



U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General

Washington, D.C. 20530

APR - 7 2011

The Honorable Michael A. Delaney
Attorney General
State of New Hampshire
Department of Justice
33 Capitol Street
Concord, NH 03301

Re: United States' Investigation of the New Hampshire Mental Health System Pursuant to the Americans with Disabilities Act

Dear Attorney General Delaney:

We write to report the findings of the Civil Rights Division's investigation of the State of New Hampshire's mental health system, which offers services to persons with mental illness at the New Hampshire Hospital ("NHH") in Concord, NH, the Glenclyff Home ("Glenclyff") in Benton, NH, and other settings across the state. During our investigation, we assessed the State's compliance with Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12131-12134 (Part A), and its implementing regulations at 28 C.F.R. pt. 35, as interpreted in Olmstead v. L.C., 527 U.S. 581 (1999), requiring that individuals with disabilities, including mental illness, receive supports and services in the most integrated setting appropriate to their needs. The Department has authority to seek a remedy for violations of Title II of the ADA. 42 U.S.C § 12133; 28 C.F.R. §§ 35.170-174, 190(e). In our investigation, we did not assess or reach any conclusions about the quality of the care and services offered at NHH or Glenclyff.

Consistent with legal requirements set forth in the ADA and its implementing regulations and in Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d-1, we write to provide you notice of the State's failure to comply with important aspects of the ADA and of the steps New Hampshire needs to take to meet its obligations under the law. By implementing the remedies set forth in this letter, the State will correct identified ADA deficiencies, fulfill its commitment to individuals with disabilities, and better protect the public fisc.

I. SUMMARY OF FINDINGS AND CONCLUSIONS

We have concluded that the State of New Hampshire fails to provide services to qualified individuals with mental illness in the most integrated setting appropriate to their needs, in violation of the ADA. This has led to the needless and prolonged institutionalization of individuals with disabilities who could be served in more integrated settings in the community with adequate services and supports. Systemic failures in the State's system place qualified individuals with disabilities at risk of unnecessary institutionalization now and going forward.

Our findings here, in large measure, are consistent with the State's own conclusions and admissions about deficiencies, weaknesses, and unmet needs in the New Hampshire mental health system. We have made a point to include these State conclusions and admissions in this letter, and we adopt them as part of our findings. Our specific findings include:

- The State acknowledges, and we agree, that its mental health system is "broken," "failing," and that it is in "crisis."
- The State acknowledges, and we agree, that there are serious "unmet needs" and "weaknesses" in the State's mental health system that contribute to negative outcomes for persons with mental illness, such as the day-to-day harm associated with improperly and/or under-treated mental health conditions, needless visits to local hospital emergency departments, needless admissions to institutional settings like NHH and Glencliff, and the serious incidents that prompt involvement with law enforcement, the correctional system, and the court system.
- In spite of a challenging fiscal environment, the State has continued to fund costly institutional care at NHH and Glencliff, even though less expensive and more therapeutic alternatives could be developed in community settings.
- Community capacity in New Hampshire has declined in recent years and this has led to unnecessary institutionalization, prolonged institutionalization, a heightened risk of institutionalization, and a greater likelihood that some will end up in even less desirable settings not designed to provide mental health care, such as the state corrections system and the county jails.
- The number of inpatient and residential acute/crisis bed alternatives to NHH and Glencliff has diminished dramatically in recent years.
- There is a lack of safe, affordable, and stable community housing, including supported housing, for persons with mental illness in New Hampshire, which can lead to greater levels of impairment, more difficulty in accessing needed services and supports, a loss of stability, and a greater risk of hospitalization and/or institutionalization.
- High admission and readmission numbers to NHH reveal that there are inadequacies in the State's mental health system that are forcing persons with mental illness to obtain mental health services in an institutional setting.

- Many individuals admitted to NHH and Glencliff, especially those with intensive physical and/or mental health needs, remain there longer than necessary simply because community-based alternatives with adequate and appropriate services and supports are not available in sufficient supply in the community.
- The State's failure to develop sufficient community services is a barrier to the discharge of individuals from NHH and Glencliff who could be served in more integrated community settings with adequate and appropriate services and supports. The State already provides the types of services and supports these individuals would need to live successfully in the community, but the State does not offer these needed services and supports in sufficient supply.
- Individuals with developmental disabilities have remained institutionalized in the State's mental health system because of a lack of community alternatives with proper supports.
- Even though the State recognizes, and has seen first-hand, the benefits of Assertive Community Treatment ("ACT") in terms of promoting positive outcomes among persons with mental illness, the State has no ACT program in at least half of its ten regions statewide, leaving thousands of persons in need without the ability to even access ACT. Not only does the State recognize that ACT can produce positive outcomes, it acknowledges that ACT is cost-effective, especially for frequently-hospitalized individuals.
- The State fails to provide adequate and appropriate employment opportunities, including supported employment, to persons with mental illness in integrated community settings.

Reliance on unnecessary and expensive institutional care both violates the civil rights of people with disabilities and incurs unnecessary expense. Community integration with appropriate services and supports will permit the State to support people with disabilities, including mental illness, in settings appropriate to their needs in a more cost effective manner.

II. INVESTIGATION

On November 19, 2010, we notified you that we were opening an investigation of the State's mental health system pursuant to Title II of the ADA. On January 10, 2011, we participated in a meeting at NHH with various State officials and counsel, and then participated in an onsite tour of the facility. The next day, we participated in a similar meeting and tour at Glencliff. On January 21, 2011, as a follow-up to our onsite visits, we sent you a written request for documents and information. As agreed, several weeks later, you provided us with a written response to our request. On January 27, 2011, we also participated in a meeting with various advocacy groups and the State with regard to the adequacy of the services and supports provided to persons with mental illness in the State's mental health system.

Before proceeding to the detailed substance of the letter, we would first like to thank the State for the assistance and cooperation extended to us thus far, and to acknowledge the courtesy

and professionalism of all of the State officials and counsel involved in this matter to date. We appreciate that the State facilitated the walk-through tours of NHH and Glencliff, and that the State provided us with helpful documents and information both onsite during our January visit and in late February in response to our written request. We hope to continue our collaborative and productive relationship. We are certainly encouraged by our interactions thus far with State leadership, and hope that going forward, there is a desire to work toward an amicable resolution of this matter.

III. BACKGROUND

The New Hampshire Department of Health and Human Services (“DHHS”) is responsible for establishing, maintaining, and coordinating a comprehensive and effective service system for persons with mental illness in the state. The Department provides direct services to persons with mental illness primarily at two residential facilities: NHH, an acute psychiatric hospital; and Glencliff, a long-term care nursing facility.

NHH is a 202-bed facility, and it had a census of 175 on the day we visited in mid-January; the NHH average daily census in FY 2010 was 167. NHH is the only state-operated psychiatric hospital in New Hampshire.¹

Glencliff is a 114-bed facility and it had a full census on the day we visited in mid-January; the Glencliff average daily census in FY 2010 was 111. Glencliff is located in a woody, isolated area, far from the nearest town, which makes it difficult for family members and other visitors to see their loved ones. The State informed us that Glencliff provides a specialized level of nursing home care for individuals with serious mental illness or developmental disabilities. Admission to Glencliff is subject to State long-term care approval and to Pre-Admission Screening and Annual Resident Review (“PASARR”) approval.

