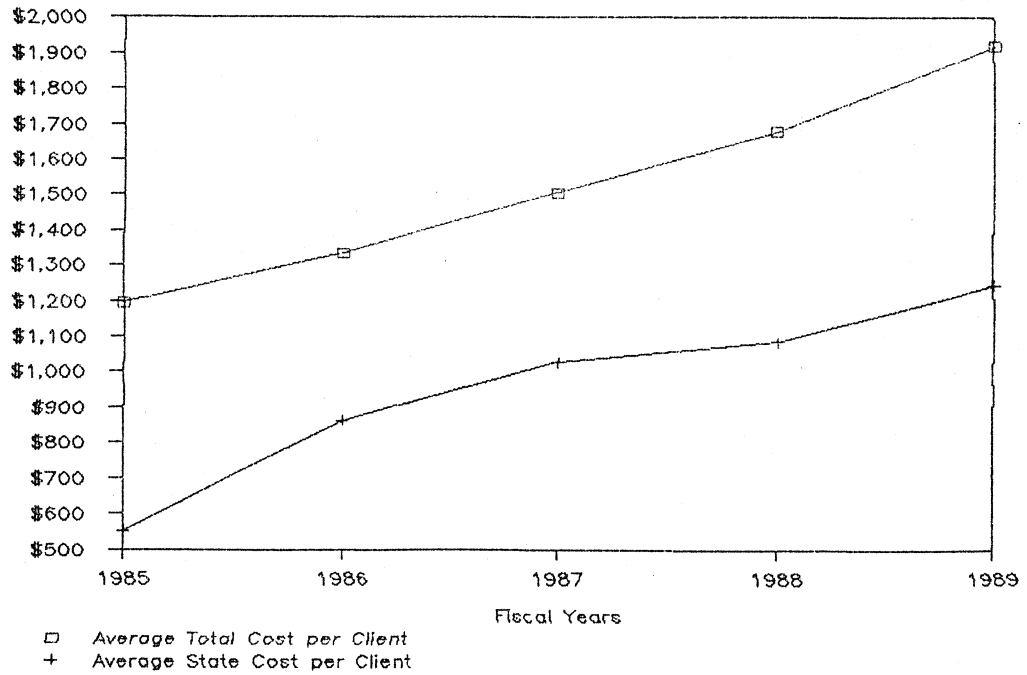
ANALYSIS OF COSTS AND FUNDING TRENDS (CONTINUED)

While community mental health centers were operating in New Hampshire during the late 1960s and throughout the 1970s, complete and comparable financial data on the centers is not available prior to about 1983 or 1984. In our financial analysis, we focused primarily on the division-contracted programs offered by the centers. Contracted programs are the only ones that receive funding from the Division of Mental Health and Developmental Services, and they generally serve the more seriously ill clients. About 78 percent of the centers' fiscal year 1989 expenditures were for contracted programs.

MENTAL HEALTH CENTER COST PER CLIENT

Community mental health center expenditures for clients served in division-contracted programs averaged $1,920 per client in fiscal year 1989. Total cost per client increased 61 percent from 1985 to 1989, illustrated below. When analyzed in constant dollars, cost per client increased only 40 percent. The average state cost per client served grew from $554 in 1985 to $1,245 in 1989, increasing 125 percent. At least part of that increase was due to larger increases in certified clients than in total clients served. Because certified clients are those who are more seriously or chronically ill than others eligible for division-contracted programs, they also tend to be more costly for the mental health centers to serve, requiring more services and more intensive services.

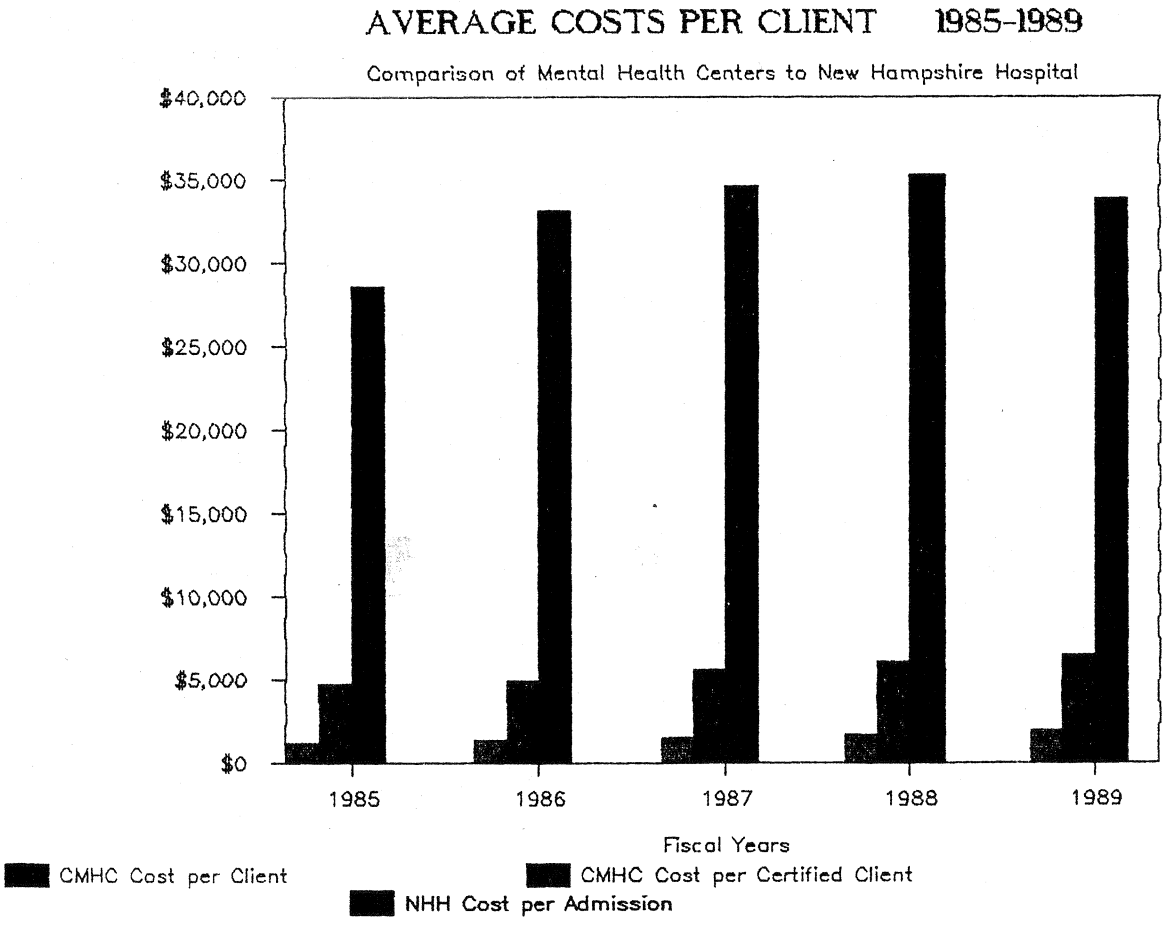
AVERAGE COSTS PER CMHC CLIENT



Source: LBA calculations based on community mental health center financial audits and DMHDS program data, 1985-89.

COMPARISON OF CMHC EXPENDITURES WITH NHH EXPENDITURES

To draw a closer comparison between costs per mental health center clients served and New Hampshire Hospital admissions served, we computed cost per certified client by allocating total mental health center contracted program costs by the overall percentage of units of service provided to certified clients. Although only a rough approximation, the graph below shows the significantly higher cost per client for certified clients. A more refined analysis of certified client costs by type of service would probably show a larger disparity since the more intensive services required by more certified clients also tend to be the more expensive. In fiscal year 1989, the average cost per certified client was 236 percent higher than the average for all clients served in contracted programs. However, the average hospital cost per admission in 1989 was still 425 percent higher than the cost per certified client served by the mental health centers. These vast differences in costs are due primarily to the relative differences in staffing levels between an accredited hospital and the community mental health centers.



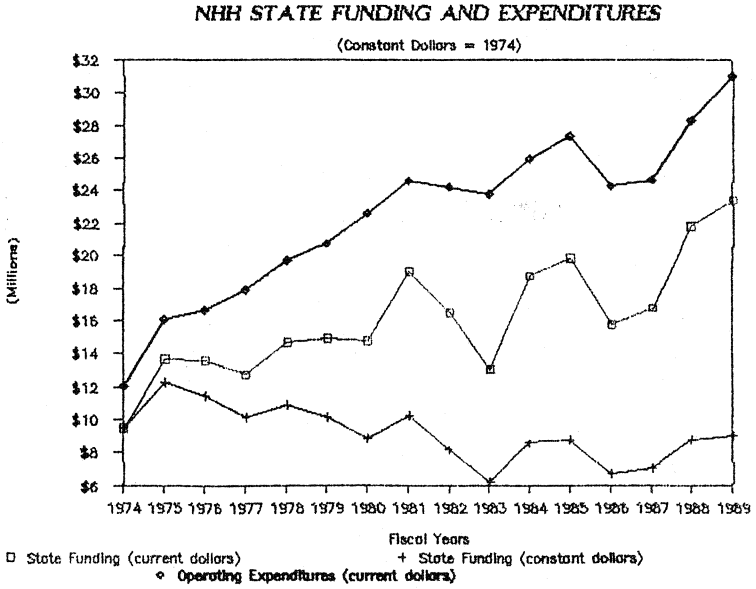
Source: LBA calculations based on Statement of Appropriation, community mental health center financial audits, and DMHDS program data, 1985-89.

ANALYSIS OF COSTS AND FUNDING TRENDS (CONTINUED)

HOSPITAL FUNDING

In fiscal year 1989, about 17 percent of New Hampshire Hospital expenditures were reimbursed through federal revenues and another 7.5 percent came from non-federal revenues such as client fees, private insurance, and other sources. About 76 percent of hospital expenditures were not covered by federal or other revenues and can be considered state-funded costs. National data from the U.S. Department of Health and Human Services show public mental hospitals received about 78 percent of their revenue from state sources in 1983, 14 percent from federal sources, 2 percent from local government sources, and about 4 percent from client fees. Hospital data from fiscal year 1983 show a higher percentage of federally-reimbursed costs (22%) and a correspondingly lower percentage of state-funded costs (55%).

State funding for the hospital has fluctuated over the past 15 years but has shown a net increase of 146 percent between 1974 and 1989. From fiscal years 1986 to 1989, state-funded costs increased steadily, about 49 percent. When adjusted for inflation, state cost figures show an overall decrease from 1975 to 1983 and then more fluctuation. In 1986, state funding of the hospital was about 30 percent below 1974 levels in constant dollars, reflecting a 38 percent net decline in admissions and a comparable drop in staffing levels during roughly the same period. However, as hospital expenditures began climbing again in 1987, so too did the level of state funding. The division and hospital staff give several reasons for recent increases in costs, including rising admission rates, implementation of the Dartmouth contract for psychiatric services in 1988, parallel costs of completing the new acute care facility while still operating the old facilities, and increased staff and New Hampshire Hospital grounds maintenance costs.

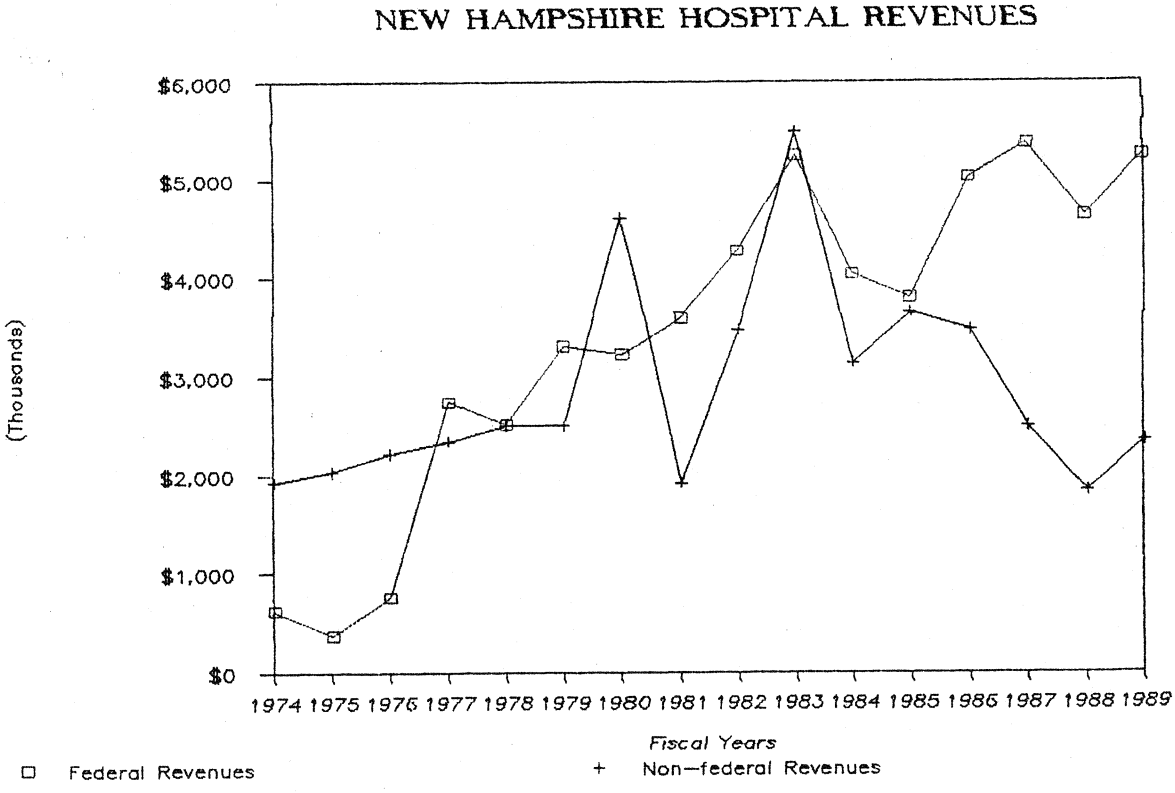


Source: Statement of Appropriation and Detail Unrestricted Revenue, 1974-89. Constant dollars based on Consumer Price Index.

