REPORT IN-BRIEF

OIG Review of the Barriers to Discharge in State-Operated Adult Behavioral Health Facilities

Office of the Inspector General
Behavioral Health and Developmental Services

G. Douglas Bevelacqua, CIG
Inspector General

April 25, 2012

This Report summarizes the results of a six-month review (July-December 2011) by the OIG of the barriers that prevent the timely discharge of individuals receiving treatment in the eight adult state-operated behavioral health facilities. The complete Report No. 207-12 can be found on the OIG website at: www.oig.virginia.gov

HISTORY: In 1963, the Federal *Community Mental Health Act* ushered-in a new era for the treatment of mental illness. During the last five decades, important milestones have transformed how we view and treat individuals with mental illness. Key achievements and events in the long march towards deinstitutionalization include:

- The creation of Virginia's forty CSBs/BHAs (1968-1982);
- *The American with Disabilities Act (ADA)* (1990);
- The *Olmstead* decision [*Olmstead v. L.C.* (98-536) 527 U.S.581 (1999)];
- Virginia's *Integrated Strategic Plan* (2006);
- The DBHDS *Creating Opportunities Plan for advancing community focused care in Virginia* (2010);
- The state's *Comprehensive State Plan* 2012-2018. (Dec 2011).

THE CURRENT PARADIGM: The *Commonwealth's Integrated Strategic Plan*, DBHDS's *Creating Opportunities Plan*, and the current *Comprehensive State Plan* all affirm the contemporary treatment model underpinned by the goal of full participation in all spheres of community life and reflecting the values of "a consumer-driven system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of consumer participation in all aspects of community life including work, school, family and other meaningful relationships" delivered in a community-based setting – instead of Virginia's state-operated institutions. [1]

The practical impact of this paradigm shift is confirmed by the impressive 77% reduction from 1976 to 2011 in the number of persons served by Virginia's state behavioral health facilities: where the average daily census declined from 5,967 to the current level of 1,252 as of December 31, 2011. By any measure, the last two generations have marked a revolution in how Virginians view and treat mental illness.

Notwithstanding Virginia's impressive progress towards a community-based system of care, a recent OIG review, focusing on scores of *discharge ready* people who nonetheless remain in state-operated facilities due to *extraordinary barriers to discharge*, supports a finding that there is an indispensible component missing from the Commonwealth's services for its citizens with mental illness: **permanent community-based supported housing.**

[1] DBHDS State Board Policy 1036 (SYS) 05-3 cited in *Comprehensive State Plan* 2012-2018.

During the six-months of this review, there were, on average, 165 individuals, or 13% of the census on December 31, 2011, who were determined clinically ready for discharge from the state's institutions, but who could not be released due to "extraordinary barriers to discharge." This discharge ready cohort has three distinct subgroups: adult civil patients (53%); the forensic population (27%); and the geriatric population (20%).

The most often cited barrier to discharge from state facilities is the lack of community-based supported housing.[2]

Community-based supported housing in Virginia (and nationally) is not a new problem. The DBHDS has maintained an EBL (Extraordinary Barriers List) for over a decade. The OIG reviewed the EBL going back to 2007, and concluded that the percentage of state-operated facility residents on the extraordinary barriers list has remained between 12% and 14% for many years.

THE DYNAMICS OF RESIDENTIAL INSTABILITY AND THE MENTALLY ILL: Many people with serious mental illness (SMI), whose psychiatric condition compels them to move periodically from less restrictive community settings to more restrictive institutional settings, with greater structure and support, lose their stable housing in the process; that is, if they had stable housing at the onset of their acute symptoms.

Decades ago, when the expectation was that individuals would remain in state facilities for years, or even a lifetime, this issue lacked its present intensity; however, deinstitutionalization has ushered-in new housing challenges for persons with mental illness and for the state's system of care.

When individuals with SMI, who are living in temporary community housing, move to a state facility, economic incentives oblige property owners to locate a replacement tenant for the residence.

Once an individual has stabilized, and is deemed ready for discharge by clinicians at a state facility, the person's previous housing is frequently unavailable because it is occupied by someone else or the person's behavior leading up to their institutionalization has disqualified him or her from their previous living arrangement.

In 2003, the Bush Administration's New Freedom Commission on Mental Health report observed that "the shortage of affordable housing and accompanying support services causes people with serious mental illness to cycle among jails, institutions, shelters, and the streets; to remain unnecessarily in institutions; or to live in seriously substandard housing."[3]

The 77% reduction in state facility census from 1976 to 2011 noted earlier has been accompanied by a 63% increase in the state's population during the last thirty-five years. The combination of shrinking facility beds (77%) and growing population (63%) helps explain the current housing predicament for persons with SMI.

[2] "Safe, decent, and affordable housing is essential to recovery, and housing stability is correlated to lower rates of incarceration and costly hospital utilization." *Comprehensive State Plan*.

[3] *Op. Cit*.

THE U. S. DEPARTMENT OF JUSTICE: Based on the 2011 *Findings* of the DOJ in the state of New Hampshire, Virginia is at risk for a similar finding of noncompliance with the relevant aspects of the *Americans with Disabilities Act* (ADA) as interpreted in the *Olmstead* decision. In New Hampshire's case, the DOJ concluded that:

> The State's failure to develop sufficient community services is a barrier to the discharge of individuals…who could be served in more integrated community setting with adequate and appropriate services and supports.…In general, therefore, systemic failures in the State's system subject qualified individuals with disabilities…to undue and prolonged institutionalization and place them at risk of unnecessary institutionalization now and going forward. **All of this violates the ADA**. [Emphasis supplied by the OIG]

This OIG study concludes that important aspects of Virginia's behavioral health system are analogous to those found objectionable by the DOJ in New Hampshire:

- Virginia's failure to develop sufficient community services is a barrier to the discharge of individuals who could be served in a more integrated community setting with adequate and appropriate services and supports;
- The lack of community-based permanent supported housing is a barrier to discharge for a significant number of individuals in state-operated facilities;
- The lack of community housing places disabled persons with mental illness at risk for unnecessary institutionalization today and in the future; and,
- Virginia continues to fund more expensive institutional care when less expensive and therapeutically effective community-based care could be developed.

THE FISCAL IMPACT OF INSTITUTIONAL VS. COMMUNITY CARE: The average annual cost of serving an individual in a state-operated facility is $214,000;[4] while a conservative estimate for serving the people on the discharge ready list in the community is approximately $44,000 per year.

The Commonwealth could annually save approximately $170,000 (per person) if it served this cohort in the community rather than continuing to serve them in state facilities. Currently there are at least 70 individuals who could reside in the community with appropriate community housing and this alone would save almost $12,000,000 annually in exchange for an estimated upfront expense of just over $3,000,000.[5]

THE IMPACT ON SAFETY NET TDO ADMISSIONS: The OIG recently published the findings of a three-month study confirming anecdotal reports of "streeting." A term subsequently reframed as "Failed TDOs."[6] Of the 72 failed

[4] *Major Issues Facing the Commonwealth's Behavioral Health & Developmental Services System*, January 13, 2011.

[5] The actual savings would not be immediate or linear because, in order to realize the savings, the structural operating cost of the state facilities would have to be reduced. For some period, facility operating cost would remain relatively unaffected by a gradually reduced census.

[6] OIG Report No. 206-11, *OIG Review of Emergency Services: Individuals meeting criteria for temporary detention not admitted to a psychiatric facility for further evaluation and treatment.* February 28, 2012.

TDOs (a statewide average of six individuals weekly) 75% occurred in Hampton Roads and Southwest Virginia. This review of the barriers to discharge concludes that, during the July-Sept period of the failed TDO study, the state facilities serving these two regions on average had 51 beds (ESH) and 8 beds (SWVMHI) occupied by individuals who were ready for discharge but remained in the state facility due to extraordinary barriers to discharge.

It could be plausibly argued that, if community services – including supported housing – had been available in Hampton Roads and Southwest Virginia, ESH and SWVMHI could have admitted many of the 54 persons meeting criteria for temporary detention (the so-called "failed TDOs") that were denied admission and referred to less intensive services than they had been clinically determined to require.

Additional OIG Findings and Recommendations appear on pages 28 - 30 of the Report and include:

- The state does not offer community services and supports in sufficient quantities to serve all Virginians;
- An average of 165 adults remained institutionalized for roughly eight months during this review;
- Recommended that the DBHDS publish on its website a quarterly HIPAA compliant summary of individuals on the EBL at each state-operated facility including the specific barriers to discharge, the time on the list, and the estimated cost to discharge the person;
- That the DBHDS's work with regional access committees to evaluate the housing needs of each region and identify the housing requirements of each PPR to curtail the extraordinary barriers list;
- That the DBHDS evaluate the discharge practices at all state-operated hospitals and replicate the best practices that have produced measurably superior discharge outcomes;
- That the DBHDS seek to expand funding for discharge assistance projects to help individuals transition to the community.

Office of the Inspector General

The Office of the Inspector General (OIG) is established in the VA Code § 37.2-423 to inspect, monitor and review the quality of services provided in the facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS) and providers as defined in VA Code § 37.2-403. This definition includes all providers licensed by DBHDS including community services boards (CSB) and behavioral health authorities (BHA), private providers, and mental health treatment units in Department of Correction facilities.

It is the responsibility of the OIG to conduct announced and unannounced inspections of facilities and programs. Based on these inspections, policy and operational recommendations are made in order to prevent problems, abuses and deficiencies and improve the effectiveness of programs and services. Recommendations are directed to the Office of the Governor, the members of the General Assembly and the Joint Commission on Healthcare.

2012

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List of Tables & Charts

Note: Data for persons deemed ready for discharge at state-operated facilities was provided by the DBHDS from the monthly "Extraordinary Barriers to Discharge List" for July through December, 2011.

FOREWORD

In 1963, the Federal *Community Mental Health Act* ushered-in a new era for the treatment of mental illness. During the last five decades, important milestones have transformed how we view and treat individuals with mental illness. Historically significant achievements and events in the prolonged march towards deinstitutionalization include:

- Virginia's forty CSBs/BHAs created (1968-1982);
- *The Americans with Disabilities Act (ADA)* (1990);
- The *Olmstead* Decision [Olmstead v. L.C. (98-536) 527 U.S.581 (1999)];
- The Bush Administration's *New Freedom Commission* (2003);[1]
- The Commonwealth's *Envision the Possibilities: An Integrated Strategic Plan for Virginia's Mental Health, Mental Retardation and Substance Abuse Services System (ISP)* (2006);
- The DBHDS *Creating Opportunities Plan for advancing community focused care in Virginia* (2010);
- Virginia's *Comprehensive State Plan* 2012-2018 (Dec 2011).