In addition, the DHHS Division of Community-Based Care Services (“DCBCS”) and its Bureau of Behavioral Health (“BBH”), which is the New Hampshire State Mental Health Authority, oversees community-based services for persons with mental illness by contracting

¹ As of last year, the Philbrook Center for children is now located on a wing of the main NHH building. In addition, on the greater NHH campus, there is also a Transitional Housing Service (“THS”) program, comprised of six houses with a total of about 49 beds, currently serving approximately 45 persons. The State informed us that the THS is technically not a component of NHH, although it is a part of DHHS. According to the State, the THS provides an intermediary step between NHH and less restrictive community placement for individuals who it claims are not ready to fully transition to more independent living. In his 2011 budget address, the Governor announced plans to privatize the THS units and to replace them with community-based housing that will help integrate people back into their homes and lives. The Governor also announced that the State intended to close another unit at NHH, but he did not provide any further details about the unit closure or the THS privatization plan.

with ten regional Community Mental Health Centers ("CMHCs") located throughout the state.² Each CMHC is supposed to be a full-service entity, offering a variety of programs and services in community settings, including: evaluation and assessment; emergency and crisis services; individual, family, and group therapy; medication monitoring; psychiatric evaluations; case management; symptom management services; and family support. While BBH leaves direct service delivery to each CMHC, BBH maintains oversight of the community system by conducting various types of reviews and requiring financial and performance reporting. In addition, BBH approves community service programs for each CMHC, provides staff training, and details what services are to be provided, how clinical records are to be maintained, and other aspects of CMHC operations.

The State informed us that in FY 2010, there were 51,305 persons served in the State's community mental health system; within this total figure, there were 19,577 persons designated as part of the State's "priority population" -- as either being an adult with "serious" or "severe mental illness" or a child or adolescent with "serious emotional disturbance."

As we discuss in greater detail below, the average cost of institutionalizing a person at NHH is approximately \$287,000.00 per year. The average cost of institutionalizing a person at Glenciff is about \$124,000.00 per year. By contrast, the cost of serving a person in the community is roughly \$44,000.00 per year. Given this, New Hampshire can serve about six persons in the community for each person in NHH.

Per State policy, the State's mental health service system is to provide "adequate and humane care to severely mentally disabled persons in the least restrictive environment," and is to be directed toward "eliminating the need for services and promoting individuals' independence." RSA 135-C:1, II.

IV. FINDINGS AND CONCLUSIONS

We conclude that New Hampshire fails to provide services to qualified individuals with disabilities, including mental illness, in the most integrated setting appropriate to their needs as required by the ADA.

Community capacity in New Hampshire has declined in recent years and this has led to unnecessary institutionalization, prolonged institutionalization, and a heightened risk of institutionalization for persons with mental illness who could be served with more independence and dignity, at a fraction of the cost, in more integrated settings in the community with adequate protections, services, and supports. People in the community, for example, are now often forced to seek services in the NHH institution simply because community resources are deficient -- providing improper service or under-treatment of their mental health conditions. Many individuals recycle through NHH because community capacity in the State's system is just not

² The State's BBH also contracts with: eight private, not-for-profit Peer Support Agencies that provide peer-to-peer support by people with mental illness at more than a dozen different sites; one Community Mental Health Provider that mainly provides community housing and other residential supports; and one family mutual support organization.

adequate. Individuals at Glencliff are relegated to prolonged stays at the nursing facility because discharge and transition planning and implementation efforts there are insufficient, and because housing and other critical supports and services are unavailable or in too limited supply in the community. At both NHH and Glencliff, individuals with more complex physical and/or mental health conditions typically must remain institutionalized longer than necessary simply because more intensive protections, services, and supports are not sufficiently available in the State's community mental health system.

The State's failure to develop sufficient community services is a barrier to the discharge of individuals from NHH and Glencliff who could be served in more integrated community settings with adequate and appropriate services and supports. The State already provides the types of services and supports these individuals would need to live successfully in the community, but just not in sufficient supply. In general, therefore, systemic failures in the State's system subject qualified individuals with disabilities, including those in the community, to undue and prolonged institutionalization and place them at risk of unnecessary institutionalization now and going forward. All of this violates the ADA.

A. The ADA Prohibits Discrimination on the Basis of Disability through Improper Segregation of Qualified Individuals with a Disability in Institutional Settings that Do Not Enable Them to Interact with Non-Disabled Peers to the Fullest Extent Possible

Congress declared that the simple purpose behind enacting the ADA was to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities. 42 U.S.C. § 12101(b)(1).³ Congress took action because it found that "society has tended to isolate and segregate individuals with disabilities," that this is a form of discrimination against individuals with disabilities, and that this continues to be a "serious and pervasive problem." 42 U.S.C. § 12101(a)(2).⁴ Specifically, Congress found that discrimination against individuals with disabilities often exists in such critical areas as

³ Congress found that people with disabilities, as a group, occupy "an inferior status in our society, and are severely disadvantaged socially, vocationally, economically, and educationally." 42 U.S.C. § 12101(a)(6). Congress explained that "individuals with disabilities are a discrete and insular minority who have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society, based on characteristics that are beyond the control of such individuals and resulting from stereotypic assumptions not truly indicative of the individual ability of such individuals to participate in, and contribute to, society." 42 U.S.C. § 12101(a)(7).

⁴ Nearly 20 years before enacting the ADA, Congress recognized that society historically had discriminated against people with disabilities by unnecessarily segregating them from their family and community, and in response, enacted Section 504 of the Rehabilitation Act of 1973, which forbids any program receiving federal aid from discriminating against an individual by reason of a handicap. Our findings and conclusions in this letter also implicate the State's compliance with Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 *et seq.*

institutionalization, housing, public accommodations, health services, access to public services, and employment. 42 U.S.C. § 12101(a)(3).

Congress declared that “the continuing existence of unfair and unnecessary discrimination and prejudice denies people with disabilities the opportunity to compete on an equal basis and to pursue those opportunities for which our free society is justifiably famous.” 42 U.S.C. § 12101(a)(9). In enacting the ADA, Congress emphasized that “the Nation’s proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals.” 42 U.S.C. § 12101(a)(8). Congress’ basic intent was to invoke the “sweep of congressional authority” to address the major areas of discrimination faced day-to-day by people with disabilities. 42 U.S.C. § 12101(b)(4).

Title II of the ADA⁵ prohibits discrimination on the basis of disability by public entities. This would encompass the State of New Hampshire, its agencies, and its mental health system, given that a “public entity” includes any State or local government, as well as any department, agency, or other instrumentality of a State or local government, and it applies to all services, programs, and activities provided or made available by public entities, such as through contractual, licensing, or other arrangements. 42 U.S.C. § 12131(1); 28 C.F.R. § 35.102(a); 28 C.F.R. § 35.130(b).

In Title II, Congress established a straightforward prohibition on discrimination: “no qualified individual with a disability⁶ shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.” 42 U.S.C. § 12132. The ADA’s implementing regulations mandate that a “public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.” 28 C.F.R. § 35.130(d). See also 28 C.F.R. § 41.51(d) (“[r]ecipients [of federal financial assistance] shall administer programs and activities in the most integrated setting appropriate to the needs of qualified handicapped persons”). The “most integrated setting appropriate to the needs of qualified individuals with disabilities” means “a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.”

⁵ In the ADA, Congress set forth prohibitions against discrimination in employment (Title I, 42 U.S.C. §§12111-12117), public services furnished by governmental entities (Title II, 42 U.S.C. §§ 12131-12165), and public accommodations and services provided by private entities (Title III, 42 U.S.C. §§ 12181-12189). Title II is the relevant subchapter with regard to the instant investigation of the State’s mental health system.

⁶ Like those persons served in the State’s mental health system here, a “qualified individual with a disability” is “an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.” 42 U.S.C. § 12131(2).

28 C.F.R. pt. 35 app. A. at 572 (July 1, 2010) (Preamble to Regulation on Nondiscrimination on the Basis of Disability in State and Local Government Services (July 26, 1991)).

The ADA's implementing regulations stress that "[i]ntegration is fundamental to the purposes of the Americans with Disabilities Act. Provision of segregated accommodations and services relegates persons with disabilities to second-class status." Id. at 570. The overarching intent behind the selection of the various forms of discrimination delineated in the regulations is to forbid practices that exclude and unnecessarily segregate. See also id. at 569 ("Taken together, these provisions are intended to prohibit exclusion and segregation of individuals with disabilities and the denial of equal opportunities enjoyed by others, based on, among other things, presumptions, patronizing attitudes, fears, and stereotypes about individuals with disabilities. Consistent with these standards, public entities are required to ensure that their actions are based on facts applicable to individuals and not on presumptions as to what a class of individuals with disabilities can or cannot do.")

