

Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
Mental Health Block Grant

Program and Fiscal Monitoring Report
New Hampshire
July 14 – 16, 2014

Executive Summary

The Division of State and Community Systems Development, Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services conducts at least 10 monitoring visits each year to ensure states receiving mental health block grants (MHBG) pursuant to Section 1911 of the Public Health Service Act (PHSA) comply with grant requirements. As required by Subpart III, Section 1945 (g) of the PHSA, the CMHS conducts these investigations in partnership with the states to,

- Monitor the expenditures of MHBG funds;
- Assess compliance with required funding agreements and assurances;
- Identify strengths (e.g., best practices, exemplary efforts) of state and local mental health systems; and
- Recommend areas for improvement and possible technical assistance.

The MHBG monitoring site visit to the New Hampshire Bureau of Behavioral Health (BBH) occurred from July 14-16, 2014. The monitoring team reviewed materials and spoke with agency leadership and members of the New Hampshire Behavioral Health Advisory Council (NHBHAC) prior to the visit and during the onsite monitoring.

The BBH is the State Mental Health Authority (SMHA) for mental health. As the SMHA, BBH's responsibilities include; planning, coordinating services, contracting, regulating, and monitoring New Hampshire's system of public mental health services for BBH-eligible adults with a serious, or a severe and persistent mental illness (SMI/SPMI) and children with a serious emotional disturbance (SED). Peer support services are an integral part of the New Hampshire behavioral health services delivery system of care and accounts for the majority of the mental health block grant funding.

In 2008, the state developed a report for the public mental health system, referred to as the "10 Year Plan" because of a Department of Health and Human Services Commissioner-appointed task force. This report identifies the critical mental health needs of New Hampshire's citizens and addresses:

- housing and residential supports;
- more community supports to prevent hospitalization;
- mental health workforce retention and development;
- capacity for community-based inpatient psychiatric care;
- services for special populations; and
- an increase in Assertive Community Treatment (ACT) teams.

Since the previous monitoring visit in 2009, BBH began planning and implemented a new data reporting system transformation. This system will replace their outdated system and allow for the transfer of data between the Community Mental Health Centers (CMHC) and State Hospital. The New Hampshire Public Mental Health Consumer Survey is conducted annually and identifies the strengths and challenges of the mental health service delivery system and supports.

New Hampshire is exploring new innovative ways to gather this data to improve their system of care.

The state has placed strong emphasis on the following areas:

- prevention,
- holistic approach to intervention, programs and services,
- evidence-based practices,
- access to care and timely delivery of services.

In the area of prevention, the state has robust outreach and health promotion programs that target either reducing barriers to services or raising awareness and enhancing community participation in wellness programs, (i.e., In-Shape, Healthy Choices Healthy Changes). Most programs and services focus assessments and evaluations on multiple levels of functioning, (i.e., physical, social, mental, family, are assessed). New Hampshire's effort in implementing Project Red, including; standard policies and procedures in transitional care and discharge planning are excellent indicators of their valuable effort to provide seamless transition of care, ensuring continuity of care and prevent relapse or re-hospitalization. New Hampshire utilizes evidenced-based programs and practices including Assertive Community Treatment (ACT), Cognitive Behavioral Therapy (CBT), and Dialectical Behavior Therapy (DBT). BBH is committed to provide consumers the best possible care.

The BBH implements an array of services for children including psychiatric diagnostic and medication services; family support and education; and crisis intervention. It addresses the needs of specific children's population, such as those with physical and intellectual disabilities. The bureau also promotes service and support collaborations with other state government agencies and the implementation of school-based intervention programs. The state agency also focuses on family supports for children.

The monitoring team was impressed with New Hampshire's Behavioral Health Advisory Council (NHBHAC) efforts to integrate their council by expanding the size and composition of the members. The consumer and family members are advocates for peer services and supports. Several national peer service models provide New Hampshire consumers and family members with effective supports that aide in their treatment and recovery journey.

Technical Assistance

- BBH should receive state-to-state technical assistance with regard to the Consumer Satisfaction Survey administration including exploration of new methods for survey distribution.
- NHBHAS should receive technical assistance from the National Association of Mental Health Planning and Advisory Councils to provide orientation on statutory responsibilities of the Advisory Council.

Table of Contents

Executive Summary	iii
PROGRAM MONITORING REPORT.....	1
Administration of Mental Health Services and Leadership Perspective.....	1
Performance Data, Quality Improvement and Decision Support.....	4
Adult Services.....	8
Children Services.....	11
Mental Health Planning Council.....	13
Consumer and Family Member Involvement	15
Conclusion	16
FINANCIAL MANAGEMENT REPORT.....	17
Financial Management Organization.....	17
Fiscal Operations	17
Provider Operations	18
State Single Audit	18
Subrecipient Monitoring	18
Closed Years and Appropriations	19
Methodology	19
Observations	19
Obligated and Expended Funds	24
State MOE Expenditures.....	24
Children’s Set-Aside Expenditures.....	25
Administrative Expenditures.....	25
Appendix A- Listing of Federal Monitoring Team Members.....	26
Appendix B- Listing of State Staff Interviewed	27

PROGRAM MONITORING REPORT

Administration of Mental Health Services and Leadership Perspective

As the State Mental Health Authority situated within the Department of Health and Human Services (DHHS), the Bureau of Behavioral Health (BBH), is mandated to provide efficient and effective services to those citizens who are most severely and persistently disabled by mental, emotional, and behavioral impairments. The BBH mission is to ensure all New Hampshire citizens receive optimal physical, mental, and social well-being through proper access to health and mental health services and supports. Services and supports must meet the needs of adults and children in the state in an effort to promote life, education, employment, and participation in their communities.

BBH works to ensure the provision of efficient and effective services to those citizens who are most severely and persistently disabled by mental, emotional, and behavioral dysfunction as defined by NH laws and rules. To this end, BBH has divided the entire state into community mental health regions. Each of the 10 regions has a BBH contracted Community Mental Health Center and many regions have Peer Support Agencies. Eight peer support agencies provide support in these regions at 14 different physical sites.

Behavioral Health Service Administration

The administration of behavioral health services and supports are provided in three ways to New Hampshire consumers.

- (1) *Psychiatric Emergency & Crisis Services.* Inpatient services are provided through general hospitals with inpatient psychiatric capacity, the state hospital, and a community based Acute Psychiatric Residential Treatment Program (APRTP). The New Hampshire Hospital (NHH) is a fully accredited public state-operated psychiatric facility with 202 certified beds, serving children and adults, of which, 158 beds are currently open. Managed in partnership with Dartmouth Medical School, it is the only freestanding psychiatric facility in the state. NHH provides hospital-based psychiatric care for children, teens 14 and over, and adults.
- (2) *Community Mental Health Centers (CMHC).* Outpatient community mental health services are provided through 10 regional community mental health centers that are private, non-profit, providers contracted with BBH as the designated provider for behavioral health services. These full service clinics offer behavioral health services and supports including individual and group therapy, medications, and symptom management. CMHC also provides special intensive services to persons who meet the BBH eligibility requirements because they have a severe mental illness or emotional disability; offer specialized programs for older adults, children, and families; and provide services and referrals for short-term counseling and support.
- (3) *Peer Support Agencies (PSA).* PSA are community-based, private, non-profit agencies, contracted with BBH to provide peer-to-peer support by adults with mental illness, to adults with mental illness. The New Hampshire mental health block grant financially supports over 65 percent of the eight PSA and satellite locations and outreach programs. Peer support is provided statewide and is an essential resource for hands-on, pro-active

recovery supports, consumer advocacy, and help with navigating the various systems and fighting stigma. PSA provide services that assist individuals on their road to recovery. Services and supports include, but are not limited to

- face-to-face and telephone peer support;
- outreach;
- monthly educational events;
- activities that promote self-advocacy;
- wellness training;
- after hours warm line; and
- crisis respite (24-hours, short-term, non-medical crisis program).

