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JEFFREY A. MEYERS
COMMISSIONER

July 6, 2017

Via Email (.pdf) and First Class Mail

Mr. Stephen Day
Senior Consultant
TAC Collaborative Assistance
31 Saint James Avenue, Suite 710
Boston, MA 02116

Re: Amanda D.; Expert Reviewer Report No. Six

Dear Mr. Day:

The Department has reviewed your June 30, 2017, report. We appreciate that you have recognized the significant progress the State has made in achieving the objectives of the Community Mental Health Agreement (CHMA). Among the areas of progress are increased supported employment penetration rates, transitions of individuals from the Glencliff Home to community-based, integrated settings, the Quality Service Review (QSR) process, reporting of the Central Team information, promulgation of the supported housing and Assertive Community Treatment (ACT) rule and increased data reporting on various components of the CMHA.

We also appreciate your acknowledgement of the very significant investment in community mental health resources that are included in the State's new Fiscal Year 2018-19 biennial budget that were collaboratively developed and supported by Governor Sununu, the Department, legislative leadership and stakeholders. These new resources, including new community-based designated receiving facility beds, community residential beds, a fourth mobile crisis team and a critical assessment of the infrastructure needs of the State's mental health system will significantly strengthen our mental health treatment capacity.

Your new report continues to cite shortfalls in the State's compliance with Assertive Community Treatment (ACT) Services and Glencliff Home Transitions. We believe that your report's characterization of these two areas presents an incomplete picture of the State's actual progress and, in the case of ACT Services, fails to acknowledge growing evidence that the State has achieved maximum saturation for these services.

I. ACT Services – The State is at maximum saturation for ACT services.

ACT team service is a comprehensive evidence-based practice that is appropriate for people who have the most intractable symptoms and the greatest level of functional impairment, who need intensive supports in order to maintain recovery in the community, rather than in institutions. ACT was developed to help people with severe psychotic and mood disorders live successfully in the community. The research establishing the efficacy of ACT focused on people with SMI schizophrenia and bipolar disorders whose impairments led to frequent hospitalizations, homelessness and criminal justice involvement.

Since the execution of the CMHA, the Community Mental Health system in New Hampshire has recognized that a measurable proportion of the individuals presenting in New Hampshire suffer from borderline personality disorder. While our administrative rule He-M 426.16 (3) provides that individuals with borderline personality disorder will not be ruled out just because of their diagnoses, ACT is not the best practice method for providing services to these individuals because persons with these personality disorders do not respond well to the intensive case treatment model of ACT.

The State believes that the CMHA levels of ACT services are too high and should be adjusted to match the population New Hampshire serves.

Based on the number of ACT staff as of March 2017, the State had the capacity to provide ACT to 1,173 people at the 1:10 ratio. As you know, the parties to the litigation that resulted in the CMHA negotiated that New Hampshire would have the capacity to serve 1,500 consumers. The CMHA does not establish the number of persons who are to be served by ACT teams.

Beginning in spring 2016, DHHS worked with CMHCs to ensure that all consumers were screened to assess whether ACT would be a clinically appropriate service to help them with their recovery. CMHCs screen people at intake, if they have been in the emergency room, after discharge from a psychiatric hospitalization, and at quarterly treatment plan reviews. Since that time, the Department has been developing strategies to promote screening (via sending databases) and to engage the centers in a regular, documented screening process. The State will begin to have regularly entered Phoenix data on all ACT screening activities in late summer 2017.