In construing the ADA's anti-discrimination provision, the Supreme Court held that "[u]njustified isolation ... is properly regarded as discrimination based on disability." Olmstead, 527 U.S. at 597. The Court recognized that unjustified institutional isolation of persons with disabilities is a form of discrimination because the institutional placement of persons who can handle and benefit from community settings "perpetuates unwarranted assumptions that persons so isolated are incapable or untrustworthy of participating in community life" and because "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." Id. at 600-01.

The Court described the dissimilar treatment persons with disabilities must endure just to obtain needed services: "In order to receive needed medical services, persons with mental disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable accommodations, while persons without mental disabilities can receive the medical services they need without similar sacrifice." Id. at 601.

A violation of the ADA's integration mandate is made out if the institutionalized individual is "qualified" for community placement – that is, he or she can "handle or benefit from community settings," and the affected individual does not oppose community placement. Id. at 601-03. Indeed, the Court stressed that states "are required" to provide community-based treatment for qualified persons who do not oppose placement in a more integrated setting unless the State can establish an affirmative defense. Id. at 607.⁷

⁷ Olmstead, therefore, makes clear that the aim of the integration mandate is to eliminate unnecessary institutionalization and to enable persons with disabilities to participate in all aspects of community life. This is consistent with guidance from the President. See, e.g., Press Release, The White House, "President Obama Commemorates Anniversary of Olmstead and Announces New Initiatives to Assist Americans with Disabilities" (June 22, 2009) (in announcing the Year of Community Living Initiative, President Obama affirmed "one of the most fundamental rights of Americans with disabilities: Having the choice to live independently.").

Both NHH and Glenclyff are segregated, institutional settings.⁸ Contrary to the requirements of the ADA and its implementing regulations, neither is a setting that enables individuals with disabilities to “interact with non-disabled persons to the fullest extent possible.” Instead, individuals housed at the two facilities live isolated lives, largely cut off from the rest of society. Most spend their entire day, every day, in an institutional setting. Individuals housed at these institutions are offered very limited opportunities day-to-day for community integration or meaningful employment, and, as a result, have few opportunities to interact with their non-disabled peers in community settings outside the institution. Moreover, both facilities limit individual autonomy and provide limitations on choice even while onsite.

B. The State Has Acknowledged Unmet Needs and Weaknesses in Its Mental Health System

In recent years, the State has been candid and open about the many limitations, shortcomings, and deficiencies in its mental health system. All of the State’s admissions lend support to our conclusion that the State is failing to provide services to persons with mental illness in the most integrated setting as required by the ADA.

Just last year, the State submitted its 2011 application to the federal government⁹ in its attempt to secure block grant funding for its mental health system, where the State admitted that there are “unmet needs” within the State’s mental health system, and admitted that there are “key issues that are weakening the system.” New Hampshire Unif. Application 2011, State Plan, Community Mental Health Services Block Grant (hereinafter “State Application”), Aug. 31, 2010 at 58, 60. The State reported that the “most emergent unmet needs” include the need to increase the availability of community residential supports through formal supported housing

⁸ An institutional setting is a segregated environment because individuals living in such a facility are separated from the community and walled off from the mainstream of society, isolated and apart from the natural community where all of us live, work, and engage in life’s many activities. Individuals living in an institution are deprived of many of the personal freedoms that citizens in the community enjoy. Institutionalized persons typically live a regimented life tied to the needs of the institution, characterized by lack of privacy and few choices. Institutionalization also stigmatizes individuals and prevents them from building lives in the community, forming personal relationships, and obtaining employment. Community-based programs, on the other hand, are integrated services both because they are physically located in the mainstream of society and because they provide opportunities for people with disabilities to interact with non-disabled persons in all facets of life.

⁹ Within the federal government, the Substance Abuse & Mental Health Services Administration (“SAMHSA”), Center for Mental Health Services, provides grant funds to establish or expand an organized community-based system of care for providing non-Title XIX mental health services to children with serious emotional disturbances and adults with serious mental illness. States are required to submit an application for each fiscal year the State is seeking funds.

programs, specialized housing, and new crisis support beds; increase capacity for community-based inpatient psychiatric care; and develop additional Assertive Community Treatment (“ACT”) teams. State Application at 60, 62.

The State reported that these unmet needs and key issues were previously identified in the August 2008 document, “Addressing the Critical Mental Health Needs of NH’s Citizens,” commonly referred to as the “Ten-Year Plan.” State Application at 58, 60. We discuss the Ten-Year Plan in greater depth below. The State, in part, was the author of this plan,¹⁰ and through its 2011 block grant application, reinforced that the findings, conclusions, and recommended action steps in the Ten-Year Plan have continuing relevance today.¹¹ As a result, the State’s Ten-Year Plan is not an aspirational document or an historical remnant of a past time, but is instead a current roadmap for steps the State believes it needs to implement in order to meet the outstanding needs of persons with mental illness in New Hampshire.

In addition to the block grant application and the Ten-Year Plan, in April 2009, the State produced a follow-up report to its Ten-Year Plan that contained additional admissions about problems in the State’s mental health system. This report was the product of five “listening sessions” across the state that produced hours of testimony and discussion and “scores of accounts” about the problematic state of mental health services in New Hampshire. Addressing the Critical Mental Health Needs of NH’s Citizens, A Strategy for Restoration, Report of the Listening Sessions (hereinafter “State Report”), April 2009, at 3.

Overall, the State admitted that the findings in its Ten-Year Plan were “stark and painted a picture of a system in crisis.” State Report at 1. DHHS Commissioner Nicholas A. Toumpas concluded: “NH’s mental health care system is failing, and the consequence of these failures is being realized across the community. The impacts of the broken system are seen in the stress it is putting on local law enforcement, hospital emergency rooms, the court system and county jails, and, most importantly, in the harm under-treated mental health conditions cause NH citizens and their families.” *Id.*; see also *id.* at 4 (in summarizing the account of one community member during a listening session, the State characterized its mental health system as “broken”).

The State reported that its State-sponsored listening sessions brought forth “very moving testimony that demonstrated the need for a long-term commitment to improve and restore the system and to help people who are not receiving the care that they need.” *Id.* at 2. The State

¹⁰ The State’s DHHS published the Ten-Year Plan in collaboration with the New Hampshire Hospital Bureau of Behavioral Health and the Community Behavioral Health Association.

¹¹ Indeed, in its 2011 block grant application, the State adopted anew the recommendations contained in the Ten-Year Plan as the “key elements designed to address the unmet needs” of the State’s mental health system. State Application at 62; see also *id.* at 60 (the State reported that its current “primary strategy” to reduce unmet needs is through the Ten-Year Plan, which centers on areas targeted for system, policy, and fiscal reform). Moreover, in his very recent 2011 budget address, the Governor expressly referenced the Ten-Year Plan as the blueprint for the State’s efforts to develop and implement “fundamental changes” to the State’s mental health system going forward.

reported that there were stories about people who had been “pushed aside by the system, and who have been denied access to basic services such as mental health screening, preventive care, and the level and type of care, in the correct setting, that would have meant a successful outcome for them and their families.” Id. The State concluded that the personal stories “illustrated the need to restore New Hampshire’s mental health system.” Id.

The State reported that the “recurring themes” of its many listening sessions included “the lack of resources or appropriate resources in the correct places; the need for improved communication and coordination between systems with a focus on individuals’ and families’ needs; and earlier intervention and access to appropriate treatment so that individuals don’t end up in acute care, incarcerated, or homeless because of treatable mental health conditions, to name just a few. There was a call for long-term solutions.” Id. at 3.