New Hampshire 10-Year Plan

The New Hampshire plan, in coordination with the Olmstead decision, is being implemented in concert with the current mission of the bureau. The foundational concept and goal of the plan is to provide care for the whole person within their community. Various activities are outlined specific for each consumer that addresses the level of need to improve and enhance their recovery journey.

A taskforce was convened by the DHHS Commissioner to assess the current status of New Hampshire mental health services in an effort to make recommendations for behavioral service and support additions or improvements. The taskforce identified services and supports that previously, had not been implemented, obsolete services, and a growing population with an increased need for behavioral health care. This plan has the four following focal areas that aim to improve consumer wellness and promote optimal behavioral health recovery:

- (1) Increase the Availability of Community Residential Supports to improve housing subsidies
 - Intensive targeted case management and formal supported housing programs
 - Bridging rental subsidy for Section 8 voucher eligible persons currently on waiting list
 - Crisis support and specialized 132 new bed residential treatment programs
- (2) Increase Capacity for Community-based Inpatient Psychiatric Care
 - Four additional statewide designated receiving facility units with 48-64 involuntary beds
 - Stakeholder taskforce to determine the availability of voluntary inpatient psychiatric care in statewide community hospitals
- (3) Develop Assertive Community Treatment Teams
 - Twelve new intensive outpatient service teams promoting patient recovery and the reduction of hospitalization, emergency room and jail/prison recidivism
- (4) Community Mental Health Workforce Retention and Development
 - Maintenance of qualified staff via adequate pay and resources
 - A strategy to increase statewide availability of residents and experienced psychiatrists
 - Increased education and ongoing training opportunities for behavioral health workforce

Integration

BBH has initiated significant programs that integrate primary and behavioral health care in an effort to decrease health disparities among the behavioral health population in New Hampshire. BBH plans to increase their integration effort by implementing the health home model. BBH has consulted with other states and currently hosts meetings with the DHHS leadership to discuss a plan amendment that will incorporate health homes in the CMHC setting.

Healthy Changes, Healthy Choices (HCHC): The HCHC program integrates primary and behavioral health care through improvements of cardiac and metabolic activities among those individuals with serious mental illness. Each of the 10 CMHC implements this initiative in an effort to reduce the risk of cardiovascular disease among this population.

The largest subpopulation served is Medicaid beneficiaries with serious mental illness and are eligible for both Medicaid and Medicare. This population incurs health care costs associated with high rates of cardiovascular disease, obesity, diabetes, and lung disease. A range of risk factors contribute to this serious health issue, which includes poor diet, smoking, lack of exercise and the effects of anti-psychotic medications such as weight gain, diabetes, and high cholesterol.

This program was slated for five-years and is currently in year three of operation. The program continues to deliver health promotion to CMHC consumers and offers incentives for improved nutrition, smoking cessation, and exercise. Over the course of the project, the program is projected to enroll 1,600 Medicaid beneficiaries in the weight management and fitness programs and 2,000 in smoking cessation efforts. Incentives fund the memberships in weight management programs, health mentors, gym fees, project management, staff evaluation, equipment, and travel expenses.

Cultural Competence

A new policy was developed in early July that addressed cultural competency and how it will be implemented throughout the bureau. Bureau staff is collaborating, to ensure effective adaptation and improvement of outreach to culturally diverse populations to facilitate the delivery of necessary behavioral health services and supports.

CMHC websites currently offer language change options for Spanish speaking individuals; however, communications for other ethnicities are deficient. Long-term supports and services are currently being published to assist consumers and family members in the state.

Each CMHC, in conjunction with the National Alliance on Mental Illness (NAMI), offers outreach services that go into the community and address the cultural differences including, languages, and native behaviors. The centers include these efforts in their strategic planning guidelines. The bureau is not responsible for monitoring this effort. The Office of Minority Health and Refugee Affairs (OMHRA) perform this task under the guidance of the Department of Mental Health.

OMHRA has a strategic plan to provide culturally competent mental health screening services to refugees and minorities in the State of New Hampshire. The OMHRA collaborates with contracted agencies to provide a wide array of supportive services such as language interpreters,

language teaching services, and case management to assist people with resettlement. The OMHRA has a Communication Access Plan to support their commitment to providing meaningful communication assistance to New Hampshire's increasingly diverse population.

Recommendations

- While the team acknowledges, the state has made some effort to increase their cultural competency for full inclusion of diverse populations, the state should continue to encourage and support the outreach efforts of their OMHRA. In addition, the state should consider the development and implementation of community outreach activities that address cultural differences, which should include languages and native behaviors.
- The state should also consider providing more outreach to consumers and family members of different ethnicities that live in rural parts of the state, as this appears to be needed to enhance the membership of the consumer and family council, and the Behavioral Health Advisory Council.

Performance Data, Quality Improvement and Decision Support

In FY 2012, the number of adults served in CMHC was 37,062. Due to a lower poverty rate in New Hampshire, relatively higher overall health rankings, and the less restrictive federal definition of SMI than the state definition, New Hampshire's estimated rate for state-eligible adults is less than the federal estimate. Consequently, the state definitions are applicable to a smaller segment of the population served.

There were 11,038 (30 percent) adults served through eligible state-funded services according to the FY 2012 Uniform Reporting System (URS) data. Due to the economic downturn in New Hampshire, there has been an increase of 70 percent of adults seen in CMHC, who do not meet the criteria for state-eligible services, who may not have private insurance or Medicaid, and who have low income. The community mental health system is the resource most utilized by this segment of the population. Reports continue to indicate, the level of uncompensated care is unsustainable for the public mental health system, without additional funding, Medicaid reform, and other health insurance coverage reform.

The number of children served in CMHC in FY 2012 was 12,622 of which, 9,260 (73 percent) were eligible for state funded services. As with adult services, this level of uncompensated care is unsustainable. Over 25 percent of children seen in CMHC, do not meet the criteria for state eligible services, may not have private insurance or Medicaid, and may come from low income families.

New Hampshire State Epidemiological Outcomes Workgroup for Mental, Emotional and Behavioral Health (SEOW-MEB)

The SEOW is a group of data analysts and specialists with access to epidemiological and other data that provide information on substance abuse and mental health problems in New Hampshire. This workgroup meets bi-monthly and has an established charter, membership structure, and an operational plan, updated regularly. Members report out to an oversight committee comprised of state-level administrators from the NH Bureau of Drug and Alcohol Services (BDAS) and the New Hampshire BBH. They also serve in an advisory capacity to the New Hampshire

Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment. The SEOW member from BBH provides data to the New Hampshire Behavioral Health Advisory Council (NHBHAC), for monitoring and evaluation awareness.

SEOW accomplishes its mission of promoting analytical thinking and methods in support of improved mental, emotional and behavioral (MEB) health in New Hampshire through the interpretation of data from a variety of sources, such as:

- The determination of priority problems;
- Populations, and risk factors affecting the MEB health;
- The development and dissemination of accessible data products; and
- Establishment of regular analysis of key MEB indicators for community and population health monitoring.