ANALYSIS OF COSTS AND FUNDING TRENDS (CONTINUED)

Federal revenues, primarily Medicaid and Medicare, increased significantly in fiscal year 1977 and have fluctuated since then. Division and hospital staff suggest that periodic settlements with Medicare may account for some of the fluctuation. Some decline in federal revenues is expected due to the declining number of Medicaid-certified beds under the intermediate care facility (ICF) programs. The ICF for elderly mentally ill has basically closed admissions and will consolidate all clients in one building as client populations decline. Also, the hospital no longer has an ICF unit certified for clients with both developmental disability and mental illness.

Non-federal revenues (primarily client fees and third party reimbursements) have also fluctuated over the years and show a net decline of about 36 percent since 1985. (See graph below.) Hospital staff attribute at least some of this decline to the shift in treatment environment from the hospital to the mental health centers for many clients. Because clients at the hospital are usually those who are most seriously ill and least able to cope in the community, they also tend to be less likely to have insurance or to afford to pay for the services they receive. They are less likely to have jobs than clients served in the community and more likely to have used up their mental health benefits from any insurance they did have by the time they require hospital care.



Source: Statement of Appropriation and Detail Unrestricted Revenue, 1974-89.

ANALYSIS OF COSTS AND FUNDING TRENDS (CONTINUED)

MENTAL HEALTH CENTER FUNDING

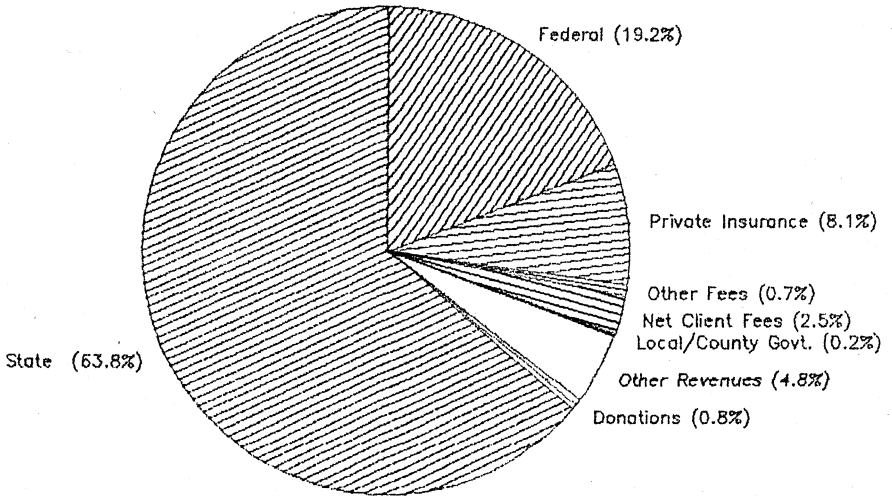
In fiscal year 1989, the private, non-profit, community mental health centers (including two housing providers contracted by the division directly) had total revenues of $52.6 million. They received 52 percent of their revenues from state sources, 16 percent from federal funds, only 1 percent from local government, and 22 percent from client fees and insurance. In comparison, data from a 1987 survey of community mental health centers by the National Council of Community Mental Health Centers indicated that on average, responding centers received 48 percent of their funding from state sources, 15 percent from federal funds, 13 percent from local government, and 17 percent from client fees and insurance. New Hampshire's centers differ most from those National Council member centers surveyed in the significantly lower revenues from local government sources, which are made up by higher revenues from all other categories.

Of the centers' total revenues, about $41.9 million (80%) were for division-contracted programs. There are significant differences in funding sources between contracted and non-contracted programs. Whereas 64 percent of the centers' non-contracted program revenues come from client fees and insurance payments, only 11 percent of contracted program revenues come from these sources. Most contracted program revenues come from state government. (See graphs on following page.)

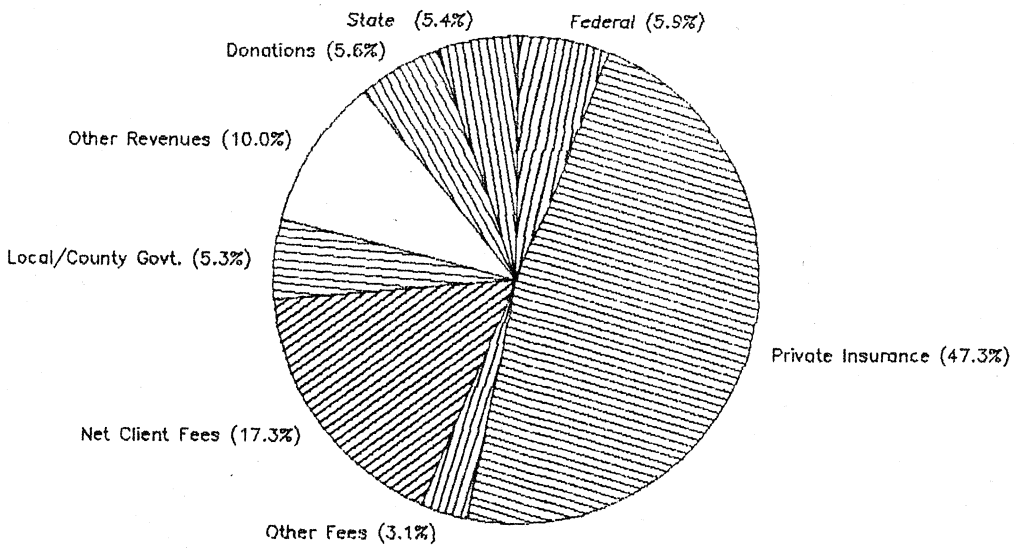
State funding of mental health centers is primarily through the Division of Mental Health and Developmental Services' annual contracts and through the state portion of Medicaid reimbursements. Figures on state funding of the centers are incomplete prior to about 1984, but the figures available for 1979 to 1984 suggest relatively small increases each year. The state increased its funding significantly in fiscal year 1985 as it continued to shift from providing general grants for services to contracting for specific services defined by program standards, with increased emphasis on services for the seriously and chronically mentally ill. (See graph at top of page 54.)

Federal categorical grants for the mental health centers were replaced by federal block grants to the states in 1981. Because the division allocates its mental health block grant dollars to the centers as part of its annual contract process, the large state funding increases in 1985 and 1986 may be at least partially due to some federal block grant dollars being counted as state contract dollars by the centers. Centers are now required to separate these funds in their financial reporting. In 1983, the state implemented the Home and Community-Based Service Waiver, which greatly expanded the services that were reimbursable under Medicaid, affecting both state and federal revenues. State funding increases for the centers have slowed significantly since fiscal year 1987 and are primarily attributable to the state's portion of Medicaid reimbursements, which have increased much faster than division grants.

CMHCS' CONTRACTED PROGRAM REVENUES
Fiscal Year 1989

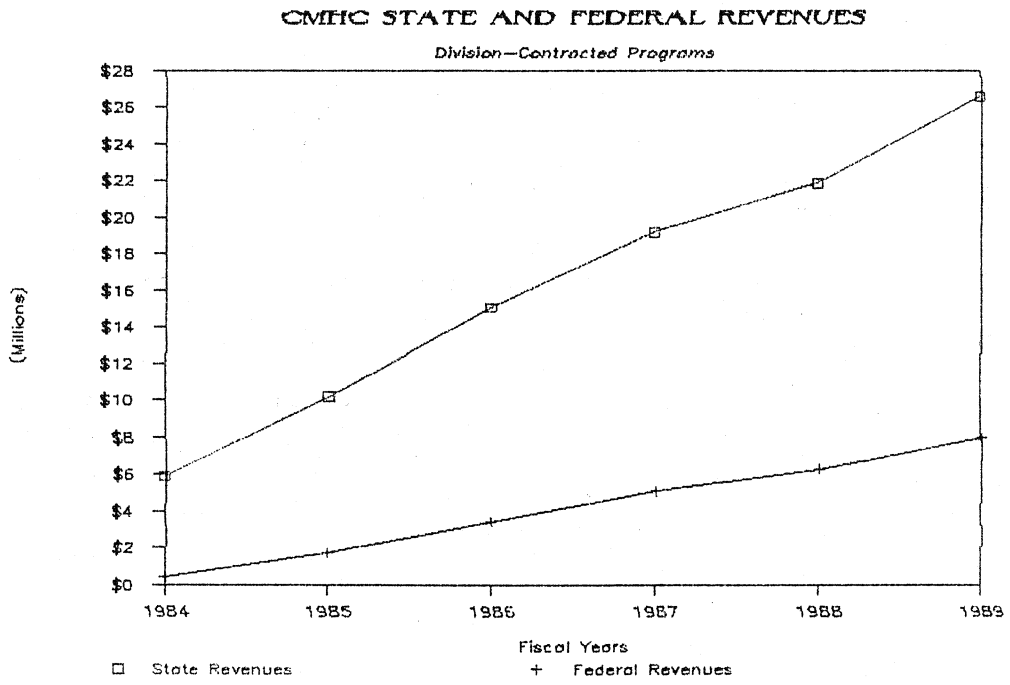


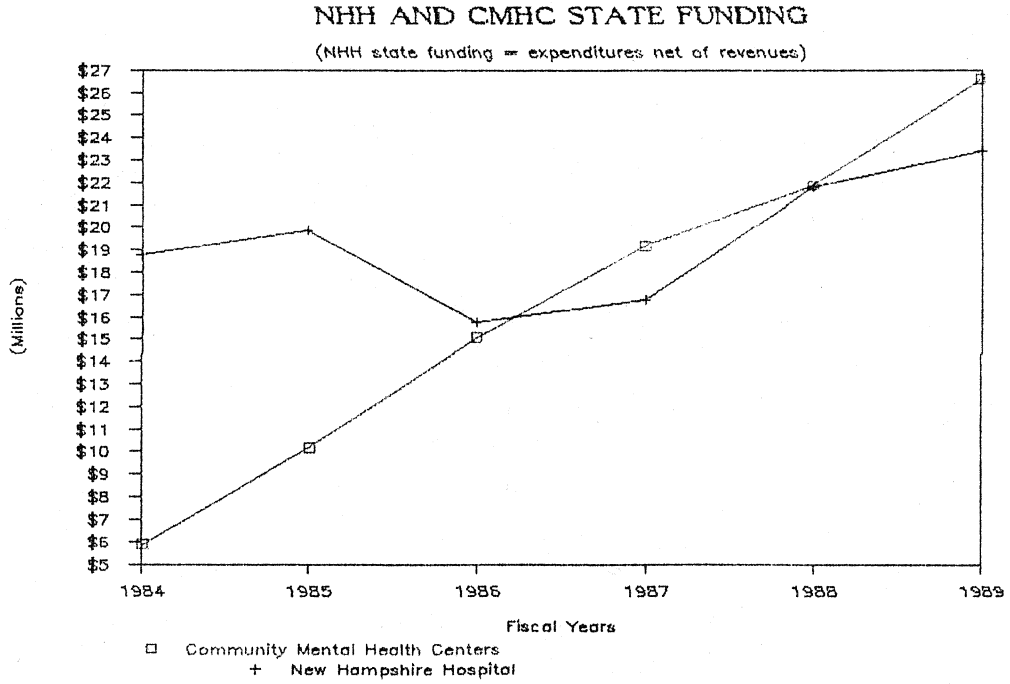
CMHCS' NON-CONTRACTED PROGRAM REVENUES
Fiscal Year 1989



Source: LBA calculations based on community mental health center financial audits, 1989. (State revenues include the state portion of Medicaid funds.)