In its Ten-Year Plan, the State outlined a series of recommendations that were to be implemented over the course of the subsequent ten years. Specifically, these recommendations included the need to: increase supported community housing; to develop and maintain a community housing subsidy bridge program linked with clinical services; to increase the number of community residential beds; to increase the number of community beds for persons in short-term crisis, for persons with co-occurring mental illness and substance abuse problems, and for persons with serious mental illness who have histories of violence or criminal involvement; to increase capacity for community-based inpatient psychiatric care; to develop additional ACT teams in the community; and to facilitate discharge of persons with developmental disabilities at NHH. State Ten-Year Plan at 9-15.

In September of 2010, at about the two-year anniversary of the State’s publication of its Ten-Year Plan, the New Hampshire Community Behavioral Health Association (“CBHA”), provided a short report on whether or not the State had accomplished what had been set forth in the plan. The CBHA noted some progress in a handful of areas, but concluded that little or no action had been taken in other important areas. For example, inconsistent with the State’s plan, the CBHA concluded that: admissions to NHH had increased 104 percent over the previous ten years; the five ACT teams recommended in the plan were not added in FY 2009 or FY 2010, putting additional demand on NHH for inpatient care; none of the target items for persons with developmental disabilities were achieved; CMHCs had closed 44 community beds in the previous two years; there had not been appropriations for the addition of 132 community beds; no additional DRF beds had been added; and a taskforce had not been convened to expand voluntary inpatient psychiatric care throughout the state. CBHA, New Hampshire Ten-Year Mental Health Plan Progress, Two Years Out, Sept. 24, 2010, at 2-3.

C. The State Has Continued to Invest in Expensive, Segregated Institutional Services While Denying Resources to the Community System

In spite of a challenging fiscal environment, the State has continued to fund costly institutional care at NHH and Glenciff, even though less expensive and more therapeutic alternatives could be developed in integrated community settings. This misplaced emphasis on institutional care reinforces the conclusion that the State is violating the ADA with regard to services provided to qualified persons with a disability.

The State informed us that its failure to implement recommendations from its Ten-Year Plan and other needed remedial measures is due, in part, to budget cuts and general fiscal constraints. These fiscal limitations have contributed to the State's failure to minimize the risk of institutionalization for qualified individuals with a disability pursuant to the ADA. For example, the State acknowledged that budget adjustments from deficits have caused staff reductions throughout DHHS, the closure of certain facilities and programs, and the potential reduction in certain services with an unknown specific impact on adult mental health services. Id. at 41.

In its 2011 block grant application, under the heading "A Stressed System," State Commissioner Toumpas admitted that millions of dollars in budget cuts to his Department in recent years have had an impact: "Given that the amount ... was so large, (and) ... coming on top of previous reductions, we could not avoid cutting into some of our direct services. Although every attempt was made to minimize the impact on clients, we simply cannot make reductions of this size and magnitude without there being consequences for the families and individuals we serve and for the staff who provide those services." Id. at 58.

The State acknowledged that the immediate and long-term impact of the State's budget crisis will "undoubtedly affect the State's approaches to achieving its vision" in transforming its mental health system. Id. at 67. The State admitted that the "demonstrated needs of the public far exceed the capacity of the state to meet those needs with limited and reduced public funds." Id. at 60. For example, the State reported that in New Hampshire, there is a "growing segment of the public that is clearly in high need of more accessible, available, and affordable mental health services." Id. The State reported that more individuals with mental health needs are presenting themselves to the CMHCs and that the intensity of care required is rising, at the same time that rates are being reduced, caseloads are increasing, and the number of emergency care beds is diminishing. Id. at 41.¹²

All of this is likely producing negative outcomes among inadequately or improperly served groups of persons with mental illness in the State's system. For example, the State acknowledged that in the year prior to the submission of its 2011 block grant application, there had been a 25 percent increase in the number of people taking their own lives and that the lack of sufficient staff-intensive monitoring outside the context of an in-patient stay at NHH could have played a role. Id. at 41.

All this is occurring while cuts are imposed on some important community programs. For example, the State reported that, during the 2009-2010 legislative session, spending on community behavioral health was reduced by approximately one million dollars. State Application at 44. More recently, proposed cuts to the state budget for the next biennium would, among other things, eliminate community case manager positions, eliminate community day

¹² The Ten-Year Plan earlier had identified recommended services that were "never implemented, the erosion of mental health services over the last fifteen years and a growing state population with related rising demands for mental health care." State Ten-Year Plan at 3.

programs, and change eligibility requirements for Medicaid, making thousands of persons with disabilities ineligible for the program. This would directly affect persons with severe mental illness and could contribute to poor individual outcomes and additional pressures on emergency departments and law enforcement.

We note that there is a substantial difference in the cost of providing care in institutional and community settings, which breaks down as follows:

1. *NHH*

The State informed us that total expenditures for NHH operations have risen in each of the last five years. Indeed, it cost nearly ten million dollars more to run NHH in FY 2010 than it did in FY 2006.

The per diem cost to serve a person with mental illness in an acute setting like NHH was \$788.00/day in FY 2010.¹³ Projected out for a full year, this amounts to about \$287,000.00 per NHH person per year. In 2009, Commissioner Toumpas admitted that “[w]e’re spending money for mental illness but we are not doing it effectively ... It costs \$275,000 to keep someone in NH Hospital and they are there because we don’t have the resources in the community.” State Report at 8. Importantly, services at NHH are primarily funded with State-only dollars without Federal matching funds, in contrast to community services where there is often a significant Federal matching contribution.

2. *Glencliff*

As with NHH, in recent years the State has continued to increase the flow of limited state funds to support institutional care and services at Glencliff. State general fund expenditures for Glencliff have steadily increased over the years, rising about two million dollars from FY 2006-2010, to a FY 2010 total of about \$12.5 million.

The per diem rate at Glencliff, \$340.71 per person, is less than that at NHH, but, as we set forth below, still much more than that for services in the community. Projected out for a full year, this amounts to about \$124,000.00 per person at Glencliff.

3. *Community*

The institutional NHH and Glencliff cost figures contrast markedly with the much lower per diem figures for persons with mental illness living in the community. Since July 1, 2009, the current community residence rate in New Hampshire has been \$120.00/day. This projects out to an approximate annual cost of \$43,800.00 – an amount which is about \$243,000.00 per person per year lower than the annual cost of residing at NHH and about \$80,000.00 per person per year

¹³ This per diem figure is slightly higher than the amount set in FY 2006 (\$756.00/day) and much higher than the amount set in FY 2007, which was \$671.00/day.

lower than the annual cost of care at Glencliff. So, for example, New Hampshire can serve roughly six people in the community for each person it serves at NHH.¹⁴

According to State estimates, the community cost of serving even high-risk individuals with complex needs is less expensive in New Hampshire than serving them in an acute care setting like NHH or a nursing home setting like Glencliff. For example, in its Ten-Year Plan, the State recommended a rate increase to \$170.00/day for community beds serving those with serious mental illness and complex medical conditions, and for community beds serving persons with serious mental illness and substance abuse; and a rate increase to \$260.00/day for community beds for persons with serious mental illness who have a history of violence or criminal involvement. State Ten-Year Plan at 10-11.¹⁵ Even the highest rate of \$260.00/day projects out to only about \$95,000.00 per person per year – still \$190,000.00 per person per year less than the current per diem rate at NHH; the lower \$170.00/day rate would cost about \$225,000.00 less per person per year compared to NHH.

D. The State Has Failed to Develop Adequate Capacity in Integrated Community Settings to Minimize the Risk of Institutionalization for Qualified Persons with a Disability

The State has admitted repeatedly that community capacity within New Hampshire has declined and/or failed to meet the needs of individuals with mental illness. This has led to unnecessary institutionalization and a further deepening of the daily risk of institutionalization for persons in need of mental health services, in violation of the ADA's integration mandate.

In its 2009 listening sessions report, the State concluded that, in recent years, “[a]s community capacity to serve more people declined, access to critical services became more difficult to get. More individuals found themselves in a system that could no longer meet their needs, some ending up in settings not designed to provide mental health care, such as the state corrections system and county jails.” State Report at 17.