The most recent activities of the SEOW include the following publication:

- "Mental Illness and Substance Use Hospitalizations in New Hampshire, 2000-2009: Rising Rates & Emerging Questions" by Peter Antal, Ph.D., an analysis of state hospital admissions for individuals with co-occurring substance use and mental health disorders;
- "Using Appreciative Interviews to Discover Social Capital Protective Factors for Community Health and Well-being: Positive propositions for the emergence of social capital as protective factors in the life of New Hampshire communities: A Qualitative Social Epidemiological Research Product of the NH State Epidemiological Outcomes Workgroup August 2012"; and
- Publication of a data brief specific to young adult substance abuse.

Program Integrity

The state develops Quality Improvement (QI) plans for program integrity based on standards outlined in their New Hampshire Administrative Rule. QI plans are also developed in line with contractual requirements with the program entities, federal reporting requirements, and evaluation plans or requirements of various grant awards. The National Outcomes Measurement System (NOMS) and Uniform Reporting System (URS) data are highly useful to the state and assist during their planning discussions. BBH ensures, data collecting and reporting on the NOMS for the MHBG, or providing URS Tables to National Resource Institute for use in compiling and analyzing state, regional, and national data reports is conducted in an efficient manner.

The BBH Director of the Quality Improvement (QI) Unit is responsible for MHBG QI and program integrity plans. As a result of the Olmstead decision, the unit has a staff of four, including the state planner.

The primary role of the planner is to provide general oversight of the block grant expenditures and reporting (utilization management). The planner also oversees the maintenance of the NHBHAC and the appropriate and effective use of MHBG dollars to support of the council's activities. Since the MHBG is largely dedicated to support peer services, the staff who oversee

the PSA services and contracts also attend to program integrity, in consultation from the planner and under the rules and contractual requirements.

When issues with PSA services are identified through an assessment, BBH Quality Improvement Unit, conduct:

- Compliance reviews;
- Assessments of utilization management;
- Propose recommendations for agencies when the evaluation indicate it would be beneficial; and
- Provide technical assistance in areas related to these selected priorities.

BBH will soon solicit a position that will provide management of the PSA contracts; communicate with the MHBG state planner, to attend to, utilization management and program integrity issues; and assure the timely data collection and reporting necessary for the three measures.

Data System Change and Integration

The service data system used by the State Mental Health Authority (SMHA) and BBH is named Phoenix and has the capacity to report race, ethnicity, gender, and age. However, race and ethnicity are often reported as, “unknown” by the CMHC. The current Phoenix system is currently under development. The improved system will allow the SMHA to manage a field for date of first contact and track information about how long it takes from initial call to date of first service. However, data will be lost if individuals do not ever enter service. For services, cost centers and procedure codes will be used. Phoenix will also have specified Time1/Time2 data on some variables such as living situation, employment, criminal justice involvement, and education. Data quality will depend on the comprehensiveness of the CMHC report. The SMHA will provide technical assistance to the CMHC to ensure standardized responses and accuracy of information.

The current Phoenix system does not provide any financial data but provides units of service information. The Medicaid system provides the financial data. Managed Care Organizations (MCO), control access to Medicaid data. The bureau accesses the data and reviews Medicaid financial information regularly. The MCO also generates various reports for the bureau as necessary, (i.e., the number of units of service per eligibility types). They are able to provide this information from the CMHC level down to the individual client level. BBH uses Medicaid claim queries to inform quality improvement measures and to determine, which clients are using the most Medicaid per agency.

Xerox electronic financial system: BBH has accessed data through another system (Electronic Data System) for many years. In an effort to update their financial data information dissemination system to an electronic integration information platform, the bureau has been phasing in a Xerox system in the last few years. The bureau is using both systems simultaneously, with complete transition to the Xerox claims system, coming within the next two-years.

BBH currently lacks the capability to gather or gain access to service data in this system but are able to obtain access through the CMHC. Each CMHC has its own separate electronic health system that is not integrated with the state hospital or any other CMHC. Upon full implementation of the Xerox system, the Medicaid office will work with the MCO to determine the flow of financial information through the new system and each CMHC will address the service data dissemination.

The bureau would like to access data on a specific CMHC, and the services and supports each client receives. Currently, a universal identifier is not available to track a client across DHHS. The Xerox system will have the capacity to identify a client through Medicaid. The annual consumer survey is an additional source of data that provides information regarding the individuals and services they are, or are not, receiving through the CMHC.

Consumer Satisfaction Survey

Currently, there is no focus on substance abuse analysis within the New Hampshire Public Mental Health Consumer Survey. There are three different response rates from adults, family and youths. A contractor handles the survey logistics, under the oversight of the BBH. The Office of Consumer Affairs set-up a site for consumers to complete the Peer Support Services survey electronically.

FY 2013 Consumer Survey

The Social Science Research Center at Old Dominion University conducts the administration of the New Hampshire Public Mental Health Consumer Survey. The survey was administered from March 19, 2013 through July 18, 2013 with 1,538 usable surveys collected from adults, youth, and family consumers. Some of the major findings include:

Adults

- Over 80 percent of the adult consumers reported, they are not offered, Evidence-based Supported Employment.
- Sixty-five percent of adult consumers were not informed by the CMHC, the availability of Peer-Run Crisis Respite as an alternative to psychiatric hospitalization.
- More than 79 percent of adult consumers are not employed.

Families

- Thirty-six percent of families that have children, 14 years of age and older, reported the CMHC staff began preparing their children for transition to adulthood.
- Eighty-six percent of families that reported being partners in their children's treatment planning process.
- Of the families that participated in this survey, 80 percent indicated, they were satisfied with the services provided.

Youth

- As a part of their treatment plans, 34 percent of youth that reported drug/alcohol problems were provided substance use services.
- Eighty-one percent of youth indicated satisfaction with services received.

- Eighty-six percent of youth agreed, they were active participants in their treatment process.

Prevention

The URS tables are used to develop prevention strategies in New Hampshire. That data has been used to introduce and implement Evidence-based Practices (EBP) statewide. The data also determines what public health approaches to use in improving the system. Consumer recommendations inform prevention strategies for the improvement of the behavioral health system (Healthy Changes, Healthy Choices, Illness Management, Older Adults, Warm Line, and Crisis Respite). The bureau contracts with NAMI New Hampshire (Connect Program, an EBP developed by NAM, addressing Suicide Prevention).

Recommendations and Technical Assistance

- The Quality Improvement Department, located within the state bureau, is currently understaffed. There are multiple vacancies and no funding to hire anyone at this time. The Olmstead Decision has mandated four new positions to be filled in the near future. New Hampshire should continue efforts in developing specific responsibilities for these positions.
- BBH should receive state-to-state technical assistance with regard to the Consumer Satisfaction Survey administration, including exploring new methods for survey distribution.
- The current data system in each CMHC allows for data to be collected and reports generated for their clients only. The systems are not integrated across centers and cannot access any other medical system including hospitals. New Hampshire should request technical assistance for the center providers upon implementation of the integrated system.

Adult Services

Overview

BBH is the SMHA that ensures the smooth and effective administration of its mental health programs and services. The adult services provide an array of contracted and state operated treatment services. There are in-reach and outreach programs, which are part of the state's rigorous prevention efforts in addressing its mental health challenges.