The *Commonwealth's Integrated Strategic Plan*, the DBHDS' *Creating Opportunities Plan*, and the current *Comprehensive State Plan* all affirm the contemporary treatment model underpinned by the goal of full participation in all spheres of community life and reflecting the values of "a consumer-driven system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of consumer participation in all aspects of community life including work, school, family and other meaningful relationships" [2] delivered in a community-based setting – instead of the traditional institutional setting.

[1] "'The 2003 federal *New Freedom Commission on Mental Health* report opined that "the shortage of affordable housing and accompanying support services causes people with serious mental illness to cycle among jails, institutions, shelters, and the streets; to remain unnecessarily in institutions; or to live in seriously substandard housing.'"

[2] DBHDS State Board Policy 1036 (SYS) 05-3 cited in *Comprehensive State Plan* 2012-2018.

SECTION ONE

BACKGROUND AND INTRODUCTION

In July 2011, the Office of the Inspector General (OIG) commenced reviewing the barriers to timely discharge for "discharge ready" individuals residing in eight state-operated behavioral health facilities. From July through December 2011, the OIG monitored those individuals who had been determined clinically ready for discharge from the facility but, for the reasons discussed in this Report, were unable to leave the state facility and return to their respective communities.

During the six-month period of this review, an average of 165 discharge ready people were required to remain in their institutional settings because of the barriers to discharge discussed below. To put these 165 individuals in context, for FY 2011 the average daily census for people served by the Virginia's behavioral health facilities was 1,319, while the state facility census on December 31, 2011 was 1,252.[3] Therefore, during this review, 13% of the state's facility beds were occupied by individuals that clinicians had determined had received maximum benefit from institutional care, and could reside in their respective communities with appropriate supported housing or programs.

The OIG discovered that 78 individuals, or 47%, included in this monthly average belong to two groups of patients that are recognizably challenging to place: individuals determined NGRI[4] and the geriatric population; however, the majority (53% or 87 individuals) were classified as adult civil patients. The timely discharge of scores of adult civil patients could create safety net beds for individuals meeting TDO criteria – beds that are routinely scarce in Hampton Roads and Southwest Virginia.

[3] Virginia's *Comprehensive State Plan 2012-2018* (December 2011). http://www.dbhds.virginia.gov/OPD-default.htm#CompPlan.

[4] Section 19.2-182.5 of the Virginia Code outlines that persons found not guilty by reason of insanity (NGRI) on a felony charge and who are committed to the state-operated facility for treatment automatically get a hearing on continued need for inpatient care once a year for five years then every other year after that point. Individuals participate in a graduated release program of increasing privileges as their condition improves. An acquittee who is found not guilty of a misdemeanor by reason of insanity on or after July 1, 2002, shall remain in the custody of the Commissioner pursuant to this chapter for a period not to exceed one year from the date of acquittal.

RATIONALE FOR THIS REVIEW:

A study on the barriers to timely discharge was selected by the OIG for the following reasons:

- The inability of the state to discharge residents, who are clinically ready for community placement in a timely manner, can undermine a facility's ability to serve as a safety net by admitting persons in crisis who have been assessed to need an intensive inpatient level of care.[5]

- Delays in discharge for persons, who are clinically stable and have expressed a desire for community placement, may be contrary to federal regulations. *The Americans with Disabilities Act*, as interpreted by the *Olmstead* decision, suggests that any policy, or practice, fostering unjustifiable institutionalization of a person with a disability, including persons with mental illness, who, with the proper services and support, could live in the community constitutes discrimination. In addition, extended delays in discharge diminish the person's quality of life. As the court observed in *Olmstead*, "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."[6]

- Recent *Findings* by the U.S. Department of Justice (DOJ) regarding a similar outcome in the State of New Hampshire suggests that Virginia may be in violation of the controlling federal regulations:

> The State's [New Hampshire] failure to develop sufficient community services is a barrier to the discharge of individuals…who could be served in more integrated community setting with adequate and appropriate services and supports.…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

[5] OIG Review of Emergency Services*: Individuals meeting statutory criteria for temporary detention not admitted to a psychiatric facility for further evaluation and treatment*: Report No. 206-11 (February 28, 2012).

[6] Title II of the *Americans with Disabilities Act* ("ADA"), 42 U.S.C. § 12132, as interpreted by *Olmstead v. L.C.,* 527 U.S. 581 (1999), requiring that individuals with disabilities receive services in the most integrated setting appropriate to their needs.

institutionalization now and going forward. **All of this violates the ADA**. [Bold supplied by OIG][7]

- An extended delay in discharge has the potential to undermine the therapeutic benefits an individual has received during the course of his/her hospitalization[8] and, moreover, is incompatible with DBHDS's stated Mission and Values.[9]

- A prolonged discharge process can be viewed as an indicator of the state's failure to create sufficient community services to address the needs of individuals with mental illness in more integrated and less restrictive community settings. While DBHDS and the CSBs provide the types of services and supports needed by these individuals to live successfully in the community, the Commonwealth's system of care does not offer these needed services and supports in sufficient quantity to serve residents who remain on the discharge ready list for months or years.

REVIEW METHODOLOGY:

In order to understand the numbers, demographics, and other relevant factors contributing to an extended delay in the timely placement of persons into community-based services and supports, the OIG engaged in the following activities during the first six months of FY2012:

- The monitoring of individuals on the monthly ready for discharge lists maintained by the DBHDS from July to December 2011;

- Unannounced visits at the eight adult behavioral healthcare facilities during which the OIG conducted an in-depth review of approximately 50% of the individuals who were identified on the July 2011 extraordinary barriers list. On-site activities during the inspections included:

    - A review of the each individual's records: their individualized treatment plan, discharge notes, and documented barriers;
    - Interviews with key staff at each facility engaged in discharge monitoring; and

[7] U. S. Department of Justice, Civil Rights Division letter to Michael A. Delaney, Attorney General for the State of New Hampshire captioned "United States' Investigation of the New Hampshire Mental Health System Pursuant to the Americans with Disabilities Act" dated April 7, 2011. [Appendix A attached hereto for convenience]

[8] Op. Cit. (pg. 6)

[9]The Department of Behavioral Health & Developmental Services: http://www.dbhds.virginia.gov/CO-MissionValues.htm.

- Observations of treatment teams to determine whether discharge planning was actively addressed in team meetings.

- The OIG monitored the same individuals for a 90 day period: from August through October 2011 in an effort to measure progress towards discharge.

SECTION TWO

OVERVIEW OF FACILITY SYSTEM AND DISCHARGE PLANNING

FACILITY SYSTEM OVERVIEW:

The DBHDS operates eight behavioral healthcare facilities for adults. These include: Catawba Hospital (CH) in Salem, Central State Hospital (CSH) in Petersburg, Eastern State Hospital (ESH) in Williamsburg, Piedmont Geriatric Hospital (PGH) in Burkeville, Northern Virginia Mental Health Institute (NVMHI) in Falls Church, Southern Virginia Mental Health Institute (SVMHI) in Danville, Southwestern Virginia Mental Health Institute (SWVMHI) in Marion, and Western State Hospital (WSH) in Staunton. The state psychiatric facilities provide both acute and longer-term intensive inpatient services, which includes specialized services for both the geriatric and forensic populations.

The operating capacity for the state's behavioral health facilities on July 1, 2011 was 1,514 beds[10]. This includes the following operating capacity by facility:

Figure 1:

Operating Capacity for the State-Operated Adult Behavioral Healthcare Facilities By Facility July 1, 2011	
Catawba Hospital	120
Central State Hospital	277
Eastern State Hospital	306
Northern Virginia Mental Health Institute	123
Piedmont Geriatric Hospital	135
Southern Virginia Mental Health Institute	96
Southwestern VA Mental Health Institute	156
Western State Hospital	253
Total Operating Capacity	1, 514

[10] *Comprehensive State Plan* 2012-2018 (December 2011) pg. 7. The OIG understands that the operating capacity at SVMHI has been reduced to 72 but, for the purposes of this Report, we have used the most recent *Comprehensive State Plan* capacity of 96 for this facility. If a smaller number of system facility beds (1,490 vs. 1,514) had been used in the calculations that follow, it would not have a material impact on the Report's findings and recommendations.

The operating capacity of the state-operated regional adult behavioral healthcare facilities is probably sufficient to function as the safety net for persons in crisis in the community who have been determined to be clinically in need of an intensive inpatient level of care, particularly when combined with community alternatives, such as crisis stabilization programs and private psychiatric facilities; however, the actual availability of beds for safety net usage is diminished by several factors. These include:

- The ongoing and growing demands placed on the system by specialized populations, such as the forensic and geriatric populations (48% of facility census);

- The extended delay in discharge for persons deemed clinically ready for community living (13% of facility census); and,

- The limited capacity available in the community to serve individuals in need of intensive services and supports in less restrictive settings.

DBHDS established a workgroup to create strategies for increasing the effectiveness and efficiency of the state-operated facilities as part of its *Creating Opportunities* process. The workgroup recognized the importance of both timely admissions for persons in crisis to the appropriate level of care as well as the long-term effectiveness of treatment that occurs in the less restrictive setting. This group proposed the following goal or strategy for implementation by DBHDS leadership:

> Reduce state hospital bed utilization through aggressive monitoring of service plans and discharge efforts such as targeted discharge assistance that reduce lengths of stay and enable individuals to be integrated more quickly into the community.[11]

The Department's April 2, 2012 *Implementation Report* further states that the DBHDS intends to conduct "a review [of] issues that prevent community return for individuals determined to be clinically ready for discharge and document needed support services (August 2012)."[12] According to the DBHDS, this project is scheduled for completion by October 2012.

[11] *Creating Opportunities, A Plan for Advancing Community-Focused Services in Virginia*, Implementation Report: Accomplishments and Planned Implementation Activities, April 2, 2012.

[12] Op. Cit.

THE DISCHARGE PLANNING PROCESS:

DBHDS protocols and CSB performance contracts require that CSB case managers are responsible for facilitating discharge planning for persons receiving care in the state-operated facilities.

- According to the *Discharge Protocols for Community Services Boards and State Hospitals (2010)* CSB staffs are responsible for initiating discharge planning upon the individual's admission to a state facility.[13]

- Cooperative discharge planning between the facility and the CSB is to begin at the initial interdisciplinary team meeting and results in the completion of the *Needs Upon Discharge Form* (DBH 226), which identifies the services and supports necessary for the person to successfully reside in the community. In completing the form, the CSB is expected to consult with members of the team, including the individual receiving services or his/her legally authorized representative, and with his consent, other parties.