In its Ten-Year Plan, the State acknowledged that a number of factors have “eroded the current and future capacity of New Hampshire’s system of care” for persons with mental illness. State Ten-Year Plan at 4. For example, the State reported that funding for Medicaid services, the

¹⁴ This is not a neat comparison though, as we understand that the per diem figures for NHH and Glencliff include room and board, while the community figures do not. However, even adding a generous amount for room and board (assume \$1,500.00/month) would only increase the community per diem cost by about \$50.00/day, for a total of \$170.00/day -- still far less than the \$788.00/day at NHH. On the other hand, none of these figures reflect the increase in federal reimbursement through the Medicaid program that would be available to the State through community waiver and other funding programs; with institutional mental health care, like that provided at NHH, federal Medicaid matching funds are largely unavailable.

¹⁵ We understand that these recommended rates were never approved. The State informed us that the last community rate increase occurred on July 1, 2009, from a per diem of \$107.00/day to the current \$120.00/day.

primary insurance for people with serious and persistent mental illness, has been restricted in New Hampshire as costs have increased. *Id.* at 5. The State concluded that the end result of this is less capacity to build additional community service options for a growing population that has more challenging needs. *Id.* The State reported that this will likely have a direct, negative effect on outcomes, as research demonstrates, for example, that “decreasing appropriate outpatient services may contribute to disengagement from treatment, and an increase in symptoms and ability to do everyday tasks like caring for oneself or working, which results in increased frequency of visits to expensive emergency departments and often the need for hospitalizations.” *Id.* Indeed, the State reported that “care in the middle and at the higher intensity end of the spectrum of treatment, including intensive outpatient care, residential care, and inpatient care, is not easily available to many individuals with severe mental illness, resulting in an overburden on [NHH] and poor outcomes for individuals who are unable to access sufficient treatment choices to remain in the community or to be discharged from the hospital when ready.” *Id.* at 4.

1. Acute/Crisis Beds

The State reported that inpatient and residential alternatives to NHH have diminished over the previous 15 years in a number of specific ways. *Id.* at 5. In its 2011 block grant application, the State acknowledged that the number of inpatient psychiatric beds available has dropped from a total of 814 beds in 1990 to 496 beds in 2008, and that more psychiatry units have closed and additional inpatient beds have been lost since then. State Application at 101. The State recognized that there is a “paucity” of hospital-based psychiatric care in rural areas of New Hampshire and that this has put a “significant strain” on the local hospitals. *Id.* at 166.¹⁶ The State characterized the situation as a “crisis,” and, according to the New Hampshire Hospital Association, reported that:

- there were 236 voluntary inpatient beds in 1990, but only 186 such beds in 2008;¹⁷
- over the previous eight years, the number of community Designated Receiving Facility (“DRF”) beds had “decreased dramatically” from 101 to 8 DRF beds (at just one hospital);¹⁸ and

¹⁶ The State acknowledged that it is a challenge for persons with mental illness in rural areas of the state to access needed mental health care and services: “Small rural hospitals do not have all the resources to treat mental illnesses, forcing patients to be stabilized then transported elsewhere for care.” State Application at 100.

¹⁷ More recent State documents reveal that as of FY 2009 (the most current figures available), this number has been reduced even further to 169 voluntary beds.

¹⁸ The State acknowledged that, because DRF care is now only available at one hospital, the State is lacking regional capacity for inpatient voluntary and involuntary care. State Ten-Year Plan at 12.

- over the previous eight years, the number of Acute Psychiatric Residential Treatment Program (“APRTP”) beds had decreased from 52 to 16 APRTP beds (now only located at the Cypress Center in Manchester as part of the CMHC there).

State Ten-Year Plan at 5, 11.

By the end of the current fiscal year, the State’s Ten-Year Plan called for the creation of 12 new crisis beds, 10 new community beds for persons with co-occurring disorders, six new community beds for high-risk individuals, and 12-16 new DRF beds. Although the State informed us that it has requested additional funding for crisis/acute beds and services, it could provide no assurance that these requests will be approved. As a result, we are left with the current numbers which reveal that since FY 2008 (the time of the creation of the Ten-Year Plan), acute/crisis bed capacity in the community has dropped by at least 22 beds.

2. *Community Housing*

In addition, pursuant to the terms of its Ten-Year Plan, by the end of the current fiscal year the State was to have created 52 additional residential group home beds in the community. However, the State informed us that in the last five years, it had created a total of only 17 new supported housing beds at two locations, while closing 56 beds. Therefore, instead of adding to the community residential bed capacity in New Hampshire, the State has reduced community residential beds by 39.¹⁹

In its Ten-Year Plan, the State admitted that “lack of safe, affordable and stable [community] housing is an increasing problem for individuals with serious mental illness in New Hampshire.” *Id.* at 6. Indeed, during the State-sponsored listening sessions, a top official from BHH concluded that “we have some people at NH Hospital because they can’t find housing.” State Report at 6. The State has admitted that sufficient formal supported housing is not available to most persons with mental illness in New Hampshire and that home-based community services need to be “further developed to meet the current need.” State Ten-Year Plan at 8.

The State has recognized that the lack of supported housing increases the risk of institutionalization. The State has declared that, for the individual struggling with the daily challenges of a serious mental illness, a lack of housing “leads to greater levels of impairment, more difficulty in accessing services and supports, and a loss of stability which leads to subsequent hospitalizations.” *Id.*

The State had concluded that housing for individuals with mental illness in their communities largely “evaporated” as rental costs increased, so the State’s BBH created a housing

¹⁹ We note that group homes are not likely the most integrated setting appropriate for many NHH and Glencliff residents. Nevertheless, they are more integrated settings than those institutions.

transition program with bridge funding to cover reimbursement gaps. State Report at 17.²⁰ One of the goals of this program is to show that a housing subsidy bridge program is a more clinically-effective (and cost-effective) model than institutional care. *Id.*; State Application at 97. The State informed us that this program was designed to increase access to safe, affordable housing for adults with serious mental illness, especially those who are homeless or at risk of homelessness. The State reported that 37 individuals enrolled in the first 12 months of the bridge subsidy program, with half coming from NHH.

E. Admissions/Readmissions Data Reveals Undue State Reliance on Institutional Services for Qualified Persons with a Disability

1. NHH

Because of the State's lack of community services, people with mental illness are forced to obtain mental health services in an institutional setting, in violation of the ADA. Admissions to NHH are high. The State reported that there were a total of 2,380 admissions to NHH in FY 2010, and that there has been a steady increase in NHH admissions in each of the last five fiscal years. The high and increasing number of admissions each year reflects the need for enhanced community mental health services to address mental health concerns, especially when an individual goes into crisis. Indeed, individuals are typically admitted to NHH directly from local hospital emergency departments because they are in crisis.

The State acknowledged: "What was once a nationally recognized model of care ... began to decline in recent years. Admissions to NH Hospital doubled during a 15-year time period and the census of the hospital increased by 50%. The state lost over 100 psychiatric inpatient beds in local community hospitals, resulting in more admissions and demand for services at a facility that was already at maximum capacity." State Report at 13, 16-17.

The high number of institutional admissions typically reveals that individuals' needs are not being met in the community, often because of a lack of capacity. This is consistent with the State's own conclusions in recent years. Indeed, in its Ten-Year Plan, the State reported that the "primary finding" of its taskforce was that many individuals have been admitted to NHH because they have "not been able to access sufficient [community] services in a timely manner (a "front-door problem") and remain there, unable to be discharged, because of a lack of viable community based alternatives (a "back-door problem")." State Ten-Year Plan at 6.

The State's readmissions data reinforce this conclusion. The State informed us that scores of persons are admitted to and discharged from NHH multiple times each year, in search of effective treatment for their mental illness. The State informed us that its overall NHH readmission rate of about 33 percent is higher than the comparable national average of about

²⁰ The State informed us that, thus far, much of the funding for this initiative has come from federal stimulus funds. Although this federal funding stream is ending, the State informed us that it expects to be able to continue the program going forward.