The recent settlement agreement obligates the state to ensure, remedies to address mental health infrastructure are closely adhered to; however, the agreement also requires additional funding and support to ensure compliance and full implementation of a comprehensive and robust community-based, system of care. Given the significance of the state responsibility to comply with this decision, New Hampshire continues to ensure the needs of its most vulnerable populations of adults with severe mental illness (SMI) and children with severe emotional disability (SED), are addressed. Standards of care in BBH programs and services require the utilization of evidenced-based programs and practices, use of trauma-informed approach, person-centered and adherence in practice to achieve success in programmatic planning and ultimately, consumer satisfaction.

Criminal Justice and Forensics

New Hampshire's adult population with SMI and non-violent criminal offender cases are reviewed in mental health courts. Several counties have mental health courts designed to link non-violent offenders to community-based treatment programs while under court supervision in an effort to ensure compliance with treatment, and as an alternative solution to incarceration.

As a growing need to promote awareness and increased ability to recognize mental health issues, the state held its initial Mental Health First Aid Training for law enforcement officers and community members. Recent training of 30 people will allow for the dissemination of knowledge in recognizing mental health signs and symptoms, crisis intervention and providing community referrals. Initial training of these community members will require them to each provide three trainings a year to maintain their certification as *First Aid* trainers.

Additionally, New Hampshire recently opened its Veteran's Court designed to handle criminal cases of veterans with substance use problems or mental health issues stemming from deployments. The Veteran's Court is intended to support veterans in their recovery, assuring intensive treatment and access to resources to support their resiliency and recovery.

Recovery Services

New Hampshire actively supports and engages in recovery services as part of their comprehensive system of care. The state offers supported housing and supported employment services. The Transitional Housing Program was created in partnership with BBH to provide assistance to consumers who are transitioning into the community. The program provides services to ensure consumers' medical, clinical, and vocational needs are addressed. This program not only provides holistic treatment planning, but is also a means of empowering consumer choices that result in an independent, productive life. The newly released settlement agreement has made provisions for more community crisis apartments, supported housing, and community residences. Community residences are designed to meet the needs of consumers with mental illness and complex health care needs. These provisions are consistent with the state needs assessment and Olmstead plan, "A strategy for Restoration" (the 10 Year Plan).

New Hampshire takes pride in its Peer Support Agencies (PSA) that are statewide. These are private, non-profit agencies, that provide services to consumers with mental illness with the objective of supporting the individual throughout their journey of recovery. PSAs provide support, wellness training, and outreach, including activities promoting independence and self-advocacy. The Crisis Respite program allows for a safe haven for those struggling with various behavioral health issues. Individuals have an opportunity to work through difficult times surrounded by caring, supportive peers. It is a non-medical alternative to hospitalization, providing a non-threatening environment and a means to discover their potential, to handle a crisis without losing the independence.

Trauma-informed Care

In January 2014, a New Hampshire Commission Report was submitted on Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury. The report focused on veterans' unmet health needs, barriers to treatment, the issues of bias within the community, when seeking care and ways of improving access to care. This report was written because of the survey, *Survey Helping*

to Advance Recovery Efforts, which had, as its objective, understanding the needs of veterans and improving accessibility to services and the quality of care.

Trainings in Trauma-Informed Care have been made available to providers, some of which utilize evidenced-based treatment interventions for trauma-related health needs. The state reported, the CMHC have been trained in Trauma Focused Cognitive Behavioral Therapy. The state supports this provision of care and efforts are currently underway to develop policies in the assessment of personal history of trauma and the appropriate use of trauma-focused treatment and intervention. The state currently uses a variety of assessment tools, including PTSD Checklist, Life Events Checklist, and UCLA Trauma Scale.

Evidenced-based Practices

The state reported, all CMHC utilize evidenced-based practices, although each center may differ in the application and use of such treatment, based on the needs of the communities they serve. At the time of the monitoring visit, the following are current evidence-based practices for adults:

- Assertive Community Treatment (ACT);
- Illness Management and Recovery;
- Supported Employment;
- Cognitive Behavioral Therapy (CBT); and
- Trauma Focused Cognitive Behavior Therapy (TF-CBT).

Some agencies use Integrated Dual Disorders Treatment, Dialectical Behavior Therapy (DBT) or Seeking Safety practices. PSA, employ WRAP and IPS practices. New Hampshire is developing a credentialing process for Peer Support Specialist.

Integration

CMHC are working on a partnership with Community Health Centers for consumers to receive medical and dental services. This effort is currently in progress as the state is working to integrate behavioral health in primary care settings. The CMHC and other agency contract providers are expanding their approach to a system of care that follows tenets of a holistic approach. Several programs statewide are focused on assessing mental health needs and overall physical functioning and wellness of consumers. Integration of the concepts of total wellness, resilience, and recovery characterizes the state effort of integrating mental health and physical health. PSA holds wellness meetings, nutrition education, smoking reduction, fitness and exercise activities, cooking classes, meditation, and Whole Health Action Management, strengths-based program as a means to develop healthy habits.

Prevention

The state has placed strong emphasis on prevention and health promotion initiatives. It has outreach and health promotion programs that target reducing barriers to services, and raising community awareness and enhancing participation in wellness programs. These programs include Healthy Choices-Healthy Changes, InSHAPE (a Self Help Action Plan for Empowerment), Peer Support Programs and Suicide Prevention. The wellness programs also provide consumers with mentors and gym memberships to facilitate success in achieving targeted wellness goals. New Hampshire has expanded its prevention objectives by

strengthening discharge-planning procedures and transition plans for those leaving in-patient care.

Re-engineered Discharge (Project RED) was launched in New Hampshire Hospital. With Project RED, patients are engaged in their aftercare plan to identify any potential issues that may lead to re-admission. The patients receive follow-up phone calls to ensure they are fully aware and understand their plans after discharge.

Consumer Services

The state Office of Consumer and Family Affairs (OCFA) is committed to providing information, education, and support to families and adults, dealing with mental health problems. OCFA provides one avenue for consumer needs to be addressed. The New Hampshire Mental Health Consumer Council has a strong presence and has been instrumental in empowering consumers. The council ensures, services and programs addressing recovery are strengthened.

Recommendations

- The state should identify a single point of contact or case manager for consumers who have complex mental health and physical issues or co-occurring mental health and substance abuse issues, including those identified as high risk for readmission to hospital. There should be policies and procedures in place to ensure the identification and elimination of any duplication or redundancy of services provided.
- The CMHC would benefit from the development of core competencies in each field of practice including, Integrated Behavioral Health and Primary Care, Peer Support Specialist and Case Management, and provider competency in therapeutic services.

Children Services

BBH oversees new program development and provides training and technical assistance to the community based mental health system with regard to the public mental health services for children.

Array of Services

The following programs provide services to children:

- Family Support and Education, including designation of a family liaison;
- Psychiatric diagnostic and medication services;
- Case management, including appropriate interagency involvement;
- Individual, family, and group therapy;
- Intake and assessment;
- Crisis intervention;
- Outreach support to children and their families, both in their homes and in community settings;
- Functional support services;
- Sexual offender assessments and treatment; and
- Specialty services for the treatment of attachment disorder.

New Hampshire focuses on outreach and community education. All of the state's CMHC, educate people in their catchment area. Additional services are available to consumers through town hall agency teams and social media.

Special Children Populations

Service coordination with the local area agency responsible for serving those with developmental disabilities are made available to children with SED, and those challenged in intellectual development. Additionally, agencies with the capacity to conduct applied behavioral analysis hire and train consumers in the community. Children with physical impairments are able to utilize handicapped accessible features, and those with medical issues are given care and coordination with other health services. The CMHC operate under a *no wrong door* policy. In this way, all children can receive a needs assessment, and identified treatment.