ANALYSIS OF COSTS AND FUNDING TRENDS (CONTINUED)





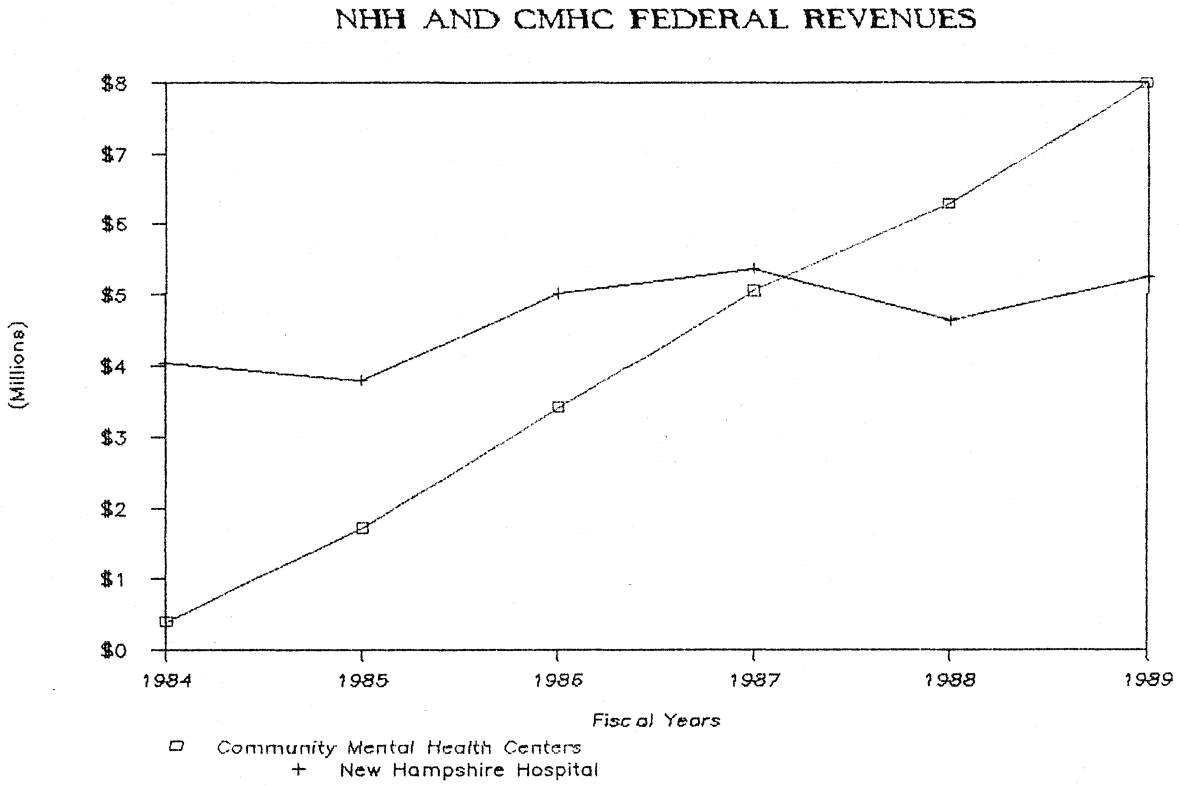
Sources: Community mental health center financial audits, Statement of Appropriation, and Detail Unrestricted Revenues, FY 1984-89.

As with total expenditures, state funding of mental health centers has exceeded that of New Hampshire Hospital since 1987. (See graph above.)

ANALYSIS OF COSTS AND FUNDING TRENDS (CONTINUED)

Federal revenues received by mental health centers include federal mental health block grant monies allocated by the division, Medicare, and the federal share of Medicaid. Mental health center financial data show large increases in federal revenue between 1984 and 1987. (See graph on previous page.) These are due partially, if not largely, to more complete and consistent financial reporting by the centers that allow better identification of federal dollars in contracted programs rather than to true increases in federal funding. However, from 1987 forward, detailed data is available, showing that most of the federal increases were from the 33 percent increase in Medicaid reimbursements between 1987 and 1989. Federal revenues for the mental health centers have exceeded New Hampshire Hospital's federal revenue since 1988. (See graph below.)

Other revenues for the centers' contracted programs come from client fees, insurance, interest, rental, and other revenues, and a minimal amount from local and county governments and private donations. They have increased sporadically over the past three years. In fiscal year 1989, the centers had a combined total of $7.1 million in non-federal, non-state revenues (17% of revenues for contracted programs) compared to New Hampshire Hospital's $2.3 million (8% of expenditures).



Sources: Community mental health center financial audits, Statement of Appropriation, and Detail Unrestricted Revenue, 1984-1989.

ANALYSIS OF COSTS AND FUNDING TRENDS (CONTINUED)

FUNDING AND QUALITY OF SERVICES

A report published in 1988 by the National Alliance for the Mentally Ill and the Public Citizen Health Research Group entitled Care of the Seriously Mentally Ill found that, beyond a necessary minimum spending level, there was no correlation between states' per capita mental health expenditures and good mental health services, as rated in the report. In fact, the report found that the single most important factor in determining states' mental health expenditures was the number of clients in state mental hospitals. The report also found that again, beyond a necessary minimum level of psychiatrists, there was no correlation between the number of doctors providing services and the state's rating in provision of mental health services.

It stated that spending more money and training more psychologists and psychiatrists would not necessarily improve services for the seriously mentally ill. The report cited other factors as more important in improving services, such as a high priority for the seriously mentally ill, organization of services for client convenience, adequate monitoring of service providers, accountability for services at a single level with a simplified funding structure, improved quantity and quality of mental health professionals, and commitment laws that ensure treatment when needed.

This report ranked New Hampshire as the third best provider of mental health services in the country. It also placed the state as the seventh highest spender per capita for mental health services. This means that although New Hampshire's mental health services are among the best in the nation, it pays well above the national average of $38.40 per capita to provide these services. Compared to the other states that rank among the ten best providers in the country, New Hampshire costs compare accordingly:

PROGRAM RANKING	STATE	PER CAPITA MENTAL HEALTH EXPENDITURE
1	RHODE ISLAND	$45.50
2	WISCONSIN	27.80
3	**NEW HAMPSHIRE**	**50.80**
4	MAINE	44.00
5	VERMONT	66.40
6	CONNECTICUT	51.70
7	OHIO	40.20
8	COLORADO	31.50
9	UTAH	27.40
10	NEBRASKA	26.90

OBSERVATIONS AND RECOMMENDATIONS

Planning for Progress, issued in 1985, outlined the state's plan to restructure its mental health service system. It identified four management objectives for the Division of Mental Health and Developmental Services which were seen as prerequisites to the successful operation of the restructured mental health system. The plan expressed heightened concern with management issues relating to (1) cost-effectiveness controls, (2) cost containment, (3) system control, and (4) service planning and management. These objectives are briefly described below.

Cost-effectiveness controls should ensure the highest quality service at the lowest cost to the state. The plan raises issues of quality assurance, discussed on pages 73-77, relating to program effectiveness, and linkages between cost-per-unit of service and program effectiveness which are related to financial controls discussed on the following page.

Cost containment should ensure that the principles of accountability and cost-efficiency are observed in the purchase and delivery of services. The plan suggests the need for objective performance indicators to improve performance-contracting methods. We discuss this objective as it relates to financial controls over mental health services provided by the community mental health centers beginning on page 60.

System controls should ensure sound managerial control of the whole service delivery system, in addition to control of individual contracted providers. Issues such as linkages of services provided at different levels by different providers are addressed on pages 66-72 relating to overall coordination and communication within the mental health system.

The fourth objective — service planning and management — is concerned with adequate access to services in the least restrictive environments for the target population. This objective is addressed on pages 78-84 which includes issues of eligibility and the adequacy and accessibility of mental health services.

Our observations and recommendations relating to the implementation of these management objectives are presented on the following pages, under the general headings of financial and administrative controls over mental health services, coordination of mental health services, adequacy and accessibility of mental health services and the effectiveness of mental health services.

FINANCIAL AND ADMINISTRATIVE CONTROLS OVER MENTAL HEALTH SERVICES

Sound managerial controls that encourage and define systems to maximize productivity and set standards for cost-per-unit of service are instrumental in procuring cost efficient mental health services in a decentralized service delivery system.

Our analysis of division controls in this section focuses primarily on cost containment and cost effectiveness controls over contracted services provided by the ten community mental health centers. We also discuss system controls of New Hampshire Hospital utilization and program data reported by the mental health centers.

WIDE COST VARIANCES EXIST BETWEEN CENTERS ON A UNIT OF SERVICES BASIS

OBSERVATION #1

Wide cost-per-unit variances for program services exist among community mental health centers. Review of the division's quality assurance evaluations of specific services shows no apparent correlation between unit costs and service quality, as measured by adherence to division standards. (See exhibit on the following page.)

Brief hospitalization and intake and placement services show the most pronounced differences between regions. These differences are minimized somewhat when individual services are grouped by general service type, such as "outpatient services."

Insufficient data on the effectiveness of various service models make it problematic for the division to determine whether a more expensive service in one region costs more because it is less efficient than the same service in other regions or because it is more effective. Reasons for unit cost variances appear to be primarily due to differences in service models developed by the regions, historical costs, and to some degree, the number of clients receiving a particular service, especially services with greater fixed costs.

Without measurable and comparable data on client outcomes of different program models, the division cannot adequately ensure that it is contracting for the most effective services at the lowest overall cost. As the number of clients being served by community mental health centers continues to grow and resources remain limited, the division needs to make stronger efforts to ensure that effective services are provided in the most cost-efficient way.

FINANCIAL AND ADMINISTRATIVE CONTROLS OVER MENTAL HEALTH SERVICES (CONTINUED)

UNIT COST VARIANCES BY REGION - FISCAL YEAR 1989

REGION	EMERGENCY SERVICES	BRIEF HOSP.	INTAKE PLACEMENT	VOCATIONAL SERVICES	CASE MGMNT	TREATMENT MAINTENANCE	CHILDREN	ELDERLY	OUTPNT * SERVICES	DAY TMNT	HOUSING **
NORTHERN	$60.23	$77.76	$31.17	$ 4.10	$25.70	$22.12	$56.11	$44.30	$31.05	$4.69	$31.00
W. CENTRAL	$53.90	$49.31	$26.72	$ 5.76	$18.35	$21.14	$16.97	$18.16	$20.78	$3.74	$74.00
LAKES	$55.71	$28.15	$18.20	$12.98	$15.01	$17.85	$25.07	$30.18	$23.99	$2.44	$55.00
CENTRAL	$55.82	$51.98	$58.36	$ 9.11	$12.77	$22.46	$22.35	$21.29	$19.85	$4.23	$46.00
MONADNOCK	$61.81	$64.74	$22.80	$ 2.95	$10.45	$ 9.42	$24.76	$16.98	$19.80	$5.87	$34.00
NASHUA	$38.46	$36.42	$26.23	N/A	$12.69	$18.97	$23.96	$14.31	$18.27	$6.95	N/A
MANCHESTER	$64.38	N/A	$14.30	$15.66	$22.06	$19.40	$19.42	$18.69	$21.86	$4.76	$51.00
SEACOAST	$63.75	$55.67	$31.52	$ 2.06	$12.46	$22.33	$19.13	$15.05	$22.41	$2.27	$39.00
STRAFFORD	$33.73	N/A	$22.55	$12.83	$10.58	$15.27	$21.07	$25.44	$17.69	$2.74	$57.00
SALEM	$42.14	$71.97	$32.85	$ 1.17	$16.55	$24.27	$18.06	$31.32	$22.66	$3.11	$66.00
AVERAGE	$52.99	$54.50	$28.47	$ 7.40	$15.66	$19.32	$24.69	$23.57	$21.84	$4.08	$47.00
HIGH	$64.38	$77.76	$58.36	$15.66	$25.70	$24.27	$56.11	$44.30	$31.05	$6.95	$74.00
LOW	$33.73	$28.15	$14.30	$ 1.17	$10.45	$ 9.42	$16.97	$14.31	$17.69	$2.27	$31.00

SOURCE: DIVISION KEY PERFORMANCE INDICATORS - FY 89 FOURTH QUARTER SUMMARY REPORT

N/A - NOT AVAILABLE OR NOT APPLICABLE

* INCLUDES EMERGENCY SERVICES, INTAKE, CASE MANAGEMENT, MAINTENANCE, CHILDREN, AND ELDERLY SERVICES

** SOURCE: COMMUNITY MENTAL HEALTH CENTER FINANCIAL AUDITS & DIVISION PROGRAM STATISTICS

RECOMMENDATION

The division should identify the least effective and least cost-efficient service models in each program area. It should then take all available steps to help mental health centers restructure those programs that are high cost but cannot be linked to more effective results. Such steps could include providing technical assistance, training, and withholding or reducing contract funds. In cases where centers do not reduce costs and/or increase the effectiveness of such programs, the division should analyze the administrative and other costs of seeking other providers.

USE OF PERFORMANCE MEASURES NOT STANDARDIZED IN MENTAL HEALTH CENTER FUNDING DECISIONS

OBSERVATION #2

The division's use of performance measures in allocating funds to the community mental health centers is not widely standardized, although new procedures implemented during the most recent contract negotiations suggest the division is moving toward greater standardization.

To ensure the best use of state dollars, funding negotiations and decisions should be based on the centers' cost efficiency in providing services and on their effectiveness in meeting division program standards and achieving positive outcomes for clients receiving services. To help ensure fairness and objectivity, the efficiency and effectiveness of centers' performance should be assessed through reliable and consistent data-based measures and those measures should be applied in a standardized way.