20 percent.²¹ Readmissions to NHH within 180 days of discharge represent about one-third of the annual admissions. In FY 2008, 230 persons were readmitted to NHH a total of about 700 times; all 230 persons had a minimum of two readmissions and at least one person was readmitted to NHH 25 times. The State estimated that about one-third of those readmitted that year had four or more readmissions to NHH. Thus, certain critical supports and services necessary to keep persons stable and healthy in the community and away from institutional care are often not present in the State's mental health system. These deficiencies cause unnecessary institutionalization and create an undue risk of institutionalization that violate the ADA.

In its 2011 block grant application, the State acknowledged that adult 30-day and 180-day readmission numbers to NHH have worsened in recent years; for example, the number of adult NHH readmissions within 180 days of discharge increased about 73 percent from FY 2008 to FY 2009. State Application at 119, 120. The State cited a number of factors as causing an increase in readmissions to NHH: limited housing and community supports post-discharge combined with the increased need for inpatient psychiatric beds as the number of inpatient beds has been decreasing. *Id.* The State recognized that the lack of adequate, safe, stable, and affordable housing is likely to be detrimental to supporting resiliency and recovery for individuals with serious mental illness. *Id.* at 132. Certainly, repeated institutionalization makes it difficult for persons with mental illness to maintain apartments, jobs, and relationships in the community.

2. *Glencliff*

The admissions data for Glencliff stand in stark contrast to that for NHH. The State reports that in 2010, there were only 15 admissions to Glencliff. The average number of admissions to Glencliff from 2006 through 2010 was about 17 per year. While we were onsite, Glencliff officials informed us that about 60-70 percent of Glencliff admissions now come from NHH, and that this is an improvement from prior years where the percentage was about 85 percent. The State also informed us that there is a waitlist of about two dozen people who are seeking admission to Glencliff.

Glencliff readmission numbers are small; the State reported that no individual discharged from Glencliff has returned to the facility since April of 2008. The State informed us that, since 2000, a total of seven persons discharged from Glencliff later returned -- two individuals returned in 2008; two individuals returned in 2007; and three individuals returned in 2004.

Nonetheless, as referenced earlier, the acknowledged lack of capacity in the State's community system to serve persons with mental illness and/or developmental disabilities, especially those with complex health care needs, places increased emphasis on providing needed services to these individuals in an institutional setting like Glencliff. Naturally, community capacity limits would tend to create undue institutional pressure and impact on the State's PASRR process, which is supposed to keep persons with mental illness and/or developmental disabilities out of institutional nursing home settings whenever possible. Sometimes, capacity

²¹ The NHH readmission figure includes individuals who had been released from the facility on a conditional discharge who then did not receive adequate services and supports in the community, thus necessitating re-institutionalization.

limits even prompt nursing home admissions of younger individuals. Indeed, the State's admissions data for Glencliff reveal that in recent years, it is tending to admit individuals who do not fall within traditional "frail elderly" parameters. For example, in 2009 and 2010, Glencliff admitted 37 persons, and about two-thirds of these individuals were 64 years old or younger, including 21 persons in their 40s or 50s. Glencliff is not exclusively admitting younger individuals, though; it admitted eight persons age 70 or older in 2009 and 2010.

F. Data on Length of Stay in State Institutions Reveals Unnecessary and Prolonged Institutionalization of Qualified Persons with a Disability

1. NHH

The State informed us that the majority of individuals admitted to NHH are discharged within 30 days of admission.²² Nonetheless, the State has acknowledged that, once admitted to NHH, almost a third of the individuals remain "longer than necessary." State Ten-Year Plan at 6. The State recognized that the doubling of admissions to NHH and the more than 50 percent increase in the NHH census occurred because "a number of individuals have stayed longer at [NHH] ... as community-based options for intensive treatment have declined." *Id.* at 4.

The State informed us that in FY 2010, for those who were in residence for less than a year, the average length of stay at NHH was 71 days. For those in residence for more than a year though, the average length of stay was 1,383 days, or more than three-and-a-half years.

The State informed us that there are 31 persons who have remained at NHH for over one year, and of these, 17 individuals have been held for longer than two years. A number of these individuals have been involved in serious incidents, including those that involve law enforcement; a small sub-group has been determined at some point to be "not guilty by reason of insanity." Many individuals have complex mental health issues. In its Ten-Year Plan, the State explained that individuals such as these have lived at NHH for "prolonged periods of time" because adequate community housing and treatment alternatives are "not available." State Ten-Year Plan at 6. The State explained that the "scarcity of high intensity community resources, including supervised residences and intensive community treatment" is one of several "barriers to discharge." *Id.*

The State also admitted that about half of the persons with developmental disabilities at NHH remained there "longer than required" to provide acute evaluation and stabilization of their presenting psychiatric symptoms. *Id.* at 14. The State informed us that at least four of the individuals who have resided at NHH for more than a year have a developmental disability and that three of these individuals have been institutionalized at NHH for over seven years each. In its Ten-Year Plan, the State acknowledged that half of the individuals at NHH with developmental disabilities were "unable to be discharged due to a lack of residential placement or insufficient specialized community services." *Id.* The State reported that the majority of

²² The 30-day metric is important, as around this time, an institutionalized person is at greater risk of losing community housing and other supports while away from a community home.

these persons experience behavioral disturbances that require a high level of structure and support that it claimed is currently only available at NHH; but the State admitted that these individuals could be served in the community with appropriate services. Id.

2. *Glencliff*

Once again, the situation at Glencliff is decidedly different from that at NHH. Whereas a large number of individuals regularly enter and leave NHH, individuals who enter Glencliff typically stay for prolonged periods, without much prospect for discharge to the community. This implicates State compliance with the ADA.

For some time at Glencliff, the overall average length of stay per person has been over five years; this is true both for individuals currently at Glencliff and for those who have been discharged or died. Some individuals have lived at Glencliff for decades; the State informed us that as of the end of last year, there were about a half-dozen individuals who have lived at Glencliff for over 20 years (with a total of 15 who have lived there for over ten years).

Some of these individuals at Glencliff have been involved in serious incidents over the years and many have complex physical and mental health concerns. However, in general, other than age in some cases, it does not appear that the individuals at Glencliff present any novel or different set of disabilities than their peers at NHH -- all of whom are at least nominally in the active, State-endorsed pipeline towards placement in a more integrated community setting. Given this, it is unclear then why similar placement efforts are not, and have not been, underway for the individuals at Glencliff. Certainly, maintaining individuals with mental disabilities unnecessarily in institutional settings violates the ADA, and is inconsistent with the State's own mandates, which require service in the least restrictive environment in the community. See RSA 135-C:1, II (the State's service system is to provide "adequate and humane care to severely mentally disabled persons in the least restrictive environment," and is to be directed toward "eliminating the need for services and promoting individuals' independence"); State Application at 37 (the objective of all programs in the State's system is the "reintegration of all persons into the community); Id. at 47 (State shall promote "respect, recovery, and full inclusion").

The State is maintaining two distinct and very different practices with regard to discharge planning and placement at the two facilities. The State informed us that at NHH, "[a]t the time of admission, there is a focus on developing a discharge plan for return back to the community, in collaboration with the individual, his/her family and the local community mental health center." But, at Glencliff, there appears to be virtually no immediate focus on discharge planning. Instead, the State takes a passive approach, generally not pursuing discharge and placement efforts unless and until a particular individual affirmatively asks for them. During our onsite visit, we learned that there was no meaningful discussion of community placement in any individual's regular Plan of Care meetings at Glencliff if the person does not expressly request it. As a result, team-driven placement plans are typically not developed or implemented for all but a handful of individuals at Glencliff each year. At best, it appears that there may only be a summary reference to placement status or interest in an individual's chart in the Plan of Care document, the Minimum Data Set ("MDS") data, and/or in the Social Services Progress Note section. In any event, this discharge planning is inadequate and a violation of the ADA.