Agency Collaboration

Children with SED receiving mental health services may also receive services and assistance from child welfare, juvenile/criminal justice, education/special education, and substance abuse or housing agencies. These agencies coordinate with BBH to provide services and care to children with SED statewide.

These agencies are part of an inter-agency team that meets to discuss service collaboration activities. Meetings occur monthly and address the management of case specific issues. There are a number of centers with primary care offices in addition to innovative Boys and Girls Club and Head Start programs. The programs provide training to first fathers, local police and fire department staff. New Hampshire has a system of care initiative that is housed within the Division of Children, Youth, and Families, which coordinates care management and a variety of children services.

The CMHC often review cases to address specialized needs of children and their family that are not directly related to their mental health issues. CMHC additional supports are designed to assist families in times of hardship, such as providing food and clothing for the family. The Department of Education also collaborates with this effort.

School-based Services

BBH has been working to increase access to behavioral health services within low-income areas of the state. The bureau supports an integrated systems framework in each of the schools that includes volunteers in every school throughout the region. A promising service for children is the Rehabilitation for Employment, Natural Supports, Education and Work (RENEW) program. It is designed to address the needs of youth with emotional/behavioral challenges, including the need for self-determined planning and services. The key features of the RENEW intensive model are:

- self-determination,
- creative and individualized school-to-career services,
- unconditional services and supports,
- strengths-based approach,
- emphasis on building relationships and linkages in the community,

- flexible resource development and funding,
- wraparound team development, and
- workplace or career-related mentoring.

BBH is finalizing a comprehensive plan, which will be submitted in August 2014. The plan will encompass individual agency input and collaboration on all children services and supports.

BBH's goal is for all school-based behavioral health interventions to be available statewide. One region offers individual and family therapy including, psychiatric services in the school. BBH also plans to expand this program to other schools to ensure all children receive psychiatric services. As in many states, rural areas are particularly challenging due to the distance of the CMHC and a lack of transportation; it is difficult to get children to clinics. To address this difficulty, services are offered in schools and in the home. Functional support workers also go into classrooms to provide model behavioral interventions and support children through one-on-one interactions. Some classrooms also provide physical supports and teach coping skills. The schools grant, healthy services, include a wraparound center person and integrated access to intervention and health centers.

New Hampshire's focus for child services is *family-driven* and *youth-guided*. These are the principles that guide the BBH efforts for their children's behavioral wellness program and its system of care. BBH welcomes the inclusion of parents in the child's treatment and recovery process. Parental involvement is always encouraged; and the primary objectives reflected throughout the treatment plan are encouragement and support of the child within the home environment. BBH staff promotes multi-layer services and supports to sustain the family dynamic and assist the child in recovery.

Mental Health Planning Council

The mission of the of the New Hampshire Behavioral Health Advisory Council (NHBHAC) is to bring consumers and families representing children and adults throughout the life span, and other stakeholders, together as partners and advocates in the creation, expansion, planning, monitoring, and evaluating of public behavioral health services and systems of care.

Overview

The New Hampshire Mental Health Planning Council was renamed the NHBHAC in July 2011. The advisory council is charged by federal statute, SAMHSA policy, and council bylaws to review the mental health block grant and make recommendations for the modification, monitoring, reviewing, and evaluating the public behavioral health service system. The council serves as a forum to bring consumers, family, and other stakeholders together as partners, to provide their voice through recommendations to the state regarding the state plan for community based services. The state has eight peer recovery centers, six satellite locations, and outreach programs. Over 60 percent of the peer centers budgets come from the MHBG, which allocates 85 percent of its discretionary funding to support these centers. The council affirmed that peer support services are located throughout the states, 10 regions. Four of these sites and one outreach program are located in the state's most rural region (the northern most region of the state).

Membership

The council bylaws were revised and approved March 12, 2013. The bylaws state, the council may have up to 35 members, serving terms of four years, with no more than two additional terms. NHBHAC currently has 26 members of which 50 percent are consumers, family members, and advocates. Membership terms are staggered, allowing for one-third of the membership terms to expire each year. The mandatory membership not represented, are parents of a child with SED. The BBH Administrator or designee appoints individuals to council membership. The NHBHAC meets monthly and all meetings are held in Concord. Reportedly, members are reimbursed for travel.

NHBHAC Activities

The principles of recovery and resilience, and person centered planning, are regularly discussed at the council meetings. Most council members and consumers have attended trainings modeled after Mary Ellen Copeland's of Wellness Recovery Action Plan (WRAP) and Sherry Mead's Respite Center and Intentional Peer Support programs.

New Hampshire also supports an annual peer conference for over one hundred participants.

The state commitment to develop a recovery-based system of care is apparent by ensuring consumer and family driven decision-making, which exists at all levels. Within BBH there is a Consumer Council that meets monthly, with some of the same members as the NHBHAC. This group has 25 members and no restrictions with regard to attendance.

BBH provides ongoing staff support for the council during their subcommittee meetings. According to current members, NHBHAC has developed by becoming more active and providing a more accurate assessment of the block grant plan.

The current administrator has made a personal commitment to work closely with the NHBHAC and other statewide peer groups. The administrator attends monthly meetings with the council and discusses problems and possible solutions, responding to the content of various reports. Several council members indicated they felt they were heard and their opinions were respected. Other members stated, the administrator related well with the council and the council was stronger because it was empowered.

At the time of the monitoring visit, the state had lost revenue in the previous five years, and services statewide suffered. The administrator reported a previous shortfall of \$24 million, and services had to be cut from the budget, when he assumed office. The NHBHAC reported, it viewed the lack of access to inpatient hospital beds, crisis stabilization, and housing, as the most significant gaps in the current behavioral health system.

At the time of the visit, the current block grant plan had not been integrated with regard to the mental health and the substance abuse agencies; the agencies have yet to begin the integration of staff and programs. The council stated, it might need to focus more on the issues of the co-occurring population to sufficiently address their needs. While, the council has representation from the substance abuse agency and several of the members work in the substance abuse field,

members expressed concern, that the needs of those with co-occurring mental illness and substance use disorders are being overlooked.

Recommendations and Technical Assistance

- **The** NHBHAC lacks the mandatory representation for a parent, of a child with SED. The council must address this issue within 30-days of receiving this report (if it has not already done so), as this is a MHBG compliance issue. The council should also receive technical assistance from SAMHSA to evaluate whether one member of a child with SED is sufficient for the state.
- The council should receive more information from the state on the current issues of the co-occurring population.
- The state and council should increase outreach efforts to develop cultural diversity and regional representation on the council.
- The council should consider scheduling and advertising meetings in rural areas throughout the state to develop and encourage diversity.
- The state/council should also receive technical assistance to provide orientation on the council's statutory responsibilities.
- The council should consider developing stronger relationships with veteran organizations, substance use consumers, and conducting more outreach to rural areas.
- The council should educate providers and peers on the needs and issues of the co-occurring population.

Consumer and Family Member Involvement

Peer Support Services

BBH and the Medicaid agency do not provide for Medicaid reimbursed peer support services. New Hampshire has a long history of providing block grant dollars to support the training of peers and family members early in the recovery movement.

Several well-known, national recovery leaders have provided excellent training models for peers and family members within the state. Mary Ellen Copeland, provided trainings in her WRAP model in the early years of the development of this program. Another well-known advocate, Sherry Mead, developed models of peer support that New Hampshire is also currently employing, (i.e., Intentional Peer Support and Respite Care). This model became the national standard for Respite Care. The mental health agency also funds an annual consumer conference with several hundred paid travel opportunities for peers.