- The *Needs Upon Discharge Form*[14] must include the following information: the anticipated date of discharge from the state facility; identification of the services and supports needed for successful community placement; and specify, as available, the public and private providers that will provide these services, consistent with choice principles.

- The protocol anticipates that discharge will occur within 30-days of the individual being determined clinically ready for discharge.

- Individuals whose discharge exceeds the protocol's defined 30-day time limit are identified, and the barriers that prohibit their timely discharge are documented on the *Extraordinary Barriers to Discharge Form (DBH 1192)*. These individuals are then placed on the Extraordinary Barriers List (EBL) where they remain until either discharged, or their condition deteriorates and they are no longer considered clinically ready for discharge.

- The CSB coordinating the discharge plan is expected to outline specific steps that are being taken to address each individual's barriers, and periodic case reviews are scheduled until a person is discharged.

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[13] The 2010 version of the Departments *Discharge Protocols for Community Services Boards and State Hospitals* is located at: http://www.dbhds.virginia.gov/documents/omh-dischargeprotocols.pdf.

[14] This form can be found at: http://www.dbhds.virginia.gov/documents/forms/inst1190cemh.pdf.

While thirty days beyond discharge readiness does not seem to be a significant amount of time for actual discharge to occur, it is noteworthy for the following reasons:

- Even though the record reviews revealed that there was little involvement by the CSBs during the initial treatment planning meeting, in the vast majority of the cases reviewed, 98%, the CSB discharge liaisons and case managers were actively involved in working with the individuals and the facility on an ongoing basis throughout their hospitalization.

    - Defined needs of individuals were routinely discussed and options for placement and services needs were, more often than not, identified long before the person was determined clinically ready for discharge.
    - Potential barriers to discharge were identified and options for addressing each in advance of actual clinical readiness were explored.

- Most significant is the fact that for each day an individual remains at the inpatient level of care after being clinically ready for discharge, and for which they have actively engaged in planning, constitutes both a waste of limited state resources and contrary to the integration mandate of the *Olmstead* decision.

Interviews with key personnel at each facility revealed that all the facilities have established procedures for identifying, monitoring, and actively addressing each case until discharge occurs. The frequency of case reviews vary across the facilities, but occur generally at all the facilities no less than monthly. Reviews across the system occur at the level of the treatment team and the regional utilization group or committee.

Specialized case conferences, that also include DBHDS Central Office personnel, occur for individuals who have been on the EBL for periods greater than six months. CSBs are responsible for maintaining the EBL database that contains information regarding the length of time each person has been on the list, the primary barriers to discharge and notations regarding the efforts to resolve the documented issues.

Even though all of the facilities have a system for addressing individuals once they have been placed on the EBL, Western State and Central State Hospital have the most comprehensive approach to discharge planning. For both facilities, discharge planning is an integrated part of treatment planning, and very much a part of a complete treatment focus.

To assure that discharge planning stays in the forefront of treatment interventions, WSH and CSH rate each person according to their readiness for discharge. This rating begins at the time of admission. For example, a person with a designation of 4 is typically a newly admitted individual, while an individual determined clinically ready for discharge is classified as a 1. All individuals who are rated as a 1 or 2, meaning an individual approaching clinical readiness for discharge, are discussed both in treatment team meetings and in census

management meetings. Discharge barriers are readily identified and resolutions sought well in advance of the anticipated discharge dates. Based on the operational capacity of the facilities, Western State Hospital, Central State Hospital, and Southwestern Virginia Mental Health Institute had smaller numbers of patients on the barriers list per 100 patients than most facilities, with 7.6, 3.8, and 5 respectively.[15] The rate of discharge ready patients per one hundred for all state facilities is profiled below.

During the six-months of this review, approximately 13% of the system's beds were occupied by individuals on the EBL that had been determined to be clinically ready for discharge for over thirty days. The table below illustrates that facility operating capacity was most degraded at SVMHI and NVMHI because 22% of their beds were occupied by discharge-ready residents that previously had been determined to be appropriate for a less restrictive level of the community care.[16]

Figure 2:

Percentage of Individuals on the Extraordinary Barriers List By Facility				
CAT	12.5%		PGH	10%
CSH	3.8%		SVMHI	22%
ESH	17%		SWVMHI	5%
NVMHI	22%		WSH	7.6%

Not all the facilities have the same system for classifying an individual as "clinically ready" for discharge. For example, WSH does not place an individual on the barriers list if that person refuses to participate in active discharge planning. The person's hospital dependence becomes a focus of treatment with community-based strategies developed and implemented in order to support the person in achieving a successful community transition.

[15] SWVMHI had a 5% rate (EBL/Operating Capacity) that was less than WSH's 7.6% rate; however, during the six-months of this review, SWVMHI did not serve any NGRI individuals who were placed on the EBL (Figure 6 below) so, while SWVMHI's discharge performance is excellent relative to other state-operated facilities, it may be an apple-to-oranges comparison for this six-month window. What appears to distinguish WSH and CSH from other facilities, and we suspect improves their discharge outcomes, is the rating system approach briefly discussed above.

[16] The loss of actual operating capacity at SVMHI is greater than 22%. If this Report had used the current 72 bed operating capacity for SVMHI, instead of 96 beds listed in the *Comprehensive State Plan*, its loss of capacity would have registered the highest in the state facility system at 29%.

SECTION THREE

DATA COLLECTION AND MONITORING

There was a combined monthly average of 165 individuals on the extraordinary barriers list from July through December 2011. This number includes: Adult Civil – an average of 87 individuals (53%), NGRI – an average of 45 individuals (27%), and Geriatric – an average of 33 individuals (20%).

Figure 3 below shows the actual number of individuals on the EBL at each facility, as well as the combined monthly average.

Figure 3:

Total Number of Individuals on the Barriers List by Facility and Combined Monthly Averages July Through December 2011

	July	August	Sept	Oct	Nov	Dec	Average
Catawba Hospital	18	18	15	16	13	11	**15**
Central State Hospital	11	9	12	10	10	9	**10**
Eastern State Hospital	46	46	49	56	58	52	**51**
Northern Virginia MH Institute	18	26	31	31	28	26	**27**
Piedmont Geriatric Hospital	15	15	12	12	16	12	**14**
Southern Virginia MH Institute	21	23	23	21	21	20	**21**
Southwestern VA MH Institute	8	7	10	11	7	5	**8**
Western State Hospital	16	15	22	25	18	18	**19**
Totals	153	159	174	182	171	153	**165**

As noted above, CSBs have the responsibility for facilitating discharge options for the individuals served in the state-operated facilities. The information in the table below lists the break-down of individuals in the system from July to December 2011 by board and region.

Figure 4:

Number of Individuals on EBL by CSB: July 2011 - December 2011			
PPR	**CSB**	**POPULATION**	**SIX-MONTH AVERAGE**
I	CENTRAL VIRGINIA	254,240	3.7
I	HARRISONBURG-ROCKINGHAM	127,354	1.2
I	NORTHWESTERN	223,491	1.8
I	RAPPAHANNOCK AREA	332,707	5.2
I	RAP-RAPIDAN	167,473	2.0
I	REGION TEN	238,830	6.0
I	ROCKBRIDGE AREA	41,030	0.0
I	VALLEY	121,408	2.2
	Totals	**1,506,533**	**20.7**
II	ALEXANDRIA	143,464	1.5
II	ARLINGTON	214,373	12.0
II	FAIRFAX-FALLS CHURCH	1,131,456	9.8
II	LOUDOUN	324,337	3.0
II	PRINCE WILLIAM	468,131	4.0
	Totals	**2,281,761**	**30.3**
III	CUMBERLAND MTN.	98,296	0.0
III	DICKENSON COUNTY	15,762	0.0
III	HIGHLANDS	72,959	1.5
III	MOUNT ROGERS	120,586	2.8
III	NEW RIVER VALLEY	178,926	6.8
III	PLANNING DISTRICT 1	94,074	3.3
	Totals	**580,603**	**13.5**
IV	CHESTERFIELD	319,641	2.7
IV	CROSSROADS	105,041	2.8
IV	GOOCHLAND-POWHATAN	50,043	0.0
IV	HANOVER	100,704	1.0
IV	HENRICO	336,859	2.7
IV	PLANNING DISTRICT 19	174,230	2.0
IV	RICHMOND	206,238	4.5
	Totals	**1,292,756**	**15.3**
V	CHESAPEAKE	225,898	8.3
V	COLONIAL	161,343	4.7
V	EASTERN SHORE	45,768	1.5
V	HAMPTON-NEWPORT NEWS	318,399	16.2
V	MPNN	142,093	4.2
V	NORFOLK	243,985	8.2
V	PORTSMOUTH	96,368	3.3
V	VIRGINIA BEACH	441,246	4.8
V	WESTERN TIDEWATER	148,543	2.8
	Totals	**1,823,643**	**53.0**
VI	DANVILLE-PITTSYLVANIA	106,318	6.5
VI	PIEDMONT REGIONAL	142,704	9.7
VI	SOUTHSIDE	86,520	7.0
	Totals	**335,542**	**23.2**
VII	ALLEGHANY-HIGHLANDS	22,272	1.2
VII	BLUE RIDGE	253,503	8.2
	Totals	**275,775**	**9.2**
	Grand Totals	**8,096,613**	**165.2**

THE EXTRAORDINARY BARRIERS LIST

The state-operated behavioral healthcare facilities provide both acute and longer-term intensive rehabilitation services. A shift in the mid-1990s in service provision created a more defined role for publicly funded behavioral healthcare facilities as primarily serving individuals with intensive long-term care needs. This shift in service provision includes adults who need inpatient psychiatric hospitalization for extended periods because of the severity and persistence of a serious mental illness or because of behaviors that are deemed unmanageable in the community setting, the forensic population, and the elderly.

These groups are arranged in this Report under the classifications: Adult Civil Patients, NGRI Patients, and the Geriatric Population:

ADULT CIVIL PATIENTS: The largest classification of individuals on the EBL for the review period is the adult civil population. The combined monthly average for this classification of individuals is 87, or 53%. Like the overall combined averages, of the 75 cases that were reviewed in greater depth during the OIG site visits, approximately 50% were classified as adult civil patients. All of these individuals were identified by their respective facility as being hospitalized for more intensive or extended rehabilitation services.