The Glencliff placement data reinforces this conclusion. The State reported that no individual housed at Glencliff was discharged to a community residence in all of 2010, and that only one person was placed in the community in 2009. The only person discharged from Glencliff in 2008 was placed in NHH, perhaps an even more segregated and institutional setting than Glencliff.

The State reported that in the past ten years, from 2001-2010, a total of only eight individuals from Glencliff were placed in what the State designated as a community setting, and one of these individuals returned within two months of placement. This averages to less than one community placement per year from Glencliff. During this same ten-year period, the State reports that 11 individuals housed at Glencliff were placed in NHH or some other facility; all three of the people placed in an "other" facility though, eventually returned to Glencliff.

We find it troubling that in recent years, far more individuals housed at Glencliff have died each year than have been placed into community settings. For example, in 2009, one person was placed in the community from Glencliff, but 16 individuals died.

G. Some Placements from NHH May Not Be to the Most Integrated Setting

Although many individuals are placed in private residences or households in the community, we are concerned that part of the State's community system relies heavily on congregate housing resembling institutions. The State reported that it currently utilizes about two dozen community group homes with an average census of about 11 persons per site; one unlicensed home in Manchester serves 23 persons at one location. The large census size of such group residences typically renders them more institutional, less therapeutic, and, as a result, often unable to meet the needs of many persons with serious mental illness.

It is also of concern that about ten percent of the individuals discharged from NHH in FY 2010 were sent to homeless shelters, jail or other correctional facilities, or other residential or institutional settings. Indeed, in FY 2010, there were 687 persons served in the State's mental health system who were homeless or in a shelter. Consistent with the State's conclusions referenced above, without community housing, individuals with mental illness who are discharged to, or are at times living in, a homeless shelter are at increased risk of institutionalization going forward.

H. The State Has Developed Inadequate Assertive Community Treatment Team Resources to Prevent Unnecessary Risk of Institutionalization for Qualified Persons with a Disability

The State seems to recognize that in order to build needed capacity in the community so as to reduce the risk of institutionalization and to generally improve individual outcomes, it needs to expand its Assertive Community Treatment ("ACT") program.

ACT is a team-based model of providing comprehensive, intensive, and flexible treatment, services, and supports to individuals with mental illness, when and where they need

them – in their homes, at work, and in other community settings – 24 hours a day, seven days a week. ACT teams combine treatment, rehabilitation, and support services from professionals in a variety of disciplines, including but not limited to, psychiatry, nursing, substance abuse, and vocational rehabilitation. ACT is often intended for persons with severe mental illness who are at an elevated risk of inpatient hospitalization. Often these persons have high rates of co-occurring substance-related disorders, health care issues, and social risks such as poverty and homelessness. When ACT teams operate with high fidelity to established evidence-based practice models, they can reduce the risk of institutionalization and improve the quality of life for persons with mental illness, especially those with severe mental illness.²³ The Dartmouth ACT Scale, for example, is a widely-recognized tool for measuring the fidelity of ACT teams.

As part of its statewide evidence-based practice initiative, New Hampshire has begun to develop ACT teams to provide more proactive services and supports to persons with mental illness who live in the community. In its Ten-Year Plan, the State reported that ACT has been shown to be effective at helping individuals with serious mental illness manage their illnesses while living independently in the community: ACT reduces homelessness among those with serious mental illness, and ACT reduces hospital use and enhances the ability to maintain employment among persons with frequent hospitalizations. State Ten-Year Plan at 13. In its 2011 block grant application, the State again made this point, reporting that ACT teams in New Hampshire have made a positive “impact on the quality of life” for some individuals with mental illness with increased or high-volume hospitalizations, those who have experienced homelessness, or have had a high number of legal and police involvement incidents. State Application at 89-90.

Through FY 2010, the State informed us that it had created six ACT teams – three adult teams in the Northern region, one adult team each in the Nashua region and the Manchester region, and one children’s team in the Riverbend region (Concord). The State has taken steps to add an adult team in Riverbend and an adult team in the Center for Life Management (“CLM”) region (Derry). Even with these two new teams, that would still leave no ACT team in five regions – half of the ten total regions throughout the state. This is important, as we understand that ACT teams from one region do not provide services and supports to persons in need in other regions, even if they are geographically nearby. As a result, many thousands of persons with mental illness in New Hampshire do not even have the ability to access ACT team services, a foundational bedrock support upon which the State is looking to reform its community-based service system.

The need to provide more proactive ACT team services to persons with mental illness in the community is a pressing issue, given the worsening readmission numbers at NHH and the increased use of inpatient psychiatric beds at NHH. Moreover, the State informed us that the

²³ In its Ten-Year Plan, the State concluded that “[w]hen delivered with good fidelity to the model,” ACT has been demonstrated to reduce psychiatric hospitalization rates for individuals with severe mental illness and to improve other outcomes. State Ten-Year Plan at 13. In its 2011 block grant application, the State re-emphasized that evidence-based practices are “known to be effective, when practiced with fidelity to the model.” State Application at 121.

number of individuals receiving emergency services from CMHC Emergency Service Teams has increased over 16 percent from FY 2006-2010, totaling more than 10,000 individuals served in an emergency in FY 2010 alone.

In its Ten-Year Plan, the State called for the creation of five additional ACT teams by the end of the current fiscal year. Given that there were four ACT teams in FY 2008 (at the time of the creation of the Ten-Year Plan), that means that there should be nine ACT teams by the end of June 2011. With only six ACT teams, however, the State is far from its plan.

During our onsite visit, the State informed us that ACT teams in New Hampshire generally include, among other professionals, two Master's-level clinicians, a designated psychiatrist, and some nursing support. However, it is not clear that the New Hampshire ACT teams are currently operating with full fidelity to the ACT model. For example, the number of psychiatry hours appears to be somewhat limited in the New Hampshire ACT teams that are already operating. For example, the State informed us that the Riverbend children's team only has access to 0.15 Full-Time Equivalent ("FTE") of psychiatry, the Nashua adult team has access to 0.20 FTE of psychiatry, and the three Northern adult teams each only have access to between 0.07-0.20 FTE of psychiatry. The number of nursing hours are similarly limited, for example, never amounting to a full FTE at any of the ACT teams in Riverbend or Northern.

In spite of some important limitations, the State reported to us that as a result of its ACT initiatives, it had achieved very positive outcomes for individuals served thus far, including reduced admissions to institutions like NHH, and reduced visits to local hospital emergency rooms. For example, the State reported a 78 percent reduction in hospitalizations after its Riverbend children's ACT team began operations. The State also reported that in the first year of ACT in the Northern region, the annual bed day utilization dropped in half, from over 6,000 bed days per year to about 3,000 bed days per year. With regard to the Nashua region, the State informed us that, comparing the one-year period prior to ACT with the one-year period after ACT, the number of hospitalizations dropped from 37 to 22, and more dramatically, the number of inpatient days dropped from 1,454 days to 245 days – a notable 83 percent reduction.

Not only does the State recognize that ACT can promote positive outcomes for persons with mental illness, the State has also reported that ACT is fiscally prudent: when considering the overall cost of services, ACT is "cost-effective" for frequently hospitalized individuals, as one month of care at NHH costs a bit more than the cost for an entire year of ACT. State Ten-Year Plan at 14. Moreover, during our onsite visit, the State informed us that almost half of the cost of an ACT team is borne by the federal government through the Medicaid program. By comparison, the State reported that in FY 2010, Medicaid paid for less than five percent of total expenditures at NHH.

I. The State Fails to Provide Adequate Integrated Employment Opportunities for Qualified Persons with a Disability

The State is not currently meeting the needs of persons with mental illness who need adequate and appropriate employment opportunities in integrated community settings. These opportunities can arise in a variety of contexts, but typically involve employment in the private

sector in the open market. The State reported that only 21.5 percent of adults in the mental health system are competitively employed to some extent. State Application at 130. The State reported that only 7.8 percent of adults with severe mental illness received supported employment services in FY 2009. Id. at 123.