Several of the eight regional peer centers provide 24-hour warm lines that address the questions and needs of people with mental illness. The NAMI provides several educational programs; Family to Family, Provider Education, and family support groups for adults, children, adolescents, clinicians, and peers statewide.

Mental health community providers support peer integration within their communities by referring clients to primary care agencies and peer provider groups throughout the state. There is

a mental health court supported in the state, which also refers clients to appropriate groups and resources.

Conclusion

The monitoring team commends BBH for its system of care approach to providing services to the citizens of New Hampshire. The bureau is making major system improvements to build a state level infrastructure supporting behavioral health services in the community, quality outcomes and data informed decision-making, system-wide community education, and workforce development through peer support services. BBH is also working to ensure responsible fiscal and programmatic oversight, accountability, and support for a comprehensive continuum of care that promotes resiliency, recovery, and inclusion.

The monitoring team appreciates the time and effort of BBH staff, state stakeholders, NHBHAC members, and consumer and family members who participated in this monitoring visit. The team was impressed by the commitment of all who participated in the interviews to maintain and improve mental/behavioral health services for citizens of New Hampshire.

Financial Management Report

This section presents the fiscal management responsibilities, systems capabilities, available documents, and established procedures, including provider reimbursement systems, funding sources and trends, and fiscal management capability and practices, particularly as they relate to the Mental Health Block Grant (MHBG).

Financial Management Organization

The MHBG award is administered by the New Hampshire Department of Health and Human Services (DHHS), Division of Community Based Care Services (DCBCS), Bureau of Behavioral Health (BBH). The DHHS, the largest agency in the state government, is responsible for the health, safety, and well-being of the citizens of the state. The DHHS provides services for individuals, children, families, and seniors and administers programs and services such as mental health, developmental disability, substance abuse, and public health. This is accomplished through partnerships with families, community groups, private providers, other state and local government entities, and many citizens throughout the state who help make New Hampshire a special place in which to live.

The DCBCS provides a wide range of support and services in partnership with community systems for individuals with developmental disabilities and acquired brain disorders, individuals with serious mental illness or emotional disturbance, adults aged 18 to 60 who have a chronic illness or disability, and individuals age 60 or older. The DCBCS is also comprised of several functional areas: behavioral health, developmental disabilities and acquired brain disorders, drug and alcohol services, elderly and adult services, homeless and housing services, and inpatient psychiatric services.

The BBH seeks to promote respect, recovery, and full community inclusion for adults, including older adults who experience a mental illness, and children with an emotional disturbance. BBH works to ensure the provision of efficient and effective services to those citizens who are severely and persistently disabled by mental, emotional, and behavioral dysfunction as defined by New Hampshire laws and rules. To this end, BBH has divided the entire state into community mental health regions. Each of the ten regions has a BBH contracted Community Mental Health Center (CMHC) and eight Peer Support Agencies (PSAs) provide support at 14 sites throughout these regions.

Fiscal Operations

The financial administration of the MHBG is managed by the Financial Management Unit (FMU) under BBH, which functions as the business office not only for BBH but for several other bureaus within DCBCS. The functions of FMU include payment processing, budget entry into the state's accounting system, cost allocation, and preparation of management reports. The FMU also has a reimbursement section that is responsible for the reimbursement functions of BBH. These functions include billing private and third-party payers, accounts receivable, interviewing patients to determine ability to pay, and estate collection.

Provider Operations

The BBH provides mental health services to adults and children through the CMHCs and PSAs. However, the MHBG in New Hampshire is used primarily to fund PSAs. The PSAs are all private, non-profit, consumer-run organizations, which provide:

- face-to-face and telephone peer support;
- educational events;
- wellness training;
- crisis respite;
- transitional housing; and
- twenty-four hour, short-term, non-medical crisis services.

The PSAs, which are funded on a historical basis, must respond to a request for a proposal each year. The funds awarded to the PSAs are considered grants. BBH contracts with PSAs are issued for a two-year period and include the amounts of each source of funds available in the contract. All contracts in New Hampshire that exceed \$2,500 must be approved by the governor and executive council. The PSAs are required to submit, on a monthly basis:

- 1) a balance sheet,
- 2) a profit and loss statement,
- 3) an aged accounts payable report, and
- 4) a budget-to-actual comparison of revenues and expenditures.

BBH staff review the financial information and follow up with any questions resulting from the review. The PSAs are required to submit revised reports when adjustments are made by BBH. These reports allow BBH to determine how MHBG funds are being spent. The PSAs are generally paid 1/12 of their contract amount each month. The BBH draws MHBG funds from the Substance Abuse and Mental Health Services Administration (SAMHSA) at the end of each month after the expenditures have been made.

State Single Audit

The DHHS is a component of the state and, as such, the results of its financial operations are reported in the state's *Comprehensive Annual Financial Report (CAFR)* and Single Audit of Federal Financial Assistance Programs (SAFFAP) each fiscal year. The CAFR and SAFFAP are prepared by New Hampshire's Department of Administrative Services with the assistance of the independent auditing services provided by KPMG, LLC, a certified public accounting firm. The independent auditor's reports are prepared annually in accordance with the *Office of Management and Budget (OMB) Circular A-133, "Audits of States, Local Governments, and Non-Profits Organizations"* (A-133), to provide information about the state's expenditures of federal awards. The latest SAFFAP prepared, at the time of SAMHSA's monitoring visit, covered the fiscal year ended (FYE) June 30, 2013; but there were no findings or questions costs related to the MHBG program.

Subrecipient Monitoring

The BBH requires all of its contractors to submit annual financial statement audits to its Office of Improvement, Integrity, and Information. The majority of contractors do not submit A-133

audits because they do not meet the applicable threshold. The audits are reviewed and follow up questions are asked concerning any findings.

Closed Years and Appropriations

At the time of the monitoring visit, the most recently closed MHBG awards were the federal fiscal year (FFY) 2011 and FFY 2012 grants. SAMHSA awarded New Hampshire \$1,491,079 and \$1,613,013 in MHBG funds for FFY 2011 and 2012, respectively. New Hampshire reported expenditures of \$1,491,079 and \$1,613,013 for FFY 2011 and 2012, respectively.

Methodology

SAMHSA's Office of Financial Advisory Services (OFAS) staff interviewed several of FMU's staff to gather information and documentation of BBH's financial management of the MHBG awards and to trace amounts reported in DHHS' MHBG application and behavioral health reports for the FFY 2009 through FFY 2012 grants, to accounting reports from the state's accounting systems. OFAS staff also interviewed several of BBH's staff to gather information and documentation regarding the policies, procedures, and practices for procuring, contracting, and monitoring the providers of mental health services to adult and children. State staff provided expenditure information that was used to complete Tables 1-4 included in this report.

Observations

1. Fiscal Procedures for MHBG Awards – Inadequately Documented

- **Condition:** BBH did not have written fiscal policies and procedures (P&P) that address how the agency complies with requirements of the MHBG grant including;
 - (1) activities allowed or unallowed,
 - (2) allowable costs and costs principles,
 - (3) maintenance of effort and set aside expenditure requirements,
 - (4) period of availability of federal funds,
 - (5) financial reporting requirements,
 - (6) independent peer reviews,
 - (7) cash drawdowns,
 - (8) disbursements,
 - (9) invoice payment processes,
 - (10) federal financial reporting, and
 - (11) fiscal monitoring of providers.

