



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

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

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

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

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

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

## Innovations

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

## Urgent Needs

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

## Consumer and Family Comments

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

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

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

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

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