On closer examination, facility staff indicated that the lack of housing options was a barrier for at least 10 of these same individuals because many adult care facilities would not serve as willing providers due to the complexity of the individuals needing placement. Reasons provided to the OIG included the patients' histories of aggression and violence and/or past histories of non-compliance with treatment recommendations in community settings, even if neither of these factors had been an issue for the person while in the state-operated facility at the time of proposed discharge.

The following table shows the number of adult civil patients on the barriers to discharge list by facility for the first six months in FY 2012.

Figure 5:

NUMBER OF ADULT CIVIL PATIENTS ON THE BARRIERS TO DISCHARGE LIST BY FACILITY FROM JULY 2011 TO DECEMBER 2011 WITH COMBINED MONTHLY AVERAGES							
	July	**August**	**September**	**October**	**November**	**December**	**Average**
Catawba Hospital	10	10	6	7	5	4	6
Central State Hospital	5	4	7	5	5	3	5
Eastern State Hospital	17	21	23	33	31	29	26
Northern Virginia MH Institute	14	19	22	23	20	18	19
Piedmont Geriatric Hospital	0	0	0	0	0	0	0
Southern Virginia MH Institute	10	13	11	8	9	9	10
Southwestern VA MH Institute	6	6	9	11	7	5	7
Western State Hospital	11	9	15	15	11	12	12
TOTALS	**75**	**82**	**93**	**102**	**88**	**80**	**87**

Facility staff repeatedly reported that, in the broadest sense, finding suitable housing options is the primary barrier to discharge for the majority of adult civil patients.

"Safe, decent, and affordable housing is essential to recovery, and housing stability is correlated to lower rates of incarceration and costly hospital utilization." [17]

THE FORENSIC POPULATION: Like many hospitals nationwide, Virginia is dedicating increased resources to the care, custody, and treatment of forensic patients. Even though the definitions vary across states and types of mental health settings, the term forensic typically refers to a legal status when the person has a mental illness and is involved with the criminal justice system.

Categories of forensic patients may include defendants referred for court-ordered pretrial psychiatric evaluations, defendants found by the courts to be incompetent to stand trial, defendants acquitted as not guilty by reason of insanity (NGRI), defendants convicted as guilty but mentally ill, and some convicted defendants who committed sex crimes. The role of public psychiatric hospitals in the treatment of forensic patients has expanded in recent years as some states' public psychiatric hospitals have experienced a dramatic increase in the number of forensic patients they serve. As a result, the care and treatment of forensic patients is consuming a large percentage of the resources of those hospitals. This is the case in Virginia.

In FY 2010 DBHDS facilities provided forensic services to 1,165 individuals and the average daily census for the forensic population was 469, or 36% of the total inpatient population. The forensic population utilized 171,073 bed-days in the facilities in FY 2010. The growth in forensic bed utilization since 2005 has been cited as a contributing factor to facilities having fewer civil beds for treatment of individuals needing crisis or extended rehabilitation services.[18]

Members of the forensic cohort on the EBL were all classified as NGRI and, in addition to clinical issues related to discharge, must be approved by the court following a risk assessment. Individuals determined not guilty by reason of insanity on a felony charge and who are committed to the state-operated facility for treatment automatically get a hearing on continued need for inpatient care once a year for five years, then every other year after that point. Individuals participate in a graduated release program of increasing privileges as their condition improves. The majority of individuals on the EBL were waiting for a legal release determination before community placement could occur.

[17] *Op. Cit. Virginia State Plan*, (pg. 50)

[18] OIG Review of Behavioral Health Forensic Services OIG Report No. 200-11.

The following table shows the number of forensic individuals by facility on the barriers list by month from July to December 2011.

Figure 6:

NUMBER OF NGRI* PATIENTS ON THE BARRIERS TO DISCHARGE LIST BY FACILITY FROM JULY 2011 TO DECEMBER 2011 WITH COMBINED MONTHLY AVERAGES							
	July	**August**	**September**	**October**	**November**	**December**	**Average**
Catawba Hospital	0	0	0	0	0	0	0
Central State Hospital	6	5	5	5	5	6	5
Eastern State Hospital	12	13	14	14	17	15	14
Northern Virginia MH Institute	4	7	9	8	8	8	7
Piedmont Geriatric Hospital	0	1	1	1	0	1	1
Southern Virginia MH Institute	9	10	12	13	12	11	11
Southwestern VA MH Institute	0	0	0	0	0	0	0
Western State Hospital	5	6	7	10	7	6	7
TOTALS	**36**	**42**	**48**	**51**	**49**	**47**	**45**

THE GERIATRIC POPULATION: Older adults with psychiatric needs are served in the state hospital geriatric centers located at Catawba, Eastern State's Hancock Center, Piedmont Geriatric Center and Southwestern Virginia Mental Health Institute. According to the *DBHDS' Comprehensive State Plan 2012-2018*, the geriatric population represented 12% of the total hospital bed days in these settings in FY 2011.

The lack of community capacity to adequately address the behavioral management needs of geriatric individuals with psychiatric illnesses results in an ever increasing demand on the state facilities to provide the needed safety net services. Even though the state facilities are actively engaged in partnering with community nursing homes and other community settings to support the transition of individuals no longer in need of an inpatient level of care to the community, the dynamics of the free-market permits providers to select individuals, without psychiatric complications and fewer behavioral demands.

Figure 7:

NUMBER OF GERIATRIC PATIENTS ON THE BARRIERS TO DISCHARGE LIST BY FACILITY FROM JULY 2011 TO DECEMBER 2011 WITH COMBINED MONTHLY AVERAGES							
	July	**August**	**September**	**October**	**November**	**December**	**Average**
Catawba Hospital	8	8	9	9	8	7	8
Central State Hospital	0	0	0	0	0	0	0
Eastern State Hospital	17	12	12	9	10	8	11
Northern Virginia MH Institute	0	0	0	0	0	0	0
Piedmont Geriatric Hospital	15	14	11	11	16	11	13
Southern Virginia MH Institute	0	0	0	0	0	0	0
Southwestern VA MH Institute	2	1	1	0	0	0	1
Western State Hospital	0	0	0	0	0	0	0
TOTALS	**42**	**35**	**33**	**29**	**34**	**26**	**33**

SECTION FOUR

PROFILE OF INDIVIDUALS ON THE EXTRAORDINARY BARRIERS LIST (JULY 2011)

The OIG completed unannounced inspections at the eight adult behavioral healthcare facilities during the months of July and August 2011. During these inspections, the OIG conducted an in-depth review of 75 individuals, or 49%, of the individuals who were identified on the July 2011 extraordinary barriers list. Onsite activities during the inspections included:

- A review of the each individual's records, their individualized treatment plan, discharge notes, and documented barriers
- Interviews were conducted with key staff at each facility engaged in discharge monitoring, and
- Observations of treatment teams occurred to determine whether discharge planning was actively addressed in team meetings.

The OIG followed the same individuals for a 60 day period, September through October 2011 in an effort to measure systemic progress towards discharge.

A profile of the individuals on the EBL that were reviewed during the OIG site visits is as follows:

- Of the 75 individuals reviewed 44, or 59%, were male and 31, or 41%, were female.

- Thirty-one individuals, or 42%, were adult civil patients; 25 individuals, or 33%, were classified as geriatric; and 19, or 25%, were classified as NGRI.

- Forty-five percent of the individuals reviewed had at least one previous admission.

- 25% of the individuals had multiple previous admissions, including one individual who had been hospitalized 25 times. Readmissions to state-operated facilities are a potential indicator of the inadequacies of the mental health system to support and maintain individuals in community-based settings, particularly in times of crisis.

- The majority of individuals (57%) had a primary thought disorder diagnosis (i.e. schizophrenia, schizoaffective), 21% a primary mood disorder diagnosis (i.e. major depressive or bi-polar), and 23% were diagnosed with dementia. One individual was diagnosed with borderline personality disorder.

- Sixteen individuals, or 21%, were identified as having a co-occurring mental health and substance use disorder.

- Twelve individuals had been on the EBL before, but removed after their conditions deteriorated and they no longer were deemed clinically ready for discharge.

LENGTH OF STAY: Prolonged discharge can be viewed as an indicator of the state's failure to create sufficient community services to address the needs of individuals with mental illness in more integrated and less restrictive community settings. While DBHDS and the CSBs provide the types of services and supports needed by these individuals to live successfully in the community, the system of care does not offer these needed services and supports in sufficient quantity.

Each individual that remains on the EBL for an extended period diminishes the state's capacity to provide needed safety net services for individuals in acute crisis (TDOs) and is, at the very least, an inefficient use of the state's limited resources because most people can be served in the community for a fraction of the $214,000 annual cost of serving a person in a state-operated facility.

As previously noted, 16% of the individual cases that were reviewed had been on the barriers list previously during the same hospitalization. This means that 12 of the 75 individuals became unstable, or their status deteriorated, while they were waiting to be discharged, and subsequently they were removed from the EBL. Once stabilized and determined to be clinically ready again, the "clock resets" for that individual and the count begins again.

For the 153 individuals that were on the EBL for July 2011, 56, or 36%, had been on the list for a period of greater than six months. Twenty-four individuals, or 16%, had been on the list for a period of time greater than one year. The chart below shows the number of persons, the average time on EBL (Total on List or TOL), the longest and shortest TOL for any one individual by CSB for the month of July 2011. Of the 75 individuals reviewed by the OIG during the on-site inspections, 36 or 48% remained on the list for a period of up to 60 additional days and 21 or 28% remained on the list for 90 days.