In addition, BBH did not have written procedures to support the methods staff used to calculate:

- (1) MOE expenditures for state fiscal year (SFY) 2009 through SFY 2013,
- (2) administrative expenditures for the FFY 2009 through FFY 2012 awards, and
- (3) children's set-aside expenditures for the FFY 2009 through FFY 2013 awards.

- **Criteria:**
 - Per 42 U.S.C. 300x-4 (b), the state shall, for each fiscal year, maintain aggregate state expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the state for the two state fiscal years preceding the fiscal year of the grant.
 - Per 42 U.S.C. 300x-5 (b), the state may not expend more than five percent of grant funds for administrative expenses with respect to the grant.
 - Per 42 U.S.C. 300x-2 (a) (1) (C), the state shall, for each fiscal year, expend an amount not less than an amount equal to the amount expended in fiscal year 1994 for systems of integrated services for children with serious emotional disturbance.
 - Per 45 CFR § 96.30 “Fiscal control and accounting procedures be sufficient to (a) permit preparation of reports required by the statute authorizing the block grant and (b) permit the tracing of funds to a level of expenditure adequate to establish that such funds have not been used in violation of the restrictions and prohibitions of the statute authorizing the block grant.”
- **Cause:** BBH did not have sufficient fiscal control and accounting procedures to ensure the agency complied with MHBG requirements.
- **Recommendation:** BBH should develop and implement fiscal control and accounting procedures to ensure;
 - (1) agency staff develop P&P for complying with MHBG requirements,
 - (2) appropriate agency officials review and approve the P&P,
 - (3) agency staff receive adequate training, and
 - (4) there is ongoing review of staff adherence to established practices.

2. MOE Expenditures – Incorrectly Computed

- **Condition:** BBH staff reported MOE expenditures during the review that incorrectly included MHBG funds that were paid to a suicide prevention program. The expenditures amounted to \$75,399 in SFY 2010, \$73,186 in SFY 2011, and \$75,824 in SFY 2012.
- **Criteria:**
 - Per 42 U.S.C. 300x-4 (b), the state shall, for each fiscal year, maintain aggregate state expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the state for the two state fiscal years preceding the fiscal year of the grant.
 - Per 45 CFR § 96.30, “Fiscal control and accounting procedures must be sufficient to (a) permit preparation of reports required by the statute authorizing the block grant, and (b) permit the tracing of funds to a level of expenditure adequate to establish that such funds have not been used in violation of the restrictions and prohibitions of the statute authorizing the block grant.”
- **Cause:** BBH did not have sufficient fiscal controls and accounting procedures to ensure, MHBG funds were computed correctly.
- **Recommendation:** BBH should enact fiscal control and accounting procedures to ensure;
 - (1) agency staff develop acceptable methods for computing MHBG MOE expenditures,
 - (2) appropriate agency officials review and approve the methods, and

- (3) agency staff correctly compute and report MHBG MOE expenditures to SAMHSA on a consistent basis.

Expenditures reported to SAMHSA should be traceable to information maintained in the state's financial management systems. The methods used to calculate these amounts must be clearly documented and the individual amounts must be traceable to the state's financial management systems.

3. Maintenance of Effort (MOE) Waiver – Inadequately Documented

- **Condition:** Based on documentation provided during the review, BBH incurred a shortfall in the MOE expenditures for FFY 2009 (\$686,050) and FFY 2010 (\$4,741,672); however, BBH was unable to provide the waivers approved by SAMHSA for the MOE shortfalls.
- **Criteria:**
 - Per 42 U.S.C. 300x-4 (b), the state shall, for each fiscal year, maintain aggregate state expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the state for the two state fiscal years preceding the fiscal year of the grant.
 - Per 45 CFR § 96.30, "Fiscal control and accounting procedures be sufficient to (a) permit preparation of reports required by the statute authorizing the block grant and (b) permit the tracing of funds to a level of expenditure adequate to establish that such funds have not been used in violation of the restrictions and prohibitions of the statute authorizing the block grant."
- **Cause:** BBH did not have sufficient fiscal controls and accounting procedures to ensure, agency staff retained documentation of the MOE waivers approved by SAMHSA.
- **Recommendation:** BBH must develop sufficient fiscal controls and accounting procedures including P&P to ensure the state is able to maintain supporting documentation to confirm SAMHSA's approval of MOE waivers and findings of material compliance. BBH should also obtain and retain copies of the documents in question.

4. MOE Expenditures – Inaccurately Reported

- **Condition:** During the monitoring visit, BBH staff provided supporting documentation, which indicated that the amount of MOE expenditures reported to SAMHSA in the state's plan for FFY 2009 was not accurate (overstated by \$4,414,314). In addition, BBH reported inaccurate MOE expenditure amounts to SAMHSA in the state plans for FFY 2010 through FFY 2012.
- **Criteria:**
 - Per 42 U.S.C. 300x-4 (b), the state shall, for each fiscal year, maintain aggregate state expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the state for the two state fiscal years preceding the fiscal year of the grant.
 - Per 45 CFR § 96.30, "Fiscal control and accounting procedures be sufficient to (a) permit preparation of reports required by the statute authorizing the block grant and (b) permit the tracing of funds to a level of expenditure adequate to establish that such

funds have not been used in violation of the restrictions and prohibitions of the statute authorizing the block grant.”

- **Cause:** BBH did not have adequate internal controls to ensure MOE expenditures were computed correctly or that subsequent adjustments to earlier reported amounts were adequately documented and used to amend prior reports.
- **Recommendation:** BBH should develop appropriate internal controls including written P&P to ensure;

- (1) MOE expenditures are computed correctly and reported consistently for related reporting requirements,
- (2) adjustments and modifications to previously reported expenditures are adequately documented, and
- (3) prior reports are revised accordingly.

5. Expenditures for Services for Children with Serious Emotional Disorders (SED) – Inaccurately Reported

- **Condition:** During the monitoring visit, BBH staff provided supporting documentation, which indicated that the amount of expenditures for services for children with SED reported to SAMHSA in the state’s plan for FFY 2010 and FFY 2013 was not accurate (overstated by \$480,559 and \$613,858).
- **Criteria:**
 - Per 42 U.S.C. 300x-2 (a) (1) (C), the state shall, for each fiscal year, expend an amount not less than an amount equal to the amount expended in fiscal year 1994 for systems of integrated services for children with serious emotional disturbance.
 - Per 45 CFR § 96.30, “Fiscal control and accounting procedures be sufficient to (a) permit preparation of reports required by the statute authorizing the block grant and (b) permit the tracing of funds to a level of expenditure adequate to establish that such funds have not been used in violation of the restrictions and prohibitions of the statute authorizing the block grant.”
- **Cause:** BBH did not have adequate internal controls to ensure MOE expenditures were computed correctly or that subsequent adjustments to earlier reported amounts were adequately documented and used to amend prior reports.
- **Recommendation:** BBH should develop appropriate internal controls including written P&P to ensure that

- (1) MOE expenditures are computed correctly and reported consistently for related reporting requirements,
- (2) adjustments and modifications to previously reported expenditures are adequately documented, and
- (3) prior reports are revised accordingly.

6. Expenditures for Services for Children with SED – Inadequate Documentation

- **Condition:** BBH maintained excel spreadsheets to support the state’s expenditures for services for children with SED for FFY 2009 through FFY 2012, but the spreadsheets were not adequate to validate the expenditures.