Since 1986, the division has used measures of efficiency, productivity, and compliance it developed, called key performance indicators, in negotiating with centers on program costs and revenues. However, the use of these indicators has generally not been systematic or standardized. As the division's 1989-1992 mental health services plan describes it, performance indicators have been used to achieve program changes through the "photogenic method" — exposing the performance data to the light of day. The plan also states that the division is examining methods to tie the indicators more closely into the contracting and allocation process. Other cost efficiency data used in the division's contract negotiations with the mental health centers include historical analysis of centers' budget requests to the past year's budgets and financial statements. The centers' effectiveness in meeting division program standards is also used in funding decisions, although measures of program outcome effectiveness are still under development. (See page 73 for further discussion of outcome measures.)

In fiscal year 1990 contract negotiations, the division did use two key performance indicators systematically to determine the level of funding increases — ranging from 3.5 to 7 percent — for the mental health centers. The division measured the centers' efficiency in using New Hampshire Hospital beds and division contracted funds during the past year on three levels: use per capita, use per certified client, and use per chronically mentally ill client served. The division weighted these measures and assessed the results, grouping the centers as low (efficient), average, or high (non-efficient) users. The centers ranked as more efficient received larger percentage increases.

The division could link funding for mental health center services more closely with centers' performance by applying standardized use of performance measures, as was done for a small portion of centers' fiscal year 1990 funding, to a larger portion of division contract dollars. The division could also use a greater variety of efficiency and effectiveness measures, including program outcome measures, in assessing centers' performance for funding allocations.

RECOMMENDATION

To better ensure effective service provision and more efficient use of state dollars by the mental health centers, the division should increase the standardized use of performance measures in its funding process and expand the types of performance measures used, especially of program effectiveness.

THE DIVISION HAS NOT CONSISTENTLY USED FINANCIAL PENALTIES AND INCENTIVES TO ENFORCE NEW HAMPSHIRE HOSPITAL BED QUOTAS

OBSERVATION #3

The community mental health centers have a high degree of control over admissions to New Hampshire Hospital through the screening process; however, they are not required to bear the cost of services provided by the hospital. The hospital and mental health center budgets are separate, and costs for hospital bed use are applied to the hospital's budget. Although the division sets quotas to establish the maximum number of New Hampshire Hospital beds each center can use, the division has not consistently used financial penalties and incentives to enforce these quotas. Six of the ten mental health centers exceeded their hospital bed quotas in fiscal year 1989.

Most admissions to New Hampshire Hospital today are screened by community mental health center staff at general hospitals, designated receiving facilities, or center offices. In fiscal year 1986, center staff screened 80 percent of New Hampshire Hospital admissions; by 1989, the percentage had increased to 99 percent. To control New Hampshire Hospital bed days used and encourage non-hospital options, the division sets quotas for hospital bed use (excluding the intermediate care facility) for each region as part of the mental health centers' annual contracts. If the centers exceed that quota, they face a possible penalty, based on a portion of the costs of the extra bed days used. The division actually implemented penalties once, in 1987, withholding about $134,000 from seven centers, and has planned to do so again in fiscal year 1990.

Although division staff indicate that a few centers did receive "incentive" payments in 1987 for their under-utilization of hospital beds, such payments are not authorized in the division's contract with the mental health centers. Consistent use of both penalties and incentives every year for variance from quotas in centers' hospital use would bring the centers' financial accountability for hospital admissions more in line with their existing accountability for screening clients.

The method for setting hospital bed day quotas is a key component in this system. According to division staff, quotas are set on the basis of the percent of certified clients in a center's region and, to a lesser extent, the region's population. In our survey of all the mental health centers, six out of ten rated their fiscal year 1989 bed day allotments as "not adequate," and seven of the ten rated 1990 allotments as inadequate. Achieving greater consensus on methods for setting quotas may help improve overall system effectiveness.

A more direct means of assigning financial responsibility to the mental health centers for their hospital admissions would be to allow the centers to "buy" hospital bed space. If the division funded the centers for "acute psychiatric service," much as the centers are currently funded for other program services, the centers would have direct responsibility for their regions' hospital costs as well as their admissions. In addition, it would link New Hampshire Hospital and the centers more closely together in providing services for those with mental illness.

RECOMMENDATION

The division should consistently use both penalties and incentives to create a more direct link between mental health centers' use of New Hampshire Hospital and the costs of such use. It should also work with the centers to refine methods for setting quotas and determining rates of penalties and incentives. The division should study the feasibility and potential effectiveness of reallocating funds and revising current structures to assign community mental health centers direct financial responsibility for their use of the hospital.

CONTROLS OVER CENTERS' ADMINISTRATIVE COSTS SHOULD BE STRENGTHENED

OBSERVATION #4

The division's existing controls over community mental health centers' administrative costs should be strengthened to ensure that state dollars are being used most effectively for client services. The largest portion of centers' total administrative costs is salaries. In the centers' fiscal year 1990 budgets, 72 percent of administrative costs were for personnel. The division's primary control of these costs is a "rule-of-thumb" 15 percent cap on total administrative expenses. Audit guidelines developed by the division for independent financial auditors of the mental health centers do not include specific procedures for testing administrative expenses.

Budget guidelines define administrative expenses to include executive and financial management staff, clerical, typing, and data entry staff providing support for executive and financial management activities, and related supplies, equipment, staff training, and other costs. However, according to division staff, all mental health centers may not allocate these expenses the same way because of variations among their programs and organization. The division has no restrictions on the levels of mental health centers' administrative salaries, although salaries for key administrators are required to be included in administrative costs and would thus be included within the 15 percent cap. One difficulty facing the division in controlling administrative costs is that both division-contracted and the centers' non-contracted programs are part of top administrators' responsibilities.

Comparisons of salaries of top administrators in New Hampshires' community mental health centers (such as executive director and associate executive director) to regional and national norms reported in a 1989 study by the National Council of Community Mental Health Centers show that New Hampshire's center administrators receive salaries significantly above the New England regional average. Executive directors of seven out of ten mental health centers receive annual salaries above the median high salary ($60,000) paid in the region. This is true for four of the seven reported associate directors, as well. (Median high for associate directors is $44,000.) The median high and the median average salaries for New England's executive directors are among the highest in the country.

While medical directors are not necessarily considered administrative positions, eight of ten New Hampshire mental health center medical directors receive salaries greater than the regional median high salary ($90,000). However, when compared to the national norms, only three New Hampshire medical director salaries exceeded the median high salary ($95,000). Although high salaries alone do not necessarily indicate inadequate controls, when coupled with the lack of formal, explicit policies on administrative cost control, they suggest a need for more comprehensive controls.

RECOMMENDATION

To ensure that state dollars are being used most effectively for client care, the Division should develop stronger, more comprehensive, and more formalized controls over administrative costs at the centers. Audit guidelines should be revised to include specific testing procedures on centers' administrative expenses.

PROGRAM DATA REPORTED TO THE DIVISION ARE NOT INDEPENDENTLY VERIFIED

OBSERVATION #5

The division's financial and program data on community mental health centers are provided to the division through quarterly reports prepared by the mental health centers. Currently, the division does not systematically verify the accuracy and consistency of the program data.

Financial data are verified each year through financial audits conducted by independent auditors and reviewed by the division. Because the division uses program data, such as number and type of clients served and units of service provided, for program planning, evaluation, and funding decisions, failure to verify the accuracy and consistency of such data can lead to decisions that do not promote a service system that is as efficient and effective as possible.

The division has developed procedures for data audits that would be used to test and verify the number of total active clients, unduplicated clients served, units of service provided, and the average daily client population for selected programs. It has also conducted pilot testing of these procedures. One weakness appears to be that the procedures do not provide tests to verify that similar services are recorded in comparable program categories. Discussions with mental health center and division staff indicate that some centers may label similar services differently. For example, a service that one center

classifies as part of an independent living housing program, another may classify as part of a supervised apartment housing program. Data accuracy will help ensure a reliable data base while consistency is necessary for a meaningful data base, especially if differences in cost and effectiveness of various program models are to be assessed.

RECOMMENDATION

The division should begin full-scale implementation of the data audit procedures already developed, using either its own staff or contracting, or having the mental health centers contract, with independent auditors. The division should also develop procedures to ensure data consistency among program service categories.

MANAGEMENT LETTERS OF CENTERS ARE NOT REVIEWED REGULARLY

OBSERVATION #6

The division's review of the independent audits of community mental health centers does not include a standard review of management letters that may accompany the audited financial statements.

The management letter may identify other issues not included in the audit report that would enable the division to monitor and assess mental health center activities to a greater extent.

RECOMMENDATION

The division should require the mental health centers to provide it with the management letters along with the audited financial statements and should review all management letters as standard review practice.

COORDINATION OF MENTAL HEALTH SERVICES

Coordination of services within the state's mental health system is especially important since deinstitutionalization and restructuring have reduced the system's reliance on institutions like New Hampshire Hospital. When clients were served primarily by a centralized institution, that institution met all needs for shelter, food, and other such services, as well as mental health services. While community-based services are generally closer to clients' homes and provide less restrictive environments, they also make meeting the needs of clients more complex. Not all services needed by clients at any given time are provided in one location or necessarily by one provider, and thus require more coordination to effectively meet their needs. Clients' needs over a long period may require not only services offered within the community, but also those offered by a designated receiving facility or New Hampshire Hospital. With different levels of service provided by a variety of providers throughout the system, coordination becomes even more important to ensure clients the easiest and smoothest access to services and movement between service levels. Coordination is also necessary to ensure that the individual services available are integrated and function as a true system of care.

The community mental health centers play the primary role in coordinating services since their staff screen most admissions to New Hampshire Hospital and the designated receiving facilities, work with hospital staff to plan hospital discharges, and provide services at general community hospitals, as well as at the mental health center offices. The division has the ultimate responsibility for ensuring that policies, organizational structures, and functional mechanisms are in place that allow and encourage the most effective communication and coordination between service providers in the system and for monitoring the process to determine that appropriate communication and coordination take place.

THE ROLE OF DESIGNATED RECEIVING FACILITIES HAS CHANGED OVER TIME

OBSERVATION #7

The role and level of development of designated receiving facilities (DRFs) have changed from what the 1985 mental health restructuring plan originally outlined. Although the majority of community mental health centers indicate some need for more DRF beds, the division appears to be shifting its emphasis away from the current model of inpatient DRF beds. Data indicates that a DRF can help a region reduce its use of New Hampshire Hospital beds, but that the impact of DRFs may not be long-lasting.

Designated receiving facilities were originally conceived as the "anchor of mental health services in the community," according to the 1985 restructuring plan. DRFs are mental health care units designated by the division to provide secure psychiatric treatment and to serve as regional alternatives to New Hampshire Hospital. Their mission is to provide short-term treatment and stabilization, with a rapid return of the client to community-based treatment. In all existing cases, they are located in general hospitals and have contract agreements with the community mental health center in their respective regions.

Coverage of DRFs

In 1985, five to six DRFs were planned with a total capacity of 84 beds. In 1987, planned beds were expected to total 62 by fiscal year 1988. Currently, there are only three DRFs with a total bed capacity of 45. The division attributes at least part of the slowness in development to a greater reluctance of hospitals to participate in the DRF program than originally anticipated. As an incentive for participation, the division has funded subsidies that allow the mental health centers to pay the DRF a per diem for indigent clients who are not otherwise covered by Medicaid or private insurance. In fiscal year 1989, division data show only one DRF received subsidy payments specifically for clients. However, all DRFs receive some division subsidy for staffing costs.

When surveyed, a majority of the mental health centers indicated some need for additional DRF beds. In response to our survey of all ten centers in October 1989, three of the four centers that have used DRFs said existing beds were not adequate. Of the other six centers without DRFs, three indicated a strong or moderate need for DRF beds in their regions. However, the division appears to be shifting its emphasis away from hospital DRF development. According to the division's plan for mental health services from 1989 to 1992, alternatives to inpatient care provided by DRFs include crisis beds, continuous treatment teams, and intensively supervised apartments. The division director indicates that crisis beds would be designated as DRFs, just as hospital beds are now. These alternatives offer the advantage of lower costs with comparable outcomes, according to the division. The 1989-1992 plan identified a strategy of reallocating resources from DRF subsidies to greater support for these non-hospital alternatives. The division has already implemented this strategy in one region this year.

Role in System

The role of the DRFs in the mental health system appears to have changed since the restructuring plan was developed. The three DRFs generally serve clients only in the DRF's region. Clients in other regions who need DRF services receive them at New Hampshire Hospital, which is designated as the "backup" DRF for all regions. In regions

that do have DRFs, other inpatient care services, namely brief hospitalization, appear to have been absorbed into DRF inpatient services. Division staff suggest that running two different hospital programs in the same region is not likely to be financially feasible or practical. The implications for patient care are not clear.