Figure 8: **Time on List (EBL) by CSB – July 2011**

PPR	CSB	No. Persons	Average TOL	Longest TOL	Shortest TOL
I	CENTRAL VIRGINIA	2	127	196	57
I	HARRISONBURG-ROCKINGHAM	1	209	209	209
I	NORTHWESTERN	2	195	320	69
I	RAPPAHANNOCK AREA	7	213	783	28
I	RAP-RAPIDAN	0	0	0	0
I	REGION TEN	7	121	562	91
I	VALLEY	1	56	56	56
II	ALEXANDRIA	2	44	52	35
II	ARLINGTON	9	359	770	97
II	FAIRFAX-FALLS CHURCH	7	352	760	31
II	LOUDOUN	2	374	650	97
II	PRINCE WILLIAM	3	74	133	58
III	HIGHLANDS	0	0	0	0
III	MOUNT ROGERS	2	187	211	162
III	NEW RIVER VALLEY	8	112	243	24
III	PLANNING DISTRICT 1	3	181	329	24
IV	CHESTERFIELD	5	184	321	22
IV	CROSSROADS	4	70	240	65
IV	HANOVER	0	0	0	0
IV	HENRICO	3	118	143	92
IV	PLANNING DISTRICT 19	2	86	92	79
IV	RICHMOND	4	213	347	85
V	CHESAPEAKE	9	129	274	56
V	COLONIAL	3	125	240	65
V	EASTERN SHORE	0	0	0	0
V	HAMPTON-NEWPORT NEWS	9	253	984	70
V	MPNN	3	346	632	45
V	NORFOLK	7	362	982	72
V	PORTSMOUTH	2	77	104	49
V	VIRGINIA BEACH	6	331	1236	56
V	WESTERN TIDEWATER	5	192	721	30
VI	DANVILLE-PITTSYLVANIA	7	283	968	23
VI	PIEDMONT REGIONAL	13	170	472	43
VI	SOUTHSIDE	5	94	175	44
VII	ALLEGHANY-HIGHLANDS	1	76	76	76
VII	BLUE RIDGE	9	143	660	28

PRIMARY BARRIERS TO DISCHARGE: Facility personnel reported that the lack of safe, affordable, and stable community housing, including supervised settings, was the primary reason for the delay in timely discharge. Other reasons reported are as follows:

- Lack of discharge assistance funding;
- An increase in the complexity of both psychiatric and medical issues for the individuals on the list, which complicate finding either willing providers or community settings capable of addressing the specialized needs of these individuals;
- Challenges in accessing resources, such as the completion of social security benefit applications that can take up to six weeks to secure an appointment;
- An increasing number of individuals with co-occurring disorders; and
- Delays in the completion of the gradual release process for the forensic individuals.

EXTRAORDINARY BARRIERS LIST UPDATE: (APRIL 2012)

As this Report approached completion, the OIG realized that our review had not considered the fiscal impact of serving people in the community instead of state facilities, and we requested that the seven PPRs update the extraordinary barriers to discharge list (EBL) and provide the following information about each patient on the list:

- age;
- gender;
- time on discharge ready list;
- primary barrier to discharge; and
- estimated annual cost to serve the individual in the community.

The turnaround time for the regional access committees was about five days and some of the data furnished came with qualifiers and caveats. Even with the qualifiers, it supports a finding that, like New Hampshire, the Commonwealth continues to fund more costly institutional care even though less expensive and more therapeutic alternatives consistent with *Olmstead* could be developed in community settings.[19]

PPR V (Hampton Roads), which includes about a third of the individuals on the EBL list, concluded that the average annual cost of serving the 54 people on its extraordinary barri-

[19] Op. cit. (pg. 2)

ers list was $51,471;[20] however, this sum included federally funded SSI, SSDI, Medicaid, and Medicare payments. When the federal subsidy was removed from the service estimate, the average cost to Virginia was about $22,000 a year to support a person in the community. The $22,000 sum is generally consistent with the estimated service costs reported by other regions. When compared to the $214,000 cost to serve an individual in the state-operated facilities, this suggests that Virginia could serve nine people in the community for the cost to serve one person in a state facility.

Assuming for the sake of discussion that the hasty, and admittedly incomplete, snapshot of estimated costs for serving individuals on the EBL in the community is overly optimistic, and that it will actually cost double PPR V's historic average of $22,000, or $44,000, to serve these individuals in the community, then the Commonwealth stands to save roughly $28 million annually if it serves this cohort in the community rather than continuing to serve them in state facilities.[21]

This review supported a finding that the average time on the list from July-December, 2011 was 206 days,[22] and the April update confirmed that a lack of housing remained the primary barrier to discharge for over seventy individuals in state facilities. In other words, if appropriate supported housing existed, approximately 80% of the adult civil population on the discharge ready list could reside in the community.

Setting aside the prospect of future savings generated by serving people in the community instead of in state facilities, this analysis suggests that about 70 individuals could be released from state facilities for approximately $3,000,000 in new discharge assistance (DAP) funding; thus, freeing-up dozens of beds to admit future challenging TDOs.

According to the *Comprehensive State Plan* (16), "Virginia's Public Behavioral Health and Developmental Services System Expenditures for FY 2011" were $1.27 billion and it is unimaginable that the relatively modest resources necessary to create the needed community capacity cannot be found. It is hard to imagine a greater impact on the Commonwealth's system of behavioral healthcare from any $3,000,000 expenditure that holds-out the promise of creating access to scores of needed state facility beds, improving compliance with *Olmstead's* integration mandate, and, over time, reducing overall system cost.

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[20] Several regions have extreme outliers with an estimated annual service cost of $100,000 or more, but our data reflects that the vast majority of individuals in the Commonwealth can be served in a community setting for less than $ 44,000 per year – plus federal Social Security and Medicaid subsidies.

[21] ($214,000[facility care] - $44,000[community care] = $170,000[annual savings] X 165 = $28,050,000)

[22] As of April 2012, the following percentages of individuals remained on the EBL: 1-90 Days 39%; 91-180 Days 18%; 181-365 Days 22%; 366+ Days 21%.

SECTION FIVE

FEDERAL REGULATIONS

THE AMERICANS WITH DISABILITIES ACT AND THE OLMSTEAD DECISION

Based on the 2011 findings of the U. S. Department of Justice (DOJ) in the state of New Hampshire,[23] Virginia is at risk for a similar finding of noncompliance with the relevant aspects of the *Americans with Disabilities Act* (ADA)[24] as interpreted by the controlling *Olmstead* decision.[25] Through its 2011 findings letter, the DOJ advised the State of its conclusion that:

> …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.[26]

DOJ's investigative findings also determined that:

- That "there is a lack of safe, affordable, and stable community housing, including supported housing, for persons with mental illness in New Hampshire…"
- New Hampshire continued to fund more costly institutional care "even though less expensive and more therapeutic alternatives could be developed in community settings."
- "Many individuals admitted to NHH and Glencliff [NH's two state-run behavioral health facilities], 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."

[23] *Op. Cit.* U. S. Department of Justice, April 7, 2011,

[24] *Americans with Disabilities Act* (1990)

[25] *Olmstead v. L.C.*, (98-536) 527 U.S. 581 (1999)

[26] U.S. Department of Justice, April 7, 2011, Op. Cit.

- "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 setting with adequate and appropriate services and supports."

- When considering the relative cost of serving individuals in a state-run facility, versus a community-based setting, the investigation concluded that "New Hampshire can serve about six persons in the community for each person in NHH (the state facility]." (Average NHH of $287,000 vs. $44,000 annually for community-based services.)

Finally, and of relevance to the Commonwealth, the DOJ concluded that:

> 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 setting with adequate and appropriate services and supports.…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**. [Bold supplied by OIG]

The State of New Hampshire registered its vigorous disagreement with DOJ's findings arguing that its psychiatric beds have "a median length of stay for an adult of 7 days", compared to the national average of "47 days."[27] During the six-months of this review, Virginia's average time on the EBL was 239 days.[28] While comparisons of the number of days for what may be different cohorts in New Hampshire and Virginia is clearly imprecise, the disparity in number of days is striking nonetheless.

New Hampshire also argues that in 2008 it undertook a critical analysis of its "mental health system and concluded that improvements needed to be made," and, since it is only three years into a ten-year implementation effort, that DOJ's recommendations amount to proceeding with "remedial measures on an expedited basis."[29]

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[27] Letter from Michael A. Delaney, Attorney General, New Hampshire to Thomas E. Perez, Assistant Attorney General, DOJ, Civil Rights Division, captioned *State of New Hampshire's Response to Your April 7, Letter Regarding New Hampshire's Mental Health System* dated December 6, 2011. [Appendix B attached hereto for convenience]

[28] The DOJ has joined the Disabilities Rights Center in a federal lawsuit alleging that New Hampshire failed to provide adequate community services – like transition housing – and this advocacy group will cite DOJ's 2011 investigative Findings as evidence.

[29] Michael A. Delany to DOJ, Op. Cit.

The OIG review concludes that Virginia's behavioral health system is strikingly similar New Hampshire's in the salient following respects:

- "The State's failure to develop sufficient community services is a barrier to the discharge of individuals…who could be served in more integrated community setting with adequate and appropriate services and supports.";[30]
- Virginia continues to fund more expensive institutional care when less expensive and therapeutically effective community-based care could be developed;
- The lack of community-based permanent supported housing is a barrier to discharge for a significant number of individuals in state-operated facilities;
- The lack of community housing places disabled persons with mental illness at risk for unnecessary institutionalization today and in the future.

If DOJ's conclusions about New Hampshire's mental health system are correct, then Virginia may be noncompliant with the ADA as interpreted by the Supreme Court in *Olmstead*.

SECTION SIX

VIRGINIA'S RESPONSE

CREATING OPPORTUNITIES: A PLAN FOR ADVANCING COMMUNITY-FOCUSED SERVICES IN VIRGINIA (JUNE 25, 2010) & THE COMPREHENSIVE STATE PLAN 2012-2018 (DECEMBER 2011)

The OIG's 2010 Semi-Annual Report noted that, "the *Creating Opportunities Plan* is likely the most consequential document created by the DBHDS in a generation." The OIG's high regard for the framework created by the *Creating Opportunities Plan* is undiminished; however, two years later, and despite the promise of future efforts, insofar as aligning services with transformational values to create a genuine community-based system of care, this aspect of the *Creating Opportunities Plan* remains more aspirational than tangible.

According to the *Creating Opportunities, Implementation Report* (April 2, 2012), the workgroup tasked with enhancing the effectiveness and efficiency of state hospital services will be "Conducting a review [of] issues that prevent community return for individuals determined to be clinically ready for discharge and document needed support services (August 2012) [Color in original]." While the *Creating Opportunities* workgroup focused on address-

[30] *Op. Cit.* DOJ April 7, 2011 Letter to New Hampshire.

ing the housing needs of individuals with behavioral health issues, there is scant evidence of actual progress to address the ready for discharge issue. That said, this July there is a planned two-day statewide summit titled “Housing Stability and Mental Illness Summit.”

The Comprehensive State Plan 2012-2018 recognizes the need for “permanent supportive housing [that] does not place limits on a person’s length of tenancy as long as he or she abides by the conditions for the lease or agreement.” The State Board of Behavioral Health and Developmental Services updated its housing policy in 2010 (Policy 4023 (CSB 86-24) to recognize the following pertinent principles:

- Individuals should live in stable, decent, and affordable housing of their choice;

- Appropriate, flexible, accessible, and effective support services should be available;

- Housing should be available in integrated settings throughout the community; and

- To ensure choice, the behavioral health and developmental services system has the responsibility to facilitate access to existing housing and stimulate the preservation and development of housing.