- **Criteria:**
 - Per 42 U.S.C. 300x-2 (a) (1) (C), the state shall, for each fiscal year, expend an amount not less than an amount equal to the amount expended in fiscal year 1994 for systems of integrated services for children with serious emotional disturbance.
 - Per 45 CFR § 96.30, “Fiscal control and accounting procedures be sufficient to (a) permit preparation of reports required by the statute authorizing the block grant and (b) permit the tracing of funds to a level of expenditure adequate to establish that such funds have not been used in violation of the restrictions and prohibitions of the statute authorizing the block grant.”
- **Cause:** BBH did not have sufficient fiscal controls and accounting procedures to ensure the state’s methods for computing and reporting expenditures for systems of integrated services for children with SED were adequately documented.
- **Recommendation:** BBH should develop appropriate internal controls including written P&P to ensure;
 - (1) expenditures for services of integrated services for children with SED are computed correctly and reported consistently for related reporting requirements,
 - (2) adjustments and modifications to previously reported expenditures are adequately documented, and
 - (3) prior reports are revised accordingly.

7. Capital Expenditures – Incorrect Allocation

- **Condition:** BBH mistakenly used MHBG funds instead of its state general funds to pay the H.E.A.R.T.S. Peer Support Center \$14,167 for capital expenditures to open and run a two-bed peer-operated crisis respite program.
- **Criteria:**

Per 42 U.S.C. 300x-5 (a), “...the state involved will not expend the grant to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or any other facility, or purchase major medical equipment.”

 - Per 45 CFR § 96.30, “Except where otherwise required by federal law or regulation, a state shall obligate and expend block grant funds in accordance with the laws and procedures applicable to the obligation and expenditure of its own funds. Fiscal control and accounting procedures must be sufficient to (a) permit preparation of reports required by the statute authorizing the block grant, and (b) permit the tracing of funds to a level of expenditure adequate to establish that such funds have not been used in violation of the restrictions and prohibitions of the statute authorizing the block grant.”
- **Cause:** BBH did not have sufficient fiscal control and accounting procedures to ensure the agency recorded the transaction in question, correctly.
- **Recommendation:** BBH must determine if the transaction in question is an unallowable MHBG expenditure based on the state’s procurement policies. If the agency determines the expenditure is unallowable, BBH staff should make an adjustment to its accounting records to re-allocate the expenditure to an appropriate funding source or make arrangements to reimburse the amount of the expenditure to SAMHSA.

Obligated and Expended Funds

Table - 1. Summary of Obligated and Expended Funds¹

Federal Fiscal Year	Total Award	Obligation Period	Amount Obligated	Expenditure Period	Amount Expended
FFY 2009	\$1,603,631	10/01/08 – 09/30/10	\$1,603,631	10/01/08 – 09/30/10	\$1,603,631
FFY 2010	\$1,510,763	10/01/09 – 09/30/11	\$1,510,763	10/01/09 – 09/30/11	\$1,510,763
FFY 2011	\$1,491,079	10/01/10 – 09/30/12	\$1,491,079	10/01/10 – 09/30/12	\$1,491,079
FFY 2012	\$1,613,013	10/01/11 – 09/30/13	\$1,613,013	10/01/11 – 09/30/13	\$1,613,013

¹Any amounts paid to the state for a fiscal year shall be available for obligation and expenditure until the end of the fiscal year following the fiscal year for which the amounts were paid (42 U.S.C. 300x-62).

State MOE Expenditures

Table - 2. State MOE Expenditures¹

Period³	State Expenditures²	Previous Two-Year Average Expenditures	Percent Over/ (Under) MOE Requirements
SFY 2009	\$44,121,137	\$44,807,187	(1.53%) ¹
SFY 2010	\$39,776,194	\$44,517,866	(10.65%) ²
SFY 2011	\$39,960,238	\$41,948,666	(4.74%) ³
SFY 2012	\$48,933,630	\$39,868,216	22.74% ⁴
SFY 2013	\$48,753,152	\$44,446,934	9.69%

¹The state shall, for each fiscal year, maintain aggregate state expenditures for community mental health centers at a level that is not less than the average level of such expenditures maintained by the state for the two state fiscal years preceding the fiscal year of the grant (42 U.S.C. 300x – 4 (b)).

²Actual expenditures listed under the “State Expenditures” column are averaged, and the average of the two-year period is placed in the “Previous Two-Year Average Expenditures” column on the line next to the fiscal year studied.

³The state fiscal year listed in Table - 2 should cover the two most recently completed state fiscal years.

¹For SFY 2009, BBH incurred a MOE shortfall of \$686,050 and did not have a waiver from SAMHSA.

²For SFY 2010, the MOE BBH reported to SAMHSA, included federal funds of \$75,399; resulted in a shortfall of \$4,817,071; and was not supported by a waiver from SAMHSA.

³For SFY 2011, the MOE BBH reported to SAMHSA included federal funds of \$73,186; resulted in a shortfall of \$2,023,914; and was supported by a waiver from SAMHSA.

⁴For SFY 2012, the MOE BBH included federal funds of \$75,824.

Children's Set-Aside Expenditures

Table - 3. Children's Set-Aside Expenditures¹

Period	State Children's Set-Aside Expenditures	MOE Base	Difference Over/(Under)
SFY 1994 (Base)		\$3,828,725	
FFY 2009	\$15,583,474	\$3,828,725	\$11,754,749
FFY 2010	\$16,302,653	\$3,828,725	\$12,473,928
FFY 2011	\$15,806,155	\$3,828,725	\$11,977,430
FFY 2012	\$16,094,942	\$3,828,725	\$12,266,217
FFY 2013	\$16,389,005	\$3,828,725	\$12,560,280

¹The state shall, for each fiscal year, expend an amount not less than an amount equal to the amount expended in fiscal year 1994 for systems of integrated services for children with serious emotional disturbance (42 U.S.C. 300x – 2 (a) (1) (C)).

Administrative Expenditures

Table - 4. Administrative Expenditures¹

Period	Maximum Allowable Expenditure	Maximum Allowed Percentage	Actual Expenditure	Difference Over/(Under)	Percentage of Difference
FFY 2009	\$80,182	5%	\$80,182	\$0	100%
FFY 2010	\$75,538	5%	\$75,538	\$0	100%
FFY 20 11	\$74,554	5%	\$74,554	\$0	100%
FFY 2012	\$80,651	5%	\$80,651	\$0	100%

¹The state may not expend more than 5 percent of grant funds for administrative expenses with respect to the grant (42 U.S.C. 300X – 5 (b)).

Appendix A- Listing of Federal Monitoring Team Members

Rasheda Parks, MHBG Federal Monitor
Monique Browning, Interim MHBG Project Officer
Marivic Fields, MHBG Project Officer
Bonnie Pate, Recovery Support Specialist
Lisa Stallworth, MHBG Financial Officer

Appendix B- Listing of State Staff Interviewed

Geoffrey Souther, Interim Administrator
Sarah Emerson, Assistant to the Director
Lorrie J. Ripley, State Planner
Patricia Reed, Children's Director
Chip Maltais, Adult Services
Mary Brunette, Medical Director
Michelle Hanan, CMHC Administrator
Thomas Grimey, Program Planner Office of Consumer Affairs
Kelley Capuchino, Administrator, Medicaid Policy
Peter Reid, Financial Manager
Janet Horne, Data Analyst
Elizabeth Fenner-Lukaitis, Acute Care Services Coordinator
Emily Larson, Word Processor