DRF Effectiveness

The main measure of DRFs' effectiveness is the degree to which they reduce a region's use of New Hampshire Hospital beds. Data indicate that in at least two of the three regions with DRFs, the opening of the DRF was followed by a significant decrease (34% and 42%) related to NHH utilization. However, in 1989, only two to three years after the DRFs opened, decreases stopped and in one case, hospital utilization increased. After the newest DRF opened, just before the beginning of fiscal year 1989, there was actually an increase over fiscal year 1988 in its region's use of New Hampshire Hospital beds. It is not clear whether DRF effects on hospital use are only of short duration or whether unique conditions in fiscal year 1989 contributed to increased hospital use by all DRF regions.

RECOMMENDATION

The division should continue to assess the effectiveness of DRFs as new models are developed and should work to identify and reduce obstacles to achieving and maintaining reduced New Hampshire Hospital admissions. The division should increase communications with mental health centers concerning their need for DRF beds and the feasibility of alternatives such as crisis beds, continuous treatment teams, etc. The division may wish to consider encouraging multi-region use of DRFs but would have to address matters such as staffing and funding for the "sponsoring" mental health center.

COMMUNICATION AND COORDINATION BETWEEN SERVICE LEVELS NEEDS IMPROVEMENT

OBSERVATION #8

Communication and coordination between New Hampshire Hospital and the community mental health centers and designated receiving facilities (DRFs) do not appear to be as strong and consistent as they could be. Gaps in communication and coordination between the different levels of service providers, especially concerning discharges from New Hampshire Hospital, reduce the effectiveness of each service level and prevent service providers from functioning efficiently as part of a unified system of services.

COORDINATION OF MENTAL HEALTH SERVICES (CONTINUED)

Results of an LBA-Audit survey of the mental health centers, as well as interviews with staff of the three DRFs and New Hampshire Hospital, indicate inconsistent coordination between the DRFs and the hospital; in some cases it appears to be quite good, and in other cases not. Open and clear communication concerning transfers of clients from DRFs to the hospital and discharges of clients from the hospital were of special concern. Hospital concerns are that DRFs transfer clients too readily to the hospital, and DRFs' were that clients were discharged too soon from the hospital and without adequate notification to the region.

The survey results also indicate problems in coordination between the mental health centers and New Hampshire Hospital, again, particularly with hospital discharges. Five of the ten centers rated overall coordination between them and the hospital as high. However, when asked specifically about center/hospital coordination of follow-up client treatment after hospital discharge, only one center rated coordination as high; six rated it as moderate and three rated it as poor. A majority of the centers indicated that the one change they would most like to make in their interactions with the hospital is improved communication, coordination, and/or collaboration.

RECOMMENDATION

The division should develop or revise mechanisms to ensure maximum communication and coordination between all service providers, especially with regard to New Hampshire Hospital discharges. The existing designation of a mental health center liaison from each region to the hospital seems to be a good beginning on which to build.

MANAGEMENT INFORMATION SYSTEM WOULD IMPROVE SYSTEM WIDE INTERACTION

OBSERVATION #9

The division's ability to compile, coordinate, process, and analyze a wide variety of program and client service data as efficiently and effectively as possible is hampered by its lack of an adequate computerized management information system.

The existing system:

- does not provide New Hampshire Hospital with a unified information system that links admissions, medical records, pharmacy, and all other key patient services together within the hospital,

- does not allow for tracking clients through the system or for cross-tabulating client and program information across different

levels of services (for example, between New Hampshire Hospital and the community mental health centers or among the individual mental health centers), and

- does not allow the division to compile, compute, and distribute quarterly financial and client service statistical data on community mental health centers promptly because of the lag time between centers' preparation of such data and the division's receipt and compilation of the data.

These weaknesses in the existing system reduce the ability of the hospital to provide client services effectively and efficiently, reduce the division's ability to analyze service trends and demands for planning and evaluation purposes, and reduce the ability of the division and the mental health centers to analyze and use quarterly program data well into the succeeding quarter or even the second succeeding quarter. Long-term tracking of clients, their service use, and their outcomes would also provide useful information for assessing the effectiveness of various types of services and service combinations and could be used to help improve provision.

The division's need for a management information and client tracking system was recognized as early as 1985, in the Planning for Progress report. The division has not received state funding for the proposed Psychiatric Hospital Information System for New Hampshire Hospital, but has received a federal grant to begin preliminary planning of a "Uniform, Integrated Mental Health Data Collection System," which would serve the entire mental health system and be compatible with the Psychiatric Hospital Information System if and when it is funded. The proposed Integrated Mental Health Data Collection System would provide the data collection, coordination, and processing abilities that the existing system lacks.

RECOMMENDATION

The division should continue to pursue planning and development efforts of its proposed centralized computerized management information system and take all intermediate steps possible to improve data collection, coordination, and processing across the mental health system.

NEED FOR CONTINUING EFFORTS TO COORDINATE CHILDREN'S SERVICES

OBSERVATION #10

The lack of a clear legislative mandate for any one state agency to be responsible for comprehensive mental health services for all children and the involvement of at least three separate agencies in providing public mental health services for children indicate a strong need for continuing efforts by all relevant agencies to coordinate and improve children's services.

COORDINATION OF MENTAL HEALTH SERVICES (CONTINUED)

Under RSA 135-C:14, the legislature has designated as optional the Division of Mental Health and Developmental Services'(DMHDS) responsibility for providing children's services. In addition, RSA 135-C:13 provides that eligibility for mental health services for children and youth under 21 years old shall be determined "after consideration" of the services provided under Division of Children and Youth Services and Department of Education statutes. DMHDS provides outpatient services to children through age 17 by its contracts with community mental health centers. Although intake and emergency services are available for all children, only children meeting the division's eligibility criteria (which are similar to adult certification criteria) can receive division-contracted services at the mental health centers.

The Division of Children and Youth's Services' (DCYS) mandate under RSA 169-B, C, and D is to provide comprehensive services, including any mental health services needed, for adjudicated children. These children are basically those who have been abused, neglected, or have committed some offense, and include those identified as "children in need of services" (CHINS).

DCYS provides inpatient and outpatient mental health services to children under its mandate either directly, or through purchase from other providers, including some community mental health centers. DCYS has administered the Philbrook Center for children, on the grounds of New Hampshire Hospital, since 1985 when it was transferred from DMHDS's authority. As of February 1990, it still administered Philbrook, although legislation was in process to transfer it back to DMHDS in order to maximize opportunities for Medicaid reimbursement.

Philbrook is the state's only designated receiving facility to receive involuntary emergency admissions of children under the mental health law provisions (RSA 135-C). Philbrook also admits children for inpatient, psychiatric evaluations ordered by district courts, and children committed to the center by probate courts. In April 1989, Philbrook added a unit to provide longer-term (more than three months) inpatient psychiatric care for children. DCYS also administers the Tobey School on New Hampshire Hospital grounds for children coded as emotionally disturbed by the schools.

Under RSA 186-C, the Department of Education (DOE) is to ensure that all children, ages 3 to 21 years old, who are "educationally handicapped" receive appropriate educational services as designated in their individual education plans. DOE's Special Education Bureau and the local school districts are to work together to ensure that any special education services needed by a child are provided, either at the local school or in another placement. A child with mental or emotional problems may be determined to be educationally handicapped and receive special education services from the local school or another provider.

COORDINATION OF MENTAL HEALTH SERVICES (CONTINUED)

The differing mandates for each of the state agencies, with their differing statutory categories and definitions, leave the possibility for gaps or confusion in agencies' responsibilities for children in particular circumstances. For example, non-adjudicated children who require inpatient mental health services, such as those offered at DCYS-run Philbrook Center, would not be the responsibility of either DMHDS or DCYS under existing statutes, but would fall under the responsibility of the local schools and DOE, assuming the children are determined to be educationally handicapped.

Development of additional community-based residential services for children with mental health needs seems to be an area of unclear responsibility. DCYS staff indicate that they believe it is a DMHDS responsibility. RSA 126-A:39 assigns the director of DMHDS the responsibility of developing a statewide program of community living facilities for individuals with mental illness. However, 186-C:22 provides that DOE, with technical assistance from DMHDS, is primarily responsible for community-based residential and educational services for severely emotionally disturbed children. The DMHDS mental health services plan for 1989-1992 indicates that these services should be primarily the responsibility of DOE and DCYS.

DMHDS identifies lack of planning and service coordination as one of the current weaknesses in the state's provision of children's mental health services. It would appear that this must be addressed first before other problems identified by DMHDS can be addressed, including the need for more case management, day treatment, specialized inpatient, in-home support, and a variety of housing services; the lack of priority attention given to children discharged from psychiatric hospitals and other residential treatment services; and the need for further reduction of out-of-home placements.

Preliminary coordination work has started under the federal Child and Adolescent Services System Planning grant (CASSP). DMHDS staff indicate that one interagency agreement has been signed between DMHDS and DCYS, and work is in process on an interdepartmental agreement between the Department of Health and Human Services (which oversees both DMHDS and DCYS) and the Department of Education. According to DMHDS, it has had agreements with DOE covering various areas, and those continue to evolve.

RECOMMENDATION

The three state agencies primarily responsible for children's mental health services, as well as the local schools, should continue to dedicate themselves to developing coordinated planning and service mechanisms, definitions, evaluation and placement criteria, and other tools to ensure effective and cost-efficient services to all children with mental health needs.

EFFECTIVENESS OF MENTAL HEALTH SERVICES

Effectiveness, in the context of performance auditing, is measured by comparing actual performance against an ideal or standard. "Effectiveness implies that as a result of habilitation or treatment, [clients']...quality of life will improve, to the extent possible." (Planning For Progress, p. 7) Analysis of program effectiveness can help determine whether programs achieve their objectives and to generate recommendations for improvement.

To maintain our focus on the overall system of mental health services, we chose not to evaluate the effectiveness of specific community mental health services. Instead, we reviewed findings of the division's Office of Evaluation and Quality Assurance, which assesses and works to ensure the effectiveness of mental health center policies and performance.

The LBA also surveyed, by mail, the ten community mental health centers in October 1989, regarding the quality of regional mental health services. The survey asked centers to judge the services they provide, and to consider those offered by other providers in the region.

The majority of community mental health centers (6) rated the quality of adult inpatient and housing services as "good", while the other centers rated them "fair". Eight centers gave a "good" rating to outpatient services, but the centers were divided over the quality of children services, with half each rating them as "good" or "fair." Seven of the ten mental health centers rated elderly services as "fair."

THE BASIS OF QUALITY ASSESSMENT IS NOT TIED TO OUTCOME MEASURES

OBSERVATION #11

Program standards are the principal basis for monitoring the quality of community mental health services in New Hampshire. Although program standards are necessary to define basic guidelines for service provision, and are commonly used in the profession to evaluate services, other outcome-oriented measures of program effectiveness need to be developed that tie the delivery of mental health services to resulting improvement, or the lack thereof, in client conditions and behavior. In the absence of outcome effectiveness measures, the division cannot evaluate which service models and which providers are delivering the most effective programs to mentally ill clients.

EFFECTIVENESS OF MENTAL HEALTH SERVICES (CONTINUED)

Program standards concern the administrative and clinical facets of care, such as staff levels, training and duties, record keeping, treatment and emergency procedures. Outcome measures proposed by the division would directly address the daily living and social conditions of clients and their capacity to cope with psychiatric symptoms and behavior, the needs for employment and housing and other independent living issues.

One monitoring tool, currently used as part of regular quality assurance reviews of community mental health centers, is intended to assess the appropriateness of care provided by the centers. The "Client Tracking System," which involves direct client contact, documentary research, and staff interviews by quality assurance, is the division tool that appears to come closest to evaluating the outcome of client care, but it is extremely limited.

Although the Quality Assurance office looks at the progress of a percentage of the clients it tracks with the current system, quality assurance does not systematically track clients over a long term. The office's choice of a small client sample for review is unmethodical and relies too heavily on certain quality assurance staff and their personal knowledge of clients. A systematic selection of clients for long-term tracking would provide more useful information, until the division establishes an outcome-oriented monitoring system, currently in planning stages.

The planned system will be a more comprehensive system to measure the outcome of treatment and services for clients based on four categories: the time clients have been in the community, and housing, vocational services and social supports. With outcome measures, the division will be able to assess client movement along a continuum of independent functioning in each of the four categories. An outcome-oriented measurement system would provide the necessary data to enable the division to determine which program models are best at helping clients move toward greater independence in less restrictive environments.

RECOMMENDATION

The division should develop its proposed outcome-oriented monitoring system, and should use the information gained from it to promote the most effective program models for services. The division should also concentrate on methods to evaluate clients longitudinally to obtain clearer evidence of the success or failure of current program models in helping clients prosper.

THE DIVISION DOES NOT CONDUCT SITE REVIEWS OF CENTERS ANNUALLY

OBSERVATION #12

The division does not conduct quality assurance site reviews at all community mental health centers annually, despite their usefulness in identifying problems at the centers. Quality Assurance staff indicate, and related documents support, that the division's original intent was to conduct quality assurance site surveys at all the centers on an annual basis. The surveys, by which the division evaluates the clinical and administrative activities of the mental health centers, generate information used by the division in planning and in contract negotiations with the centers.