The OIG is encouraged by the activities planned for this year to discuss or review the issues preventing the discharge of individuals deemed ready for discharge and by the *Comprehensive State Plan’s* recognition of the importance of available supported housing in the community. That said, Virginia has maintained an EBL for over a decade and the percentage of discharge ready individuals, who cannot return to their community, has remained relatively constant since at least 2007 at between 12% and 14% of facility operating capacity.

The issue of permanent supported housing for persons with serious mental illness (SMI) has been long-discussed in Virginia and has been the subject of iterative requests for study. The appended “Staff Report: Housing for the Mentally Ill” contains a 2007 PowerPoint presentation describing many key aspects of this issue. The OIG is not recommending adoption of suggestions in the Staff Report, but including it to illustrate the long-standing effort and thought that has gone into the housing problem and because the Report defines key issues. A copy of this Report is attached as Appendix C.

CONCLUDING OBSERVATIONS AND THE DYNAMICS OF RESIDENTIAL INSTABILITY AMONG THE MENTALLY ILL: The following observations are straightforward and, we believe, are not controversial:

- Many people with SMI, whose psychiatric conditions compel them to move from less restrictive community settings to more restrictive institutional settings, with greater structure and support, lose their stable housing; that is if they had stable housing at the onset of their acute symptoms. Decades ago, when the expectation was that individuals would remain in state facilities for years or even a lifetime, this was less of an issue; however, deinstitutionalization has ushered-in new housing challenges for persons with SMI and for the state;

- When individuals with SMI, who are living in temporary community housing, move to a state facility, economic incentives oblige property owners locate a replacement tenant for the residence;

- When a person has stabilized and is deemed ready for discharge by clinicians at a state facility, the person's previous housing is frequently unavailable because it is occupied by someone else or the person's behavior leading up to their institutionalization has disqualified them from their previous living arrangement;

- Scores of individuals remain in state facilities today, at an annual cost of $214,000 each, because the Commonwealth has yet to create sufficient supported community housing to serve this cohort. This group of individuals that could be served in their community for less than a fifth of the cost to treat them in state-operated facilities.

The bottom line is that, despite the express commitment and aspirational alignment by the DBHDS, this review suggests that the Commonwealth has yet to create sufficient community-based treatment, especially including supported housing, to realize the worthy goals expressed in the 2010 Creating Opportunities Plan.

In closing, this review has found that scores of individuals remained in the Commonwealth's behavioral health facilities for an average of almost eight months after they had been determined by clinicians to be discharge ready. This outcome may be contrary to the ADA, as interpreted by the *Olmstead* decision requiring that individuals be served in the most integrated setting appropriate to their needs and is contrary to the Virginia's values as expressed in Virginia's *Integrated Strategic Plan*, the DBHDS *Creating Opportunities Plan for advancing community focused care in Virginia*, and the state's *Comprehensive State Plan* 2012-2018 (Dec 2011).

The OIG also observed that the Commonwealth continues to fund more expensive institutional care when less expensive and therapeutically effective community-based care, most notably supported housing, could be developed. And finally, this review suggests that state facilities have refused to admit people in crisis meeting TDO criteria because, in some instances, the beds needed for TDO admissions are occupied by the 13% of the facility population that are discharge ready, but who nevertheless remain in the state facility.

SECTION SEVEN

FINDINGS AND RECOMMENDATIONS:

Finding No. 1: There was an average of 165 adults on the extraordinary barriers to discharge list (EBL) from July through December 2011, and, on average this population has been discharge ready for almost eight months. According to the DOJ's New Hampshire *Finding's*, the maintenance of individuals at an inpatient level of care, who have been determined clinically ready for discharge, is contrary to the ADA as interpreted in the *Olmstead* decision.

No recommendation associated with this Finding.

Finding No. 2: Prolonged discharge may be an indicator of the state's failure to create sufficient community services to address the needs of individuals with mental illness in more integrated and less restrictive community settings.

While DBHDS and the CSBs provide the types of services and supports needed by these individuals to live successfully in the community, the statewide system of care does not offer these needed services and supports in sufficient quantity to serve all Virginians.

Recommendation No. 2: The DBHDS to publish on its website a HIPAA compliant quarterly update summarizing the number of individuals on the EBL at each state hospital to include: the specific barrier(s) to a person's discharge, the estimated cost (supplied by the sponsoring CSB or regional access committee) to discharge each person, and the length of time each individual has been on the list.

It is the intent of this recommendation that this list will become a metric to measure the Commonwealth's actual progress in creating a true community-based system of care.

DBHDS Response: *DBHDS will continue to monitor the discharge planning process and use this information to support increased community access.*

Epilogue to DBHDS Response to Recommendation No. 2: The above DBHDS response is ambiguous and may be nonresponsive to a recommendation calling for a transparent reporting system to monitor the Commonwealth's progress in curtailing the EBL. The response leaves open the question, "Will the DBHDS make public its Extraordinary Barriers List, in a HIPAA compliant format, to be used to measure Virginia's progress in creating a true community-based system of care?"

If the DBHDS is unable to produce a quarterly report with the information listed, the OIG will build-on the information contained in this Report and create the quarterly updates and publish the results on its website.

Finding No. 3A: Each individual that remains on the EBL for an extended period diminishes the state's capacity to provide needed safety net services for individuals in acute crisis meeting the criteria for temporary detention (TDO).

No recommendation associated with this Finding.

Finding No. 3B: The State of New Hampshire was recently criticized by the DOJ for continuing to fund more costly institutional care even though less expensive alternatives could have been created in community settings. Virginia is at risk for the same findings as New Hampshire. It is an inefficient use of the Commonwealth's limited resources to keep individuals in the state facilities because it costs significantly less to serve people in the community.

A cursory review of the estimated cost to create the capacity to serve the individuals currently on the ready for discharge list suggests that the sum of about $3,000,000 could fund the discharge of dozens of individuals on the EBL. The annual savings of state dollars for serving about 70 members of this cohort in the community, vs. in state facilities, would approach $12,000,000, and it would release a corresponding number of beds for use by persons meeting criteria for temporary detention (TDO).

Recommendation No. 3B: That DBHDS seek to expand funding for Discharge Assistance Projects that help individuals transition to the community, facilitating access to entitled federal benefits that can support community-based services.

DBHDS Response: *DBHDS's Creating Opportunities Strategic Plan identifies the expansion of funding for discharge assistance plans as a high priority and cost effective means of helping people return to their communities and thereby simultaneously facilitating increased access to acute care at state hospitals in response to documented needs.*

Finding No. 4: The primary barrier throughout the Commonwealth to the timely discharge of clinically ready individuals is the lack of permanent supported housing.

Recommendation No. 4A: That the DBHDS advocate with the Department of Housing and Community Development (DHCD) to make funds available from the $7,000,000 housing trust fund recently appropriated by the General Assembly, and to use these funds to serve people in state-operated facilities with unmet community housing needs and homeless individuals at risk of institutionalization;

DBHDS Response: *In keeping with the Governor's Housing Policy Initiative and the DBHDS Creating Opportunities Plan, DBHDS will continue to work with the DHCD and others to expand community housing options for persons with behavioral health disorders, including people in state-operated facilities with unmet community housing needs and homeless individuals at risk of institutionalization.*

Recommendation No. 4B: That the DBHDS work with CSBs to assure that housing needs are considered a priority in the use of unexpended state balances by CSBs—especially in regions with large numbers of individuals on the EBL.

DBHDS Response: *DBHDS concurs with this recommendation.*

Recommendation No. 4C: That the DBHDS, in conjunction with each PPR regional access committee and the *Creating Opportunities* workgroup, evaluate the supported housing requirements necessary for each region to materially reduce the extraordinary barriers list and report findings to the Commissioner and the OIG by January 1, 2013. The report should include an evaluation of all community supports needed to sustain an individual on the EBL in his or her community of choice.

DBHDS Response: *DBHDS concurs with this recommendation.*

Finding No. 5: Based on the operational performance of the facilities, some state-operated hospitals had a significantly smaller percentage of patients on the EBL than other facilities and some facilities presented a more comprehensive approach to discharge planning.

Recommendation No. 5: That DBHDS's *Creating Opportunities* Effectiveness and Efficiency of State Hospital Services Workgroup review the discharge planning processes at all hospitals and revise the state's discharge planning protocols as needed to incorporate and standardize the existing best practices that have produced measurably superior discharge outcomes.

DBHDS Response: *DBHDS will conduct the suggested review and based upon the findings of the review, revise the discharge planning protocols as determined appropriate by DBHDS.*

APPENDIX A

U.S. Department of Justice, Civil Rights Division letter to the State of New Hampshire, dated April 7, 2011

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 Glencliff Home ("Glencliff") 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 Glencliff.

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 Glencliff 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

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[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 ADA[5] 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 disability[6] 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."

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[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]

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[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 Glencliff 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 government[9] 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

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[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

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[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 Glencliff, 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

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[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

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[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 than 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 de-toxification 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 Glencliff to an integrated community setting that meets their individualized needs, including their need for habilitation, health care, and, where applicable, mental health care.

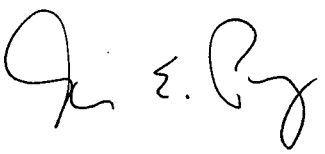
VI. CONCLUSION

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
Associate Attorney General
Chief of Civil Litigation
Department of Justice
State of New Hampshire

Michael K. Brown
Senior Assistant Attorney General
Department of Justice
State of New Hampshire

John P. Kacavas
United States Attorney
District of New Hampshire

John Farley
Assistant United States Attorney
District of New Hampshire

APPENDIX B

Letter from Michael A. Delaney, to DOJ, Civil Rights Division,
dated December 6, 2011

ATTORNEY GENERAL
DEPARTMENT OF JUSTICE

33 CAPITOL STREET
CONCORD, NEW HAMPSHIRE 03301-6397

MICHAEL A. DELANEY
ATTORNEY GENERAL

ANN M. RICE
DEPUTY ATTORNEY GENERAL

December 6, 2011

Thomas E. Perez
Assistant Attorney General
United States Department of Justice
Civil Rights Division
950 Pennsylvania Avenue, NW
Washington, DC 20530

Re: State of New Hampshire's Response to Your April 7, 2011 Letter Regarding New Hampshire's Mental Health System

Dear Assistant Attorney General Perez:

This letter responds to your April 7, 2011, letter regarding your review of the New Hampshire mental health system. We deferred submission of a written response last April based on your desire to meet with us to discuss your letter. Since then our respective offices met numerous times. Given the status of these on-going discussions, we believe it is appropriate to memorialize our objections in writing at this time.