The State provided us with its recent State Health Authority Yardstick ("SHAY") evaluation for supported employment in the state. NH SHAY Evaluation, Update on Recommendations, January 2011. The State informed us that it has addressed all of the recommended areas from this evaluation. However, the evaluation document primarily focused on process elements such as improving training efforts and written policies and regulations. There was nothing in the document that referenced increases in the number of persons with mental illness actually working in competitive and/or supported employment across the state. The positive momentum that may have been generated through this SHAY evaluation will only have meaning if outcomes have been achieved in that more persons are actively engaged in employment activities in integrated community settings.

V. RECOMMENDED REMEDIAL MEASURES

To remedy its failure to serve individuals with mental illness in the most integrated setting appropriate to their needs, consistent with the mandate of Title II of the ADA and its implementing regulations, the State should promptly implement the minimum remedial measures set forth below:

- The State should develop and implement a plan to address the already identified "unmet needs" and "weaknesses" in the State's mental health system that contribute to negative outcomes for persons with mental illness, such as the day-to-day harm associated with improperly and/or under-treated mental health conditions, needless visits to local hospital emergency departments, needless admissions to institutional settings like NHH and Glencliff, and the serious incidents that prompt involvement with law enforcement, the correctional system, and the court system. The State should develop and implement effective measures from its Ten-Year Plan that support this goal.
- The State should provide a sufficiently rich mix of supports and services for persons with disabilities, including mental illness, so as to support positive individual outcomes such as to minimize or eliminate the harm associated with improperly or under-treated mental illness, to minimize or eliminate institutionalization and the undue risk of institutionalization, to minimize or eliminate emergency room/hospital visits/admissions, and to minimize or eliminate serious incidents involving law enforcement, local jails and correctional facilities, and the court system. The State should develop and implement effective measures from its Ten-Year Plan that support this goal.
- The State should expand less expensive and more therapeutic community placements, with adequate and appropriate services and supports, as an effective alternative to the costly and less therapeutic institutional care offered at NHH and Glencliff.

- The State should expand community capacity throughout the state so as to minimize or eliminate unnecessary institutionalization, prolonged institutionalization, and a heightened risk of institutionalization, and to reduce the risk that some qualified persons with a disability will end up in undesirable settings not designed to provide mental health care, such as the state corrections system and the county jails.
- The State should expand the number of inpatient and residential acute/crisis bed alternatives to NHH and Glencliff that have diminished in recent years.
- The State should expand safe, affordable, and stable community housing, including supported housing, for persons with mental illness in New Hampshire, so as to prevent greater levels of impairment, more difficulty in accessing needed services and supports, a loss of stability, and a greater risk of hospitalization and/or institutionalization. To this end, the State should increase the availability of community residential supports through formal supported housing programs, specialized housing with high-intensity community resources (especially for those with complex physical and/or mental health conditions that have led to serious incidents and/or past involvement with law enforcement), an adequate housing subsidy bridge program, and new short-term acute/crisis support beds, to meet the needs of persons with disabilities, including mental illness, in its mental health system in the most integrated community setting. Supported housing should provide individuals with their own leased apartments or home, where they can live alone or with a roommate of their choosing. The housing is to be permanent (e.g., not time-limited) and is not to be contingent upon participation in treatment. The supported housing provided by the State should be scattered-site, meaning in an apartment building or housing complex in which no more than ten percent of the units are occupied by individuals with a disability. Group homes should not constitute supported housing. The State should ensure that individuals in supported housing have access to a comprehensive array of services and supports necessary to ensure successful tenancy and to support the person's recovery and engagement in community life, including through ACT services.
- The State should ensure that any and all remedial plans cover and impact all individuals who are in or at risk of entering NHH, Glencliff, or other restrictive institutional settings.
- The State should create sufficient ACT teams to ensure that the needs of persons with disabilities, including mental illness, in the community are met and that undue risks of institutionalization are minimized or eliminated. The State should ensure that the ACT services deliver comprehensive, individualized, and flexible treatment, support, and rehabilitation to individuals where they live and work and operate with fidelity to effective ACT models. At a minimum, there should be adequate ACT team services in each of the ten state regions. The ACT services should be provided through a multi-disciplinary team with services that are individualized and customized, and address the constantly changing needs of the individual over time. ACT teams should have the full array of staff on each team that are necessary to provide the following services: case management, initial and ongoing assessments, psychiatric services, assistance with employment and housing, family support and education, substance abuse services, crisis services, and other services and supports critical to an individual's ability to live

successfully in the community. ACT teams should provide crisis services, including helping individuals increase their ability to recognize and deal with situations that may otherwise result in hospitalization, increase and improve their network of community and natural supports, and increase and improve their use of those supports for crisis prevention. ACT teams should provide services to promote the successful retention of housing, including peer support and services designed to improve daily living skills, socialization, and illness self-management. ACT teams that serve individuals with co-occurring substance abuse disorders should provide substance abuse treatment and referral services to those individuals. Such ACT teams should include on their staff a clinician with substance abuse expertise. ACT services should be available 24 hours per day, seven days per week. Finally, the number of individuals served by an ACT team should be no more than ten individuals per ACT team member.

- The State should provide adequate integrated vocational services to qualified individuals with a disability through supported employment programs, the access to which should be facilitated by ACT teams. Supported employment services should assist individuals in finding competitive and other employment in an integrated setting based on the individual's strengths and interests. Supported employment programs should assist individuals in identifying vocational interests and applying for jobs and should provide services to support the individual's successful employment, including social skills training, job coaching, benefits counseling, and transportation. Supported employment services are to be integrated with the individual's mental health treatment. Enrollment in congregate day programs does not constitute supported employment.
- The State should expand upon the current community structure so as to create an effective statewide crisis system. The State should enhance crisis stabilization programs operated by community providers so that they provide psychiatric stabilization and detoxification services as an alternative to psychiatric hospitalization. The State should provide crisis apartments in the community to serve as an alternative to crisis stabilization programs and to psychiatric hospitalization.
- The State should develop and implement criteria to assess the adequacy of the individualized supports and services provided to persons by CMHCs to see whether their efforts are: reducing repeated admissions to institutional settings; increasing the stability of community residences; increasing housing services to individuals who have serious mental illness and who are homeless; retaining employment and/or schooling; increasing supported housing; and increasing supported employment.
- The State should develop and implement a plan to promptly discharge all persons with a developmental disability at NHH and Glenclyff to an integrated community setting that meets their individualized needs, including their need for habilitation, health care, and, where applicable, mental health care.

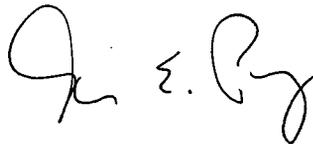
VI. CONCLUSION

Please be aware that this is a public document. Although we have already had some preliminary discussions about needed remedial steps, we now hope to engage the State in a more in-depth dialogue about remedies in the context of structured negotiations. Ultimately, we hope to be able to reach agreement with the State on a written, enforceable, voluntary compliance agreement that would set forth the remedial actions to be taken within a stated period of time to address each outstanding area. Such a disciplined remedial structure would provide all interested parties with the greatest assurance that discrimination will not recur.

If the State declines to enter into voluntary compliance negotiations or if our negotiations are unsuccessful, the United States may then need to take appropriate action, including initiating a lawsuit, to obtain redress for outstanding concerns associated with the State's compliance with the ADA. Nonetheless, as referenced above, we are encouraged by our interactions thus far with State leadership, and hope there is a desire to work with the United States toward an amicable resolution here.

Thank you again for your ongoing cooperation in this matter. We will contact you soon to discuss the issues referenced in this letter and to set a date and time to meet in person to discuss a remedial framework in which to address any outstanding individual and systemic concerns. If you have any questions, please feel free to contact Jonathan M. Smith, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-5393, or Richard Farano, the lead attorney assigned to this matter, at richard.farano@usdoj.gov, and/or (202) 307-3116.

Sincerely,



Thomas E. Perez
Assistant Attorney General

cc: Anne M. Edwards
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