During the last six years, the division has surveyed each of the ten centers an average of every 17 months, according to quality assurance schedules of reviewed contract programs from fiscal year 1985 through fiscal year 1990. Fiscal year 1985 is the last time the division completed site reviews in all regions. In 1983 and 1984, the division also conducted surveys at all the centers. The schedules show that only one mental health center received surveys during each of the last six years. During the same period, one center went as long as 42 months unsurveyed, two were surveyed only twice, while two others were surveyed three times.

The quality assurance staff also select roughly 11 to 13 areas from a field of approximately 19 possible survey areas for each survey. The areas include client rights, the client-centered conference, placement into the mental health service delivery system, case management, treatment and support services, housing and vocational training and others.

RECOMMENDATION

To better ensure compliance with standards and to avoid extended absences from the centers, the division should consider ways to survey all mental health centers each fiscal year. A decrease every other year in the coverage of survey areas when their exclusion would not compromise other survey areas, or the addition of more staff in site survey work are possible steps toward this goal.

THE DIVISION HAS NOT DEVELOPED STRONG ACTIONS TO ENSURE COMPLIANCE IN NON-PROGRAM AREAS

OBSERVATION #13

Beyond the site survey/corrective action process, the division has not developed stronger actions to ensure compliance in survey areas that are not program-specific, such as deficiencies related to client rights. To bring about greater compliance in programs it monitors at the community mental health centers, such as vocational, housing and emergency services, the division occasionally sets aside money in a development fund, common to each center, which the non-compliant center may access only after its program improves sufficiently.

Our review of division site survey reports indicates that centers are recalcitrant in program specific areas, as well as areas that are not program-specific. An example of a non-program area is the client centered conference, at which a client's treatment and individual goals are determined and client rights issues are discussed.

In its fiscal year 1988 Summary of Community Mental Health Site Surveys, the Office of Evaluation and Quality Assurance reported that all mental health centers had deficiencies concerning the client-centered conference. The summary states that centers have failed to conduct conferences, to assure client attendance and to satisfactorily document the meetings. At one center, the division reported only 30 of 150 active clients had received a client-centered conference, while a fiscal year 1989 summary indicates that all but one center had deficiencies in this survey area.

RECOMMENDATION

The division should develop stronger measures, possibly monetary, to encourage compliance in non-program areas, just as it does in specific program areas such as vocational and housing services.

THE QUALITY ASSURANCE OFFICE LACKS AN INDEX OF SITE SURVEY CORRECTIVE ACTIONS

OBSERVATION #14

Despite extensive documentation, the Quality Assurance office lacks a listing or index of each mental health center's status in correcting deficiencies cited in division site reviews. A chronological index of deficiencies and corresponding corrective actions would provide a record of each center's compliance progress. It would serve as a permanent accessible source of information for staff not directly or currently involved in quality assurance activities. Also, a synopsis of compliance steps would be effective in coordinating the activities and goals of both quality assurance staff and review specialists; review specialists work closely with each center throughout the year to correct their deficiencies and develop their strengths. The specialists cooperate with quality assurance staff for site surveys by providing written and consultative analysis of community mental health centers.

RECOMMENDATION

The division's Office of Evaluation and Quality Assurance should maintain a permanent, chronological index or listing of each mental health center's deficiencies and corrective actions in order for division staff to better monitor the progress of centers toward compliance.

ADEQUACY AND ACCESSIBILITY OF MENTAL HEALTH SERVICES

The adequacy and accessibility of community mental health services are measured by the degree to which people needing psychiatric care receive the services their conditions require when they are required. In trying to provide services that are adequate and accessible, the division faces a variety of diagnoses and degrees of mental illness demanding individual service plans. This mandate for personalized care drives the division's efforts to coordinate, monitor, and provide community mental health services.

In response to our October 1989 survey of mental health centers, seven of ten centers rated the availability of adult inpatient and outpatient services in their regions as "adequate." However, most (9 of 10) rated availability of adult housing and all services for children and the elderly as "not adequate." Most centers also rated services for the mentally ill homeless population as "not adequate."

On the issue of accessibility, most mental health centers reported that community services were "well-publicized" and "well-known." However, only three of the centers said services were "easy to obtain." The other seven rated services overall as "obtainable, but with some difficulty."

To determine the adequacy and accessibility of state-funded mental health services in New Hampshire, we concentrated on several areas: housing services, the homeless mentally ill, unmet needs/waiting lists and client eligibility (certification).

COMMUNITY HOUSING FOR CLIENTS IS INSUFFICIENT

OBSERVATION #15

Housing for the mentally ill is insufficient to meet the needs of clients currently receiving state mental health services, as the demand for community-based housing continues to out-pace the supply. Although the division allocates 40 percent ($9.1 million) of its community mental health center funds to housing programs and declares one of its current biennium goals is to "provide additional residential support services to address the waiting list of individuals who are in need of residences within the community," housing services are insufficient.

Eight of the nine mental health centers that provide housing have current waiting lists for that service. Results of our survey of the mental health centers show that, as of October 1989, the eight centers had a total of 107 clients waiting for housing, ranging from 4 to 25 clients in individual regions. A division survey of all ten regions done in March 1989 identified 298 clients awaiting housing.

In addition to clients in the community, New Hampshire Hospital clients also await community housing beds. The hospital and division report that, at any given time, some hospital clients who are ready for community housing are unable to leave because of bed shortages. For example, in March 1989, the division identified 43 clients waiting for community housing; in May the division and mental health centers identified 31 hospital clients ready for community placement.

The kinds of community housing, and not just the quantity of available beds, is part of the problem; housing that is inappropriate for a given client still does not satisfy the need for shelter in the community if the bed is more restrictive than necessary. Division housing programs include community residences or group homes, varying levels of supported or supervised apartments, crisis housing and respite care. An inadequate supply of particular housing options can mean that some clients are placed or remain in housing that is unsuitably restrictive by division standards.

The division's quality assurance surveys of mental health centers often identify clients whose housing placements do not conform to the division standard to provide the least restrictive environment given each client's needs. Some client placements have been to homeless shelters. The division's current plan reports that as of July, 1988, there were 473 persons known by community mental health centers to be in substandard housing or in housing with insufficient support. Mental health centers responding to our survey indicate that crisis beds and supervised apartments (supported housing) are some of their most pressing needs.

RECOMMENDATION

The division should continue its efforts to expand housing options in the community. As the housing environment in New Hampshire changes, the division should make renewed efforts to educate landlords, developers, and others in the housing industry about the special housing needs of mentally ill persons and about ways to meet those needs.

INCREASED DATA COLLECTION EFFORTS COULD IMPROVE TARGETING OF SERVICES TO THE MENTALLY ILL HOMELESS

OBSERVATION #16

Studies reviewed by the LBA indicate the majority of homeless people are not mentally ill. However, no precise estimate of that subgroup exists. The estimates of 18 studies conducted throughout the nation between 1983 and 1988 range from as low as 10 percent to as high as 56 percent, with an average of 28 percent. A 1988 study by the New Hampshire Task Force on Homelessness estimates that 30 percent, or about 4,300, of the state's homeless are mentally ill. Although presently very active in assisting the state's homeless population, the division could improve targeting of services to the homeless mentally ill through expanded data collection efforts.

Division Activities

The division's current activities on behalf of the homeless include the administration of federal funds available through the Stewart B. McKinney Homeless Assistance Act, and oversight of two HUD grants: Permanent Housing for the Homeless Handicapped and Supplemental Assistance for Facilities Assisting the Homeless. Under the state's Emergency Shelter Grant-in-Aid program, the division also contracts with 26 non-profit shelters serving homeless persons.

The division also oversees the Mental Health Services to Homeless (MHSH) Block Grant, specifically addressing the homeless mentally ill. The division received $267,944 under the MHSH Grant in fiscal year 1988, which it allocated to six community mental health centers. With the grant, centers are to provide services for the homeless chronically mentally ill persons as well as those at risk of becoming homeless, including diagnostic, rehabilitative and referral services, outreach, crisis intervention and case management.

Each of the two survey tools currently used by the division to collect data on homeless services, the Review Tool for Emergency Shelter Facilities and the Homelessness Service Providers Monthly Utilization Report, has only one question regarding shelter use of local mental health centers. The division could expand the number of questions included on these survey tools to obtain more comprehensive data on mental illness among the homeless and needed services.

ADEQUACY AND ACCESSIBILITY OF MENTAL HEALTH SERVICES (CONTINUED)

Prevalence Estimates

Our audit survey of seven community mental health centers shows that, as of September 1989, centers estimated the number of homeless and near homeless clients (those living in temporary circumstances or with family) to be about 1.6 percent of their active clients. Eighty homeless and an additional 153 near homeless were reported by the responding community mental health centers.

There are several problems in identifying the prevalence of mental illness among the homeless. Researchers use widely dissimilar methods to measure illness in sample populations, such as expert judgement, self-reported symptoms, structured interviews, record abstracts and provider estimates, or standardized psychiatric scales that measure the extent of depressive and psychotic symptoms.

Rates of psychiatric disorder vary dramatically depending on whether current symptoms, clinical diagnosis or treatment history is used. The accuracy of research is also affected by inconsistent sample characteristics like homeless mobility and diffusion throughout communities and movement in and out of homelessness. Regional and municipal attributes like economic development, housing alternatives and governmental assistance all affect the variation of estimates.

Challenging the assumption of many studies that mental disorders precipitate homelessness, research now suggests that mental illness or symptoms similar to mental illness tend to result from homelessness. Current work in the field tends to identify conditions of extreme poverty such as unemployment, income loss or debt, family crisis, homelessness, disability, malnutrition, or physical abuse as the catalysts or precipitants of mental disorders. In addition, recent analysis shows that what appears to researchers and laymen as serious mental illness, may often be psychiatric symptoms resembling those of mental illness brought on by impoverished conditions or be exaggerated or aberrant behavior that helps victims of homelessness adapt to their circumstances.

RECOMMENDATION

For the purposes of planning, analysis and coordination, the division should increase its efforts to track, collect and disseminate information about the homeless mentally ill population as a component of the entire New Hampshire homeless population, for which it is now responsible. One option is to increase the number and scope of questions concerning that subgroup in survey tools already available to the division. The division should also increase efforts to locate housing for homeless clients, and to support the development of preventive homeless services at the centers such as rental and security deposit assistance and other outreach services.

THE DIVISION DOES NOT TRACK UNMET CMHC CLIENT NEEDS SYSTEMATICALLY

OBSERVATION #17

The division does not regularly collect data on the number of clients on mental health center waiting lists and thus cannot fully document trends in the number of clients needing services that are unavailable. While waiting lists do not necessarily reflect the total number of persons waiting for services, (at least one mental health center does not keep formal waiting lists), they are evidence of the number of clients in need of particular services that are at full capacity. The division does collect comprehensive data on services needed by New Hampshire Hospital clients in order to return to their communities.

The division also does not maintain a "needed services database," as required by its rules. Administrative rule He-M 401.08 requires centers to notify the division, in writing, of services which are needed but are not offered by current providers, and requires the division to maintain a related database. RSA 135-C:13 also requires community mental health centers to notify the division of unavailable client services.

Division and mental health center staff indicate that centers do inform the division of clients' unmet needs, but not necessarily formally or in writing. The division receives data on these needs from a variety of other sources such as regular meetings with mental health center directors, the Mental Health Planning Advisory Council, quality assurance activities, and others. However, there appears to be no systematic or standardized format for compiling the data, as the requirement for a database suggests. Formalized documentation of unmet client service needs, received on a regular basis, would enhance the division's ability to track changes in the amount and type of services needed for each region over time.

Better data and documentation of needed but unavailable services would also provide the division with a more comprehensive information base to address questions and concerns of the public, press, legislators, clients and families about the statewide availability of services. Compiling waiting list data from all the centers on a regular basis would provide the division with more information to plan programs and to analyze long-term trends in service needs. Over the past three years, the mental health centers have maintained waiting lists for housing, vocational, partial hospitalization, case management, maintenance, and children's services.

RECOMMENDATION

The division should begin compiling waiting list data from community mental health centers on a regular basis and should develop a system for documenting identified service needs in a formal, standardized database.

CERTIFICATION REVIEWS LACK REGULARITY & BREADTH

OBSERVATION #18

The division has not conducted regular certification reviews of all mental health centers during the last two fiscal years. Certification reviews test the eligibility of clients served by state-contracted programs. The division last conducted certification reviews at all community mental health centers during 1986 and 1987. In 1988, the division did not conduct any certification reviews. In 1989, it reviewed certification for chronically mentally ill in four of the ten mental health centers, but excluded clients diagnosed as seriously mentally ill, which comprise about one half of the certified population.

Because of clinical relevance of client certification and its use in contracting, the division's stated policy has been to monitor it during annual quality assurance site visits. However, 1985 was the last year during which the division carried out site visits at all community mental health centers. **(See p. 75)**

Certification reviews ensure the accuracy of client eligibility, and thereby affect the cost assumed by the state for yearly contracts with the mental health centers. Certification is the principal means by which the state guarantees services to the most seriously mentally ill and is a prerequisite for clients to receive many division-contracted services in the community.

