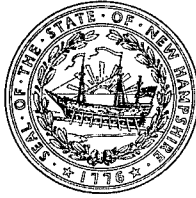


**ATTORNEY GENERAL
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December 6, 2011

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, Glenclyff 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

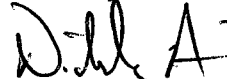
interpreted in the *Olmstead* decision. The threatened litigation by the federal government and federally funded advocates will waste precious state and federal taxpayer dollars that could be better spent on providing services.

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. Wicczorek, 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