In 2017, among New Hampshire's estimated 1,090,600 adults, 0.089% were receiving ACT services. One published study modeled appropriate numbers served and found that .06% of a state's population would need ACT services. This figure is calculated based on individuals needing three or more psychiatric hospitalizations for serious mental illness (SMI) in the past year. This study translated to New Hampshire only needing to provide ACT services for 790 individuals. In contrast, at this time, New Hampshire is serving 970 individuals, a much higher number than were estimated to need ACT with these methods, with a current capacity to serve 1,173 individuals. *See G. Cuddeback, J. Morrissey and P. Meyer, How Many Assertive Community Treatment Teams Do We Need, Psychiatric Services, Vol. 57, No. 12, December 2006.*

DHHS also reviewed National Outcome Measurement System (NOMS) data for the proportion of people eligible for rehabilitation services that received ACT in other states. The most recent data available is from 2015. The national average of ACT enrollment in states was 2%. In comparison, New Hampshire provided ACT services to 7.8% of eligible consumers in 2015 and 9% in the winter quarter of 2017. While New Hampshire believes that the 970 individuals currently being served benefit from ACT services, it does not believe that there are significantly more individuals who require ACT services.

ACT Teams – Work force issues continue to be a challenge for full staffing of ACT teams.

All of the ten community health centers have ACT teams. As of May 2017, New Hampshire's ACT teams ranged in size from 4 to 21 staff, excluding psychiatrists. The CMHA states that each CMHC will have an ACT team with 7-12 staff. As of Spring 2017, some ACT teams were missing certain members, including: peer specialists on two teams at one community mental health center, a substance abuse treatment specialist on one team and supported employment specialist on one team.

The NH Community Behavioral Health Association issues a monthly report, which demonstrates the difficulties CMHCs are incurring with hiring necessary staff. Given the nationwide shortage of psychiatrists and the improved economy in New Hampshire, staffing challenges will continue. Additionally, as the State made clear throughout this case, building excess capacity simply to have it in existence, even if there are no individuals to use that capacity, is not reasonable or cost effective. As a result, at this time, the State has the capacity to serve more than 200 additional individuals than currently are requesting ACT services. It does not make sense to build increased capacity.

As a result of the better understanding of New Hampshire's population of individuals with SMI and efforts to increase intake for ACT services, New Hampshire believes that it has reached its saturation point with respect to ACT services and believes that the parties should reconsider the CMHA requirements for increased ACT services and plan for possible reallocation of the funds for those services. For example, as noted in your report, the current mobile crisis teams are making significant strides in diverting individuals from hospitalizations.

Glencliff Home Transitions

At the time the State entered into the CMHA, individuals residing in the Glencliff Home (GH) seldom would transition into the community. Part of that reality was based on federal regulations but some of it was based on a view that this would be the final residence for many of the individuals who lived there. This perception has been changed completely and, since signing the CMHA, more than 25 individuals have transferred to other residences. Not all of these transfers would qualify as transfers to integrated settings under the CMHA as several were to nursing homes. However, it needs to be recognized that for these individuals, these transfers moved them into their communities and close to family and friends who can more regularly visit with them. This has resulted in a much improved quality of life for these individuals and their families.

Additionally, the State believes that it has 11 out of the required 16 transfers of GH residents to integrated settings. The parties are continuing to discuss this matter, as noted in your report, and GH is continuing to move forward with adding more individuals to its queue of potential discharges and locating appropriate community settings for these individuals. For example, DHHS has outreached to dozens of community providers and is in the process of releasing a request for applications for providers to create additional integrated settings of 4 people or less and enhanced family support settings.

The State remains committed to the implementation of the Community Mental Health Agreement and to addressing the mental health and behavioral health needs of all its citizens beyond the limited measures of the CMHA. The State's commitment to mental health services in FY 2018 exceeds $130 million dollars when considering the resources allocated through the managed care program, the 1115 Building Capacity Transformation Waiver, the State payments to the Community Mental Health Centers, the new House Bill 400 measures and funding for the CMHA.

As New Hampshire continues to make significant investments in its behavioral health system, the experience and knowledge gained through the implementation of the Community Mental Health Agreement must be taken into account by the parties and the agreement must reflect the best practices for serving the needs of those who are among the most vulnerable of our citizens. We look forward to continuing to work with you to ensure that the CMHA is tailored to achieve that result.

As always, we welcome further conversation and input regarding this matter.

Sincerely,

Jeffrey A. Meyers
Commissioner

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