In order to receive mental health services at the expense of the state, chronically and severely mentally ill persons must be certified (approved) by the centers, according to criteria outlined in division standards He-M 401.04 and 401.05. The criteria include psychiatric history and diagnosis, behavioral impairment, and inability to improve by other means.

The division has cited conditions that have made annual certification reviews impractical for fiscal years 1989 and 1990. According to a division official, the transfer of one quality assurance staff and the resignation of the division medical director forced the quality assurance staff to omit the fiscal year 1988 certification reviews.

RECOMMENDATION

Because certification is the basis for determining eligibility for most state-funded programs, the division should review the certifications of both the seriously and chronically mentally ill at all community mental health centers on an annual or biennial review cycle.

OTHER ISSUES CONCERNING MENTAL HEALTH SERVICES

In this section, we outline various points that came to our attention throughout our audit, but which we have not developed or explored in depth. No observations and recommendations are presented in connection with these issues. However, they may touch on areas that the division, the legislature, or other interested parties may wish to give additional attention or consider for further study in the future. The points presented below include various legal and client issues, as well as information from our October 1989 survey of the ten community mental health centers that has not been presented elsewhere in the report.

LEGAL ISSUES

Involuntary Emergency Admissions Criteria

Criteria for involuntary admission and commitment to state psychiatric hospitals throughout the country generally became more restrictive after the mid-1950s, when total state hospital populations were at their peak. New Hampshire's mental health laws were revised in 1973 to establish civil procedures relating to the admission and treatment of the mentally ill. Provisions included restricting involuntary emergency admissions to those individuals whose mental condition, as a result of mental illness, created a "strong likelihood of danger" to themselves or others. Subsequent revisions of the law added specific criteria defining behaviors that would be considered dangerous and shortening involuntary emergency admissions from 30 to 10 days. In 1986 involuntary emergency admission statutes were revised to loosen admission criteria. Among the changes, eligibility for admission based on a "strong likelihood" of danger was changed to just a "likelihood" of danger to self or others.

We reviewed involuntary admission laws in four of the other states, in addition to New Hampshire, that were nationally rated as among the top in mental health service provision: Wisconsin, Maine, Vermont, and Connecticut. We also reviewed Massachusetts's laws. New Hampshire's involuntary emergency admission criteria and procedures are generally consistent with those we reviewed.

In our survey of the community mental health centers, we asked them to rate the current involuntary emergency admission laws on their effectiveness in three areas. Eight of the ten centers rated the laws as "very effective" in protecting clients' rights, while the same number of centers rated them as only "somewhat effective" in assuring the safety of individuals and society. Nine of the ten consider current involuntary admission laws "somewhat effective" in assuring that mental health services are provided to those who need them.

The survey also asked whether involuntary emergency admission laws needed revision. Nine of the ten mental health centers thought they did. All of the centers suggested changes that would broaden the criteria for admission in various ways. While selected police we talked to also generally favored broadening the criteria for involuntary admissions, staff of the division and New Hampshire Hospital generally thought the existing criteria were appropriate.

Incompetency and Involuntary Admissions

Because the laws governing involuntary admission to the state's mental health system and those governing criminal defendants' competency to stand trial are based on different criteria, they leave a gap which can allow individuals accused of crimes to be declared incompetent to stand trial yet also found not sufficiently dangerous to be involuntarily admitted to the mental health system. Unless these people seek mental health treatment voluntarily, their problems go unaddressed by either the mental health system or the correctional system.

While such a gap would generally only occur in cases involving less serious crimes, such as criminal mischief, the individuals involved may repeat such actions until they receive some kind of treatment. Defendants who are ruled incompetent to stand trial for more serious, violent crimes would, in all likelihood, meet the criteria of a danger to themselves or others to be involuntarily admitted to the mental health system.

Possible means for addressing the gap left by the mental health and criminal justice laws include revising involuntary admissions criteria for those persons declared incompetent to stand trial for criminal offenses.

Outpatient Commitments

Although the law currently provides for courts to involuntarily commit individuals to outpatient mental health services, including community mental health centers (RSA 135-C:45), this provision appears to be little used. The division does not currently collect data on outpatient commitments to mental health centers. There do not appear to be any criteria or procedures that specifically address outpatient commitments, other than the statutory provision that the court retains jurisdiction of the case if there is an order for treatment at a facility other than an inpatient receiving facility. The criteria for nonemergency, involuntary admissions currently address admissions to receiving facilities only.

Outpatient commitment may be a useful alternative to inpatient commitment for those clients with a history of multiple hospitalizations, who have been shown to benefit from treatment, but who do not comply with community treatment, especially if used in conjunction with other outreach services such as continuous treatment teams. Increased use of outpatient commitment might be encouraged through development of clear criteria and procedures to be used specifically for outpatient commitment orders and their enforcement. North Carolina is one state that has implemented more detailed statutory provisions specifically for the use of outpatient commitment.

CLIENT ISSUES

Services for Elderly

Despite a nationwide trend of an increasing elderly population, and thus a likely need for increased mental health services at all levels for this population, the division is in the process of reducing the long-term nursing care beds at New Hampshire Hospital's Intermediate Care Facility for elderly mentally ill. According to hospital staff, this reduction is a budget-cutting measure, as it will allow the hospital to close another building. The plan is to reduce beds approximately 46 percent from the 240 that were available in 1986. Glencliff Home, which also provides care for elderly mentally ill, has no plans to expand in the near future and currently has a waiting list of those seeking placement there. With the likelihood of increasing demand for elderly mental health services, as well as the growing issue of treatment for Alzheimer's disease, planning for additional elderly inpatient beds may need to be made a higher priority.

Readmissions

One criticism of stricter commitment criteria and overall shorter client stays at psychiatric hospitals in recent years is that they have turned hospitals into "revolving doors," with clients being readmitted over and over again, and discharged before they can cope with their illness for any length of time in the community. In New Hampshire, there is some evidence that readmissions have increased more than new admissions.

Between 1955 and 1971, total admissions to New Hampshire Hospital continued to increase although client census was steadily declining, suggesting decreases in average length of client stays. During that period, new, first-time admissions and readmissions increased at about the same rate as total admissions. However, when total admissions began declining after 1971, new admissions decreased to a much greater extent than readmissions. As a result, the number of readmissions have exceeded new admissions consistently since 1974. The data suggest that the stricter hospital commitment criteria established in 1973 had some effect on readmission rates.

Division data on clients' average length of stay from 1983 through 1989 show that the number of readmissions varies conversely with the average length of stay. In years where average length of stay increased, the number of readmissions decreased, and vice versa. A direct cause and effect cannot necessarily be assumed because length of stay data for a given year were not necessarily for the same clients who had readmissions in that year.

According to hospital officials, increased numbers of readmissions do not indicate inadequate or ineffective treatment. They cite the nature of mental illness itself, which often follows a cyclical pattern of relapse and remission. Although some of the professional literature suggests that one, relatively longer, hospital stay initially may be more therapeutic than several short stays, division and hospital staff said that shorter stays help clients avoid the "institutionalization" syndrome of passivity and helplessness and allow them to remain in less restrictive environments when hospitalization is not required. Hospital staff do track readmissions of clients and said they work to lengthen the time between admissions and address those factors that contributed to the readmission.

SURVEY POINTS
(See Appendix B for a copy of the survey instrument and full results.)

Staffing

Average staffing reported by the ten mental health centers for fiscal year 1989 was 126. Turnover for all centers was about 13 percent, although two centers had rates as high as 25 percent. Eight of the ten centers rated the level of competition for staff from private facilities as high.

Certification Criteria

The majority of centers rated the division's certification criteria for seriously mentally ill and chronically mentally ill as "appropriate." Eight of the ten centers said certification criteria were "moderately effective" in ensuring that the most seriously ill clients were served; the other two rated them as "very effective." Despite general approval of the certification criteria, six of the ten centers said they needed to be changed. Suggestions for change included broadening the criteria to include clients with addictions, substance abuse, or antisocial behavior, to include less ill clients who cannot afford private services, and to allow clients to remain certified longer once they start improving.

OTHER ISSUES CONCERNING MENTAL HEALTH SERVICES (CONTINUED)

Vocational Services

Seven of ten centers rated employers in their regions "somewhat receptive" to employing mentally ill clients; two rated them "very receptive." Three centers reported having clients who were employable but for whom jobs were not available during fiscal year 1989. Eight centers reported a total of 513 clients who became employed in that same year.

Working Relationships

The centers had split opinions on their working relationship with the division. Three rated it "very good," four said "good," two rated it "fair," and one, "poor." Half the centers agreed their relationship was "much better" now than it was five years ago. Four said it was "somewhat better," and only one rated it as "worse" than five years ago.

As for the centers' working relationships with other agencies, eight rated their relationships with the other centers as either "good" or "very good." With only three categories — good, fair, and poor — the majority of centers rated their relationships with police, other law enforcement, and homeless shelters in their regions as good. They were evenly split between characterizing their relationships with local hospitals as "good" or "fair."

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March 19, 1990

TO: WILLIAM KIDDER, CHAIRMAN
LEGISLATIVE FISCAL COMMITTEE

FROM: DONALD L. SHUMWAY, DIRECTOR
DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL SERVICES

RE: LBA PERFORMANCE AUDIT

In responding to the Performance Audit of the Mental Health Services System, I would like to first compliment the LBA audit staff for a thorough and thoughtful product. We find this audit helpful to our management priority setting. We also find this audit a validation of many of the efforts we have been engaged in to provide accountable, life-supporting services to some of the most needy citizens of this state.

Given the stresses of these times, we are especially appreciative of the findings on Page 2 of the audit where it indicates that we have had many successes in transitioning clients from expensive institutional care to community services and that we have done so with "well defined systems of accountability in place". The staff of the Division have worked with skill and diligence in developing an accredited acute psychiatric hospital and an affiliation with Dartmouth Medical School. We also appreciate the recognition of our use of private grant funds to establish continuous treatment (outreach) teams in the community, and our establishing successful vocational training and placement programs. We are thankful for the support we have received from this Committee and the Legislature as a whole.

We also took to heart the suggestions that the LBA made for further improvements in the mental health system. We do not take exception to any of the listed audit findings. In most cases we are proceeding in directions that are indicated and find the audit a helpful refocusing on management issues. We would particularly like to comment on the findings in number 15 and number 16.

#15 The community housing needs of our citizens with mental illness continues to outpace the supply. We are the only state that has reduced and stabilized our high cost institutional population. We will not be able to maintain that stability without additional community housing support. We are planning new low cost models of outreach housing support and would hope to have them considered in the future. Instead of looking to group homes, where a fairly constant, shift staffing pattern occurs, supported housing is based on a client's personal choice of apartment (or other setting). The agency titrates its staffing to the minimum necessary levels such as phone contact, crisis outreach, routine visits, or crisis supervision. This offers the best hope of an economical support base for our clients.

#16 Again, we are the only state to have both a major homeless shelter development effort, as well as a community mental health-to-shelter liaison effort managed concurrently by a state mental health administration. We will continue to develop the homeless prevention/transition programs on behalf of mentally ill persons. We are expanding our planning effort per the recommendation.

I assure the Fiscal Committee that we will further develop the accountability mechanisms listed in the audit to the extent of our resource capabilities. It should be noted, however, that major personnel reductions have limited our capacities. Again we thank LBA staff and the Fiscal Committee for their support to mentally disabled people.

DLS:mry

SUMMARY OF RESPONSES

OFFICE OF LEGISLATIVE BUDGET ASSISTANT
SURVEY OF COMMUNITY MENTAL HEALTH CENTERS

OCTOBER 13, 1989

Please respond to the following questions by choosing the one best answer. If you feel you have no basis on which to form an opinion, simply indicate your answer as "Don't Know." Please feel free to add any comments or explanations you wish to make to the questions or to your responses.

All survey responses will be kept strictly confidential. Results of the survey will only be reported in the aggregate so that specific regions cannot be identified.

We would appreciate your participation in order that we can prepare a more accurate and comprehensive report on New Hampshire's mental health system.

ORGANIZATION AND COORDINATION

1. Overall, how would you rate the effectiveness of the state's current structure of mental health services with community mental health centers, designated receiving facilities (DRFs), and New Hampshire Hospital?

3 very effective	7 somewhat effective
____ not very effective	____ don't know

2. How would you rate the Division of Mental Health and Developmental Services' overall coordination of the three levels of mental health services?

1 very good	6 good	2 fair
1 not very good	____ poor	____ don't know

3. How would you rate the degree of coordination between the following service provider levels in your region? (check one response for each item)

	High	Moderate	Low	Don't know	Does not apply
a. mental health center and DRF?	2	1	1	____	6
b. DRF and New Hampshire Hospital?	2	____	2	1	5
c. mental health center and New Hampshire Hospital?	5	4	1	____	____

NOTE: When all ten mental health centers did not respond to a question, the number that did respond is indicated in parentheses.

4. a. FOR CENTERS CURRENTLY USING A DRF: How adequate are the number of DRF beds for the needs of clients in your region?