As part of a nation-wide initiative, the U.S. Department of Justice (USDOJ) conducted a brief review of the New Hampshire mental health system. After reviewing documents and visiting our state, USDOJ issued a letter alleging that New Hampshire has violated the Americans with Disabilities Act (ADA) by failing to provide services to people with mental illness in the most integrated setting appropriate to their needs.

We disagree.

New Hampshire has long demonstrated our commitment to provide comprehensive treatment and community-based services for persons with mental disabilities. More than two decades ago, we closed the only state-operated facility for persons with developmental disabilities and transitioned those services to community settings. Our only in-patient psychiatric hospital has evolved from a chronic care institution of over 2500 residents into a fully accredited acute care hospital. With a state-wide population of 1.3 million, New Hampshire Hospital (NHH) has fewer than 130 adult psychiatric beds, with a median length of stay for an adult of 7 days. The national

average is 47 days. Our sole psychiatric nursing home in the state, Glencliff Home, serves only 120 people with severe mental illness and complex medical needs. Now, the vast majority of people are served through our regional community mental health centers and area agencies, which are the backbone of the state's community care system.

New Hampshire's system of community-based mental health services fully complies with the ADA and *Olmstead. See Olmstead v. Zimring*, 527 U.S. 581 (1999) (interpreting ADA requirements).

The ADA provides, in pertinent part:

> Subject to the provisions of this subchapter, no qualified individual with a disability 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 subject to discrimination by any such entity.

42 U.S.C. § 12132.

According to USDOJ regulations governing administration of the ADA, a public entity must administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities. *Id.* at 591-92; 28 C.F.R. § 35.130(d)(2010). The most integrated setting appropriate to the needs of a qualified individual with a disability is a setting that enables the individual with a disability to interact with nondisabled persons to the fullest extent possible. *Olmstead*, 527 U.S. at 592; 28 C.F.R. pt. 35, app. B (March 15, 2011). The ADA prohibits discrimination against qualified individuals, *i.e.*, persons with disabilities who "with or without reasonable modifications to rules, policies, or practices, . . . mee[t] the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity." *Olmstead*, 527 U.S. at 602 (quoting 42 U.S.C. § 12131(2)). A state generally may rely on the reasonable assessments of its own professionals in determining whether an individual meets the essential eligibility requirements for habilitation in a community based program. *Id.*

In *Olmstead,* the United States Supreme Court addressed whether the ADA may require placement of persons with mental disabilities in community settings rather than in institutions. Its answer was a qualified yes. *Olmstead*, 527 U.S. at 587. Such action is in order when the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities. *Id.*

The Court offered guidance to states on achieving compliance with the ADA. The Court recommended that states "develop a comprehensive, effectively working plan

for placing qualified persons with mental disabilities in less restrictive settings...." *Olmstead*, 527 U.S. at 605-06. New Hampshire has created just such a plan.

In 2008, the New Hampshire Department of Health and Human Services (DHHS), Bureau of Behavioral Health (BBH) undertook a critical analysis of the mental health system and concluded that improvements needed to be made. Collaboration with consumers and providers resulted in a document entitled, "Addressing the Critical Mental Health Needs of New Hampshire's Citizens: A Strategy for Restoration." The plan established a ten-year timetable and budget to expand a series of services and programs designed to enhance community integration.

New Hampshire has made significant progress implementing the plan during an extremely challenging fiscal climate:

- Eight Assertive Community Treatment (ACT) Teams have been developed in areas of the state that show the highest admission and readmission rates to New Hampshire Hospital (NHH);
- Evidence Based Practices, including Illness Management and Recovery (IMR), have been implemented on a state-wide basis;
- Access to these Evidence Based Practices exceeds national averages;
- Access to the Evidence Based Practice of supported employment is five times the national average;
- A Housing Bridge Subsidy Program has been established to provide housing subsidies to people with mental illness who are homeless to allow them to obtain their own apartments;
- All ten community mental health centers are in the process of implementing Electronic Medical Records;
- BBH is working with the Peer Support Agencies to expand the peer run crisis respite program that has proven successful in one region of the state; and
- BBH is working with NHH to develop a community psychiatry program to expand access to psychiatry services at the community mental health centers, particularly in the area of child psychiatry services.

New Hampshire is also employing a strategy, endorsed by the federal government, to rebalance funding between institutional care and community-based care. This strategy has already resulted in the closure of a 12-bed unit at NHH and re-direction of the savings to the creation of two new ACT teams. DHHS has privatized its Transitional Housing Services to place more individuals in supported housing in the community, and to reinvest savings in the expansion of intensive level residential programs in the community.

New Hampshire is only three years into implementing the ten-year plan. It is disappointing that, at a time when this State and this nation are facing the worst economic crisis since the Great Depression, your office has taken this action. Simply stated, we do not believe New Hampshire is required by the ADA or the *Olmstead* decision to institute your recommended remedial measures on an expedited basis.

Many of your findings are drawn directly from our state's critical analysis of the state-wide mental health system. Our thorough and candid reports, specifically written to advance the goals of the ADA and *Olmstead,* address the challenges faced by New Hampshire's mental health system. Contrary to good public policy, you mischaracterized statements in those reports as "admissions" of noncompliance with federal law. Strategic reports should be used by the state and its citizens as a pathway to improve services – not by the federal government as ammunition for overreaching *Olmstead* litigation.

The crux of your allegations is inadequate community capacity and undue reliance on institutions, including unnecessary and prolonged stays at NHH and Glencliff. We disagree.

With respect to the reliance on institutions, 250 in-patient beds for our 1.3 million citizens is entirely reasonable. Your conclusion regarding the alleged high hospital admission rate is based on a misunderstanding of our unique conditional discharge process, a process designed to promote successful community integration. *See* NHRSA 135-C *et seq.* All admissions to Glencliff are thoroughly evaluated using the Preadmission Screening and Residential Review (PASARR), and all residents are engaged in appropriate discharge planning. Your critique of the Glencliff location as too remote and isolated reflects a noticeable lack of appreciation for North Country living and our state's rural heritage.

Following the recommendations of the Centers for Medicare and Medicaid Services (CMS), as a method to comply with *Olmstead,* DHHS and BBH are in the process of changing the community-based care system by implementing a Medicaid Managed Care Plan. The plan will expand access, improve quality and focus on treatment outcomes by transitioning from a fee-for-service program to a capitated managed care model. Implementation is expected by July 2012.

Our ten-year plan encompasses the remedial measures included in your findings letter. The "prompt implementation" expectation, however, fails to recognize the current economic climate and competing needs. As *Olmstead* clearly points out, states are allowed to allocate available resources in a way that is equitable, given the responsibility they have for the care and treatment of large and diverse populations of persons with mental disabilities. *Olmstead,* 527 U.S. at 604. The ADA is not reasonably read to require states to phase out institutions, placing patients in need of close care at risk. *Id.* at 604-05. Nor is it the ADA's mission to drive states to move institutionalized patients into inappropriate settings. *Id.* Some individuals may need institutional care from time to time "to stabilize acute psychiatric symptoms." *Id.* For other individuals, no placement outside an institution may ever be appropriate. *Id.*

New Hampshire remains committed to serving people who have mental illness in a setting that maximizes individual freedom and autonomy. We believe that the most effective way to accomplish that goal is to stay focused on the implementation of the ten-year plan. We are confident that New Hampshire is in compliance with the ADA as

interpreted in the *Olmstead* decision. The threatened litigation by the federal government and federally funded advocates will waste precious state and federal taxpayer dollars that could be better spent on providing services.

We urge USDOJ to withdraw its erroneous findings and allow New Hampshire to continue its implementation of the ten-year plan without the distraction and expense of needless litigation.

Sincerely,

Michael A. Delaney
Attorney General

Nicholas A. Toumpas
Commissioner
Department of Health and Human Services

cc: His Excellency, Governor John Lynch
Honorable Raymond S. Burton, Executive Councilor
Honorable Daniel St. Hilaire, Executive Councilor
Honorable Christopher T. Sununu, Executive Councilor
Honorable Raymond J. Wieczorek, Executive Councilor
Honorable David K. Wheeler, Executive Councilor
Honorable Peter Bragdon, Senate President
Honorable William L. O'Brien, Speaker of the House
Health and Human Services Oversight Committee Members
John Kacavas, United States Attorney for the District of New Hampshire
Judy Preston, Deputy Chief, United States Department of Justice
Richard Farano, Senior Trial Attorney, United States Department of Justice
John Farley, Assistant U.S. Attorney General, District of New Hampshire
Disabilities Rights Center
Center for Public Representation
Judge David L. Bazelon, Center for Mental Health Law
Alex Walker, Devine, Millimet & Branch, Counsel for DRC

APPENDIX C

Joint Commission on Health Care Report, October 26, 2007

Virginia Joint Commission on Health Care

Staff Report: Housing for the Mentally Ill

HJR 636 (Patrons: Delegates O'Bannon & McClellan)

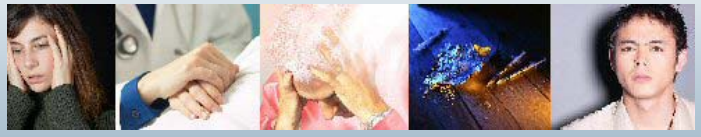
Michele Chesser, PhD
Senior Health Policy Analyst
October 26, 2007

Introduction

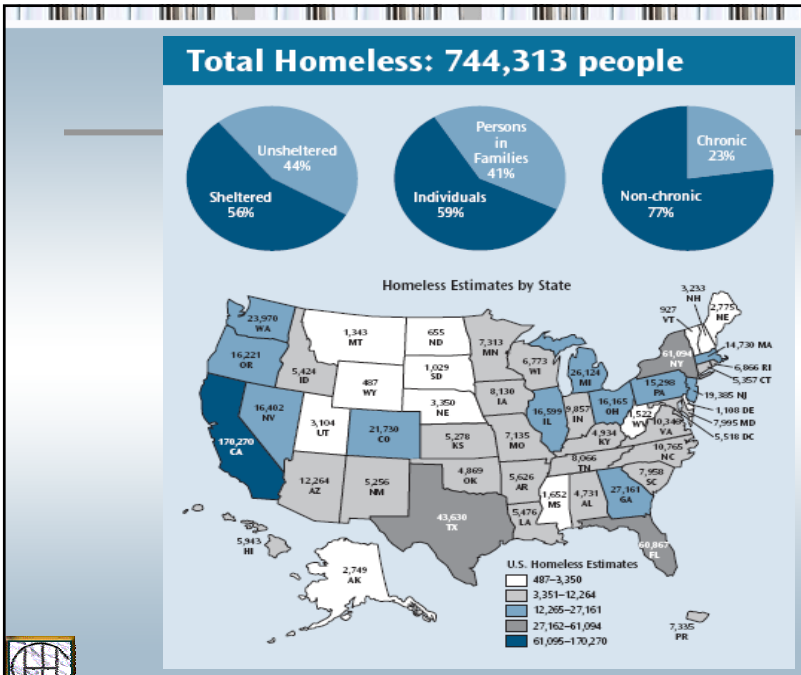
- HJR 636: Directs the Joint Commission on Health Care to study ways to improve housing opportunities for persons with mental illness.
- Left in House Committee on Rules.
- Delegate O'Bannon requested by letter that JCHC undertake the study.

Introduction

- Lack of affordable housing options is one of the most significant barriers to recovery for the mentally ill.
- There are a significant number of individuals who are currently in state facilities who cannot be discharged due solely to a lack of community housing.
- As a result, many individuals who could be integrated into communities are either unnecessarily institutionalized or homeless.



Source: Unpublished report by Jennifer Faison for the Virginia Association of Community Services Boards



Source: National Alliance to End Homelessness. January 2007.

Barriers to Housing for the Mentally Ill

- High housing costs
- Limited housing options
  - Very few supported housing programs in Virginia
  - Multi-year waiting time for public housing
  - Significant wait time for mental health residential programs
    - Average wait time for supervised residential services is 42 weeks
  - Felony conviction excludes access to the Public Housing and Housing Choice Voucher programs
- Federal programs are limited and/or difficult to access
  - Medicaid regulations prohibit the use of funding for housing
- Increasingly restrictive local zoning and land use regulations
- Stigma and discrimination against low-income individuals, especially the mentally ill

Sources: 1) Unpublished report by Jennifer Faison for the Virginia Association of Community Services Boards and 2) Fairfax County Jail Diversion Program, PowerPoint presentation.

Evidence Based Model: Supportive Housing

- What is supportive housing?
  - Independent housing coupled with the provision of community-based mental health services
  - A non-facility based and person-centered alternative to the residential continuum model & hospitalization/institutionalization
    - "The continuum model consists of residential services settings differing in intensity of care and levels of restrictiveness with consumers matched to residential placements based on their service needs and psychiatric impairment. Criticized for its undue emphasis on the residential facility as primary location for treatment and rehabilitation, residential instability induced by the movements along the continuum as consumers demonstrate increased (or decreased) level of functioning, loss of social supports associated with moves, and assumption that mental health services are not needed once one graduates to independent housing"

Source: Wong, Yin-Ling Irene et al. 2006. "From Principles to Practice: A Study of Implementation of Supported Housing for Psychiatric Consumers."

Evidence Based Model: Supportive Housing

- What is supportive housing?
  - **Recent research indicates it is an effective intervention approach for reducing homelessness, achieving residential stability, and reducing hospitalization**
  - **Core Principles of Supportive Housing:**
    - **Home in the community is a basic right**
    - **Normal roles as regular tenants and community members**
    - **Consumer empowerment**
    - **Functional separation between support services and housing**

Source: Wong, Yin-Ling Irene et al. 2006. "From Principles to Practice: A Study of Implementation of Supported Housing for Psychiatric Consumers."

Evidence Based Model: Supportive Housing

- Supportive housing helps people live more stable and productive lives
- Supportive housing is permanent
- Supportive housing is cost-effective
- Impact of Supported Housing
  - Positive impacts on:
    - health
    - employment
    - treating mental illness
    - reducing or ending substance use

Example of Supportive Housing for Mentally Ill

Highline West Seattle Housing

24 units of transitional housing and supportive services for mentally ill individuals

Example of Supportive Housing for Mentally Ill

Albion Place. Seattle, Washington

12 units of permanent housing for adults with mental illness

Example of Supportive Housing for Mentally Ill

Alder Commons. Marysville, Washington

18 Studio apartments for low-income individuals with mental illness

Solutions Recommended by Virginia Association of Community Services Boards

- Housing voucher program for individuals with serious mental illness
  - Establish a pool of state money and develop a state housing voucher program solely for individuals with serious mental illness that is similar to the Housing Choice federal program
- Landlord subsidies
  - Establish a pool of state money and develop a Landlord Lease Subsidy program. Similar to the housing voucher program, but the monies would flow directly to landlords who agree to participate in the program rather than to the consumer
- Auxiliary Grant Portability
  - Establish a pilot program for auxiliary grant portability (based on the Olmstead ruling) for individuals with serious mental illness. This strategy would be a shift in the allocation of funds and would not require additional revenue

Source: Unpublished report by Jennifer Faison for the Virginia Association of Community Services Boards

Solutions Recommended by DMHMRSAS Regarding Local Zoning Ordinances

- Supportive Housing models, such as SRO (Single Room Occupancy) housing, should be defined in local comprehensive plans in addition to nursing homes and assisted living facilities (ALF) as affordable housing for low-income single residents with disabilities pursuant to §15.2-2223 of the *Code of Virginia*
- Streamlined review and approval processes for special use permits should be provided for in affordable dwelling unit ordinances to encourage development of Supportive Housing models, such as SROs
- SRO housing should be defined as affordable dwelling units in local zoning ordinances pursuant to §15.2-2304 and §15.2-2305 of the *Code of Virginia*

Source: "The Extent to Which Local Zoning Ordinances In Virginia Accommodate Innovative Housing Initiatives for the Benefit of Virginians with Mental Illness." Report by James S. Reinhard, Commissioner, DMHMRSAS. September 1, 2007.

Solutions Recommended by DMHMRSAS Regarding Local Zoning Ordinances

- The General Assembly should consider amending §15.2-2304 of the *Code of Virginia* to make it apply to additional high population-density localities in Virginia, such as those with over 300 persons per square mile
- Virginia should develop a statewide housing plan that includes Supportive Housing to meet the needs of Virginians with mental illness and encourages VHDA to provide additional incentives for SROs in its Low-Income Housing Tax Credit Program and other housing development programs pursuant to §36-55.33:1(D)(2)(e) and §36-55.33:2 of the *Code of Virginia*

Source: "The Extent to Which Local Zoning Ordinances In Virginia Accommodate Innovative Housing Initiatives for the Benefit of Virginians with Mental Illness." Report by James S. Reinhard, Commissioner, DMHMRSAS. September 1, 2007.

Solutions Recommended by DMHMRSAS Regarding Local Zoning Ordinances

- The Department of Social Services should more broadly interpret §63.2-800 of the *Code of Virginia* to allow for auxiliary grants to be provided to eligible individuals with disabilities who prefer to live in Supportive Housing units, as opposed to ALFs or adult foster care homes, to help offset the operating costs of such housing
- CSB/BHA should develop joint written agreements with State and local housing agencies pursuant to §37.2-504 and §37.2-605 to provide for the appropriate individualized services required by residents of Supportive Housing programs within their jurisdiction

Source: "The Extent to Which Local Zoning Ordinances In Virginia Accommodate Innovative Housing Initiatives for the Benefit of Virginians with Mental Illness." Report by James S. Reinhard, Commissioner, DMHMRSAS. September 1, 2007.

Legislation Likely to be Introduced in 2008

- Virginia Housing Trust Fund
  - HB 92/SB 277, 2006
  - Chief Patrons: Delegate Suit & Senator Whipple
  - HB 92 as amended passed in the House of Delegates unanimously in 2006; in the Senate, HB 92 was continued in Senate Finance until 2007 and left in Senate Finance by voice vote
  - SB 277 unanimously passed the Committee on General Laws and Technology with amendment, but was continued in Senate Finance until 2007 and left in Senate Finance by voice vote
  - Likely to be introduced again in 2008

Legislation Likely to be Introduced in 2008

- Virginia Housing Trust Fund
  - Housing trust funds are perpetual sources of funding designed to alleviate housing costs by providing funds to affordable housing projects and to developers to create affordable housing and mixed-income communities
  - Important feature is that it is funded by a dedicated stream of revenues which ensures there will be a reliable source of funds for affordable housing

Source: The Virginia Housing Coalition. www.vahousingcoalition.org/trust_fund.html

Legislation Likely to be Introduced in 2008

- Virginia Housing Trust Fund
  - 37 states have established housing trust funds to address rising housing costs, including Maryland, North Carolina, & West Virginia
  - An existing dedicated stream of state revenue would support the fund, so no tax increases would be necessary
  - In 2006, The Virginia Housing Coalition proposed using the recordation tax (a tax placed on real estate transactions) as the source of funding
    - $.02 of the $.25 per $100 that the state collects
    - Funds would only be allocated to the trust fund in years that tax collections surpassed $200,000

Source: The Virginia Housing Coalition. www.vahousingcoalition.org/trust_fund.html

Legislation Likely to be Introduced in 2008

- The Virginia Housing Coalition 2006 proposal's collection method would have yielded:
  - FY 03: $20.1 million
  - FY 04: $23.8 million
  - FY 05: $42.2 million
- October 10, 2007: U.S. House of Representatives passed JR 2895, the National Affordable Housing Trust Fund Act of 2007, by a vote of 264 to 148

Source: The Virginia Housing Coalition. www.vahousingcoalition.org/trust_fund.html

Conclusion

- A number of studies are underway with recommendations to address the…
  - need for an increase in units of affordable housing;
  - need for an increase in financial assistance options for low-income mentally ill individuals for housing;
  - need to coordinate funds from multiple sources (federal, state, and local government; private/non-profit organizations, etc.) and use to:
    - Provide incentives for new development and/or renovation of affordable housing
    - Provide rent vouchers; and
  - need for increased choice and empowerment of consumers.

JCHC Members

Delegate Phillip A. Hamilton, Chairman
Senator Stephen H. Martin, Vice-Chairman

Senator J. Brandon Bell, II
Senator Harry B. Blevins
Senator R. Edward Houck
Senator Benjamin J. Lambert, III
Senator Linda T. Puller
Senator Nick Rerras
Senator William C. Wampler, Jr.

Delegate Clifford L. Athey, Jr.
Delegate Robert H. Brink
Delegate Benjamin L. Cline
Delegate Franklin P. Hall
Delegate Kenneth R. Melvin
Delegate Harvey B. Morgan
Delegate David A. Nutter
Delegate John M. O'Bannon, III
Delegate John J. Welch, III

The Honorable Marilyn B. Tavenner
Secretary of Health and Human Resources

Internet Address

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http://jchc.state.va.us/

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