(4) ___ more than adequate _1_ adequate _3_ not adequate ___ don't know

b. FOR CENTERS NOT USING A DRF: How would you rate the need in your region for DRF beds?

(6) _1_ strong need _2_ moderate need _3_ slight need ___ don't know

5. How would you rate the effectiveness of DRFs in serving their intended client population?

(9) _3_ good ____ fair _3_ poor _3_ don't know

6. a. How adequate is your current allotment (fiscal year 1990) of New Hampshire Hospital beds for the needs of your clients?

___ more than adequate _3_ adequate _7_ not adequate ___ don't know

b. How adequate was last year's (fiscal year 1989) allotment of New Hampshire Hospital beds?

___ more than adequate _4_ adequate _6_ not adequate ___ don't know

7. How would you rate the effectiveness of New Hampshire Hospital in serving their intended client population?

_5_ good _4_ fair _1_ poor ____ don't know

8. How would you rate the level of competition from other private (for-profit) mental health facilities for your center's:

	High	Moderate	Low	Don't know
a. staff?	8	2	____	____
(9) b. paying clients?	6	2	____	1

9. To what degree does the competition from other private mental health facilities affect the ability of your center to operate efficiently and effectively?

_2_ a high degree _6_ moderate degree _2_ low degree ___ don't know

ADMINISTRATION AND CONTROL

10. How important is the state's designation of your agency as a "community mental health center" to the successful operation of your agency?

__10__ very important ____ moderately important
____ not important ____ don't know

11. How would you rate the Division of Mental Health and Developmental Services' controls over the revenues and expenditures of your agency's state-funded programs? (for example, financial records required, independent audits, financial reviews, etc.)

__9__ burdensome (too many and/or too strict controls)
__1__ adequate
____ not adequate (too few and/or too loose controls)
____ don't know

12. How much have the Division's financial controls over your agency's state-funded programs changed in the last five years?

__6__ much stricter now __2__ a little stricter now
____ much looser now ____ a little looser now
__2__ stayed about the same ____ don't know

13. How would you rate the Division's controls over the clients served, units of service provided, staffing, and other program elements of your agency's state-funded programs? (for example, program records required, quality assurance or program reviews, staffing requirements, etc.)

__9__ burdensome (too many and/or too strict controls)
__1__ adequate
____ not adequate (too few and/or too loose controls)
____ don't know

14. How much have the Division's program controls over your agency's state-funded programs changed in the last five years?

__6__ much stricter now __2__ a little stricter now
____ much looser now ____ a little looser now
__2__ stayed about the same ____ don't know

15. If you could make one change in the way the Division administers its contract with your agency, what would it be?

(9) **Two centers each suggested reducing controls over details and reducing duplicative monitoring. Other suggestions addressed cash flow, fixed rate per service unit, incentives, and business needs.**

CLIENT DATA AND STAFFING

16. Please indicate the number of unduplicated clients served in your agency's state-funded programs for the year July 1, 1988, through June 30, 1989, by the following diagnostic categories:

(8)

1,530	schizophrenic disorder	3,344	affective disorder
1,173	substance abuse disorder	799	personality disorder
372	organic mental disorder	5,124	adjustment disorder
233	impulse control disorder	1,138	anxiety disorder
86	paranoid disorder	1,659	all other disorders
413	psychosis not classified elsewhere	192	diagnosis unknown

17. Please indicate the number of unduplicated clients served in your agency's state-funded programs for the year July 1, 1988, through June 30, 1989, by their sex:

8,521 male 11,525 female 103 unknown

18. Please indicate the number of unduplicated clients served in your agency's state-funded programs for the year July 1, 1988, through June 30, 1989, by the following age categories:

4,509 0 - 17 years old 156 age category unknown

4,666 18 - 34 years old >

(6) 3,104 35 - 49 years old > > > 12,812 18 - 59 years old if more

915 50 - 59 years old > specific data is not available (10)

2,533 60 years or older

19. Please indicate the number of unduplicated clients screened through the intake process by your agency for the year July 1, 1988, through June 30, 1989, who:

724 were admitted to a designated receiving facility voluntarily

(4) 88 were admitted to a DRF involuntarily

(6) agency does not use a DRF

20. Please indicate the total number of unduplicated clients served in your agency's non-funded programs for the year July 1, 1988, through
(9) June 30, 1989: 10,924 (1 no data available)

21. How would you rate the appropriateness of existing criteria for certifying clients?

SMI:	too strict	2	appropriate	8	too lenient _____
CMI:	too strict	3	appropriate	7	too lenient _____

22. How effective is the certification system in ensuring that the most seriously ill clients receive needed services?

2	very effective	8	moderately effective
____	not effective	____	don't know

23. Do the criteria for certification need to be changed?
6 yes 4 no

(6) If so, how? **All suggestions were to broaden criteria or definitions in various ways, such as including clients with addictions, substance abuse, antisocial behavior, less ill clients on public welfare, etc. Other suggestions were to not remove certification as fast for those starting to improve and clarifying children's standards.**

24. How many full-time equivalent staff did your agency have (on average) during the year July 1, 1988, through June 30, 1989? 1,260

25. What was your staff turnover during that same year?
(respond with either percent turnover or actual number of full-time equivalent staff who left during the year)

(9) 12.6 % (Total) (1) no data available

26. What is the current average case load for case managers in your agency? 364

27. What was the average case load for case managers last year? 384

FUNDED SERVICES

28. Please indicate how many clients your agency had on waiting lists for the Division-funded programs listed below on the dates specified. If data is not available for all dates, please indicate "NA." If there were no clients on waiting lists at certain dates, please indicate "0."

	10/1/89 or Most Current	6/30/89	6/30/88	6/30/87
a. Housing	107 (8)	92 (5)	84 (3)	95 (3)
b. Vocational Services	35 (3)	22 (3)	31 (2)	17 (1)

(6) Please list any other services for which your agency maintains waiting lists and the number of clients waiting: **Two centers each listed children's services and restorative/rehabilitative partial hospitalization. One center each listed case management, maintenance, adult outpatient, and adult non-certified services.**

29. How has the number of beds in Division-funded housing programs changed from a year ago?

(9) gained 5 lost _____ stayed the same 4

30. If your agency has lost beds, how many? _____
(0) To what do you attribute this loss? _____

_____

31. Please rank the following housing options by need in your region. (1= most needed, 2 = second most needed, . . . 6= least needed)

(7) 2.29 independent living
(9) 1.88 supervised apartments
(9) 3.44 community residences
(8) 1.87 crisis housing
(6) 4.00 respite care

(Scores are average combined response.)

32. What client populations are hardest to place in appropriate housing? (for example, clients with families, elderly clients, dual diagnosis, etc.)

(8) **Seven centers cited clients with dual diagnosis of mental illness and substance abuse, four cited those with disruptive or threatening behavior, and three centers each cited elderly and those with poor daily living skills.**

33. As of September 30, 1989, how many clients does your agency estimate to be:

(7) homeless? 80 near homeless? 153 (living with friends, relatives, or others in a temporary situation)

don't know (2)

34. Of the unduplicated clients served in your agency's state-funded vocational services program during the year July 1, 1988, through June 30, 1989, how many:

(8) a. became employed in a "non-sheltered," salaried job? 322

(4) b. became employed in a "sheltered" job? (full-salaried or subsidized) 191

(3) c. became employable, but no jobs were available? 40

d. no data available (2)

35. How would you rate the receptiveness of employers in your region toward hiring your agency's vocational services clients?

2 very receptive
7 somewhat receptive
not receptive
1 don't know

36. Please rate the availability and quality of mental health services in your region, taking into consideration services provided by private agencies/institutions and any other public agencies/institutions, **in addition** to services provided by your agency.

AVAILABILITY OF SERVICES IS:
(check one response for each item)

	Services	Adequate	Not Adequate	Don't Know
a.	Adult inpatient	7	3	
b.	Adult outpatient	7	3	
c.	Adult housing		9	1
d.	All child/adolescent	1	9	
e.	All elder services	1	9	
	Dual Diagnosis:			
(9) f.	/substance abuse		9	
g.	/mentally retarded	2	6	2
(9) h.	/homeless	1	8	

36.(Continued) **QUALITY OF SERVICES IS:**
(check one response for each item)

Services	Good	Fair	Poor	Don't Know
i. Adult inpatient	6	4		
j. Adult outpatient	8	2		
k. Adult housing	6	3	1	
l. All child/adolescent	5	5		
m. All elder services	3	7		
Dual Diagnosis:				
n. /substance abuse	1	6	2	1
o. /mentally retarded	2	4		4
p. /homeless	2	3	3	2

37. In general, how would you rate the accessibility of mental health services in your region: (check one in each section)

a. Available services are:
- 6 well-publicized/well-known
- 4 somewhat publicized/known
- ____ not publicized/little-known
- ____ don't know

b. Available services are:
- 3 easy to obtain
- 7 obtainable, but with some difficulty
- ____ difficult to obtain
- ____ don't know

38. Any additional comments?

(7) **Four centers cited lack of service options for non-certified, non-insured adults; two centers noted that clients with private insurance have access to private sector services. Other comments mentioned inadequate insurance coverage, substantial waiting lists, inadequate public transportation in rural areas and the success of the division in providing an array of services and opportunities for chronically and severely mentally ill.**

NEW HAMPSHIRE HOSPITAL AND INVOLUNTARY COMMITMENTS

39. How would you rate your agency's control over admissions to New Hampshire Hospital from your region? (which clients, when, etc.)

1 more than adequate 8 adequate 1 not adequate
____ don't know

40. How would you rate your agency's control over discharges from New Hampshire Hospital to your region?

____ more than adequate __6__ adequate __4__ not adequate
____ don't know

41. How would you rate the coordination of client treatment between your agency and New Hampshire Hospital on:

a. admissions to NHH? __2__ high __6__ moderate __2__ low ___ don't know

b. follow-up after discharge from NHH? __1__ high __6__ moderate __3__ low ___ don't know

42. Overall, how would you rate your agency's working relationship with New Hampshire Hospital?

__2__ very good __4__ good __2__ fair __2__ not very good
_____ poor ____ don't know

43. If there were one way you could change your agency's interactions with New Hampshire Hospital, what would it be?

(8) **Five centers suggested the need for more communication, collaboration, and/or coordination, especially on discharges and follow-up. Two cited the need for more resources to improve coordination and to emphasize clinical needs over quotas. Other suggestions included center control over its share of the hospital budget and the need for more extended treatment beds.**

44. How effective are current standards for involuntary emergency admissions (IEAs) in : (check one response for each item)

	Very effective	Somewhat effective	Not effective	Don't Know
a. providing mental health services to those who need them?	__1__	__8__	__1__	____
b. protecting clients' rights?	__8__	__2__	_____	____
c. assuring the safety of individuals and society?	__1__	__9__	_____	____

45. Do current IEA laws need to be changed? __9__ yes ___1__ no

(7) If yes, how? **Three centers suggested allowing IEAs of clients who are not dangerous but are too disturbed to know they need care. Others suggested allowing a serious possibility of harm to count more than an actual recent act, allowing psychologists as well as doctors to institute IEAs, and allowing those who are intoxicated, dangerous, and have a history or symptoms of mental illness to be involuntarily admitted.**

OTHER AGENCIES

46. How much interaction does your agency have with other community mental health centers in the state?

__4__ a lot (daily to weekly contact)
__6__ moderate (monthly)
____ not much (less than once a month)
____ virtually none
____ don't know

47. Overall, how would you rate your agency's working relationships with other mental health centers?

__2__ very good __6__ good __1__ fair
____ not very good ____ poor __1__ don't know

48. Overall, how would you rate your agency's working relationship with the Division?

__3__ very good __4__ good __2__ fair
__1__ not very good ____ poor ____ don't know

49. How has your current relationship with the Division changed from five years ago?

__5__ much better now __4__ somewhat better now
____ about the same __1__ somewhat worse now
____ much worse now ____ don't know

50. Please rate the working relationships your agency has with the following groups in your region: (check one response for each item)

	Good	Fair	Poor	Not Applicable	Don't Know
a. police	9	1			
b. other law enforcement	6	3			1
c. homeless shelters	7	1		1	1
d. local hospital	4	6			
e. DRF	2	1	1	6	
f. private mental health hospital	3	1	2	4	

50. (Continued)

		Good	Fair	Poor	Not Applicable	Don't Know
	Others you deal with regularly:					
(7)	g. **Division of Children & Youth**	2	____	1	____	____
	h. **Schools**	2	1	____	____	____
	i. **State Welfare**	2	1	____	____	____
	j. **Local Welfare**	2	____	____	____	____
	k. **Clergy/Church**	2	____	____	____	____

Other organizations were listed by only one community mental health center each.

REPORT

51. Would you like a copy of the final performance audit report?

10 yes ____ no

Please return this survey with your responses by **OCTOBER 27**, 1989, in the enclosed, postage-paid envelope to:

Office of Legislative Budget Assistant -- Audit Division
State House, Room 102
Concord, NH 03301

If you have any questions, please call Linda Warmack, senior auditor, at 271-2785.
